



**A Qualitative Look at Early Childhood Oral Health and
Healthy Smile Happy Child Activities in Manitoba**

Report on Findings

**The Manitoba Collaborative Project for the Prevention of
Early Childhood Tooth Decay**

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INTRODUCTION

The Healthy Smile Happy Child Project was developed in response to the growing wait list for pediatric dental surgery under general anesthesia. Rather than relying on traditional oral health promotion, which has been shown to be essentially ineffective, this collaborative group adopted a community development approach to address the issue of early childhood tooth decay (ECTD) in Manitoba. Healthy Smile Happy Child has been guided by three fundamental principles, namely, relationship building and community development, oral health promotion, and research and evaluation. The project began as a demonstration project, partnering with 4 communities in Manitoba, but has now expanded to a province wide initiative in part to a grant from Manitoba Health.

One of the key objectives of the project has been to increase the knowledge of existing service providers and parents about the importance of prevention of ECTD and then work to build capacity within these programs. Healthy Smile Happy Child works with existing programs and services which target young children to give service providers and parents the tools they need to prevent ECTD.

All of the research conducted in the area of preschool oral health in Manitoba to date has been quantitative in nature. However, there is a growing realization that additional research methodologies are needed to uncover other issues that are impacting on infant and preschool oral health. There is limited qualitative on the topic of preschool oral health.

Healthy Smile Happy Child completed 6 focus groups during the Fall of 2007. The following is a report of the findings of these focus groups. Recommendations from the focus groups participants are compiled at the end of this report along with a response and subsequent action plan from the Healthy Smile Happy Child Project steering committee.

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EXECUTIVE SUMMARY

The Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay (MCP) recently undertook a qualitative research study to assess community members' knowledge and awareness of early childhood oral health and to evaluate the impacts of Healthy Smile Happy Child (HSHC) project activities. A series of six focus group discussions with parents, caregivers, health care professionals and other service providers were conducted at locations throughout Manitoba.

The findings from this research study provide a composite picture of what parents, caregivers and service providers may have gained (directly or indirectly) from HSHC activities. This will help HSHC to evaluate the progress it is making towards its goals and to plan future activities. However, given that focus groups were held in only a few of the communities that HSHC serves and that participants' experience of and access to oral health education and other services varies regionally, findings cannot be generalized to all HSHC activities in all regions of Manitoba. Also, because parents and caregivers were recruited through service providers, a reasonable assumption is that parents and caregivers who have not established relationships with service providers are underrepresented in the sample.

Parents' and caregivers' responses relating to the question *how do caregivers define early childhood oral health and view ECC* indicate that, in general, these participants have a well-developed understanding of early childhood oral health and its implications for children's overall health and well-being. They noted the important roles that nutrition and oral health care practices play in early childhood oral health. Their responses suggest that they understand and value the information they have gathered about oral health care and are making a real effort to take care of their babies' and young children's teeth, although, as they acknowledged, it is sometimes difficult for them to do everything they feel they should do to take care of their children's teeth. Every parent and caregiver group included participants whose children had had baby teeth removed and/or had gone through dental surgery, an experience that had been difficult for both the children and their parents.

Service providers' responses relating to the question *how do service providers define early childhood oral health and view ECC* focused on practices that support early childhood oral health. They emphasized the importance of parents establishing and maintaining good oral health routines for their children at an early age and ensuring that their children are provided with healthy age-appropriate nutrition. They recognized that many families' access to dental care is limited, particularly because of associated costs and the difficulty some parents have finding dentists who will see young children. The service providers have been involved in a broad range of educational activities and resource sharing to help parents and caregivers achieve optimal early childhood oral health. Encouragingly, many of their activities incorporate information, materials and activities available through HSHC, along with other education and prevention programs. Service providers identified hands-on activities and visual teaching materials as particularly effective ways to get oral health messages out to parents and caregivers; emphasized the importance of presenting parents with practical information and doable activities; and noted that it is important not to overwhelm parents with information or shame them. They also advised that, while they know that they are getting oral health

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messages out to parents, they cannot measure the extent to which this is changing parenting practices.

Parents' and caregivers' responses relating to the question *what are caregivers' perspectives on current early childhood oral health promotion and ECC prevention activities in Manitoba* indicate that they have learned a great deal about early childhood oral health care from service providers. They described the importance of cleaning babies' mouths, avoiding bottle propping, providing appropriate nutrition, and establishing oral health routines in early childhood. They suggested that hands-on activities, visual teaching methods and personal interaction are particularly effective ways to get information out to parents and families about dental health for babies or young children.

Service providers' responses relating to the question *what are service providers' perspectives on Healthy Smile Happy Child* offered both praise and helpful feedback. HSHC training and education sessions had increased their knowledge of early childhood health and helped them understand how to share that information with families. Generally, while participants appreciated the information and tools they had gathered at the training, some felt that more emphasis should be placed on practical strategies for implementing or using these resources with families. Others suggested that the training should be designed for a broad range of learning styles. Participants also asked that HSHC identify the most important oral health messages for parents and families.

Participants' responses, in the context of the question, *what are the similarities and differences among service providers and caregivers about their perceptions of oral health*, indicate significant concordance between how the service providers and parents and caregivers who participated in this study perceive oral health. Both groups provided similar definitions of 'healthy teeth' and 'good early childhood oral health', identified similar causes of ECC and drew links between the condition of children's baby teeth, their adult teeth and their overall health. Both participant groups identified personal interaction, visual presentations and hands-on tools as the best way to get oral health information out to parents. Both also referred to the negative impacts of limited access to dental care and the costs associated with care on oral health outcomes for children. Service providers' observation that it is important to maintain a positive and encouraging attitude when working with parents was affirmed by parents, some of whom described feeling shame about their children's poor oral health or hygiene and some of whom spoke honestly about their own struggles to get their children on board with good nutritional choices and oral hygiene routines.

Both parents and caregivers and service providers who participated in this study offered recommendations for further oral health promotion and ECC-related activities, including recommendations that will build communities and individual parents' and caregivers' capacity. Service providers called for more oral health-related training for health professionals and other service workers. Parents called for education for oral health practitioners to help them understand how not to shame parents. Parents also identified key messages that parents and other family members need to hear about oral health and offered recommendations about how to get those messages out. Both parents and service providers suggested involving a broader sector of service providers in oral health education activities than currently are, including the public school system and day cares. Both parents and service providers called for more meaningful access to oral health care services for all children and families throughout Manitoba.

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INTRODUCTION

The Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay (MCP) recently undertook a qualitative research study to assess community members' knowledge and awareness of early childhood oral health and to evaluate the impacts of Healthy Smile Happy Child project activities. This study complements other research work by MCP, including the published results of a baseline cross-sectional study of early childhood oral health in 4 pilot communities and a recently completed follow-up survey in these same communities.

Healthy Smile Happy Child (HSHC) draws on community development principles. A major objective of the project has been to increase parents', caregivers', health care professionals' and service providers' understanding of the importance of early childhood caries (ECC) and to build health care professionals', other service providers', and communities' capacity to support parents and other caregivers in the prevention of ECC. HSHC works with existing programs and services that target young children to give service providers and parents knowledge and tools that will help them to prevent ECC. HSHC's overarching goal is to support parents' ability to take care of their family members' oral health.

This research project was designed to assess the extent to which HSHC has met its objectives. Key questions explored in this study are:

1. How do caregivers and parents define early childhood oral health and view ECC?
2. How do service providers define early childhood oral health and view ECC?
3. What are caregivers' and parents' perspectives on current early childhood oral health promotion and ECC prevention activities in Manitoba (i.e., HSHC)?
4. What are service providers' perspectives on HSHC?
5. What are the similarities and differences among service providers and caregivers about their perceptions of oral health?
6. What recommendations do caregivers and service providers have for further oral health promotion and ECC activities?

By exploring these questions, HSHC hopes to gain a greater understanding of parents'/caregivers' and service providers' attitudes and beliefs about early childhood oral health and ECC; and to evaluate whether the capacity building approach used by HSHC has effectively increased knowledge and changed service providers' behaviour.

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With this knowledge in hand, HSHC will be able to assess whether its current health promotion strategies are making a difference in the community and find alternate ways to promote early childhood oral health and prevent ECC.

To answer these questions, focus group discussions with parents, caregivers, health care professionals and other service providers were conducted at locations throughout Manitoba. Participants were asked to share their understandings and experiences relating to early childhood oral health and to provide feedback on approaches used by HSHC to educate parents, other caregivers, health care professionals and service providers about early childhood oral health care.

METHODOLOGY

Focus group discussions are an effective way to learn about people's lived experience; how they think, feel and behave; and the attitudes, beliefs and conditions that shape their thoughts, feelings and actions. Focus groups provide participants with the opportunity to share their lived experiences and insights with the research and to gain knowledge and validation in their interactions with other participants. The questions explored in this project (what people are thinking and doing about early childhood oral health and ECC, and whether or not knowledge gains are translating into behavioural changes) fit well with focus group research.

A series of six focus groups (three with parents and caregivers and three with health care professionals and other service providers) were held at locations throughout Manitoba. Focus groups with parents and caregivers were held in Northern Manitoba (9 participants), Eastern Manitoba (6 participants) and a southern urban centre (10 participants). Focus groups with health care workers and service providers were held in Central Manitoba (8 participants), Northern Manitoba (6 participants) and a southern urban centre (11 participants).

For service providers, participation in the focus group discussions was restricted to those who facilitate early childhood programs (for children under 6 years of age); work directly with parents, caregivers and their families; and have previously attended HSHC workshops and received HSHC resources. Service providers who met these criteria were invited by letter to participate in the focus group discussions.

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For parents and caregivers, participation in the focus groups was restricted to those who have taken part in a group that received an HSHC workshop or other resources; and who presently care for children under 6 years of age. Parents and caregivers who met these criteria were recruited using flyers, which were distributed through service providers and posted in community centres.

The research team facilitating the focus group discussions included two experienced qualitative research assistants (one attending each discussion) and an HSHC staff member. Study design was approved by the Health Research Ethics Board at the University of Manitoba. The discussions followed established community research protocols. Before the formal discussion began, participants were asked to review and sign an Information and Consent Form. Participants were also asked for their consent to make an audio-recording of the discussion, which was permitted by participants in five of the six groups. In addition to the audio-recording, the research team recorded notes on the discussions on a flip chart. This gave participants an important opportunity to see how the research team understood and interpreted their comments. Participants were invited to review the notes throughout the discussion and to correct, delete or add to any inaccurate or inadequate representations of their comments. Food was provided at each focus group discussion and all participants were given a small honorarium when they left. To support community members' participation, childcare was provided at the three groups for parents and caregivers.

The focus group discussions followed a sequence of guiding and probing questions. Guiding questions were used to keep the group discussion focused on the overarching research questions and probing questions elicited more or specific detail or clarification from respondents.

One of the objectives of this research was to learn how parents, caregivers and service providers understand early childhood oral health and view ECC. To achieve this, it was crucial for the facilitator to maintain an open atmosphere that encouraged participants to share their experiences and to respond to participants' comments in a non-judgmental way. The facilitation team avoided taking up opportunities to 'educate' participants during the focus group discussions. However, the HSHC staff member made herself available to answer questions and share information with participants following the discussions.

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The notes taken at the discussions and recordings were transcribed and analyzed by the qualitative researchers on the team. When analyzing the data, the research team first looked at the data sets from each of the two participant groups (i.e., parents/caregivers and health care workers/service providers) independently, drawing out participants' responses to the overarching research questions. The team then looked at the data as a whole, noting whether or not findings from each of the groups concurred. As they reviewed the data at each step in the analysis, the team noted emerging themes in relationship to the research questions. Data from each set of groups (i.e., parents/caregivers and service providers) was then categorized and collated under each theme. A descriptive summary of findings is presented below.

FINDINGS

The findings from this research study provide a composite picture of what parents, caregivers, and service providers who participated may have gained (directly or indirectly) from HSHC activities. This, in turn, will help HSHC to evaluate the progress it is making towards its goals and to plan future activities.

However, the findings from this study cannot be generalized to all HSHC activities in all regions of Manitoba nor do the views expressed by participants necessarily reflect the views of all residents of a given region. Focus groups were held in only five of the eleven health regions in Manitoba and, as the findings indicate, participants' experience of and access to oral health education and other services varies regionally.

Since participants taking part in the parents'/caregivers' groups were recruited with assistance from workers at service providing organizations, it is reasonable to assume that many or most of the participants in these groups were parents who had established relationships with these workers or organizations. The corollary to this is that parents who are not part of this service loop (a group from which all health providers may have a great deal to learn) were likely underrepresented in the study sample.

Participants for the service providers' groups were recruited from lists of front-line workers who had attended HSHC training workshops. These lists were provided by regional HSHC facilitators. All focus groups were attended by the HSHC Project Coordinator, who had facilitated some of the training workshops held in the southern urban centre. To support participants' confidentiality and ability to speak freely in the

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focus group discussion, no one who had participated in workshops facilitated by the HSHC Project Coordinator was recruited for this focus group.

How do caregivers define early childhood oral health and view ECC?

The focus group discussions for parents and caregivers opened by asking *what 'healthy teeth' means for babies and very young children*. The first responses in each group referred to teeth being free from cavities or decay. Parents described healthy teeth as clean, strong and white and mentioned having a “healthy mouth” and “pink gums”. Parents in one group pointed out the importance of the “structure” of a child’s mouth and teeth, that teeth come in properly or straight, that teeth are not loose and that everything “works how it’s supposed to.” Parents also discussed the importance of good oral hygiene, noting that healthy teeth implies that they are being brushed or cleaned regularly or, in the case of babies, that their gums are cleaned with a washcloth. One participant stated that when she sees a child with “good teeth,” she thinks that the child is “well taken care of” and that “they have good hygiene.”

When asked if it is *important for children to have healthy baby teeth*, participants in all the parent groups indicated that it was. Parents in two groups drew a link between the condition of children’s teeth and their adult teeth, pointing out that lifelong oral health habits may be set in childhood. Parents also spoke of more immediate impacts. Poor oral health, they stated, can contribute to other medical problems, such as gum disease or stomach aches.

Another parent noted that children may be made fun of if they have bad teeth. One participant noted that it is difficult for parents to take their children for oral surgery, stating that “it’s really hard to put them through that suffering when it was totally preventable.”

When asked *what makes very young kids get cavities or decay in their baby teeth*, parents’ and caregivers’ responses focused on nutrition and oral health care practices. Parents in all groups noted that sugar intake (in the forms of juice, milk, candy and snacks such as fruit roll ups and cereal that are “just like candy”) contributes to decay.

Participants also discussed the important role that parents and caregivers have in early childhood oral health and health care. Parents in all groups identified “bottle propping” as a contributor to decay. As one participant in the Eastern Manitoba group stated, “If

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they fall asleep when they're nursing, that's really bad – or with a bottle as well.” Allowing children to sleep with a bottle or sleep immediately after nursing or giving children drinks other than water close to bed were also identified as causes of decay by participants in other groups.

Participants in Northern Manitoba emphasized parental responsibility for their children's oral health and health care. They noted that parents are responsible for brushing their children's teeth or showing their children how to brush their own teeth. They felt that parents should “lift the lip” to check for decay. They also indicated concern about sharing germs, offering the example of mothers who clean soothers by putting them in their own mouths.

Participants in the parent groups noted that, whether children are breast fed or bottle fed, it is important to clean infants' and babies' mouths, gums and teeth. They also acknowledged that not all parents are aware of or manage to do this. When one Eastern Manitoba participant commented that “[If a baby falls asleep while nursing], after you're done, you can wipe their mouth,” another participant responded, “But you don't think about that in the middle of the night.” Participants in another group pointed out that it's important for parents to know why mouth care for babies is important and offered a range of reasons why parents may not clean their babies' mouths, including: the baby doesn't open their mouth; the baby cries; or the parents think that baby teeth aren't important because they fall out and are replaced by adult teeth (described as a “second chance” at healthy teeth”).

Parents in the southern urban centre and the Eastern Manitoba group suggested that children may develop cavities or decay because of “something genetic”: “I know it's rare, but if you have some kind of iron or mineral deficiency, then your first teeth will come out badly.” Another participant in the same group noted that ECC may also be related to women's self-care during pregnancy: “I know some people that have [lost] layers of teeth, where their parents have been drinking and doing drugs and stuff with the mother.” Participants in all parent groups observed that diet during pregnancy and other aspects of prenatal care can affect a baby's oral health. One Eastern Manitoba parent related that she had been told by “people from the university dentistry program... that if you don't take care of your own teeth when you're pregnant, it can hurt your baby too. It was on a poster.”

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When asked *whether or not a child's teeth are healthy is linked to their overall health*, participants in all parent groups agreed that a link exists, offering many examples. One parent pointed out that cavities can lead to abscess, a swollen face, fever and bad breath. Other parents linked oral health problems to ear infections, blood infections, stomach problems and heart problems. Parents in the southern urban centre spoke at length about their understandings of the links between oral hygiene and the risk of infection for babies and very young children:

Participant 1:¹ Anything bad that's happening in your mouth, at some point you're going to be swallowing that bacteria and it can go through your stomach [and] cause other medical problems.

Participant 2: Sometimes ear infection, too, if they sleep with a bottle.

Participant 1: That's only if the milk leaks out and goes into the ear... You're never supposed to prop a bottle because they can get ear infections if they spit it out. Other than that, I think it's also if it pools... because they don't swallow the last swallow and it sits there... In the cheek and the back of your jaw and you ear's right close so an infection can run through the gums and up.

Parents in Northern Manitoba commented that whether or not a child's baby teeth are healthy may affect their self-esteem and that it also may affect their adult teeth, particularly for individuals who do not develop good oral hygiene habits in childhood.

Parents in the Northern Manitoba and Eastern Manitoba groups observed that when children have unhealthy teeth, they may experience so much pain that they become reluctant to eat, to chew or eat only "soft" foods (which excludes healthy choices like vegetables). One participant described her own child's experience: "I have a hard time with her eating. She's just [skinny]... Her teeth are so bad that it just hurts her to eat. She's going through surgery."

Participants were asked *how they take care of their babies' or young children's teeth*. In all groups, responses indicated that parents are taking up the information they have gathered about oral health care and making a real effort to take care of their babies' and young children's teeth. Parents in all groups reported that they were wiping their babies'

¹ When reporting exchanges between participants and/or the facilitator, participants are referred to as "Participant 1", "Participant 2", "Participant 1", etc., to distinguish who has said what. More than one such exchange is included in this report. The two participants in the first reported exchange are referred to as Participant 1 and Participant 2; the two participants in the second exchange are referred to as Participant 3 and Participant 4, etc. It should be noted that to protect participants' confidentiality and anonymity, regardless of whether any given person participated in more than one of the reported exchanges, new referents were assigned to each participant in each reported exchange.

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mouths, using infadents, either brushing their young children's teeth or helping or supervising their children with their own brushing, and providing positive modeling with their own oral hygiene practices. Some parents in the Eastern Manitoba and Northern Manitoba groups floss their children's teeth. Participants shared things that encourage their children to brush, such as children's spin brushes, children's flavoured and non-fluoride toothpaste, and songs and games during tooth brushing. Parents in all groups reported that they restrict sugary foods and junk food.

The parents acknowledged that they sometimes find it hard to do everything they feel they should do to take care of their children's teeth. If babies or children fall asleep when nursing or if mothers are nursing in the middle of the night, it can be hard to clean their mouths or teeth. In every parent group, participants described their children's resistance (expressed as crying, refusal or aggression) to brushing. They also observed that it can be hard to fit their children's oral health care needs into their own busy schedules, particularly for parents with large families. Group members shared strategies for managing this, including (as noted above) playing games or singing songs during tooth brushing, using child-oriented dental products, incorporating tooth brushing into bath time, or posting sticky notes as reminders.

Participants in the parent groups also spoke of their experiences with the dental profession. For some, these experiences contradicted what they had learned from service workers, other health practitioners and education materials. In the Northern Manitoba and Eastern Manitoba groups, participants shared stories about attempts to take their babies or very young children (under the age of two) to the dentist and being told to come back when the children were older. One Eastern Manitoba parent who had taken her one-year old child to the dentist was told that she hadn't needed to bring him because his teeth were fine. A year later, her child's teeth needed to be extracted. Another participant had not been able to get her young children in to see a local dentist:

They say that you should try to take your kids to the dentist right away. But I tried to take my kids when they were two and younger and the dentist was like, no, no, forget it. Bring them back when they're three. He wouldn't even look at them. In that book, it says six months. As soon as their teeth come in, it says to take them in. I tried both dentists in town here and they were like, "Bring them back when they're older."

Similarly, a participant from the Northern Manitoba group felt she had been brushed off when told that the local dentist would not see small children. Another parent from that

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group had seen early signs of decay in her child's teeth. Her local dentist did not seem concerned by this, so she took her child to see a dentist in Winnipeg, who, she noted, did help her. Parents in the Northern Manitoba group agreed that the dental professionals in their community need to work to improve services to very young children and their families and suggested that dental hygienists may need training specifically about how to work with children. Parents in all groups also indicated that the relatively high cost of dental services and the dearth of widespread public dental health programs for children and families make it difficult for some families to access dental care.

Every group included parents whose *children had had baby teeth removed and/or had gone through dental surgery*. In the southern urban centre group, one parent stated that a couple of her children had had teeth removed: "It was scary. They have to put them to sleep to do their dental work. You just have to be sitting in the waiting room, waiting for them to work." She noted that, while the surgery only took one day, she and her children had to wait a very long time to get surgery. "I was so happy to get in there and get it over and done with. It's like, 'Oh, now it's better.' Because I know that their teeth return when they're eight years old." The daughter of another participant in that group had gone through dental surgery at age three:

Participant: It was day surgery. We went into the hospital early in the morning and we were home for supper. It really traumatized her, because now she's thirteen and I practically have to tie her down to brush her teeth and clean her mouth. She doesn't like to brush her teeth or clean her mouth, ever since that. Even before that. For the pain, she was in a lot of pain, so her appetite, she lost a lot. She didn't eat much before the surgery. She wouldn't drink. She wouldn't drink water. The only thing she would drink was juice and pop. It got really frustrating for me because of the waiting list, with the doctor especially, because they wouldn't put her on the emergency list. You know how they have the wait list and the emergency list, just in case they get a cancellation. They wouldn't put her on that emergency list, so we had to wait all that time. In that time, she lost a lot of weight.

Facilitator: Did the dentist know that?

Participant: Yes. I'd bring her there. It was really frustrating for me because my daughter was three, she was in daycare. They saw her appetite changing, her mood, the pain. They saw how it affected her.

Facilitator: What did the dentist say when you talked to him about those things?

Participant: He'd tell me to give her more Tylenol and penicillin, or whatever they give to kids. I was thinking, 'I don't want to drug my daughter up just because of that.' So now she's thirteen. I know she's still traumatized by it. That was ten years ago. Even to go for a cleaning. I took them for a cleaning at the start of last school year and when I took her up there for the dentist, oh, it was hard! She

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cried the night before. I try to be really careful about it, just get them when they're older, because she cried. When I went to the dentist, she's asking the receptionist, "Does it really hurt just to get a cleaning?" They had to really calm her down. .. It was really hard for me, because all the work they needed to do on her baby teeth – those are just her baby teeth. Her two front teeth, she had to get them capped and whitened or whatever. Then all her back teeth. It was really hard. For parents and for kids.

In Eastern Manitoba, one participants' child was scheduled for dental surgery in the next month. The participant described her daughter's current condition:

[Her teeth are] just rotten and brown now. It used to be black but not it's just brown. And her front teeth are broken in half already. She's three. She's quiet. She's skinny. She does eat, but all she wants is cereal and I'm not going to just give her cereal all the time.

In addition to this parent, three other participants in the Eastern Manitoba group had taken their children for surgery. They talked about what this had been like for them, as parents:

Participant 3: It's hard to go for that surgery.

Participant 4: It's hard.

Participant 3: It's horrible!

Participant 4: Because you have to take your kid there. Then they take him away from you...

Participant 3: You're sitting there crying, and then when the kid comes out...

Participant 4: You have to sit there and wait and you can't go with him when he goes....

Participant 5: You feel bad.

Participant 4: I think it's a whole traumatizing...

Participant 3: Not just for them but for us.

Participant 4: And then when they come out! They come out of the surgery...

Participant 5: When my son got his done, I was thinking to myself, "I wonder if they're thinking I'm a bad parent now." I felt really guilty.

Participant 6: That's what I thought when I went to the dentist too with my daughters. I thought "Oh, no." But I didn't put pop and stuff in their bottles. I would give my daughters water at night because they do love drinking water all the time. It's either milk, water or juice.

Participant 5: And then when they take him to the day surgery, you're not allowed to go right in with them, so you feel bad for them.

Participant 4: That's why I say it's traumatizing for you! Because you have to...

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Participant 5: I found it torture. It's like torture because you're always with them and then just at that moment when they need you the most, you get pulled apart. And you feel real bad.

Participant 3: You sit there and you cry through the whole thing – or you're out there smoking like a champ! My kid, my kid! Can I go upstairs? Oh, go back downstairs.

Participant 4: When your kid goes for day surgery, because they have to go for anesthetic, you have to sign a form...

Participant 3: Yeah, that's the scary part!

Participant 4:.. Saying that if your child dies during surgery, you're not going to sue for it or anything...

Participant 4: Yeah, they gave her an anesthetic and then you have to sign, because her heart could stop or, you know? It's scary!

Participant 3: Because you have all these things running through your head. My god!

Participant 4: What if? What if? What if? ... When I took one of my kids, they let me go in with him until he was right out. But my other child, they didn't, because it was right at the hospital and the other one it was just at this little clinic. I'm glad I went but it was so scary, because they hooked him up to all these little things on his chest and then they put that thing over him and then they said, "Count up to three!" And then... [mimes passing out].

Participant 5: And it's scary not being in there, because you don't really know what they're doing.

Participant 4: Yeah. And then when they tell you what they're going to do, it's like, "Ugghh." They tape their little eyes down, because when they're under the anesthetic their eyes can open and get dried out. She told me this. I don't know if they do it at Children's but I know they did it at the clinic.

Participant 5: At Children's, they get them to drive this little toy car around. And then as they're getting closer to the operating room, they tell you to go. And then they make the kid go around the corner with that little toy car. But still they notice you're gone and you can hear them just crying.

Participant 4: Really, it's really a traumatizing experience, I find.

When the group was asked what it had been like for their children, participants explained that the most difficult part for children was after the surgery:

Participant 7: They're all lethargic and they're trying to cry and they're trying to, "Mommy!" and you're trying to hold your baby because they have to stay on the bed and you're sitting there crying and it's the worst thing you could ever go through. The after part is totally the worst. For both the parents and the little ones.

Participant 8: And they puke sometimes. They have a fever. It's not good.

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Parents in the Northern Manitoba group shared similar stories. One participant's child had decay along the gum line and had to undergo surgery under general anesthetic to fill cavities. This mother described the experience as horrible and heart-breaking for her. One parent's two-and-a-half year old child had traveled to Winnipeg for surgery to cap teeth and another stated that their child had undergone a procedure at the dentist's office without parental consent. Parents in this group recognized the risks associated with general anesthetic, but also noted that, in some ways, surgery under anesthetic can be easier for children, because they are not alert during the procedure.

Other observations from the focus group discussions with parents include:

- Many of the parents' comments suggest that they do not necessarily have the financial resources to care for their children's teeth in all the ways they would like to. Participants appreciated supports that helped ease the cost of oral health care, ranging from relatively small things like free samples of infadents, toothbrushes or toothpaste to access to free or low-cost dental care.
- Participants often talked about not just what they're doing (or supposed to do) but also why they should be doing it. This suggests that it may be easier for parents to make behavioural changes if they understand the reasons for them. Getting this kind of knowledge out to parents also seems to encourage them to share what they've learned. In the discussions, parents frequently explained things to each other, exchanged tips and strategies and passed on information about community programming and resources.
- A few parents revealed that they found it difficult to get their own (extended) families on board with what they were trying to do about their children's oral health. For example, one parent whose child is scheduled for dental surgery indicated that she is very careful with her children's nutrition and oral hygiene. She feels that her child's ECC is due, in large part, to the sweet snacks and sugary drinks in bottles that the child's father and grandparents give her. Another participant reported that her parents had told her that the things she had learned about oral health care were wrong. This may point to a need for materials specifically designed for distribution within families.
- Participants' comments suggest that inconsistent and/or incomplete information is circulating in two areas: the age at which children should see a dentist and the

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relationship between breast-feeding and oral health. As noted above, several parents had taken their infants and/or very young children to see a dentist at what they understood (from oral health education materials) to be an appropriate age and then been told to bring their children back when they were older. HSHC may want to develop strategies to address this.

An exchange between participants in the Eastern Manitoba focus group raises some concern about what parents and caregivers understand, hear or are learning about the relationship between breast feeding and early childhood oral health:

Participant 9: They say that breast feeding is best for the baby when they get older and all that, but I breast-fed all my kids and my last one went through that day surgery. I breast fed him until he was one and a half years old and at age two he had to go for day surgery... So I don't know if that's true.

Participant 10: It's the same for [my child]. I breast-fed him until I had [my next child]. The breast is best, but only to a certain point, because when your breast milk is so sweet and our dentist said that I should have taken him off a long time ago.

One of the parents later stated that when she breast fed her babies, she did not need to clean their mouths, because she didn't see any residue of breast milk on or in their mouths. This suggests that some parents may believe that breast milk is 'safe' for their babies' teeth or that while they are breast-feeding, parents do not need to clean their children's mouths. The exchange also suggests that when children who have been breast-fed develop severe ECC, parents and caregivers may begin to question the health benefits of breast-feeding. If this is true, HSHC may want to provide more information about the benefits of breast-feeding, the relationship between breast-feeding and oral health, and oral hygiene for infants.

How do service providers define early childhood oral health and view ECC?

When service providers were asked *what good early childhood oral health means* to them, responses included brief descriptions of what healthy teeth are (teeth with little or no decay, which in turn means less pain or surgery for children), but focused on practices that support early childhood oral health. Prevention of dental decay, service providers in the Central Manitoba group noted, begins prenatally. Participants in all service provider groups observed that proper, age-appropriate nutrition is important to oral health and singled out "bottle propping" and sugary foods and drinks as contributors to ECC. Service providers felt that it was important that parents establish (at an early

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age) and maintain oral health routines (such as wiping a baby's mouth with a washcloth after feeding or brushing older children's teeth). Ensuring that children see a dentist at an early age, they pointed out, will help children learn not to be afraid of the dentist and will mean fewer trips to the dentist later in life.

When asked *how important is it to keep baby teeth healthy*, service providers generally agreed that it is very important. Drawing a link between bacteria from the mouth, the risk of infection and other health conditions, service providers noted that, in addition to tooth loss, early childhood tooth decay can cause pain, irritability, inability to eat and loss of sleep. These conditions, in turn, can affect children's behaviour and self-esteem. Because keeping baby teeth healthy will aid in good formation of adult teeth, poor oral health can also affect speech development. A dietician in the Northern Manitoba group reported that she often sees children both pre- and post-dental surgery. Before surgery, children often stop eating and may suffer from malnutrition and failure to thrive.

When asked *why do baby teeth get decay*, service providers in all groups suggested that some parents may not understand the importance of baby teeth. A Northern Manitoba service provider stated that it is important to get the message out to parents that they need to start taking care of young children's teeth at an early age and advised that expectant mothers should hear about oral health before they deliver their babies. The service providers saw nutrition - beginning with the prenatal nutrition and health of expectant mothers – as a vital part of oral health. Again, bottle propping and providing children with sweet drinks like juice, iced tea or pop (particularly when they're offered in bottles or sippy cups) and unhealthy snacks like candy or junk food were identified as contributors to early childhood tooth decay. Service providers in Central Manitoba and the southern urban centre pointed out that low-income families may not have enough money to buy healthy food, offering the example that pop is cheaper than milk.

Service providers also referred to the important role that parents and caregivers have in preventing early childhood tooth decay through good oral hygiene practices. Service providers in the southern urban centre expressed concern about parents passing on germs to babies and young children by cleaning their soothers with their own mouths. Parents also may not clean their babies' mouths at all before their teeth come in or neglect to clean their mouths or teeth after the child has breast fed or consumed sugar in other forms. A service provider in Central Manitoba noted that cleaning babies' gums

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and 'lift the lip' are new information and families may need time to turn that new knowledge into practice. Service providers in the southern urban centre and Central Manitoba suggested that some parents need to take a more active role in supervising their children's tooth brushing and establishing tooth brushing as a family routine. A Northern Manitoba service provider felt that some parents may need opportunities to learn oral health skills, such as brushing and flossing, so that they can pass them along to their children.

Service providers pointed out that access to dental care is an issue for some families. Dental care, service providers in Central Manitoba and the southern urban centre observed, is expensive and that may prevent some families (especially those with no insurance) from taking their child to see a dentist, especially if nothing appears to be wrong with the child's teeth. A participant in Central Manitoba noted that some dentists will not see people who are on social assistance. While some community resources are available for low-income families, many of these resources have long waiting lists. Service providers in Central Manitoba and the southern urban centre also reported that, in spite of the fact that oral health materials typically recommend that children visit a dentist when they are one year old, some dentists will not see children under two or three years of age. Parents also may not have easy access to transportation to get to those dentists who do see very young children. It is often very hard for parents whose children have disabilities to find a family dentist. For example, as participants in Central Manitoba noted, some of these families must travel to Winnipeg for dental care.

Service providers in Central Manitoba observed that oral health care experiences and practices vary across cultures. In their experience, Newcomer Canadians and Hutterite people do not take their children to the dentist as often as most other Canadians do. The service providers think this may be because the parents have not had good experiences with dentists or because they don't view baby teeth as important. This group also observed that while First Nations people who live on reserve in Southern Manitoba generally have good access to dental care, those who live off-reserve often have difficulty accessing dental services. They also noted that dental surgery occurs at a higher rate in Aboriginal communities and speculated that may be because quality of life issues create stress for families and make oral health care a low priority for community members. Service providers in the southern urban centre and Northern

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Manitoba also pointed out that rural community members may not have access to fluoridated water.

When asked *how important good early childhood oral health is to overall health*, service providers in all groups indicated that there is a relationship between them. This begins during pregnancy, because if an expectant mother's oral health is not good, she may not be able to eat properly or it may affect the pregnancy in other ways. They pointed out that bacteria from a child's mouth can lead to ear and other infections, stomach aches, pneumonia and heart problems and that when a child is battling tooth decay, their immune system is weakened. When children are in pain due to tooth decay, they are less likely to eat or be active and more likely to be fussy or act out (particularly children who may be disabled or unable to describe their health problems or pain), which, in turn, can create stress and frustration for parents and other family members. Children with oral health problems may also develop self-esteem issues.

Poor oral health is linked to poor nutrition, which also has implications for overall health, particularly if children are malnourished. Service providers pointed out that sugary diets damage teeth and also may damage children's overall health. Service providers in the Central Manitoba group suggested that we live in a sugar-saturated society and many families (particularly those with low-incomes) rely on fast foods and processed pre-made food that is high in sugar and preservatives. Participants in Central Manitoba and Northern Manitoba called for more education about healthy food choices.

When asked *how they help caregivers achieve optimal early childhood oral health*, service providers described a broad range of educational activities and resource sharing. In the Northern Manitoba group, service workers emphasized the importance of maintaining a focus on prevention rather than treatment in oral health activities. The registered dietician in the group checks children's teeth and uses 'lift the lip' as part of routine assessments at the out-patient clinic. They also share information about healthy food, breast feeding and bottle propping with parents. Parents can also get free infadents and toothbrushes from the dietician. The Maternal and Child Health program in one community promotes increased awareness and provides education during family visits, accentuating the positive. The program uses the "Growing Great Kids" curriculum (similar to that used by the Families First program), which includes oral health education and starts during the prenatal period. MCH also networks with other programs, such as

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the Canadian Prenatal Nutrition Program and public health. In some First Nations communities, service providers have received training from the federal First Nation and Inuit Health Branch's Children's Oral Health Initiative. The Head Start in one First Nation has a tooth brushing program and will soon be administering fluoride varnish to children at the centre. In the First Nations community of Lac Brochet, workers are using resources (such as pictures and a puppet) to educate children attending a Head Start program and share information with the local school. Service providers in this group identified the *Dustin's Story* video² as an effective way to help parents understand the importance of oral health care and see what children experience when they go for dental surgery.

Service workers in the Northern Manitoba group felt that oral health information should be presented verbally and visually. They have found Cree language materials from HSHC (which include a flipchart and handouts), along with a 'lift the lip' handout (from Calgary) particularly useful. They find it helpful to be able to distribute toothbrushes and other resources to families – and noted that sometimes they don't have access to these. Northern Manitoba workers also appreciate other community education events and resources, such as health fairs or the dental hygiene program at the school in First Nation community. The group noted that, at this year's parades in two local communities, toothbrushes (rather than candy) were thrown out to the crowd.

Service workers in the Northern Manitoba group identified limited access to dental care as a significant barrier to good oral health for children in their region. Even in the larger centres, it can be difficult to get in to see a dentist. Some First Nations communities are served by fly-in dentists who spend only a few days each month in these communities. It is difficult to get in to see dentists in these communities, and the service workers noted that even when people have appointments, they often must wait a long time in the office. Some people get frustrated with this wait and leave before seeing a dentist. Some clinics will see a child in an emergency situation but, as the workers pointed out, by then, the child usually has significant decay and an associated infection. Some families end up taking their children to Thompson or Winnipeg for surgery. Access to dental service is also affected by transportation needs and the workers pointed out that bad weather can result in cancelled appointments. The Northern Manitoba service workers also felt

² *Dustin's Story*. First Nations and Inuit Health Branch.

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that poverty in the region was a barrier and suggested that some families on social assistance cannot even afford to buy toothbrushes. Many families in the north live in overcrowded homes and these living conditions can make it hard for parents to keep up with their children's oral health care needs. Group members also observed that in the region, many children continue to use bottles and sippy cups until they are relatively old and suggested that some parents find it hard to wean their children.

In Central Manitoba, workers have educated parents about things such as the importance of wiping babies' mouths, brushing as soon as teeth appear, and reducing babies' and children's consumption of sweet beverages. Oral health care information has been incorporated into the checklist that guides workers during child health clinic visits and into care plans for Well Baby family visits. Families First home visitors' agenda includes discussing basic care and oral hygiene with families. In prenatal classes, workers are teaching expectant mothers that if they eat a wide range of foods while they are pregnant and nursing, their children will be open to many food tastes. Workers doing postnatal visits sometimes remind mothers to wipe their babies' gums but cautioned that it is important not to overwhelm new moms with too much information. Participants who work with families with disabled children encourage families to incorporate tooth brushing into bed time routines. The daycare and preschool workers in the group reported that their projects have a tooth brushing program in place and another worker has helped another daycare develop a strategy to get rid of sippy cups. Group members also noted other oral health care and education activities in the region, including oral health incorporated into individual education plans for students at local schools, oral health presentations in Healthy Baby programs and a local wellness fair (which featured an oversized set of teeth and toothbrush that drew kids in). As one family worker stated, as service providers, they know that they are getting the message out, but have no way of measuring what is happening in the homes of the families they serve.

The workers in Central Manitoba advised that it is most effective to present parents with concrete and practical information and resources. For example, some have helped families to find a dentist who will see (disabled) children or children from families on social assistance. As one worker noted, families who are on social assistance and have been refused service by their local dentist typically cannot get money from social assistance to cover transportation costs to get to a dentist in a different community. One

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group member volunteered that a dentist in the region has offered to provide free dental care to low-income families. Families First workers bring toothbrushes to families and another local health service provider has developed funding to distribute toothbrushes four times a year, a program that they expect will become standardized in the region. Like other service workers, the Central Manitoba group found visual teaching tools a particularly effective way to reach parents. The Families First workers reported that the So Sweet demonstration and poster (sugar cubes in bottles), the Dustin's Story video and oral health Bingo (with prizes) can have real impact on young mothers and other families. They cautioned, however, that the video may also offend or shame some parents. The Central Manitoba group reported that offices with a Lactation Consultant do not allow any bottles or images of bottles on site (including the So Sweet bottles) on the basis that they may encourage bottle-feeding. The group also acknowledged that many service providers do not have the time or other resources to go through the HSHC workbook or develop the resources it offers, such as the So Sweet bottles.

The Central Manitoba workers felt that parents put their children down with bottles or use sippy cups for many different reasons, including family practice, learned behaviour or simply because it's sometimes easier for both parent and child to do this. They offer families strategies to prevent this, such as slow dilution of sweet beverages with water (with the goal of replacing the beverage with water) or using straws to transition children from sippy cups to regular cups. They recognize, however, that many parents need more support than systems currently offer them:

Participant 11: It's good for us to give them education, but we're not there at four'o'clock in the morning when the baby is screaming. Especially if you're a single mom or a working mom. We may say to them, put water in your bottle, but if that child has been used to milk in the bottle and they're screaming at you at four'o'clock in the morning, you're going to break down. I think we have to look at the overall picture of how we're supporting families.

Participant 12: How can we support mom's at four'o'clock in the morning? We don't have the answers, but know that that's the place where things break down.

Service providers in Central Manitoba observed that, while they know they are working to educate parents and families, they don't know if their efforts are making a difference.

Service providers in the southern urban centre group are also working to educate parents and families in areas such as how to take care of a baby's teeth or reducing sugar in children's diets. Some programs bring speakers in to talk to parents and staff

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about oral health care. Families First workers have incorporated oral health into their basic care curriculum. Workers use HSHC's True and False game and Bingo with families, as well as the flip chart from the Circle of Smiles kit, designed for Aboriginal families. They distribute resources like toothbrushes to families and encourage and assist them to access community resources. For example, some Families First workers distribute handouts on an RHA-operated children's dental program's in-home fluoride treatments and sign families up for the program. The workers noted that this program offers incentives (such as bibs, tooth brushes and cups) to families on each visit. One worker has accompanied a family to a dental appointment and helped them to advocate for services. Participants in this group emphasized that it's important when working with new parents, it's important not to overwhelm them with too much information. It may be best to first focus on key messages, such as the importance of wiping a baby's mouth after feeding and then, as families are ready, offer more new information later. It is important to have information available to parents who are interested, so it may be useful to develop a newborn kit or oral health overview packages or establish a dental care health line. For example, new parents may have little information about teeth eruption and may not recognize that a child who is cranky may be teething. Service workers in the southern urban centre also recognize their own responsibility to model good oral health practices by taking care of their own teeth, providing healthy snacks to program participants and educating the larger community about oral health.

Service workers in the southern urban centre identified several barriers to optimal early childhood oral health. Some parents do not understand the importance of early childhood oral health or may have other issues in their lives that leave oral health low on their list of priorities. Families may find it difficult to take up the information that workers are offering, especially if it requires breaking intergeneration habits (the "Well, my mom did it" argument). In any case, they observed, knowing and doing something are two different things. Sometimes families will try to engage in a new behaviour but stop after a few days, which may make them feel like they've failed. This makes it particularly important for service providers to maintain an encouraging attitude. While workers in the southern urban centre praised the So Sweet demonstration as an effective education tool, they also noted that some families don't believe the information it presents. They pointed out that families may not understand the differences between various juices, what beverages actually qualify as juices or the appropriate amounts to serve. Parents

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may also resist the idea that they need to clean their children's mouths before they get their teeth. One strategy these workers use is to emphasize that they are offering "new" information (which clients typically are open to and interested in) and let clients decide what they want to do with it. Another is to repeat knowledge until parents seem to understand it.

Service workers in the southern urban centre acknowledged that oral health care is "intertwined with discipline and punishment issues." For some parents, it may be easier to let their children eat sugary foods than set boundaries. Many parents also find it difficult to force their child to brush their teeth. The oral health of children is also impacted by access to dental services. As noted earlier, service workers in the southern urban centre are helping families to hook up with local dental services. The workers noted, though, that some parents seem afraid of the dentist and that makes it difficult for them to get their children to a dentist. Workers also observed that families that have lived in northern or rural communities typically had very limited access to dental services in these communities and suggested that, for some, tooth decay and oral surgery may have come to seem like the norm for children. It may take a while to get these families on board with the idea that they can and should take their children for routine dental checkups. Participants also pointed out that many of the families they serve move around a lot and it can be hard for them to stay connected to service providers.

What are caregivers' perspectives on current early childhood oral health promotion and ECC prevention activities in Manitoba?

When asked *where they had learned how to take care of their babies' or young children's teeth*, parents in the southern urban centre and the Northern Manitoba group indicated that some of their learning had come from "just doing" and some from their parents. One parent in the southern urban centre described what she had learned from her oldest daughter's experience:

She's thirteen and she has poor teeth. She had gum disease already. By the time she was three, she got eight of her teeth capped because I didn't take proper care of her teeth. So I learned from my oldest daughter – and myself, of course.

Her daughter's experiences led this mother to change the way she attends to her children's oral health:

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My youngest, she's a month old. From cleaning their tongue and the inside of their mouth, from the side of their cheek to their tongue. And cleaning their gums and massaging their gums. Once they get to the age of three, they're used to getting their mouth cleaned or tongue cleaned. And then when they're in school, kindergarten to Grade 1, they know how to brush their own teeth, clean their own tongue. And to go to the dentist without any fuss or fighting. That's all I learned.

Parents in all groups had learned about oral health care from service providers and/or health care workers. In the Northern Manitoba group, parents had learned from an HSHC employee who had presented at local programs (such as Best Beginnings, prenatal classes and the Family Resource Centre). The HSHC employee gave the sugar bottle demonstration and showed participants how to lift the lip and wipe the gums of newborns. Group members also described a game that used oral health items, in which the presenter had explained how each item related to oral health. Parents reported that staff members at a Best Beginnings program made their own So Sweet sugar bottles, display posters and videos about early childhood tooth decay and have brought in other presenters, such as dental hygiene students. Best Beginnings had also included a wash cloth, toothbrush and handouts in their post-natal information bag. Some parents in the Northern Manitoba group had seen an oral health display in a public library. This group felt that, for them, the most useful tools to learn about early childhood tooth decay had been the sugar bottle displays and demonstration, as well as videos, citing *Dustin's Story* (about a young boy's experience of dental surgery) as an example.

Participants in the Eastern Manitoba parent group had taken prenatal classes at a community centre. A representative of a local dental practice had spoken to the group about the importance of prenatal nutrition and dental care when pregnant; how to brush children's teeth (including strategies for dealing with children's resistance); frequency of brushing; using gauze or a plastic finger cot to wipe babies' gums and tongues; and other information. Parents noted that they had been able to get free toothbrushes for adults, children and babies at this program and at a Safe Kids Rodeo. They felt that this event (which targets children who are five or six years old) was particularly effective, because it involved children in educational activities.

Parents in the southern urban centre had learned about dental care from family support workers. One participant had been referred to an RHA-operated children's dental program by a Families First worker. In turn, a hygienist at that program had told the parent about other dental care programs for low-income families. Another participant

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had gathered useful information during a parenting course offered by a community-based organization, where they had also seen the poster with sugar cubes. A participant stated that they had received a booklet on teeth from their family support worker, but they had not read it because they found it uninteresting.

Parents had also gathered information from medical practitioners. Eastern Manitoba parents described a kit that doctors in their community had distributed to pregnant mothers and other materials (including free samples) that had been distributed to new mothers when they left the local hospital. From these materials, they had learned about the impact of nutrition on oral health and oral health care for babies and very young children. Participants also expressed disappointment that the hospital no longer distributes materials like these to new mothers:

Participant 13: When you leave the hospital, you need information on how to take care of your baby when you get home. If you're shy and you don't know where to go in your community to get that information yourself, it's pretty hard.

Participant 14: Especially for young mothers.

A Public Health Nurse that serves Eastern Manitoba had distributed pamphlets on oral health care, toothbrushes and toothpaste samples to parents. A participant in the southern urban centre had been given a lot of information by a pediatrician and a participant in the Northern Manitoba group had learned from a hygienist how to check for decay. Health care practitioners (nurses and dentists) had also encouraged some of the mothers to transition their children from bottles and sippy cups to cups and from sweetened beverages to water, offering practical strategies for doing this.

When asked to identify *the best way to get information out to parents and families about dental health for babies or young kids*, participants in all parent groups emphasized the importance of personal interaction and effective visual tools in oral health education. Citing their experiences with Families First workers in the southern urban centre or programs such as the prenatal classes or Best Beginnings in rural communities, parents pointed out the value of learning from another person. As one parent in the southern urban centre stated, "You're more likely to listen if someone's telling you than off the radio or something." Parents also teach each other through word of mouth: "Say the Families First worker, if she talks to me about teeth, I'm going to tell my girlfriend and spread the word." Noting that there are criteria and other conditions that limit parents' ability to participate in programs, parents identified a broad range of service and health

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care workers who could take a more active role in oral healthy education, including staff at programs such as Healthy Baby, Mom and Me and Wiggle, Giggle and Munch; school employees; Public Health Nurses; and hospital staff in contact with new mothers. For example, parents suggested that the Welcome Wagon could distribute washcloths for wiping babies mouths; hospitals could include information about mouth care when parents are taught how to bath their newborn children; Public Health Nurses could incorporate oral health checks into their routine practice; schools could offer nutrition and dental health care programs; and, as one parent put it, workers could simply ask “how things are going”. Parents in both Eastern Manitoba and the Northern Manitoba groups suggested that health care workers could go door-to-door or send out flyers to homes in the communities they serve, offering oral health information and other resources to parents.

Parents in Eastern Manitoba felt that it was also important to get more information out to children and other family members. They thought this would help children to learn why and how to take care of their own teeth and encourage extended family members take more responsibility for the oral health of babies and very young children, by, for example, replacing candy and pop with more nutritious choices. They felt that dentists should be more direct with children about the importance of oral health care and that schools should provide more oral health and nutrition education.

Parents’ responses also pointed to the importance of visual teaching tools and methods. Pictures, photos and videos, they suggested, often get a message across more effectively than pamphlets. As noted earlier, the sugar bottle display had a lot of impact on many parents. Parents in Eastern Manitoba suggested that pictures that show “how a [child] would look if you were taking care of your kids’ teeth and doing the right thing and this is what would happen if you don’t” would have a lot of impact. Parents in the Northern Manitoba group felt that demonstrations of how to wipe babies’ mouths or brush children’s teeth are helpful to parents, especially if they include strategies to gain children’s co-operation. Parents in both the Eastern Manitoba and Northern Manitoba groups felt that TV could be an effective way to get oral health messages out. Participants in the southern urban centre, however, did not feel that TV (or radio) is an effective way to reach parents because, in their experience, parents rarely have the time to watch TV or listen to radio. This difference in opinion may reflect practical differences between rural and urban life. Television and radio are generally seen as one of the most

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effective ways to get information out to the dispersed populations of rural and Northern Manitoba communities.

What are service providers' perspectives on Healthy Smile Happy Child?

When asked about *their experiences with the Healthy Smile Happy Child project*, service providers in all groups offered both praise and helpful feedback.

The majority of service providers in the Northern Manitoba group had attended trainings; one participant had attended a 'lunch and learn' session. A service provider stated that, "The trainings opened up my eyes to see how important it was to get information out to parents." Participants agreed that the training increased their knowledge of early childhood health, noting that health professionals do not always receive training related to oral health and some do not know key oral health messages. They valued HSHC's train-the-trainer model, which helps to build community capacity. Northern Manitoba participants particularly appreciated that, in spite of provincial and federal jurisdictional barriers, HSHC has offered training in First Nations communities. They also felt that the training they received was well designed and delivered. They appreciated that, in a few hours of training, they gathered the basics of early childhood oral health and could then start using that information with families. The visuals used in the training and the facilitator's verbal presentation of information (rather than relying on printed materials) were engaging. Things that they found particularly valuable in the training included: the So Sweet bottles; learning that sugar-free gum with xylitol is good for teeth; learning how to wipe babies' mouth with a washcloth and how to floss and brush children's teeth;³ and the handouts provided to participants. Group members also found the *Dustin's Story* video helpful, because it shows the "reality" of what it's like for children to go through dental surgery. Service workers in the Northern Manitoba group were not aware of the games provided by HSHC, which suggest that during HSHC training, facilitators need to do a better job of reviewing the Workbook and Toolkit and pointing out available resources to participants.

The HSHC Community Facilitator in Northern Manitoba has been a valuable resource. They make themselves available to answer service workers' questions and have taken

³ It is not clear whether or not how to brush and floss were part of the HSHC training. Participants described learning this from dental therapists at a training session in an Aboriginal community.

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on tasks such as helping with the health fair in one community. One participant stated that they would like to be able to refer families to the HSHC program for basic information about oral health.

Service providers in Central Manitoba indicated that they too had gained knowledge from HSHC training and resources. Participants described the training as interesting, felt that features such as tactile activities and the PowerPoint used in the training helped hold their attention, and were happy to be provided with current information and good practices in oral health. They also appreciated that the group was mixed, which gave participants an opportunity to learn from each other's experience and to find out more about what others are doing, so that there can be more consistency across service providers. To some extent, they felt that this opportunity was not fully taken up in the training and suggested that the HSHC facilitator could incorporate activities that support this. Participants valued the information and tools that HSHC offers, but felt that they could use these resources more effectively if the HSHC training had provided practical knowledge how to implement or use these things with families. To do this, they advised, the HSHC training facilitator would need to take a more collaborative, team approach to training and work with participants to develop realistic ways for service workers to use HSHC resources in their work with families and communities.

Service providers in Central Manitoba offered recommendations to enhance the cultural sensitivity of HSHC training and materials. They suggested that Aboriginal people are overrepresented in HSHC materials, which may offend some (Aboriginal) people or lead people to assume that the project targets only Aboriginal people. They also recommended that HSHC remove references to dental surgery as a "rite of passage" for Aboriginal children or families. They felt that this, along with the *Dustin's Story* video, may offend some (Aboriginal) people. Participants in Central Manitoba thought it was important that HSHC activities cross cultures and economic classes. They noted that "rich people can get caries too" and recommended that HSHC resources be translated into other languages. They suggested that HSHC could extend its reach by working with family resource centres and community resources.

With respect to the content of HSHC training and materials, service providers in Central Manitoba made three observations. As other service providers and parents noted, group members commented on the inconsistency between HSHC's recommended age for a

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child's first visit to a dentist (one year) and the age at which most dentists will see children (three years). They advised that dental professionals need more information. One participant suggested that HSHC should provide more information about heredity and oral health. This may encourage parents whose children are prone to tooth decay because of heredity to focus on prevention. Another service provider was disappointed that the HSHC facilitator could not answer questions relating to the anti-fluoride movement and asked for more information on bottled water and fluoride.

While acknowledging the HSHC training offered valuable information and resources, service providers in Central Manitoba were concerned about the sustainability and utility of what they had learned. As discussed above, they felt they needed help to figure out how to implement what they had learned. Participants noted that many people did not even take the cellophane of their workbooks during the training. The HSHC facilitator advised them to put their workbook in a binder and laminate the games included in the materials, but some participants have not had the money, time or other resources to do this. One service provider pointed out that, for example, while the pamphlet provided in the materials is good, they do not have the clerical supports or money to duplicate it for distribution to families. Another participant stated that they and their co-workers do not use the HSHC handouts.

The Central Manitoba participants also suggested that, while HSHC offers good tools, because the project received only two years of funding, it may be difficult to sustain its educational momentum. How, they wondered, could this be kept going? Providing training participants with prepackaged tools or kits with practical resources would help service providers sustain their educational activities. They also would like to have more visual and manipulable tools (such as teeth sets) and toothbrushes for distribution to families to support their efforts to encourage families to practice oral hygiene. One participant commented that service providers need support from their supervisor before they can implement what they learned in the HSHC training (and this, in turn, may require education to help them see that oral health is one part of health promotion), which may be difficult because it is difficult for programs to find money for prevention activities. Encouragingly, the group suggested lobbying the government to continue the HSHC project.

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Service providers in the southern urban centre group described the HSHC project as very good. One participant stated that they had heard about it well before it got going and looked forward to participating in it. Early dental care, a participant noted, will lead to better healthy overall. Participants generally felt they had got useful information for their work with families. One participant, echoing the comments of a Northern Manitoba service worker, said that the training had helped her realize that oral health is important. Service providers in the southern urban centre particularly liked the flip chart and other visuals provided by HSHC, the So Sweet bottles and poster, 'lift the lip', and the True and False and bingo games. Some workers found that the 'lift the lip' handout from Calgary had the biggest impact on parents, which they attributed to the fact that it is visual, rather than literate. A few of the Families First workers in the group had received a chart from HSHC that coordinates HSHC content with Families First curriculum, which they found very helpful. Other Families First home visitors had done this on their own. Some workers found HSHC's handouts useful, although some also wondered whether some materials were helpful to people with relatively low literacy rates. Participants indicated that HSHC resources seemed effective when they were working with people from different cultures.

Service providers in the southern urban centre were dissatisfied with some aspects of HSHC training. They described the presentation as "dry" and "too formal", noting that the facilitator had not been interactive or catered to different learning styles. One participant wondered whether the information was new to the facilitator, because they had relied on notes during the training. It is notable that participants noted that when program facilitators were delivering messages on their own, they got the message out in interactive and appropriate ways. Technical information, they suggested, can be helpful but it does not necessarily engage people and the amount of information presented at the training overwhelmed some participants. More visuals would have supported participant's learning more effectively, as would 'rewards' for learners. Although the session was designed to be a train-the-trainers event, some participants left the session feeling that they did not have the right tool to get out there and start using what they had learned with families. With participants describing the training as "redundant" and "too long", the group generally agreed that the training session and the information presented at the session should be condensed. This is especially important for participants who will not have a lot of opportunity to use what they've learned. Most of the participants in

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the southern urban centre acknowledged that they have not referenced the action plan workbook and/or tool kit provided at the training. These materials were described as “a bit overwhelming.”

Like the Central Manitoba service workers, service workers in the southern urban centre wanted more guidance about how to use the information, games and other resources offered in the training. Rather than being presented with “all that information all at once” (or overwhelming parents with the same), they would have liked to be given “hot tips” or key messages on the most important aspects of oral health care for parents and families. Service providers in the southern urban centre asked what it is that HSHC really wants them to pass on to parents. If parents can only do one thing, what should that thing be? That one thing, they suggested, might be ‘lift the lip’, sitting a baby up for their last sip of milk and then wiping their mouth, or something else. They wanted to know how to help parents to do the best they can with respect to the oral health of their children in whatever place they are at today. This includes explaining how to do things to parents, problem solving with them and identifying “do-able” actions they can take. Service providers in the southern urban centre felt that more tools and props (such as teeth models or ‘lift the lip’ dolls) would help them with this work. Being able to leave something with parents (such as toothbrushes or magnets with oral health messages) helps to get parents on board. A media campaign featuring ‘hot tips’ and ‘key messages’ may be another way to reach parents.

Service providers in the southern urban centre group also emphasized the importance of helping parents to understand that they are an integral part of preventative dental care. When service providers talk to parents only about their children, they risk shaming or nagging the parent. It is important to emphasize the contribution a parent makes to their child’s oral health, including how their own prenatal care and oral health affects their children. Parents are crucial role models for children and their family’s daily oral health routines play a vital role in prevention for children. HSHC, they advised, should develop supplemental materials that are relevant to the whole family. They also recommended that HSHC develop a general overview package for new mothers and their babies.

Like the Central Manitoba participants, service providers in the southern urban centre asked for more information about fluoride and bottled water. They also noted that there are discrepancies about when parents should offer fluoride toothpaste to their children;

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some materials suggest when the child is one year old, while others suggest waiting until the child is three or five years old. Participants offered the rule of thumb that children should not start using fluoride toothpaste until they can spit. Service providers in the southern urban centre also remarked upon inconsistencies in the messages they're receiving about when a child should first visit a dentist. They also noted that if parents follow HSHC's recommendation that children should visit a dentist at one years of age, they may have difficulty finding a dentist who will see their child.

What are the similarities and differences among service providers and caregivers about their perceptions of oral health?

There was a surprising degree of concordance between how service providers and caregivers perceive oral health. Questions that explored how these groups define early childhood oral health and view early childhood caries elicited similar responses from both groups. When asked what 'healthy teeth' or 'good early childhood oral health' means, both parents and service providers referred to being cavity-free and oral hygiene practices (for both babies and very young children). Service providers' responses focused on what, for them, is teachable, including oral hygiene, the risks of bottle propping, and the importance of proper, age-appropriate nutrition. Parents' responses included discussion of the importance of ensuring that children's teeth come in properly. Interestingly, one parent commented that, to her, 'healthy teeth' signals that a child is being well taken care of, which may reflect her own sense of responsibility for her children's oral health.

Both parents and service providers felt that it was important for children to have healthy baby teeth, drawing links between the condition of children's baby and adult teeth. Both groups discussed the risk of bacteria from a child's mouth spreading and inducing other health problems. Poor oral health, they observed, can affect children's behaviour and self-esteem. Participants in both groups spoke about difficulties (for both parents and children) associated with oral surgery.

When asked why baby teeth get decay, both parents and service providers identified bottle propping, sugar intake, germs passed by parents, inadequate oral hygiene routines and self-care for expectant mothers as contributors to tooth decay. Parents acknowledged that they sometimes do not manage to maintain the oral hygiene routines

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that they feel they should, especially when they feel harried or tired or when their children resist. Service providers pointed out that, for a variety of reasons, some families have only limited access to dental care. Again, this observation may reflect the “service” focus of these participants.

When asked whether oral health affects children’s overall health, both groups of participants referred to bacteria from the mouth traveling through a child’s body and causing infection and other health problems. Both groups also linked oral health to malnutrition, noting that children with tooth decay may avoid eating. Service providers added that poor oral health is linked to inadequate nutrition, including sugary diets, which, on their own, can compromise a child’s health.

When parents were asked how they take care of their babies’ or young children’s teeth, their responses suggest that they are taking up the oral health information and practices that service providers are sharing with them. Parents described following appropriate oral hygiene routines with both their babies and very young children, avoiding bottle propping, providing good nutrition, watching for signs of decay and taking their children for routine checkups. All these parents have participated in programs or used community resources that deliver messages about early childhood oral health. It is clear that these messages have gotten through and transformed the parenting practices of many of these participants.

Parents also confirmed service providers’ assertion that the most effective way to get information out to parents is through personal interaction, visual presentations and hands-on tools. Both parents and service providers praised the So Sweet displays and the video, *Dustin’s Story*. Service providers were also correct in their suggestion that limited access to dental care is a significant barrier to good oral health for children. Parents shared stories of taking their children to the dentist and being told to bring them back when they were older. As service providers repeatedly stated, parents appreciate whatever is out there to help them manage the costs of oral health care, whether it be infadents and toothbrushes or free or low-cost dental care. Service providers are also correct in emphasizing the importance of maintaining a positive and encouraging attitude when working with parents. Evidence for this was provided by parents who described feelings of shame about their children’s poor oral health or hygiene. Several parents spoke honestly about their own struggles to get their children on board with oral hygiene

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practices or healthy food and beverage choices. As both parents and service providers recognized, many parents need more supports than are currently available to them to support good oral health for their children. As both groups recognized, this includes oral health education activities for the whole family, including extended family members.

Service providers were not asked about their experiences with families whose children have gone through dental surgery and only a few members of this group referred to dental surgery. Parents were asked about their children's experience of dental surgery and participants in each group spoke at length about this. Service providers clearly understood that dental surgery should be avoided. However, parents' comments made it very clear that dental surgery is a traumatic experience with long-term impacts on both parents and children. It was particularly striking – and difficult to convey in this report – how emotional parents were when talking about their children's surgery. This was true even of parents whose children had gone through surgery as much as five or ten years ago.

It should also again be noted that an exchange between two of the parents in Eastern Manitoba suggested that parents who breast-feed may need more education about the relationship between breast-feeding and oral health. These parents suggested that breast milk is 'safe' for babies and that parents do not need to clean the mouths of babies who are being breast-fed. Service providers may need to provide education in this area to parents.

What recommendations do caregivers and service providers have for further oral health promotion and ECC activities?

Caregivers and service providers offered recommendations for further oral health promotion and ECC-related activities (including recommendations that will build communities' and individual parents' and caregivers' capacity) in the following areas:

Training Needs and Other Professional Development Activities:

Service providers in the North asked for the opportunity to participate again (as a refresher) in the training currently offered by HSHC and asked for follow-up training as new oral health information appears.

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Service providers in the South suggested that information on oral health care be incorporated into educational curriculum for health professions (such as medicine, nursing, and midwifery), with a focus on prevention rather than disease models. This information should also be shared with practicing health professionals.

Service providers in the South recommended that opportunities to learn about oral health care should be extended to support workers in the CFS system and introduced into CFS educational materials.

Parents in the South asked that oral health practitioners be given information and/or training that will help them to learn how not to shame parents.

Service providers in the North called for a conference on oral health in Northern Manitoba.

Community Education:

Parents identified key messages that parents and other family and community members need to hear. These include:

- Cavities and poor oral health can affect children's overall health. They can lead to other health problems, like abscess, swollen face, fever or bad breath
- These are the only teeth you're going to have! When you keep your teeth, it helps you look younger.
- Parents, grandparents, friends, babysitters and children can all help children learn to brush their teeth and take care of their oral health.
- Get message out about junk food or fruit
- Grandparents can help parents take care of their children's teeth by offering their grandchildren health snacks and beverages.
- Dental surgery is preventable.
- Games, reward systems, stickers and other things can make tooth brushing fun for children.
- Parents are role models. It's important that they show their children how to eat healthily.
- It's hard when you're brushing your child's teeth and they start crying, but tooth brushing is important and helps your child to be healthy.
- Going to classes in the community is a good way to learn and share information with other parents.

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Parents in the North advised that television, radio and large posters are good ways to get messages out to parents and families.

Service providers in the North called for more posters and other educational materials that feature Aboriginal people.

Parents asked for more oral health education, information and other resources in Northern, remote and First Nations communities. This should include dental programs at schools.

Both parents and service providers called for more oral health education activities that directly involve children and their families (including grandparents), such as fun activities designed for families.

Service providers in the North called for a community awareness day about oral health for children, featuring programs such as HSHC.

Service providers in the South recommended that day care centres should take a more active role in providing oral health education to children.

Parents suggested that family support workers and programs (such as Families First, Best Beginnings and Public Health Nurses) could take an even more active role in oral health education by, for example, incorporating routine oral health checks into their services, showing families how to take care their babies' mouths and children's teeth or monitoring children's brushing.

Expanding Programs and Services:

Parents in both the North and South called for more meaningful access to oral health care services for all children and families throughout Manitoba. This includes access to dentists and hygienists who are specifically trained to work with children; free, subsidized and/or affordable dental care that, as appropriate, offers flexible payment options; and free, subsidized and/or affordable prevention initiatives.

Service providers also offered recommendations that would enhance access to dentists for children and their families:

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- The Government of Manitoba should treat dental health for kids the same way eye care is treated.
- Children between one and eighteen years of age should be allowed one free yearly visit to the dentist.
- These services could be funded, in part, by money that would no longer be needed for dental surgery.

Parents called for hospital staff and dental offices to provide oral health care information to new mothers and parents.

Parents advised that healthy foods should be cheaper than junk food.

Both parents and service providers asked for oral health programs at public schools. Service providers recommended that oral health education be incorporated into these programs.

Service providers called for more oral health human resources in communities, including someone to whom they could refer families for education.

Response to Evaluation Study Recommendations and Subsequent Action Plan:

Note that responses to focus group participant recommendations are indicated in italics and this is a sampling of initiatives that have occurred across the province and not necessarily a comprehensive listing.

Training Needs and Other Professional Development Activities:

Service providers in the North asked for the opportunity to participate again (as a refresher) in the training currently offered by HSHC and asked for follow-up training as new oral health information appears.

- *Facilitators in each region are following up with each group that they have provided training to. Facilitators will ask how else HSHC can support their efforts to prevent ECTD and pass key messages on to families.*
- *In the NOR-MAN and Parkland RHAs, the Community Facilitator has made connections with local dental offices that are willing to act as a community resource for service providers who have questions or are looking for more information.*
- *Brandon and Assiniboine RHAs have had additional training on the Regional Oral Health Resource Kit and ways to use the resources within their practices.*

Future steps: A self learning orientation module is in development as a way to provide information to new staff and serve as reference material for others in the future.

Service providers in the South suggested that information on oral health care be incorporated into educational curriculum for health professions (such as medicine, nursing, and midwifery), with a focus on prevention rather than disease models. This information should also be shared with practicing health professionals.

- *The Early Childhood Educator program at Red River College plans to include oral health into their curriculum. The RRC Nursing program will integrate some oral health information into their Health and Development and Health Promotion classes.*
- *Information has been provided to University of Manitoba Faculty of Nursing.*
- *HSHC has provided many training sessions to various groups of health professionals and will continue to work with practicing health professionals such as public health nurses, dietitians, midwives, pediatric residents etc.*
- *Facilitators in the North are doing follow-up with University College of the North and discussing the inclusion of more early childhood oral health information within their programs*

- *Central region has done training for LPN students and daycare students at the Red River Portage campus. Materials were given to instructors to incorporate into curriculum.*
- *HSHC PowerPoint training session and resource materials were shared with Brandon University Nursing program to use in their curriculum.*
- *Turtle Mountain School Division has included an oral health section in their annual Child Development Certificate day (mandatory for all grade 11 students to complete).*
- *Information has also routinely been shared with senior students in the Faculty of Dentistry and School of Dental Hygiene at the University of Manitoba.*

Future steps: The HSHC Project team will continue to connect with various health provider training programs to discuss the incorporation of oral health education within their curricula. HSHC is also working with the Faculty of Dentistry to develop a series of continuing education tools for health care providers on the importance of early childhood oral health.

Service providers in the South recommended that opportunities to learn about oral health care should be extended to support workers in the Child and Family Services (CFS) system and introduced into CFS educational materials.

- *Winnipeg/Interlake RHAs: Winnipeg CFS Support Workers have attended two hour workshop on ECTD. Resources have been left with each of the four CFS Support Worker Supervisors to lend on a sign-in/sign-out basis to their respective support workers. Interlake CFS plans to offer a training session to their support workers.*
- *Central/Assiniboine/Brandon RHAs: CFS has been invited to attend training sessions held in these regions. There has been some participation from support workers and foster parents. CFS workers will be included as a target group for the telehealth session on "oral health care for special needs children".*

Future steps: There has been limited contact with CFS Support Workers to date in the other regions. Community Facilitators plan to make contact with CFS.

Parents in the South asked that oral health practitioners be given information and/or training that will help them to learn how not to shame parents.

- *A key message HSHC Community Facilitators give to practitioners is to use strength based messages and work with the family's assets. (This is consistent with the Families First strength based approach).*

Future steps: HSHC initiatives will continue to build on community development principles enabling communities to identify strengths and opportunities.

Service providers in the North called for a conference on oral health in Northern Manitoba.

- *Burntwood RHA Facilitator hosted a session in April; open to all BRHA employees.*

Future steps: The potential exists for Northern HSHC Facilitators to use Telehealth and facilitate a conference with health providers and dental professionals within their regions. There is an opportunity to host a Lunch & Learn session with health providers within the NOR-MAN and Parkland RHAs. Another possible future step is to hold a conference, possibly provincial, for service providers to obtain new information and guidance to support sustainability and enable community partners to network.

Community Education:

Parents identified key messages that they and other family and community members need to hear. These include:

- Cavities and poor oral health can affect children's overall health. They can lead to other health problems, like abscesses, swollen face, fever or bad breath
- These are the only teeth you're going to have! When you keep your teeth, it helps you look younger.
- Parents, grandparents, friends, babysitters and children can all help children learn to brush their teeth and take care of their oral health.
- Get message out about junk food or fruit
- Grandparents can help parents take care of their children's teeth by offering their grandchildren healthy snacks and beverages.
- Dental surgery is preventable.
- Games, reward systems, stickers and other things can make tooth brushing fun for children.
- Parents are role models. It's important that they show their children how to eat healthily.
- It's hard when you're brushing your child's teeth and they start crying, but tooth brushing is important and helps your child to be healthy.
- Going to classes in the community is a good way to learn and share information with other parents.

The Materials provided by HSHC include these messages and they will continue to be used by communities.

Parents in the North advised that television, radio and large posters are good ways to get messages out to parents and families.

- *Public Service Announcements have been aired on local radio stations during Oral Health Month within various regions.*

Future steps: HSHC received a grant from Children's Hospital Foundation for the development of 4 posters depicting positive and meaningful oral health messages for parents. Ongoing efforts to engage local public messaging organizations will occur. Community input into the development of local messaging strategies will be sought.

Service providers in the North called for more posters and other educational materials that feature Aboriginal people.

- *The vast majority of materials currently used by HSHC were developed by Aboriginal communities and pilot tested in the communities. All resources will continue to be made available online at www.wrha.mb.ca/healthinfo/preventill/oral_child.php.*
- *HSHC partnered with an Aboriginal story teller who wrote "Story of the Eye Tooth" which is an Aboriginal telling of the importance of early childhood oral health. The story was provided in written and oral format to all First Nations communities.*

Future steps: The poster series that HSHC received grant funding for will feature Aboriginal people. Linkages with First Nations and Inuit Health will also continue.

Parents asked for more oral health education, information and other resources in Northern, remote and First Nations communities. This should include dental programs at schools.

- *Some daycares and Head Start programs in the Winnipeg and Interlake RHAs have implemented toothbrushing programs in their centres.*
- *River East Transcona School Division has included toothbrush and oral health pamphlets in their kindergarten registration packages.*
- *Aboriginal Parent child centres in Brandon and Central RHAs have received training and HSHC resources in Cree. Some centres have toothbrushing programs and have asked for additional information related to toothbrush programs .*

Both parents and service providers called for more oral health education activities that directly involve children and their families (including grandparents), such as fun activities designed for families.

- *Preschool BINGO was developed by a Community Facilitator after receiving numerous requests for early childhood activities by Daycares and Preschool Programs.*
- *A list of dental songs, activities & crafts has been provided to Early Childhood Programs at trainings & follow ups.*
- *Service providers are directed to online resources that have large quantities of children's activities relating to oral health as well as general health.*
- *HSHC Resource Kits created for Winnipeg Public Health, Interlake RHA, and Winnipeg Parent-Child Coalitions all feature a section on children's oral health activities.*
- *Regional Resource Kits for Central, Brandon and Assiniboine RHAs included activities and resources for preschoolers and adults. The kits were designed to make it easy and quick for daycare providers, nursery school teachers, or*

public health staff to have materials to use with clients. The kits include resources in addition to HSHC resources.

Service providers in the North called for a community awareness day about oral health for children, featuring programs such as HSHC.

- Displays have been provided at preschool & community health fairs in NOR-MAN & Parkland.*
- Burntwood RHA hosts a Health Circus in the Spring which includes dental screening.*
- Brandon, Central and Assiniboine RHAs all do numerous community events like Preschool wellness days, Teddy Bear Picnics. These have had displays and information on oral health. The CDPI communities have also been contacted and invited to include oral health with their nutrition plans.*

Future steps: Winnipeg RHA Seven Oaks Early Years Coalition is planning an Early Years Symposium in June 2008 to feature the services that are available to families in the community. Potential exists for other communities to do the same.

Service providers in the South recommended that day care centres should take a more active role in providing oral health education to children.

- Winnipeg/Interlake RHAs: All Child Care Coordinators in Winnipeg have received information on ECTD and an invitation to access HSHC resources and workshops. Workshops have taken place in individual centres and with daycare directors/networking groups in five of the twelve community areas in Winnipeg. All Interlake daycare directors have attended a two hour workshop on ECTD and have shared the resources/information with staff at their centres. Some Interlake daycares are incorporating oral health into their programming on a regular basis and some daycares have made changes to their nutrition and centre policies to encourage healthier food choices and better oral health care practices. Oral health information has been posted in centres and sent home with parents in both the Winnipeg and Interlake regions.*
- North Eastman/South Eastman RHAs: Some contact has been made with day care centres in North Eastman RHA. Community Facilitator will continue training and follow-ups with day care centres.*
- Central/Assiniboine/Brandon RHAs: All the directors in Central have received a presentation. Numerous individual centres in all three regions have had training sessions. Some centers have requested and received information on toothbrushing programs.*
- NOR-MAN/Parkland RHAs: Some day care centres in both regions incorporate oral health into their daily activities by: brushing teeth/wiping gums once a day, purchasing teeth models to demonstrate brushing, talking about dental health with children*
- Burntwood/Churchill RHAs: Various day care centres in these regions have toothbrushing programs and provide resources to parents.*

Future steps: Community Facilitators will continue to engage local day care centres and provide training to staff and follow-up as needed.

Parents suggested that family support workers and programs (such as Families First, Best Beginnings, Canadian Prenatal Nutrition Program (CPNP) and Public Health Nurses) could take an even more active role in oral health education, for example, by incorporating routine oral health checks into their services, showing families how to take care of their baby's mouths and children's teeth or monitoring children's brushing.

- Families First across the province have incorporated more oral health education into their curriculum.*
- Public Health post-partum care map – the following regions have “oral health” included on their public health post-partum care map/database; Winnipeg and Brandon RHAs. The following regions are looking at revisions to include oral health; NOR-MAN, Parkland, Assiniboine, and Central RHAs.*
- Winnipeg/Interlake RHAs: All Winnipeg RHA Public Health sites have a resource kit containing ready-to-use oral health education tools. Resource kits are being used by Public Health Nurses, Families First Home Visitors, and at Healthy Baby sites. Interlake Public Health Nurses and Families First Home Visitors are using the resources on their home visits and/or in their community programs. Families First also incorporates oral health in their community events. Selkirk General Hospital includes newborn pamphlet in the postpartum packages sent home with new moms. All Interlake Community Health Offices have a copy of the four oral health videos. The CPNP project uses HSHC resources on a regular basis and actively promotes oral health for mom and baby.*
- NOR-MAN/Parkland RHAs: In both regions, Families First home visitors often check for tooth decay on home visits; make tooth brushing posters using photos taken of children in the family brushing their teeth (to be placed in their bathrooms); help to advocate for families having trouble accessing a dentist; and give oral health information to parents at preschool wellness fairs. Public Health Nurses often talk about oral care at Child Health Clinics & postpartum visits; use the flipchart as a visual aide; and talk about oral care when speaking about relevant topics such as the introduction of solid foods. Best Beginnings holds a session on oral health in prenatal & postnatal classes; distributes a washcloth with a poem on it in postnatal bags; and only have milk & water available to drink at their sessions. In Aug 2007 partnered with another PHAC program (CAPC) to offer an Early Childhood Tooth Decay Forum in The Pas.*
- Central/Assiniboine/Brandon RHAs: Public Health Nurses use the information during baby visits, Child Health Clinics, and prenatal classes. Central and Assiniboine RHA have been investigating the costs of reproducing handouts. All Healthy Baby programs in the regions use the HSHC resource kits in their programming. Families First use the information during their visits and when planning community events. Public Health staff have been the vehicle to distribute oral health messages like the magnets used for Oral Health month. The CPNP program has incorporated oral health into their programming. Recognizing the importance of oral health for mom and baby*

they now provide transportation to dental appointments in addition to medical appointments.

- *North Eastman/South Eastman RHAs: Public Health nurses and Families First home visitors have been provided with a resource kit containing ready-to-use oral health education tools.*
- *Burntwood/Churchill RHAs: Families First in Burntwood RHA provide toothbrushes, toothpaste as well as instruction during their home visits.*

Expanding Programs and Services:

Parents in both the North and South called for more meaningful access to oral health care services for all children and families throughout Manitoba. This includes access to dentists, dental therapist and hygienists who are specifically trained to work with children; free, subsidized and/or affordable dental care that, as appropriate, offers flexible payment options; and free, subsidized and/or affordable prevention initiatives.

- *Some private dental offices offer early dental visits by 12 months of age and some, although small number of dentists, offer free first dental visit to young children.*

Future steps: The Manitoba Dental Association is aware of the need to improve access to care for young children and infants in Manitoba. They are working with their membership through their Communications Committee and partnering with HSHC to raise public awareness and provider awareness of the importance of a preventive first dental visit by 12 months of age. HSHC Facilitators will continue to support communities in identifying and advocating for their needs.

Service providers also offered recommendations that would enhance access to dentists for children and their families:

- Could the Government of Manitoba treat dental health for kids the same way eye care is treated?
- Could children between one and eighteen years of age be allowed one free yearly visit to the dentist?
- Could these services be funded, in part, by money that would no longer be needed for dental surgery?

Future steps: A member of the HSHC project partnership and a senior dental student at the Faculty of Dentistry have conducted a study on Manitoba dentist views of early dental visits and their awareness of early childhood caries. This publication has been conditionally accepted and will help identify areas for action.

Parents called for hospital staff and dental offices to provide oral health care information to new mothers and parents.

- *Obstetrics Nurses have had training sessions in The Pas. The Pas Health Complex (Hospital) plans to include Newborn Pamphlet & washcloth in postpartum bags as well as talk with mothers about newborn oral health care*

- *Healthy baby programs across the province provide oral health information to program participants.*
- *Public Health nurses across the province provide oral health information to post-partum clients.*
- *Dental office hygienists in Parkland RHA talk about oral hygiene with parents.*
- *Labor and delivery nurses have had training session at St. Boniface Hospital. These nurses plan to incorporate newborn mouth care when teaching parents about bath time.*
- *Midwives across the province provide oral health information to mothers.*
- *Maternity ward in Burntwood has infadents and handouts that are provided to new mothers after delivery. Obstetrics nurses incorporate newborn mouth care when teaching parents about bath time.*
- *Health Sciences Centre obstetrics ward has posters in each room that addresses good oral health for newborns.*
- *Postpartum posters have been provided to maternity wards in Brandon, Central, Assiniboine and Interlake RHAs.*

Parents advised that healthy foods should be cheaper than junk food.

- *Central RHA dietitians and HSHC Community Facilitator have written a school newsletter article on nutrition and dental health that was distributed to all school divisions in Central, Brandon and Assiniboine regions for Oral Health month.*

Future steps: Facilitators in the North have been provided with contacts of individuals working on food security initiatives. Facilitators will determine how they can support and collaborate with these initiatives.

Both parents and service providers asked for oral health programs at public schools. Service providers recommended that oral health education be incorporated into these programs.

- *NOR-MAN/Parkland RHAs: Community Facilitator has held training sessions in some schools in both regions. Dental assistants & Nurses are available to do school presentations – Facilitator will continue to help link community programs with those willing to present to groups. Oral health is covered in some health classes.*
- *Burntwood/Churchill RHAs: Community Facilitator has held training sessions and support in schools to inform the teachers of the issue; feedback to date has been positive.*
- *Winnipeg/Interlake RHAs: River East Transcona School Division has included toothbrush and oral health pamphlets in their kindergarten registration packages. Seven Oaks School Division has parent-child centres in all of their elementary schools. These centres have incorporated oral health into their*

programming and have submitted oral health articles to their school newsletters. The coordinators of these centres have access to resource kits through the Seven Oaks Early Years Coalition and the Seven Oaks Public Health Team. Interlake kindergarten teachers in the Evergreen School Division and Lord Selkirk School Division have received a workshop and resources to incorporate into their classes. All Hutterite Colony schools have received a workshop and resources to address the oral health concerns among colony children.

- North Eastman/South Eastman RHAs: All Hutterite Colony schools have received training sessions and information*
- Central/Brandon/Assiniboine RHAs: Hutterite Colony schools and the public elementary schools have received presentations. A display has been set up at the Hutterite kindergarten registration day in Central region.*
- The Manitoba Dental Association will be piloting a school based oral health education program. The objectives of the program will be to: provide an oral health curriculum that can be incorporated into the health curriculum for Manitoba School. The curriculum will target grades 3, 4, & 5 and will incorporate activities, nutrition, importance of brushing and flossing, and prevention, and will be taught during National Oral Health Month in April.*

Future steps: HSHC Community Facilitators will continue to connect with local schools to discuss the incorporation of oral health education.

Service providers called for more oral health human resources in communities, including someone to whom they could refer families for education.

- In NOR-MAN/Parkland regions most dental offices are willing to be a community resource for service providers.*
- In Central RHA, there has been support by a local dentist to be the speaker for a telehealth session and a dental hygienist regularly volunteers for displays and teaching. One dentist from Central RHA is now working at a Preschool Wellness fair. Assiniboine RHA has a former dental assistant that does education in the local community. People in this community often call for additional resources they can use from HSHC.*

Future steps: HSHC Community Facilitators will work to link community programs with regional oral health professionals who can act as a resource for oral health information.

HSHC has received grant funding to complete a second qualitative study targeting parents from various cultural groups using focus groups. The literature shows that there are additional populations that are at risk of developing early childhood tooth decay.

HSHC staff will continue to work with each Regional Health Authority to address the ideas and issues raised from focus group participants.

Problem Statement
Ensuring sustainability of HSHC initiatives through on-going support for parents/care givers, health professionals, other service providers and communities.

Objective
Enabling parents and care givers to take care of their families oral health

Impacts

- Knowledge: increased understanding among parents and care-givers of the importance of oral health
- Increased skills
- Changed attitudes
- New behaviour: increased number of parents and care-givers who practice oral health
- Outcomes
 - Community Systems
 - Organizational
 - Short term
 - Long term

Rationale

- Community development methodology for health promotion and planning
- Intersectoral and collaborative partnerships

Assumptions

- Parents & care-givers' basic understanding of oral health and implications for children's overall health well developed
- Access to dental care varies widely throughout the province and is limited in some regions
- In the focus group research, under representation of parents & caregivers with established relationships with service providers
- Service providers are involved in a broad range of educational activities & resource sharing to help parents/care-givers achieve optimal oral health

Strategies

1. Oral Health Promotion
 - Strategies for implementing resources within families – change management and behavioural changes based on understanding of reasons ("why") for change
 - Identify the "priority" oral health message
 - Consistent/complete information available
 - Age appropriate visits
 - Breast feeding/expectant mothers
 - Pre-natal promotion
2. Education & Training
 - Hands on training
 - Visual teaching methods
 - Personal interaction
 - Train the trainer methodologies
 - Targeted training for health professionals and service providers
 - Develop key messages for parents/families
 - Expand scope to include public school system and day cares
 - Alternate long comprehensive education sessions with short/topic based, lunch & learn, as needed sessions, repeatedly or accessed as needed
 - Set achievable, realistic goals for reinforcement and behaviour modification
3. Oral Health Services & Treatment
 - On-site visits to increase knowledge sharing and access to treatment:
 - Dental and dental hygiene students
 - Dental hygienists/Dental therapist
 - Dentists
 - Low cost/Free consultations &/or treatment
 - Free handouts (infadents, toothbrush/paste)
4. Community Capacity Building
 - Capacity building at the individual care-giver family level
 - Mixed group/sharing experiences
 - Sharing/problem solving/supportive activities groups (Autism, CNIB, CCS, Renal program)

Resources

- Communities**
- Caregivers
 - Extended family
 - Community supports
 - Natural Community Leaders
- Governments**
- Manitoba Health
 - FNIHB
 - RHA's
- Service Providers**
- Dental Professionals
 - Early Childhood Educators
 - Public School Health Services
 - Public Health
 - Other Health Professionals/Educators
 - Family Support Workers
- Technological**
- Media and Marketing
 - Videoconferencing (MBTelehealth)
 - Web Streaming
 - Internet web portals & web based learning platforms