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Child oral health concerns amongst parents and primary care givers in a Sure Start Local Programme

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Aim: To conduct an oral health promotion needs assessment amongst parents and primary care givers of pre-school children in a South East London Sure Start Local Programme (SSLP).***Objective:*** To explore the oral health concerns and oral health literacy with regard to children's oral health amongst parents and primary care givers in a South East London SSLP. ***Design:*** A qualitative study using four in-depth focus groups with a purposive sample of 20 participants. Data were analysed using the framework method. ***Results:*** The SSLP was identified as an important source of information, support and social interaction for participants. Participants rated the informal networks of the programme as equally authoritative as other formal sources of information. Oral health concerns included: introducing healthy eating, establishing tooth brushing, teething and access to dental care. While participants had adequate knowledge of how to prevent oral disease they cited many barriers to acting on their knowledge which included: parents' tiredness, lack of confidence in parenting skills, confusing information, widespread availability of sugary foods and drinks, and lack of local child friendly dentists. Parenting skills and the social support provided by the SSLP appeared to be integral to the introduction of positive oral health behaviours. ***Conclusions***: SSLPs were seen as a trusted source of support and information for carers of pre-school children. Integration of oral health promotion into SSLPs has the potential to tap into early interventions which tackle the wider support needs of carers of pre-school children while also supporting the development of positive oral health behaviours.

Key words: Oral health promotion, pre-school children, qualitative research methods, Sure Start Local Programme.

Introduction

For many years the health education model has been the dominant approach in health promotion policy and practice. Strategies focused on risk factors for individual diseases with interventions attempting to change lifestyle practices and behaviour through education and awareness campaigns (Watt 2007). Effectiveness reviews of oral health promotion and education have highlighted the limitations of these educational approaches in producing sustained behaviour change and improvements in oral health (Kay & Locker 1996). The tendency for risk factors for certain disease to cluster indicates that they are enmeshed in the social environments, networks and conditions in which people work and live (Cade & Margetts 1991). In order to reduce oral health inequality it is necessary to focus on these wider determinants of health. Health promotion interventions now emphasises the role that community development and locally led activities can have in addressing the wider determinants of health (Watt, 2007).

There is evidence that oral health attitudes and behaviour held by parents of young children can influence children's oral hygiene behaviours and eating habits (Finlayson et. al. 2007). While there is little evidence that the traditional educational based approach is effective studies have highlighted the importance of early targeting of mothers and young children and the role of outreach activities in overcoming cultural and socio-economic determinants (Twetman 2008). However, effective interventions can only be developed when the underlying causes of the problems are identified and understood (Watt, 2007). Qualitative research methods are particularly useful when studying people's attitudes, behaviours and motivations (Bower and Scambler 2007). By using qualitative research methods it is possible to describe and explore individual risk factors for oral disease while also gaining an understanding of the social contexts and processes by which these oral health behaviours are formed and shaped (Bower & Scambler 2007.). It is thus possible to plan oral health promotion interventions that are relevant and appropriate for the participants using strategies which participants have helped develop.

Sure Start local programmes (SSLPs) were set up in the UK to '*to deliver the best start in life for every child by bringing together early education, childcare, health and family support*' (SureStart, 2002). SSLPs are located in geographically defined areas with high levels of deprivation catering for populations of just under 13,000 (Belsky *et al*., 2006; Eisenstadt, 2002). While each programme has local autonomy, they are expected to provide core services which include family support,

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support for play, early learning and childcare experiences, and support for people with special needs (Belsky *et al.,* 2006.). It is the core services of primary and community health care which offer the greatest opportunity for integration with oral health promotion to establish positive oral health behaviours in early childhood .

Before an oral health promotion intervention is implemented it is essential that an oral health promotion needs assessment is undertaken to allow appropriate priorities and targets to be set (Watt and Fuller 2007) . A needs assessment in a community such as an SSLP should involve the people who are to be the focus of the intervention. This would include: first, the oral health concerns of local people; second, an understanding of existing attitudes and behaviours; third, their associated contributory factors and opportunities for and barriers to change as perceived by local people (Ewles & Simnett, 2003; Watt and Fuller, 2007).

The SSLP reported upon in this study was located in a borough of South East London and came into existence as part of the second wave of SSLPs in 2002. At the time of the study the programme had responsibility for approximately 680 families who were predominantly White and English. Previous research in the area indicated high levels of caries and unmet normative need in pre-school children (Zoitopoulos, 2004). At the time of this study a formal oral health promotion intervention was not in place, though an oral health promoter had recently joined the SSLP to develop opportunities for integration of oral health promotion into programme activities.

The aim of this study was to undertake an oral health promotion needs assessment of parents and primary care givers of pre-school children in the SSLP. The research objectives were as follows:

- To explore the oral health concerns amongst parents and primary care givers of pre-school children
- To describe oral health literacy, attitudes and behaviours in relation to pre-school children
- To explore barriers to and opportunities for oral health behaviour change.

Materials and Methods

The topic of interest in this study was an understanding of the processes and the social context in which children's oral health behaviours were formed and shaped (Bower and Scambler, 2007). A qualitative methodology was chosen as the most appropriate to answer the research questions. The methodology adhered to quality guidelines for qualitative research (Spencer *et al.,* 2003).

Sampling and recruitment

Four focus groups were conducted with a sample of 20 residents of the SSLP who had parental or primary child care responsibilities for pre-school children. Residents who were attending community groups were approached by the researchers and recruited into the study. The sampling was purposive and aimed to obtain the greatest variety of observations of residents of the SSLP rather than a statistically representative sample. Participants were recruited to include a mix of ages, gender, ethnic background, country of origin and parenting responsibilities. This reflected the diversity of the population in the SSLP. Thirty people were approached and recruited. Of those originally approached five (all young mothers of pre-school children) did not present for the interview and the remaining people refused because of lack of time or other commitments.

Consent

Written informed consent was obtained prior to the focus groups and participants informed that the focus groups would be taped. A crèche was provided in an adjoining room during the focus group session. The research protocol was reviewed and approved by the Sure Start partnership board. Research Ethics and Research & Development approvals were obtained from King's College Hospital Research Ethics Committee (ref:05/Q0703/107).

The focus groups

The focus groups were exploratory and reflexive (Bowling, 2001). The specific themes of interest were introduced using an interview guide based on the research themes. In addition, the focus group leader encouraged participants to raise new topics and areas of concern relevant to the research questions (Pope *et al.,* 2000). The topic guide was modified and added to as the focus groups progressed in order to test and clarify emerging concepts and themes. Focus groups continued until data saturation occurred (Pope *et al.,* 2000). The focus groups lasted between 45 and 60 minutes and were conducted in the SSLP community centre as the venue was familiar and less intimidating than a dental care setting. All taped focus groups were transcribed verbatim

Data Analysis

The transcripts of the focus groups and the tapes were listened to independently by two of the researchers. Framework analysis was used to analyse the data (Pope *et al.,* 2000; Ritchie *et al.,* 2003). Initial themes and concepts were identified through listening to the tapes and reading the transcripts. An initial detailed index was prepared and two researchers met to refine the initial index into a more manageable set of categories for indexation. The data were then labelled using the index and once the indexing was complete the researchers agreed the final analytical framework and the sorting of the data into the final themes.

Results

Twenty women took part in the four focus groups and ranged in age from 19 to 60 years. . All were either parents (19) or primary carers of a pre-school child. Child care responsibilities ranged from a single first baby to responsibility for five children. Participants were predominantly White English women, thought there was representation from a mix of ethnic backgrounds reflecting the diversity in the SSLP catchment's area. Educational attainment varied from no formal qualifications to a primary university degree. The results are arranged into categories based on the research themes and data analysis and include: engagement with the SSLP, oral health concerns, oral health literacy and barriers to and opportunities for behaviour change.

Engagement with the SSLP

Parents and primary care givers reported that the SSLP had been central to participants' survival during the first few months of parenthood. This was a time when they felt tired, isolated, lacking in social support and unsure of the right thing to do for their young children. Engaging with the programme provided opportunities to socialise, share parenting concerns, access information and social support. Participants liked the way that they could get information in a relaxed way while also having their children around them:

'*You can have your child sitting there while you're relaxing... socialising with other mums …* [including] p*eople from the Sure Start who are always here as well. You can ask them as well because they have children as well so it's ... so you get a lot of knowledge from them as well'*. Line 86 Focus group 4

There were also reservations about the programme with some participants saying that it had been difficult to make contact with. Others suggested that the SSLP could be 'cliquey' and many said they found it difficult when they first joined community groups because everyone else seemed to know each other.

Oral health concerns

The main child oral health concerns identified by parents and primary care givers were: healthy eating, establishing tooth-brushing, managing teething and accessing dental care. Participants were chiefly concerned with how to introduce and maintain healthy eating in their young children, manage fussy eating and the establishment of tooth brushing. Establishing tooth brushing was considered to be difficult though it appeared to be less of a concern compared to dietary issues. Teething was identified as a time when children appeared unwell, but most participants found the information on teething confusing. A minority had observed that many products marketed for teething were also high in sugar, which added to the confusion. Most participants felt it was advisable for children to go to the dentist in early childhood to minimise dental anxiety:

*"The earlier you take them the better then [*they*] are not scared. First time you take them they're scared* '. Line 604 Focus group 2.

Parents and care givers were very concerned that they were unable to establish early visiting because of the lack of local NHS child-friendly dentists. This was a particular worry as participants recalled poor dental experiences in their childhood which had triggered their own dental anxiety.

Oral health literacy

Healthy eating, avoiding sugary foods, tooth brushing and going to the dentist were all mentioned as important in protecting children's oral health. No participant referred to the use of toothpaste and there was some confusion in relation to the use of toothpastes to stop gums bleeding. There was also some confusion around the sugar content of foods that were perceived to be healthy:

'*I thought just because it said low fat they were fine, but the sugar content is ridiculous, oh my god is it ridiculous…..you just don't think*' Line 548 Focus Group 2

Participants were remarkably receptive to new ideas and information. The ways in which mothers wanted to receive oral health information were diverse. Some preferred to receive information through SSLP groups and advice sessions, while others read avidly and trawled the internet for advice. It is worth noting that the informal network of other parents and programme volunteers were rated equally important as other more formal sources of information. Most participants felt that while they had the knowledge to prevent dental disease, the problem was translating that knowledge into actions to introduce positive oral health behaviours.

Barriers to and opportunities for oral health behaviour change

A recurring theme in all four focus groups was the challenge of being a new parent, and how lack of sleep and constant tiredness affected coping and parenting skills. It was common for participants to say that they wanted to do the right thing but they were often too tired to act:

'Things aren't going as they should because of lack of sleeping. It's very hard to prioritise the same way then as it is the rest of the time…you're on auto-pilot, you're just getting through the day. Line 73 Focus Group 1.

Participants were confused about the inconsistency between some general and oral health messages. It was noticeable for example that only participants who had attended an antenatal class run by an oral health promoter had picked up appropriate dietary messages for oral health. Most participants felt it was difficult to avoid sugary foods because these were widely advertised and available. Healthy foods (described as fruit and vegetables) were scarce, of poor quality and expensive. Parental skills already compromised by tiredness were further challenged by trying to manage fussy eating, the introduction of healthy foods and coping with children's demands for sugary foods which they saw their friends enjoying:

'*The trouble I have with L's lunchbox, she's got a friend that has jam sandwiches everyday and so it's "well can I have jam sandwiches" and its "no". You can have them on Friday, and she says "but he has them everyday*" Line 220 Focus group 1

The majority of participants reported cost and dental anxiety as the chief barriers to accessing dental care. Some participants said they had stopped going to the dentist once their eligibility for free dental care had ended. The lack of a local NHS child-friendly dentist was cited by almost all as a barrier to taking children to the dentist.

The SSLP could also provide opportunities to support behaviour change. The chief opportunity was the social support provided to mothers. Recent research has shown that social support predicts better outcomes for mothers and parents living in deprived communities (Wiggins *et al*., 2004). Participants liked the informal way that they could learn new skills and relished the opportunity to discuss parental approaches to managing behaviour, particularly around foods and drinks deemed 'bad for teeth'. The SSLP was a safe trusted place and some suggested that dentists could locate practices in the programme building and be part of the child friendly ethos. Participants said that engagement with the SSLP

had helped many of them understand the nutritional content of the foods they bought and ate. Indeed some had been inspired by Sure Start workers to prepare their own baby foods:

'*What we do is cook a whole load then freeze it. So it lasts like a couple of weeks so it might take around half an hour once you put the vegetables in together, obviously all the cutting up and peeling yeah but altogether from start to finish about half an hour'*. Line 73 Focus group 2

Many of the themes addressed by the SSLP were areas of common interest for health promotion, in particular nutrition, teething and the physical care of young children.

Discussion

The oral health concerns reported in this study such as introducing healthy eating, establishing tooth brushing, teething and access to dental care have also been reported elsewhere (Mofidi et., 2009). Participants in the present study had adequate oral health literacy but further oral health promotion work would be needed to correct assumptions and clarify understanding in relation to diet and tooth-brushing. All of the participants were anxious to do their best for their children and considered their children's oral health a priority. In contrast, a qualitative study undertaken in a similar 'Head Start' programme in the US, reported that parents felt children's oral health was a low priority because deciduous teeth would be replaced and because of the need to fulfil other competing priorities (Mofidi *et al*., 2009). Participants attending the focus groups in the present study actively sought information and saw their SSLP rather than their dentist as important sources of dental advice. The staff had fostered excellent communication with participants in contrast to the US 'Head Start' programme, where mothers reported feeling judged and blamed by staff in the programme (Mofidi *et al*., 2009). Previous studies have demonstrated that mothers' oral health self-efficacy oral health knowledge, beliefs and attitudes can influence children's oral hygiene behaviour (Finlayson *et al*. 2007). This study demonstrates how a SSLP could create the conditions for mother's to act on positive motivations. In the safe supportive environment of the SSLP mothers were prepared to consider modifying their own and their families' diet and oral hygiene practices. Participants had reflected quite deeply on what some of these behaviour changes would entail, in particular the need to become more secure in their parenting skills, which was also a key finding in the US 'Head Start' (Mofidi *et al*., 2009).

Many of the issues covered by the SSLP were areas of potential input for oral health promotion particularly around nutrition, 'teething' and the care of young children. The programme was in a position to create the support networks and develop the skills necessary for participants to implement behaviour change. However it was notable that those who had received information from an oral health promoter had a clearer understanding of the food and drink choices necessary to secure oral health. This has important implications for oral health promotion. Should oral health promotion interventions be fully integrated into SSLPs and be delivered by a range of different Sure Start workers at the risk of diluting the oral health message? Is it preferable to use specialist oral health promoters? The limited evidence from this study suggests that specialist oral health promoters might be preferable for dissemination of oral health messages. However, it is essential that oral health promotion taps into the social support and networks available in SSLP to create the conditions for people to feel enabled to change behaviour (Mofidi *et al*., 2009). Future research is required to study how integration of oral health promotion and general health promotion might be operationalised to maximise outcomes.

SSLPs are not a panacea for all. Parents report that they engage with SSLP to overcome their isolation and obtain practical benefits for themselves and their children (Avis *et al.,* 2007). But there are acknowledged problems with programme such as problems with lack of engagement due to low self confidence, fear of cliques and misunderstanding about what SSLPs are about (Avis *et al.,* 2007). The targeting of deprived areas by SSLP may also be stigmatising for users of services, a limitation which it is hoped will be addressed by Children's Centres (Department for Education & Skills, 2003) which will have universal coverage. SSLPs and their successors Children's Centres present an exciting opportunity for oral health promotion. Harnessing the huge infra-structure of an SSLP or Children's Centre allows oral health promoters to work towards increasing health literacy and skills within the context of an environment which is also tackling the determinants of health at a local level.

The use of a qualitative research methodology has made it possible to describe and explore individual oral health concerns while also gaining an understanding of the social contexts and processes by which oral health behaviours are formed and shaped (Bower and Scambler,2007). The use of qualitative research methodology could also be applied to the evaluation of oral health promotion where there is a need to develop appropriate outcome measures that assess the impact of interventions on participants (Watt *et al.,* 2006).

Limitations of the study

While the study has provided insight into the social context of oral health behaviours the findings should be interpreted with caution. This is a small study reflecting the views of participants who successfully engaged with the SSLP. It is reasonable to assume that residents who excluded themselves from programme activities would have had more negative views about SSLPs compared to participants who had taken part in the study (Avis *et al.,* 2007). The views of ethnic minorities, particularly Asian groups were underrepresented in this study because of difficulties in recruitment. Participants knew that the researchers came from a dental background and as a consequence they may have been reluctant to report actual concerns and oral health behaviours. They did however report quite negative views about dentists, dental visiting and were open about the problems they encountered in trying to establish healthy eating. This suggests that they may have accurately reported their true concerns and oral health behaviours.

Conclusions

Community interventions such as SSLPs provide an exciting opportunity for oral health promotion in the future. There is the potential to tap into a wide range of resources and support services which horizontal oral health promotion programmes rarely have the resources to command. However the way in which integration of oral health and general health promotion is achieved will need further research. This study has also shown that a qualitative methodology can give insights into how oral health behaviours are shaped and formed. In the future the evaluation of oral health promotion interventions must also consider employing qualitative research methodologies.

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