# Report on Findings

# Exploring Perceptions of Early Childhood Oral Health within Different Cultural Groups in Manitoba

**Submitted by Janet Sarson & Alex Wilson**

**Submitted to Lavonne Harms**
**Coordinator**
**Healthy Smile Happy Child**
**Faculty of Dentistry**
**University of Manitoba**

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# Healthy Smile Happy Child
# Report on Focus Group Research

## EXECUTIVE SUMMARY

The Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay (MCP) recently undertook an exploratory qualitative research study to examine attitudes, beliefs, perceptions and practices relating to early childhood oral health within Aboriginal, Hutterite, refugee and immigrant communities in Manitoba (groups that are at high-risk of developing early childhood caries (ECC)). These elevated rates of ECC suggest that conventional oral health promotion activities may not be completely effective in these communities. MCP organized a series of four focus group discussions in Winnipeg and a rural location in southern Manitoba in which parents and caregivers from Aboriginal, Hutterite, refugee and immigrant communities were invited to share their personal understandings and experiences relating to early childhood oral health.

The parents and other caregivers who participated in the focus groups generally seemed to have a good understanding of what does and does not contribute to good oral health outcomes for babies and very young children. Not surprisingly, there were similarities *and* differences within and across the groups with respect to things such as how participants might understand certain aspects of oral health or how they might incorporate the things they know into the daily care they provide to their children.

Perhaps the most striking finding of this research was revealed not by what participants said but by how they interacted in their groups. Over the course of the focus group discussions, participants shared and compared experiences, information and parenting strategies, challenged and filled in each other's knowledge gaps, pulled together a collective body of knowledge on the subjects they were discussing and actively refined their own individual understandings of how to best take care of their young children's oral health. Participants were the authorities or experts in the groups; they were there because the research team wanted to learn about their experiences and their knowledge. The focus groups demonstrated what participants in all groups identified as especially effective ways to get information out to parents and caregivers: interactive and peer-led learning in the context of mutually empowered relationships.

When asked to describe "what healthy teeth means for babies and very young children", participants in all groups referred to the absence of decay and other aspects of the physical condition of a child's teeth. Aboriginal parents drew out the link between healthy teeth and a child's emotional wellness. In the groups with Hutterite, refugee and immigrant parents, participants referred to the importance of oral hygiene practices and nutrition. When participants were asked if it was important that children's baby teeth be healthy, participants in all groups indicated that it was, although a participant in both the Aboriginal and refugee groups suggested that the health of baby teeth may not be a major concern because they are replaced by adult teeth. Refugee and immigrant parents and caregivers spoke about the relationships between the health of baby teeth and the health of adult teeth. Both Aboriginal and Hutterite parents mentioned the relationship between the health of a child's teeth and their emotional wellness.

Participants in all groups agreed that candy and treats play a major role in ECC. When asked why young children develop decay or cavities, Aboriginal and refugee parents and caregivers also mentioned the importance of oral hygiene routines; refugee participants suggested that genetics may contribute and immigrant participants referred to the impacts of calcium deficiencies and other aspects of the overall health of a child's body.

Hutterite participants discussed the role that fluoride and other minerals may play in protecting teeth from ECC, an important consideration for parents who live in colonies that use locally sourced non-fluoridated water. The Aboriginal parents' and caregivers' discussion of the role that bottle feeding may play in ECC revealed that at least a few parents were not convinced that bottles or bottle propping contributes to ECC (although they did accept that bottle feeding may contribute to the development of ear infections). More generally, participants in all groups agreed that the health of a child's teeth is linked to their overall health.

In all groups, participants most frequently identified their parents and other family members as the people from whom they learned how to take care of their babies' and young children's teeth. They had also learned from health educators and practitioners, including, for some Hutterite parents, a HSHC workshop. Some of the immigrant parents noted that, in their home countries, small workshops or lessons from health practitioners were a part of routine checkups when they were expectant mothers or when they had taken their children for routine vaccinations. Participants in all groups indicated that they are practicing good oral hygiene with their babies (including cleaning the mouths of newborns) and young children. In all groups, one of the most significant challenges parents face in taking care of their children's teeth is getting their children to cooperate with or follow up on oral hygiene routines. Participants in the Hutterite, refugee and immigrant groups also identified monitoring or controlling children's consumption of sweets as an issue. A surprising number of parents and caregivers in the Aboriginal and (to a lesser extent) Hutterite groups shared stories about young children's teeth being removed and about children refusing or resisting visits to the dentist. Interestingly, parents and caregivers in the refugee and immigrant communities reported almost no significant problems with their children's teeth.

In all groups, participants shared information about culturally-specific or localized knowledge and practices relating to oral health. Participants in the group with Aboriginal parents and caregivers discussed traditional medicines and medical practices. They emphasized that because traditional medicine is inseparable from spirituality, it is important to respect and adhere to cultural protocols in this area. Muslim participants in the refugee group also touched on spirituality, pointing out that the Prophet recommends that people incorporate oral hygiene into their daily routines. Participants in both the refugee and immigrant groups also spoke about using a *sewak* or twig (in some cases, along with ash) in place of a toothbrush to clean their teeth. Parents in the group with Immigrants also discussed a belief held by some in their home country that it is a bad sign if a child's upper teeth appear before their lower teeth do. In the group with Hutterite parents and caregivers, participants mentioned several times the routine practice of giving water to babies at a very early age. This practice, which participants indicated they had learned from their parents, persists in the community even though, as one parent reported, it has been challenged by medical professionals.

Participants in all groups pointed to the importance of peer networks, interaction and personal relationships and opportunities to draw on existing resources when promoting early childhood oral health in their communities. Aboriginal parents and caregivers emphasized the value of interactive activities such as home visits by public health nurses or workshops for parents. They also called for more programming to teach children about oral hygiene (and, they noted, the children could then pass what they learned onto their parents, a point also raised by immigrant parents and caregivers) and that Elders could be a valuable part of these activities. Aboriginal, refugee and

immigrant participants suggested that oral health promotion activities could piggyback on existing programs that parents and caregivers already connect with, such as mother-and-tots programs or EAL classes. Both refugee and immigrant participants also recommended that community members be recruited and trained in oral health promotion so that they could serve as peer educators within the different distinct communities that make up the refugee and immigrant population (train-the-trainer models). Hutterite parents and caregivers held up the HSHC workshop in their community as a good example of how to get information out to parents and families, emphasizing the exponential uptake of information in their community, as parents who participated in the workshop shared what they had learned with other community members. Hutterite group members were also the only participants who identified the internet and print materials as particularly effective ways to share information.

The focus group discussions involved relatively small samples from very diverse communities. It would not be appropriate to assume that the findings of this research project apply to all members of any particular population. However, the findings do provide some promising starting points. MCP/HSHC should continue to commit to community development strategies; enhance and diversify the range of activities they provide; and work to build mutually empowered relationships with the Aboriginal, Hutterite, refugee and immigrant communities they serve. In addition to those long-term goals, the findings revealed some possible directions for activities. MCP/HSHC needs to continue to use and build upon its existing educational approaches and materials, particulary in areas such as the long-term impacts of ECC, bottle-feeding and ECC and the role of fluoride (areas where focus group participants had some gaps in knowledge). The findings also pointed to some issues that MCP/HSHC and other oral health programs should consider, including the impacts of poverty on parents' and caregivers' ability to care for their young children's oral health (including practical, do-able strategies parents and communities can use to manage these impacts); why parents and caregivers in the refugee and immigrant groups reported no dental surgery or other significant oral health problems for their young children (in contrast to the Aboriginal and Hutterite groups, where relatively high rates were reported); and what made the HSHC workshop an effective learning experience for Hutterite participants.

Ultimately, the findings of this research project point to peer-based learning and the development of mutually empowering relationships (already a central part of MCP/HSHC activities) as an effective way to improve the understanding of – and care for - early childhood oral health with high-risk populations. Meaningful community engagement and community development strategies can help us continue to develop, provide and refine effective health promotion activities.

## INTRODUCTION

The Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay (MCP) recently undertook a qualitative research study that explored attitudes, beliefs, perceptions and practices relating to early childhood oral health with Aboriginal, Hutterite, refugee and other immigrant communities in Manitoba.

The study was designed to inform future activities of MCP's Healthy Smile Happy Child project. Healthy Smile Happy Child (HSHC) is based on community development principles. HSHC seeks to increase parents', caregivers', health care professionals' and service providers' understanding of the importance of Early Childhood Caries (ECC) and to build the capacity of communities to support parents and other caregivers, other service providers, and health care professionals in ECC prevention. HSHC works with existing programs and services that target young children to provide service providers and parents with knowledge and tools that can help them to prevent ECC. HSHC's overarching goal is to support parents' ability to take care of their family members' oral health.

Within Manitoba, Aboriginal, immigrant and refugee, and Hutterite children may have an increased risk of developing ECC. This suggests that oral health promotion activities that have been undertaken thus far in these communities have not been entirely effective. MCP wanted to understand why this is and what changes it could make to its own activities that might improve outcomes in these communities. Focus group discussions with representatives of each of these communities were organized to:

- learn more about how each of these groups define early childhood oral health and view ECC,
- explore similarities and differences in the groups' perceptions, and
- gather suggestions from each group on potential ways to promote preschool and infant oral health in their communities.

Participants were asked to share their personal understandings and experiences relating to early childhood oral health and to provide ideas about how HSHC might most effectively reach parents and other caregivers in their communities.

## 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 researchers and to gain knowledge and validation in their interactions with other participants. The questions explored in this project (what people think and do about early childhood oral health and ECC, and how oral health educators might best connect with their communities) fit well with focus group research.

A series of four focus group discussions with parents and caregivers of children six years of age or younger were held at urban and rural locations in southern Manitoba:

- Aboriginal participants were recruited through an Aboriginal Head Start program and through Ma Mawi Wi Chi Itata Centre Inc., an organization that provides culturally-relevant preventive and supportive programs and services to Aboriginal families. Participation in this group was restricted to people who identified as Aboriginal. Nine people participated in this focus group discussion, which was held in the North End of Winnipeg.

- Hutterite participants were recruited through a teacher and researcher who is member of a Hutterite colonyand who already had a working relationship with the Department of Pediatrics & Child Health, University of Manitoba. Participation in this group was restricted to people who were members of a Hutterite colony. Fourteen people participated in this focus group discussion, which was held in a colony in Southern Manitoba, including 8 people on site at the colony and an additional 6 people who were at a different colony but connected to the group via closed circuit television.

- Refugee participants were recruited through the Canadian Muslim Women's Institute, which provides services and supports to Muslim women in Winnipeg. Participation in this group was restricted to people with refugee status and who had been in Canada for at least one year. Eleven people participated in this focus group discussion, which was held in downtown Winnipeg. The home countries of these participants

included Congo, Morocco, Guam, Nigeria, Chad, Somalia, Iraq, Afghanistan and Ethiopia.

- Other immigrant participants were recruited through an English-as-an-additional-language program in Winnipeg. Participation in this group was restricted to people who are landed immigrants, who had an English benchmark of at least 4 and who had been in Canada for at least one year. Six people participated in this focus group discussion, which was held in the West End of Winnipeg. The home countries of these participants included the Democratic Republic of the Congo, Nigeria, Sudan, Eritrea and Azerbaijan.

The team facilitating the focus group discussions included an experienced qualitative researcher and an HSHC staff member. Study design was approved by the Health Research Ethics Board at the University of Manitoba and 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 verbal consent to make an audio-recording of the discussion, which they permitted in all groups. The research team also made notes on a flip chart during the discussions. This gave participants an important opportunity to see the research team's initial understanding and interpretation of what they were saying. 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.

The focus group discussions followed a sequence of guiding questions developed by the HSHC partnership and designed to keep the discussion focused on the overarching research questions. Additional probing questions were used as needed to elicit more or specific detail or clarification. Food and child care were provided at each focus group discussion, participants were offered bus tickets to support their transportation to and from the groups, and all participants (regardless of their level of participation) were given a small honorarium when they left.

For two of the focus groups, language differences influenced the procedure and dynamics of the group discussion. In both focus groups with parents and caregivers who were refugees or other immigrants, all participants spoke English as an additional language. The majority of participants in the refugee group had limited English skills; the

larger group broke down into smaller language "pods" consisting of a participant who could act as an interpreter and a few of their language peers. When the facilitator presented a question, the interpreters would explain the question to their peers, who would discuss and respond to the question. The interpreters would then summarize in English the groups' responses. The interpreters, then, had control over what they communicated as the content and meaning of their language peers' responses. Additionally, the research team could not distinguish which particular participant or how many participants had offered any given bit of information.

In the focus group with immigrants, all participants spoke English well. However, when one participant was describing a particular teaching about children's teeth from her home country, she indicated that she could not find a way to say what she wanted to in English and then switched to her first language. The research team then had to rely on her language peers as interpreters, which again meant that other participants had 'interpretive control' over the meaning and content of her comments. This group also included a pediatrician. When we began the discussion, the pediatrician offered quick and thorough responses to our questions and most other participants either deferred or added little to this person's comments. To support participation from all group members, the facilitator then began to ask each participant for their individual response to the guiding and probing questions, an approach that successfully shifted the group dynamic. The facilitator was then able to resume asking questions to the group rather than individuals.

One objective of this research was to learn how parents and caregivers perceive and understand early childhood oral health and 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 opportunities to 'educate' participants during the focus group discussions. However, the HSHC staff member was available to answer questions and share information with participants following the discussions.

The notes and recordings from the discussions were transcribed and analyzed by the qualitative researcher on the team. When analyzing the data, the researcher first looked at the data sets from each of the participant groups independently, drawing out participants' responses to the overarching research questions. She then looked at the

data as a whole, noting any similarities or differences in findings from each of the groups. As she reviewed the data at each step in the analysis, she noted emerging themes in relationship to the research questions, under which she categorized and collated data from each group. Finally, she systematically reviewed the data and again recorded significant similarities and differences. A descriptive summary of findings is presented below.

## SUMMARY OF FINDINGS

The findings from this research study include information about how the parents and other caregivers who participated in the focus groups understand and take care of their children's oral hygiene needs, along with their suggestions about the best ways to get oral health information to parents and other caregivers in their communities. This, in turn, may help HSHC develop more effective community development and tailor health promotion activities for these populations.

While the findings from this study will likely be useful to HSHC, the experiences and understandings that participants shared should not be assumed to represent the experiences and understandings of all members of any of the cultural groups represented in the study.

Given that participants in all 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 or caregivers who had established relationships with these workers or organizations. A 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.

### Definitions and perceptions of early childhood oral health

The focus group discussions began by asking the parents and caregivers ***what 'healthy teeth' means for babies and very young children***.

- In their responses to this question, participants in the focus group with **Aboriginal parents and caregivers** referred to teeth being clean, free from decay and not falling out. One participant referred to children's emotional wellbeing, pointing out that "if they have a toothache, they're going to be all upset and miserable, crying, in pain."

- The majority of responses from the **Hutterite parents and caregivers** who participated in a focus group related to oral health care. Participants referred to teeth that are "well taken care of", daily brushing and flossing, and "someone [who] is taking the time to brush and wipe." Participants also mentioned a proper diet, the absence of cavities and one parent pointed out that 'healthy teeth' reflect the "whole health" of the body. Another participant later asked if "how white the teeth are" has anything to do with how healthy they are, to which another participant replied, "not really", because the teeth of young children are sometimes "translucent".
- Participants in the focus group with **refugee parents and caregivers** referred to the physical condition of children's teeth (strong, nice and don't have any problems so don't have to go to the dentist), diet (avoid giving child sweets) and oral health care practices (wash baby's mouth, brush child's teeth and keep clean).
- Participants in the focus group with **other immigrant parents and caregivers** referred to the condition of children's teeth, oral health practices and diet in their discussion of what "healthy teeth" means for young children. Healthy teeth are free from caries, broken teeth and redness, swelling or pain in the gums (the "inflammatory process"). Participants emphasized the importance of taking care of young children's teeth. For some, this meant ensuring that children's teeth are cleaned at least each morning and night (with one participant stating that night is particularly important because otherwise "food stays in their mouth for a long time") and for others 3 or 4 times a day or whenever a child eats. Participants indicated that regular visits to a dentist (including yearly cleaning) or doctor should be part of children's oral health routines. In addition to the medical care they provide, medical practitioners can help to educate parents and caregivers about oral health. For example, one mother explained that the "bottle is not good for teeth, the nipple". She learned this because her daughter "has teeth that are black" and when they went to the dentist, the dentist recommended that she should give her daughter a cup rather than a bottle. Other participants agreed that children should start using a cup at an early age. They also spoke about the importance of making sure that children do not eat many sweets (such as candy, chocolate or ice cream) and that they get lots of raw vegetables and fruit (like carrots and apples, which are "hard and good for the teeth"), milk and milk products (because calcium is good for teeth, especially when children are growing) and water.

Participants were next asked if it is ***important for children to have healthy baby teeth***.

- The **Aboriginal parents and caregivers** who responded first to this question agreed that it was important for children to have healthy baby teeth. One parent, however, felt that it doesn't matter whether or not baby teeth are healthy because they are "going to fall out anyways." Another parent quickly pointed out that "If they have a cavity, then they're going to be crabby. If they have healthy teeth, they won't be grouchy."
- **Hutterite parents and caregivers** also agreed that it was important for children to have healthy baby teeth. They pointed out that it can be painful and traumatic for children when their teeth are not healthy. One parent added that at this time in children's lives, parents may be "building habits for a lifetime of brushing."
- Participants in the group discussion with **refugee parents and caregivers** indicated that it is important to keep baby teeth healthy, noting that parents and caregivers should use a cloth to take care of their young baby's teeth. They observed that the health of our baby teeth can affect the health of our adult teeth.
- Participants in the focus group with **other immigrant parents and caregivers** seemed to agree that it is important for children to have healthy teeth. As one participant explained, bacteria/flora ordinarily present in a person's mouth are important to processes like digestion. However, if an infection develops in the mouth, bacteria/flora can change and infection may travel to other parts of the body, resulting in things like facial swelling. Another participant suggested that "if the first set of teeth starts bad then that will transfer to new [adult] teeth."

Participants were asked ***what makes very young kids get cavities or decay in their baby teeth***.

- **Aboriginal parents' and caregivers'** responses focused on nutrition and oral health care practices. They referred to sugar intake and junk food (singling out juice, pop, candies, ice cream, pudding and baby food) as contributors to decay. Some parents also described the difficulties they sometimes have getting their children to brush their teeth:

  > It's hard with my kids to get them to brush their teeth. I have to hold them there and brush them for them. They don't like to brush their teeth. It only takes a couple of seconds, but it's a big deal.

My daughter, it hurts - because you don't brush them or because she's brushing too hard.

Mine are too lazy.

Some participants had found that toothpastes or toothbrushes designed specifically for children ("if it has Buzz Lightyear on it…") can make some more willing to brush their teeth. Other parents in the group indicated that it was not difficult to get their children to brush their teeth, but this, as one parent noted, did not stop her child from developing decay in her front teeth. Another parent observed that her daughter brushes her teeth as often as seven or eight times a day and worried that this might be over-brushing.

In a later discussion of ECC, a group member suggested that children's oral health may, in part, be affected by what pregnant women eat: "Everything you eat when you're pregnant, everything that goes in your mouth, your baby gets it." Other mothers in the group concurred with this statement. The group also talked about the role that bottles might play in ECC, noting that giving children a bottle to go to sleep with at night can contribute to tooth decay. While several mothers had heard this before, a few stated that they didn't think that it was true. These same participants did, however, believe that bottle propping can cause ear infections for babies, "because the milk leaks and goes into the baby's ears."

- For the **Hutterite parents and caregivers** who participated in a focus group, what young children take into their bodies affects whether or not they will develop cavities or decay. Group participants singled out "junk food" and an "improper diet" as important contributors to ECC. One parent pointed out that if children are allowed to go to sleep after sweets or a bottle without first brushing or drinking water, the "sugar stays on their teeth for a long time." Other participants also referred to the importance of drinking and/or rinsing with water after eating. One related the story of their grandfather who rinsed his teeth with water after each time that he ate, noting that he still had all his teeth when he died in his late sixties.

  The group discussed the impacts of fluoride and other minerals on oral health. Participants were not aware of any local Hutterite colonies that add fluoride to their water but noted that fluoride does occur naturally in the water of some colonies. Other colonies use water that has been treated by reverse osmosis, a process that removes all minerals from the water. One participant wondered whether or not this

might affect oral health. Another observed that "different kinds of water can affect children's teeth" and, noting that in some colonies where people's teeth seem "pearly white" the water is particularly salty, asked whether or not some minerals "wear children's teeth down more".

The group also considered whether heredity might play a role in whether or not children develop cavities or ECC. As supporting evidence, one participant pointed out that even in colonies that "are making quite a bit of an effort" to care for children's teeth, "a lot of kids have to fill their teeth." Another participant stated that, while they did not remember ever brushing their teeth as a child, they had never had cavities and wonder if this might reflect the influence of hereditary factors or diet on the health of children's teeth.

- Participants in the focus group with **refugee parents and caregivers** identified sweet things such as chocolate and sugar (which "will stick on teeth") along with inadequate oral health care practices as contributors to ECC. As one parent stated, "If children brush teeth all the time and don't eat a lot of sweet things and go to a [dentist] regularly, it will protect teeth from cavities." Participants also suggested that genetics might play a role.
- Participants in the group discussion with **other immigrant parents and caregivers** focused on diet in their responses to this question. Consuming sugar (in the form of things like candy or juice) creates a good environment for bacteria, so it is particularly important that children brush their teeth before they go to bed. A participant also pointed out that people who take very good care of their teeth may still have problems with them that relate to or are a result of other health conditions such as a blood-borne infection or calcium deficiency. Calcium deficiency is a significant concern for children because while their bodies are growing they need more calcium than adults ordinarily do.

Participants were asked about ***the role that candy and treats play in young children developing early childhood tooth decay***.[1]

- Participants in the focus group with **Aboriginal parents and caregivers** indicated that that candy plays a major role in early childhood tooth decay. Whether or not

[1] Due to time constraints, the research team was not able to ask this question in the focus group with immigrant parents and caregivers.

treats contribute to the development of early childhood tooth decay depends, one parent stated, “on what kinds of treats you’re giving them”.

- Participants in the focus group with **Hutterite parents and caregivers** indicated that candy and treats play a major role in ECC. Sweet cookies, candies that stick to the teeth or last a long time (e.g., jujubes and hard candies) were singled out as problems and sugar-free gum as a better choice. Participants considered whether it’s best for children to eat all their candy at once (and brush their teeth afterwards) or to store them and eat small amounts over a longer period. A participant suggested that “sugar works on the mouth for only ten minutes or so, so it’s better for children to eat it once or twice a day versus all day, even if they’re eating the same amount.” Pointing out that “you can have a kid who doesn’t eat candy and doesn’t brush or a kid who eats lots of candy and brushes and the kid who eats a lot of candy will be better off,” a few participants seemed to feel that brushing and rinsing may be more important than a child’s intake of candy and treats.
- Participants in the focus group with **refugee parents and caregivers** identified sweets (singling out coke and sugar) as a contributor to ECC. One participant explained that sweets encourage the development of germs and bacteria, which in turn increase the likelihood that cavities will develop. Another participant pointed out that decay can also be generational or genetic, offering the high occurrence of “bad teeth” in her family as an example.

Participants were asked ***whether or not a child’s teeth are healthy is linked to their overall health***.

- **Aboriginal parents and caregivers** agreed that they are linked. They pointed out that, in addition to toothaches, children may develop fever or swelling as a result of poor oral health. One parent suggested that when a child wiggles their loose tooth out rather than simply waiting for it to fall out on its own, their adult teeth may grow in crooked.
- **Hutterite parents and caregivers** also agreed that they are linked. At least one parent had learned about the connections between teeth problems, heart troubles and other health conditions at an HSHC workshop. Another parent stated that, “all kinds of disorders and problems can start if you have a bad tooth and leave it for a long time.” Infections can spread through your blood and affect other parts of your

body. Additionally, as a participant pointed out, "if [children] have bad teeth, how can they eat?" Having healthy teeth, another participant stated, "supports peace of mind for mom and child."

One parent in the group shared a story that suggested that a child's overall health may also affect the health of their teeth. She reported that her seven-year old child has many cavities. A dentist initially suggested that the problem may have begun prenatally but, as the mother explained, she had drank milk and been careful while she was pregnant. The dentist then asked if the child had been sick frequently when younger and the mother recalled that her daughter had had many ear infections in the first five years of her life. They concluded that these health problems, along with antibiotics her daughter had taken to treat the infections, had affected the development of her teeth.

- Most participants in the focus group with **refugee parents and caregivers** agreed that good oral health contributes to a child's overall health. They pointed out that if a child has a lot of cavities or other problems with their teeth, they may not be able to eat, may develop a fever or headaches and will likely feel sad. One participant suggested that if a baby's teeth appear at an early age then they will be healthy when they grow up. Another participant (whose son has a bleeding disorder) reported that she had been told not to worry about the condition of her child's teeth, because they "will fall out and new teeth will come up." One participant dissented slightly from the group, stating that having a healthy body does not depend on having healthy teeth, but does depend on antibodies and a good immune system.
- Participants in the group discussion with **other immigrant parents and caregivers** indicated that a child's oral health does affect their overall health. As a parent noted, if a child who is normally active suddenly does not play or their behaviour changes in other ways then something may be wrong with their teeth. Infection can travel from a child's teeth to their body. Additionally, a parent observed, "our teeth are not there just for beauty – they work for us." Teeth are an important part of our gastro-intestinal tract and enable us to eat the full range of foods that our bodies need.

**Caring for young children's oral health**

Participants were asked ***where they had learned how to take care of their babies' or young children's teeth***.

- Participants in the focus group with **Aboriginal parents and caregivers** indicated that they had learned primarily from their mothers or grandparents. One participant explained that her grandparents had taught her to use a facecloth to clean her young babies' gums and an infant's toothbrush to clean their new teeth. Other participants mentioned tools like disposable newborn toothbrushes, swabs and toddler brushes. Only one group member indicated that they had learned about oral health care for children in a community program. This participant had learned at a Healthy Baby program about newborn toothbrushes and toothpaste and that a mother's oral health during pregnancy can affect her unborn child's health. Another participant pointed out that she had learned what to do – and what not to do – from other parents. A few participants had learned from commercials, brochures and pamphlets picked up at places like doctors' offices. One new mother had been shown by a specialist in the NICU how to care for the oral health of her child who had been born with two teeth:

  > I already knew what to do, but she said because my baby is premature, because her mouth is small, she showed me different ways of using other stuff to clean her gums and her tongue and her cheeks… That's the first premature baby they'd seen that [didn't have] thrush.

- Participants in the focus group with Hutterite parents and caregivers also indicated that they had learned much of what they know about how to care for their young children's oral health from their parents and grandparents. One parent pointed out that from her own experience as a caregiver she had learned that, for example, "when you bathe the baby, you should wipe out their mouth." In an indication of just how variable individual parents' and caregivers' knowledge and experience may be, at least two parents in the group indicated that they had not been aware of this. One related that:

  > I went to the dentist and she said, "Ok, you just had a baby. You know you have to clean their teeth." I thought she was just being funny. You know? "Take a washcloth and wipe off her gums even before she has teeth so she gets used to that washcloth in her mouth."

Other participants also referred to learning about early childhood oral health care from health practitioners, including dentists and HSHC workers. Participants in this group emphasized the important role that printed materials (including posters and articles in maternity wards and pamphlets specifically about caring for baby's mouth or teeth that were distributed to a new mother when she left the hospital after giving birth) and the internet had played in their education.

As one participant stated, "we're still gathering information" on early childhood oral health care. Several parents indicated that they read articles and actively search for information on-line using tools such as Google. One participant had been sent articles relating to oral health care by her father-in-law and another had learned about wiping a newborn's gums on a website. Participants checked websites such as Canadian Parent, parenting.com and Dr. Sears for parenting information. When asked what search terms they might use to gather information on oral health care for young children, participants suggested phrases such as "baby teeth care", "causes of tooth decay" or "ear infection tooth decay". When asked specifically if they had gathered information on oral health care from television or radio, the participants in this group indicated they had not.

- Participants in the focus group with **refugee parents and caregivers** had first learned how to take care of their children's teeth from their families and friends. As one participant stated, teachings about oral health include what you inherit from your family, what you grow up with and then what you learn. Some had gathered information on oral health care from school (in science and health classes) and from doctors and other medical practitioners at hospitals and clinics. When prompted, a few indicated that they had seen information on oral health care for young children on television commercials and in pamphlets at the doctor's office, but these did not seem to have not been particularly important information sources for most. One mother, however, stated that she did not have much information about oral health care for babies and young children until she came to Canada, where she learned things like to tell her youngest child to brush from school, television and medical practitioners.

  The majority of participants in this group were Muslim. A participant pointed out that, for people of this faith, "keeping oral hygiene is even part of our religion". She elaborated:

> It's part of the obligation. As part of Islam, we pray 5 times in the day. It is most recommended that you brush your teeth. There is a saying from our Prophet that if I would have told any human being that these are the obligations that you must do, I would have encouraged them to clean their teeth five times a day. He didn't say it's a must for you – it's a very strong recommendation that it is very important. Hygiene is one thing that is next to religion. This is in the Koran, with the deeds that the prophet did [or] recommended. It is there. You can add that to tell you more details than that. It's all where Islam talks about hygiene.

- Participants in the focus group with **other immigrant parents and caregivers** indicated that they had learned how to take care of their children's teeth first from family members or friends (such as their mothers or siblings who had children of their own) and later from medical practitioners. As one participant put it, "I do with my daughter the same my mom did with me." Another commented that her mother had given her additional information about how to care for teeth when she married and became pregnant. For example, her mother had explained how to clean babies' mouths with salt and warm water. Other participants in the group had learned to use warm water and glycerin or baking soda.

  The majority of participants in this group had also learned about oral health care for babies and young children from medical practitioners in their home countries. In some cases, after a child has developed a problem, their parents might learn from a medical practitioner "why and how to prevent it." Parents might also ask dentists or other practitioners for suggestions about care. Most of the parents in this group had also been able to access some form of prenatal and/or postnatal parenting classes or workshops that included oral health education activities at clinics, health centres or hospitals. For example, one participant said that when she was pregnant, she had to go once a month for a checkup. While she and others were waiting for their checkups, they were taught all kinds of things about caring for babies, including how to take care of their teeth and healthy foods for children. This continued after her child was born, in that teachings were also given when she took her child for vaccinations. Another participant shared similar experiences she had had in her home country. After she had given birth and until her child was five years old, each time she took her child for 1-month, 6-month and other routinely scheduled vaccinations, she first had to sit through a 15 to 30 minute class.

  One participant stated that in her home country, a nurse visits new parents at home. They routinely check babies' mouths or teeth and begin talking to parents about caring for their children's teeth before they are one year old. A participant also

reported that in her home country, children's teeth are checked when they receive vaccinations. Another participant learned about oral health care in school.

Participants had gathered more information about taking care of children's teeth since coming to Canada. Two participants indicated that they had learned from family doctors that if their children are having problems with their teeth, they can bring them to see a dentist or doctor. One participant described her experience:

> [The] family doctor, when my child's tooth was a little black, he told me to go to dentist and gave address – but no other information. The dentist said there's nothing too bad about the teeth – it's just the colour. And when her new teeth come out, they'll be better. He said to brush all the time and I don't have to feed her by the bottle. When she was small, I gave her most of the time a bottle. That's why she had the problem. So I have to feed her by the cup and you have to clean always her teeth.

Participants were asked ***how they take care of their babies' or young children's teeth*.**

- As findings presented above indicate, many participants in the focus group with **Aboriginal parents and caregivers** had already shared information about some aspects of their care for newborn, infant and young children's oral health. In response to this specific question, they provided more detail about some of their successes and challenges. One mother described how she models tooth brushing for her child:

  > I brush my teeth with her, brushing at the same time. It's easier. I know she does it. If I tell her to go brush her teeth, she'll just run the water or whatever, play around. But if I do it with her then she does it.

  Another parent acknowledged that she often has to fight with her children or yell at them to get them to brush their teeth. Other parents found it difficult to keep a supply of toothbrushes or toothpaste in their homes because of the cost of these items, they forget to buy them, they can't find them even though they know they bought them, their children play with the toothpaste or their children don't let them know that their toothbrushes have worn out.

- Participants in the focus group with **Hutterite parents and caregivers** described some of their oral hygiene routines, starting with wiping their children's gums when they are newborn. One mother explained that because she lets her child brush her (the mother's) teeth, her child in turn lets the mother brush her (the child`s) teeth.

Participants emphasized the importance of limiting sweets, drinking milk and rinsing with water after feeding. One mother noted that her child had never taken a bottle in her crib and, in fact, had never used a bottle. Another parent pointed out that the volume of most glasses that parents might buy now is much greater than the recommended serving of sweet beverages such as juice. Participants in this group also mentioned that they provided their very young children with vitamins that help support the development of healthy teeth.

When asked if anything might make it hard for them to take care of their young children's teeth, several parents in the group spoke about people giving candy to their children. One parent stated, "I never give her candy, but she gets it from everybody else!" Other things that may make it hard include children's attitude (e.g., when children are tired, grumpy or simply don't want to brush their teeth) and, for parents, finding or taking the time, something that can be especially difficult when they are tired.

- Participants in the focus group with **refugee parents and caregivers** described cleaning their babies' mouths with a cloth or finger and then switching to a brush as their teeth came in. Participants reported that they encourage their children to brush 2 or 3 times a day, including the morning, evening and lunch. Some participants stated that they teach their children to brush after they eat something sweet. One parent observed that, although she talks to her children about the importance of limiting sweets and brushing their teeth, she "doesn't know whether or not they listen." Parents shared other strategies. One participant explained that:

  > My baby is one year old and whenever I want to brush, I take him by the hand and brush in front of him. Now whenever I go to the bathroom, he will pick up the brush and put it in my mouth. When they see what we do, they will do it surely.

  Another participant stated that because her 5 year old child doesn't brush well and sometimes leaves food stuck between his teeth, she holds his hand while he brushes. When asked if anything makes it hard for them to care for their children's teeth, participants again mentioned their inability to control what happens at school. They observed that children eat a lot of sweets here, such as candies, chocolate or biscuits, and that these things lead to decay. One parent talked about how difficult it can be to make brushing an everyday, regular habit because, as a mother, she is very busy. She finds it most difficult to get her children to brush their teeth during the

daytime. As one participant noted, the concepts involved in oral health care are "universally known", but how effectively they are practiced may vary.

- Participants in the group discussion with **other immigrant parents and caregivers** spoke at length about the importance of restricting or discouraging the consumption of sweets, singling out ice cream, chocolate, candy and other chewy, sugary things. Some felt that because most children like sweets a lot, rather than saying "never, ever", parents should allow children to have a small amount every now and then. Another parent observed that "back home it's different" because candy and other sweets are not easily available. One participant has found a way to manage her daughter's access to sweets:

  > Sometimes you need to scare them. My daughter likes chocolate and sugar. When she has cereal, I give her a little sugar but she wants more. I tell her that if I give her more sugar, when I take her to the dentist, he'll remove all her teeth…. Now, sometimes she says, "Don't put sugar!"

  Another parent indicated that she helps care for her children's teeth by offering them lots of raw foods like carrots and apples, milk and milk products and water (particularly before they go to sleep).

Participants in this group emphasized the importance of establishing good oral hygiene practices. As noted earlier, participants in this group cleaned their babies' gums and tongue with warm water and salt, baking soda, glycerin or simply cotton wool. One participant started teaching her children at a year-and-a-half old to brush her teeth, pointing out that it's important to use children's toothpaste because it doesn't "attach" to or damage the kidney. Children's toothbrushes are helpful because they are soft, but children may also use adult brushes and in any case, the brush should be changed every 3 to 4 months. Other participants spoke of the importance of reminding, teaching or assisting children to brush in the morning, evening and each time they eat, including when they are at school. One participant suggested that, rather than seeing a dentist only after a problem has appeared, parents should have their family doctor check their children's teeth every three months or so.

When asked if anything makes it hard for them to take care of their babies' or children's teeth, participants responses referred to issues of control between them and their child. One participant stated that her daughter "wants to brush teeth all day – I can't keep her away!" The group discussed how difficult it is to refuse to give your

children things that they want, such as candies or sweets – and it can be hard for children to understand why they can't have what they want. As parents, they know that they need to be "the boss" and think about how the things their children eat will affect them.

Participants were asked ***when is the right time to start cleaning a child's mouth and teeth***.

- In the focus group with **Aboriginal parents and caregivers**, participants indicated that parents should begin cleaning their babies' mouths at birth and their teeth as soon as they appear:[2]

  > Even after I delivered my baby, I brushed her right away, like 10 minutes after she was born. The nurse walked in on me and I had my pinky finger in my baby's mouth cleaning. She says, "What are you doing?" I said, "What? I'm cleaning my baby's mouth, washing her gums and her tongue and her cheeks. They'd never seen that before. I said, "I've done this with all my babies." Because I've seen a lot of those posters with the [breast milk] and the formula and the amount of sugar that's in them.

- In the focus group with **Hutterite parents and caregivers**, participants also indicated that parents should begin cleaning their babies' mouths at birth. One parent acknowledged that they only do this once a day, even though they know it's recommended to wipe after each feeding. Her solution was to give her baby water to drink, a practice that other parents in the group seemed to share. As one parent pointed out, it's important to clean babies' mouths because there's "something like 8 or 9 [sugar] cubes per cup" of breast milk, only slightly less than juice. Another participant reported that she had "heard that parents used to, when their kids had a cold, just give them warm juice in a bottle and let them suck on it all day [because it] was good for a sore throat." A group member responded to this with the suggestion that parents give their children warm water instead.

- In the focus group with **refugee parents and caregivers**, participants indicated that parents should begin cleaning their child's mouth at birth.

[2] Due to time constraints, the research team was not able to ask this question in the focus group with immigrant parents and caregivers.

Participants were asked if there was ***anything that they thought that people in their cultures or communities might do to look after babies' and young children's teeth that might be different from what people do in other communities or cultures***.

- A few of the **Aboriginal parents and caregivers** shared information about traditional medicines and medical practices. As a participant pointed out, there are "all sorts of medicines out there for all different sorts of things." Group members described some of the herbal medicines used to treat conditions like thrush or colds. When asked if there is a "right way" to gather or distribute these traditional medicines, participants indicated that specific protocols exist:

  Participant 1: When somebody goes and picks those medicines and they…
  Participant 2: It's got to be an Elder or something.
  Participant 1: It's got to be an Elder because that medicine has to be blessed. When the medicine is blessed and it's ready to be passed on, then the person that medicine's being passed on to has to offer….
  Participant 2: A gift.
  Participant 3: Yeah. A gift and tobacco.

  As one participant later stated, "You can't just go anywhere and just ask for it [traditional medicine or traditional healing]." She related that, after her own diagnosis of cancer and limited success with conventional Western medical treatments, she had gone to a traditional healer. At her next scheduled appointment, the doctor asked her why the cancer had suddenly disappeared: "I just told him I had nothing to say… Honestly you've got to be careful." When asked what information they wanted us to share about this with dental professionals, a participant pointed out that, "You can't just go out and grab it or go into the store. It's a sacred thing!" They advised that before incorporating any traditional knowledge or medicines into programming, the appropriate protocol is to first ask an Elder for permission to share these things.

- Participants in the focus group with **Hutterite parents and caregivers** responded to this question with a lengthy discussion about giving water to babies:

  Participant 1: The doctor and nurse say that the baby does not need water – they only need breast milk until they're eating solids.
  Participant 2: Yeah. I heard the same thing. When our child was sick in HSC, they asked specifically whether they had water. They kind of were concerned about it.
  Participant 3: Why were they concerned?
  Participant 2: They were still trying to find out what it was. The problem… could have come from water. They were…

> Participant 3: Grasping at straws.
> Participant 4: They were covering all the bases. They were trying to figure out.
> You were giving distilled?
> Participant 1: Yes

Participant had learned this practice, which seems relatively commonplace in the community, from their own mothers and grandmothers. A participant stated that babies are given water "pretty much from birth. My mother always said one ounce a day for the first three weeks." Babies are given warm water (the same temperature as breast milk) when they don't feel well. As one mother explained, this practice may be changing:

> If your doctor asks what are you feeding your baby and you say, well, I also give him water sometimes because it helps when he's cranky to settle his stomach. I know he shouldn't be hungry because he just ate for an hour. Well, they don't really need water. They're getting all the food they need from your breast milk. I'm assuming that if someone gets all that information from their doctor, they're not going to give their baby water.

- A participant in the focus group with **refugee parents and caregivers** pointed out that while there is not much difference between the advice that's given in Canada and in her home country, there are financial differences. In her home country, families do not have much help with the costs of things like toothbrushes or visits to the dentist but in Canada a lot of support is available for these things. Participants also observed that in Canada children often stay in school through the lunch hour (so parents can't supervise what they eat or whether or not they brush), whereas in most participants' home countries children return home for their lunch. Some participants in the group discussed the practice in their home countries (particularly in rural areas) of using a twig to clean teeth, rather than a toothbrush. Muslim participants referred to this twig as *sewak* and reported that the plant used in their home countries has "lots of benefits for your teeth."
- Participants in the group discussion with **other immigrant parents and caregivers** suggested that there are many similarities in how oral health care for babies and young children is understood and practiced in Canada and in their home countries. As an example, one participant cited prohibitions of things like chocolate or candy at schools and daycares. Another participant pointed out that at the daycare she attended as a child in her home country, a dentist came on-site to check on, clean and, if needed, fill children's teeth; in Winnipeg, doctors and nurses come to schools

and check on children's ears or eyes, advising parents if any problems are observed. Parents, a participant stated, are getting the same messages.

One participant in the group spoke about the practice of using a twig from a specific tree (in place of a toothbrush) to clean teeth. The twig is reportedly very effective "Some times a brush won't get everything, but that one will take everything off." The twig has the additional benefit of being natural and chemical-free. The participant stated that people who have traveled home sometimes bring these twigs back to Winnipeg and another added that the twig can also be bought here. They noted that the twig is sometimes used with the ash left from burning dried cow manure, which is very soft and makes teeth very white.

Earlier in this focus group, participants had discussed a belief held in the home country of a few participants that it is a bad sign if a child's teeth first appear in the upper jaw, rather than the lower. They noted that some people (primarily rural people, one participant suggested) believe that these children can bring sickness or death to other children.[3]

Participants were asked if anyone had ***children who have had problems with their teeth***.[4]

- A participant in the focus group with **Aboriginal parents and caregivers** related that her child's teeth had rotted before she reached the age of two because she did not have enough enamel and she had then had surgery to remove her teeth. One mother's three-year old had had surgery, an experience she described as "awful." Another participant stated that her niece had also had all her teeth removed when she was four years old: "Her teeth rotted really quickly. By the time she was three

[3] A large portion of the discussion of this belief was conducted in a language other than English, some of which was interpreted into English by group members. One participant in the exchange made a couple of statements that suggested that most people in their home country did not hold this belief. I interpreted this as an indication she might be embarrassed by her association (through citizenship) with this belief. This reminded me of how important it is to be responsible about how we use the knowledge or information shared by research participants. For example, as a researcher, I recognize that this information is part of my findings and so I report it here. However, I also recognize that this belief surprises me and that I know virtually nothing about people who might hold this belief, including why this belief might make sense in terms of their daily lived experience. Because of that, I would be very careful about sharing or interpreting this information in contexts other than a presentation of findings.

[4] Due to time constraints, this question was not asked during the focus group with refugee parents and caregivers.

years old, her top and her bottom was just black, like on posters you see of tooth decay. That's how her teeth were."

A surprisingly large number of parents in this group (almost half) indicated that they had children who either refused or resisted going to the dentist, in some cases because they had been scared or physically hurt during previous dental encounters. One mother related that after noticing that her son "had really really bad breath all the time," she arranged a dental appointment. When they arrived, she said, "He wouldn't go in. He just freaked right out and ran out." Another parent stated that her son "has five cavities right now because he won't go to the dentist." These two parents felt that, in part, their children resisted visits to the dentist because they have seen the "big needles that they're going to poke their gums with… they hurt, too, when they poke with those. You know how it feels and you know how your kid's going to feel." Both parents agreed that it might be better if the dental staff were simply to use a gas to "just knock [their children] out."

Earlier in the discussion, a participant in this group had stated that her daughter, who had been several weeks premature and was now only a month old, already had two bottom and two top teeth and was now scheduled for day surgery to have those teeth removed. The mother did not understand why this was necessary. When the mother disclosed this information, other participants responded with strong feelings:

> Participant 1:[5] That's brutal. Why do they want to do that?
> Participant 2: I don't know. The doctor said that she wasn't supposed to have teeth yet.
> Participant 1: So?
> Participant 3: Babies are born with teeth!
> Participant 2: They said there's nothing wrong with them. They're perfectly good. But because she's breast feeding and bottle feeding that they'll get decayed faster that way.
> Participant 4: What's more painful for a little baby?
> Participant 2: She goes in next week for her day surgery to get them pulled already. She just got out of the NICU two weeks ago….
> Participant 1: She's so little…
> Participant 2: Yeah. I tried to ask the pediatrician and nobody is seeming to give the right answer…

[5] To protect participants' identities when reporting exchanges between participants and/or the facilitator, participants are referred to as "Participant 1", "Participant 2", "Participant 3", etc. More than one such exchange is included in this report and numbering restarts in each exchange, i.e., whomever is referred to as Participant 1 in the first exchange may or may not be the same person referred to as Participant 1 in the next exchange, etc.

Participant 1: Bring somebody with you who knows what to say!

- A participant in the focus group with **Hutterite parents and caregivers** shared the story of her four-year old daughter's dental surgery. After her daughter had complained about a toothache, the woman had taken her to a dentist who had "found a whole mouth full of problems" and told her that, because her daughter was young, she would need to wait for surgery. The daughter was put under and a dentist filled 5 teeth and removed two. The woman described it as a terrible experience:

> I never want to go through it again… seeing her in all this pain and you can't do anything at all. You just have to wait for this appointment. And it drives you crazy. And you're guilty. I took the blame. It's my fault. I didn't take enough care of her teeth. Seeing her going into the operating room, they're going to put her to sleep and what if she never wakes up? And all of those things…

In spite of her worries, the woman reported that after an hour her daughter was running around and seemed fine. Other participants pointed out that some children feel sick after dental surgery. One parent's child, at the age of 4 or 5, had refused to open their mouth for the dentist and so had two teeth removed surgically. The child had not been in significant pain, but had had to wait three months for the surgery. After the surgery, the child was "very sick", vomiting and apparently affected by the anesthetic. In spite of this difficult experience, the child has been "ok" at the dentist since then.

Other parents also talked about difficulties they'd had getting their children to the dentist, along with some of the strategies they used to negotiate those difficulties. One parent said their child wouldn't open their mouth to a dentist until they were 8 years old, adding "we tried bribing and everything"; another parent whose child wouldn't open their mouth at four years old had no problems when they came back 6 months later. One mother said that her children are very shy and finds the strange noises and different environment of the dentist's office difficult. To comfort her young daughter, she had held her on her lap throughout her visit to the dentist. One mother makes back-to-back dental appointments for herself and her daughter. By letting her daughter watch her mother's appointment first, she is then "ready to help the dentist." Parents at one colony book all their children's dental appointments on the same day, so that children can see their friends going to the dentist also.

One participant stated that her sister's five children's teeth chip very easily, explaining that "they don't even have a bad fall – just literally chipping." One participant suggested that this may be due to too much calcium while pregnant. Another participant said that her doctor had recommended that she take calcium while pregnant "because having a baby takes so much calcium out of your body." The woman had continued taking calcium supplements while she was breastfeeding. She noted that she had just started her own daughter (who, at just under a year had started teething and had been "very cranky all the time") on liquid calcium and she is now "a changed baby."

- The children of participants in the focus group with **other immigrant parents and caregivers** had had very few problems with their teeth. As noted earlier in this report, one participant's child's teeth had turned "a little black", which the dentist advised her was "nothing too bad… just the colour."

**Promoting early childhood oral health**

Participants were asked to identify ***the best way to get information out to parents and families about dental health for babies or young children***.

- Participants in the focus group with **Aboriginal parents and caregivers** emphasized the effectiveness of one-to-one relationships when sharing information. Front-line workers, they suggested, should visit people in their own homes and oral health education programs should take advantage of the networks that parents are already a part of. This includes schools, nursery schools and daycares, where information kits could be distributed to children who, in turn, would likely take them home to their parents and where dentists might be able to make on-site visits. Additionally, pamphlets or advertisements could be posted at community centres and other sites that offer programming to parents and families.

- Participants in the focus group with **Hutterite parents and caregivers** identified the HSHC workshop that had been previously been offered to their colonies through ITV as an example of an effective way to get information out. They appreciated that the workshop was "personal", that participants were able to ask questions right there and that the presenter shared information that was new to them about things like the "connection between bad teeth and health problems" and the "newest research that

we wouldn't have had a chance to hear otherwise." They valued the "personal, one-to-one connection" in the workshop. Their participation in the workshop had exponential effects, as they had shared information gathered at the workshop (for example, that you shouldn't give a bottle to a child over one year of age) with family members. However, they indicated that they might feel uncomfortable about passing that kind of information with people they didn't know well. Their discussion suggested that there may be particular cultural and/or community values, expectations or protocols around offering information, advice or other kinds of informal teaching:

> Participant 1: I wouldn't dream of, if I see someone giving a baby a bottle, a two-year old, saying, "Do you know that's not healthy?"
> Participant 2: Of course not.
> Participant 1: If I know them – but not if I didn't know them.
> Participant 2: They basically wouldn't have to listen to you.
> Participant 1: Well, it's none of our business. It's a personal preference.
> Participant 3: I might if I knew them a little – say do you know that this could cause this or that.
> Participant 2: But it's always better if they get it from somebody higher up.
> Participant 1: Like at a meeting or a workshop
> Participant 4: That's non-confrontational.

As findings presented earlier may have already suggested, participants in this group felt that printed materials (for example, pamphlets distributed through clinics) and the internet would be effective ways to get information out to parents. Printed materials, they advised, should include both text (with the caveat that "if language is too high tech, nobody's going to read it") and pictures ("nothing propels you more to try to help your child than to see the results of non-caring", i.e., "pictures of decayed teeth"). The HSHC materials, one participant noted, were "really good, so we hung those in our kitchen." The community kitchen seems to be an established area for information-sharing. Participants noted that, as with the HSHC materials, people hang posters and post interesting articles there for other parents to see. These articles sometimes come from the internet, and participants recommended a parenting blog, forum or email list serve or contact list (which is already used by teaching staff in the community) as ways to get information out.

- Responses from participants in the group with **refugee parents and caregivers** emphasized the importance of getting information out through classes, workshops or individual practitioners. While some thought that parents and caregivers would

appreciate getting information from a dentist, doctor or someone whose experience and knowledge they could easily trust, others felt that because what is most needed is basic information about oral health care, this could be delivered by people other than specialists or experts. Participants suggested that oral health promotion activities could be delivered through existing programs, classes or organizations in which parents are already involved, such as EAL classes or programs for moms and tots. When asked specifically if Muslim women might prefer any particular kind of instructor or facilitator, participants said that some Muslim women might find it easier to trust and be open with another Muslim woman who knows their language. Towards this, they put forward the possibility of training someone from the community to do oral health promotion activities. The participants generally agreed with the summary statement that some refugee parents or caregivers might prefer "someone who is like them" and others might prefer an expert, so community development and oral health promotion programs should be prepared to offer a couple of options.

- Participants in the group discussion with **other immigrant parents and caregivers** offered a number of strategies for getting information to parents, some of which involved piggybacking on other activities in which their community members are likely to be involved. As an example, they pointed out that their EAL classes sometimes feature guest lecturers, which have included people who spoke about PAP smears and prostate cancer. They suggested that in a province where immigrants are actively recruited, someone must be keeping track of and know how to reach newcomer families. Newcomers are already in touch with programs that provide them with information. These and the other programs, centres and schools that serve various immigrant communities are a way to reach people quickly. Participants also feel that "word will spread" because people who attend or participate in any programming tell other people about what they've learned.

  The group recommended recruitment of an English-speaking person from each major immigrant community who could be taught and mentored in oral health promotion and then educate their own community members (in their first language and in English, as appropriate). This peer educator model, which they discussed at length, has been used in other health areas, including education on cancer, breast cancer, the PAP test, and sex education. In reference to the sex education activities,

a participant noted that the educator was able to talk about "some of those things they don't teach in our country. The women learned a lot and they can tell other ladies who don't want to come to the session." Peer educators, participants noted, will have already established networks in their own communities and so will know things like who to contact to bring in participants, whether or not interpreters will be needed or how to connect with interpreters. A participant pointed out that offering an honoraria and bus tickets also helps to draw people to workshops and other educational activities.

Participants suggested that information could also be distributed to parents through their children's schools or daycares. For example, letters or brochures with oral health information could be sent home with children. While these materials can be a way to reach parents who may not participate in workshops or other events, they also might get lost or some parents may not read them. In any case, language is an important consideration when trying to get any information out to immigrant communities. As one participant observed:

> That's a good reason to use community centres – they can bring parents out, tell them what you want to say, what they need to do. For people who don't understand the language, it's better for them to see it with their eyes.

Another participant suggested putting up posters in apartments where newcomers congregate. Some participants felt strongly that talking is the best way to reach people and another option proposed was to talk about oral health at parents' meetings (where, in addition to the presentation, printed handouts or brochures could be distributed). Participants also pointed out that if children are taught about oral health care, they may in turn teach their parents. They suggested that tooth brushing programs should be established at daycares and schools and, more generally, that staff at these institutions should talk to children about caring for their teeth. One participant suggested that family doctors could distribute oral health information during vaccination/immunization appointments.

Participants were also asked if there were ***one thing that someone could do to make it easier for parents to take care of their babies' and small children's teeth***.[6]

[6] Due to time constraints, the research team was not able to present this question in the focus group with immigrant parents and caregivers.

- **Aboriginal participants**' recommendations focused on interactive activities. Some participants suggested activities that directly involved children, such as Healthy Smile days. One parent observed that pictures are particularly effective for children and another referred to "those little pink pills" (a reference to disclosing tablets). One parent suggested home visits by public health nurses, who, as another parent pointed out, are "already coming to your home." The nurses could "just check out children's teeth, talk to them, tell them how important it is, because sometimes you can't get them to the dentist." However, as one participant's comments revealed, some people may not feel comfortable with the public health nurses. "They're nosy," she stated, adding that she sometimes does not let them in to her home. Group members were more positive about learning from each other, their family members and others in their communities. Participants felt that it would be helpful to get Elders more involved. For example, one suggested, Elders could "talk to children in school about taking care of teeth and the [traditional] medicines." Another participant put forth the idea of workshops for parents, which was well-received:

  Participant 1: Like the way we're sitting here, making them sit around….
  Participant 2: Yeah – make it fun for them!

  Participants suggested that parents should teach their children at a young age to take care of their own teeth, so that they will grow up knowing about it, to talk to them about oral hygiene and "make it a game." One parent described the reward system her mother has set up to encourage her grandchildren to take care of their teeth, complete with stars, stickers and other treats. When one participant acknowledged that she sometimes puts off making dental appointments, another stated that her mother puts up little notes that help remind her to do important things.

- The first responses to this question from participants in the focus group with **Hutterite parents and caregivers** referred to the importance of maintaining a healthy diet. The group also suggested that health care practitioners should take a more active role in providing information on early childhood oral health care to parents and caregivers. Information on oral health care should be provided "right from the get-go" to new parents at the hospital. Participants felt that it might be best if the information were distributed both before birth (in a prenatal package distributed during doctor or hospital visits) and immediately after (along with "all that other information, stuff and booklets" that hospitals provide to new parents). One

participant cautioned that if parents are given this kind of information only immediately after birth, they might be too overwhelmed to actually take it up. Providing information and materials to expectant parents allows them (along with family members and other caregivers) more time to review and share that information. In this community, new mothers are relieved of their Colony duties for at least 6 weeks (12 weeks if they have a caesarean) and are provided with 2 or 3 weeks of help from an additional caregiver (e.g., their mother, sister, aunt or friend). These supports give the new mother time to bond with her child. As one participant pointed out, providing information on oral health care for newborns in advance of birth will enable expectant mothers to share that information with the other women who will help them care for their newborn child.

The participants in this group noted that doctors are not necessarily knowledgeable about the oral health care needs of very young children and, in any case, may not have or take the time to share what they do know. The public health nurses (PHN), they thought, knew more in this area. PHNs come out at least once in the first two weeks after birth to visit each new mother and child in the Colony. In these visits, the PHN checks on the physical and emotional well-being of both baby and mother and the mothers are able to ask any questions they might have. For these reasons, participants in this group felt that PHNs would be particularly effective in supporting parents' and caregivers' ability to take care of young children's teeth.

- Participants in the focus group with **refugee parents and caregivers** indicated that a workshop that helps parents learn more about taking care of their children's teeth is "the only thing we need".

**Similarities and differences between the groups**

The parents and caregivers who participated in the focus groups generally seemed to have a good understanding of **what does and does not contribute to good oral health outcomes for babies and very young children**. Not surprisingly, there are differences within and across the groups with respect to things such as how participants might understand certain aspects of oral health or how they might incorporate the things they know into the daily care they provide to the children in their care.

When asked to describe "what healthy teeth means for babies and very young children", participants in all groups referred to the physical condition of a child's teeth (in particular, the absence of decay). In the focus group with Aboriginal parents, the link between healthy teeth and a child's emotional wellness was pointed out. In the groups with Hutterite, refugee and immigrant parents, participants did not refer to the emotional well-being of children, but did speak about the importance of oral health care practices and nutrition. When participants were asked if it was important that children's baby teeth be healthy, participants in all groups indicated that it was. In response to this question, however, an Aboriginal parent suggested that the health of baby teeth may not be a major concern because they inevitably fall out and are replaced by adult teeth; a similar statement was made in the focus group with refugee parents. Participants in the groups with refugee and immigrant parents and caregivers spoke about the links between the health of baby teeth and the health of adult teeth. The relationship between the health of a child's teeth and their emotional wellness came up again in the group with Aboriginal parents and was also mentioned in the group with Hutterite parents

Participants in all groups agreed that candy and treats play a major role in ECC. When asked why young children develop decay or cavities, participants in the groups with Aboriginal and refugee parents and caregivers also mentioned the importance of oral hygiene routines, refugee participants suggested that genetics may contribute and immigrant participants referred to the impacts of calcium deficiencies and other aspects of the overall health of a child's body. Hutterite participants discussed the role that fluoride and other minerals may play in protecting teeth from ECC, an important consideration for parents who live in colonies that use locally sourced non-fluoridated water. The Aboriginal parents' and caregivers' discussion of the role that bottle feeding may play in ECC revealed that at least a few of the parents were not convinced that bottles or bottle propping contributes to ECC – although they did accept that bottle feeding may contribute to the development of ear infections. More generally, participants in all groups agreed that the health of a child's teeth is linked to their overall health.

In all groups, participants most frequently identified their parents and other family members as the people from whom they learned how to take **care of their babies' and young children's teeth**. Participants in all groups had also learned from health educators and practitioners, from whom they seemed to have gathered more technical

information. Parents in the Hutterite group clearly valued the HSHC workshop they had participated in. Some of the immigrant parents noted that they had been given small workshops or lessons from health practitioners as part of routine checkups when they were expectant mothers or when they had taken their children for routine vaccinations. Participants in all groups indicated that they are practicing good oral hygiene with their babies (including cleaning the mouths of newborn babies) and young children. In all groups, one of the most significant challenges parents face in taking care of their children's teeth is getting their children to cooperate with or follow up on oral hygiene routines. Participants in the Hutterite, refugee and immigrant groups also acknowledged that monitoring or controlling children's consumption of sweets was also an issue. A surprising number of parents and caregivers in the Aboriginal and (to a lesser extent) Hutterite groups shared stories about young children's teeth being removed and about children refusing or resisting visits to the dentist. Interestingly, parents and caregivers in the refugee and immigrant communities reported almost no significant problems with their children's teeth.

In all groups, participants shared information about culturally-specific or localized knowledge and practices relating to oral health. Participants in the group with Aboriginal parents and caregivers discussed traditional medicines and medical practices. They emphasized that because traditional medicine is inseparable from spirituality, it is important to respect and adhere to cultural protocols in this area. Muslim participants in the refugee group also touched on spirituality, pointing out that the Prophet recommends that people incorporate oral hygiene into their daily routines. Participants in both the refugee and the immigrant groups also spoke about using a *sewak* or twig (in some cases, along with ash) in place of a toothbrush to clean their teeth. Immigrant parents also discussed a belief held by some in their home country that it is a bad sign if a child's upper teeth appear first. In the group with Hutterite parents and caregivers, participants mentioned several times the routine practice of giving water to babies at a very early age. This practice, which participants indicated they had learned from their parents, persists in the community, even though, as one parent reported, it has been challenged by medical professionals.

Participants in all groups pointed to the importance of peer networks, interaction and personal relationships and opportunities to draw on existing resources when **promoting early childhood oral health in their communities**. Aboriginal parents and caregivers

emphasized the value of interactive activities such as home visits by public health nurses or workshops for parents. They also called for more programming to teach children about oral hygiene (and, they noted, the children could then pass what they learned onto their parents, a point also raised by immigrant parents and caregivers) and that Elders could be a valuable part of these activities. Aboriginal, refugee and immigrant participants suggested that oral health promotion activities could piggyback on existing programs that parents and caregivers already connect with, such as mother-and-tots programs or EAL classes. Refugee and immigrant participants also recommended that community members be recruited and taught about oral health promotion so that they could serve as peer educators within the different distinct communities that make up the refugee and immigrant population (train-the-trainer programs). Hutterite parents and caregivers held up the HSHC workshop in their community as a good example of how to get information out to parents and families, emphasizing the exponential uptake of information in their community, as parents who participated in the workshop shared what they had learned with other community members. Hutterite group members were also the only participants who felt that the internet and print materials would be particularly effective ways to share information.

Perhaps the most striking finding of this research was revealed not by what participants said but by how they interacted in their groups. Over the course of the focus group discussions, participants shared and compared experiences, information and parenting strategies, challenged and filled in each other's knowledge gaps, pulled together a collective body of knowledge on the subjects they were discussing and actively refined their own individual understandings of how to best take care of their young children's oral health. Participants were the authorities or experts in the groups; they were there because the research team wanted to learn about their experiences and their knowledge. The focus groups demonstrated what participants in all groups had identified as especially effective ways to get information out to parents and caregivers: interactive and peer-led learning in the context of mutually empowered relationships.

## NEXT STEPS

As stated earlier, given that the focus group discussions involved relatively small samples from very diverse communities, it would not be particularly useful or appropriate to generalize the findings of this research project to all members of any particular

population. However, the findings do provide some promising starting points, including direction on how to continue to build relationships with these communities and, in keeping with the HSHC project's philosophy, to support effective community development, community engagement and oral health promotion activities:

- **Commit to enhance the range of activities provided by HSHC.** Currently, Manitoba's population growth is due to the rapid growth of the province's Aboriginal and immigrant communities (which include the refugee communities). To effectively meet the needs of our increasingly diverse population, HSHC and other community development and health promotion programs may need to diversify their activities. Participants in this research have called for a range of oral health activities, including home visits by health practitioners, workshops for parents, education activities for parents, peer educators, and web-based resources. For example, given that participants in all groups identified family as the first place they learned about oral health care for young children – and as a place where they continue to learn – HSHC may want to develop activities that can engage several generations within a family.

- **Work to build mutually empowered relationships with the Aboriginal, Hutterite, refugee and immigrant communities.** This includes building, maintaining and expanding working relationships with groups and organizations that serve these communities; developing train-the-trainer programs to provide community members with the skills and knowledge to lead peer education activities; understanding and respecting culturally specific knowledge, practices, values and protocols; learning about and drawing on existing resources in each community; a demonstrated willingness to take appropriate leadership and direction from community members; and evaluating on an ongoing basis the extent to which activities are meeting community needs. Locality development initiatives require ongoing support and development.

The findings also reveal some possible **directions for activities**:

- **Provide information on the long-term impacts of ECC to all parents, caregivers and health care professionals**. A few participants in the focus

groups with Aboriginal and refugee parents and caregivers suggested that baby teeth don't matter because they inevitably fall out. While this belief was not widely held, it was proclaimed by participants who otherwise seemed to have a fairly good understanding of young children's oral health needs.

- **Provide information to parents and caregivers on the potential impacts of bottle-feeding on early childhood oral health.** In the focus group with Aboriginal parents and caregivers, a few participants indicated that they did not believe that there is a relationship between bottle-feeding and ECC (although they did accept that bottle feeding may contribute to the development of ear infections). Oral health educators may want to develop a focused message that simply and clearly presents the links between bottle-feeding and ECC.

- **Provide information on fluoride in oral health education to Hutterite communities.** This includes the benefits and risks of drinking fluoridated water and practical ways that parents and caregivers may compensate (if appropriate) for the absence of fluoride in water.

- **Design and develop oral health promotion resources that can be distributed through parenting websites, forums, distribution lists or other relevant web-based resources.**

The findings also pointed to a few areas that HSHC and other oral health promotion programs may want to increase their awareness, understanding and consideration of:

- **The impacts of poverty on parents' and caregivers' ability to care for their young children's oral health**. It was not directly stated in any of the focus groups that poverty was an issue, but in at least one focus group participants mentioned having difficulty keeping their children in toothbrushes and toothpaste. Poverty is also obviously linked to food security and parents' and caregivers' ability to provide a diet that supports their children's oral health. In many disadvantaged communities in Manitoba, healthy foods and snacks are both financially and geographically inaccessible for families. Poverty can also constrain people's ability to participate in oral health activities.

- **Why participants in the focus groups with refugee and immigrant parents reported no dental surgery or other significant oral health problems for the young children under their care**. This was particularly striking given the many participants in both the Aboriginal and Hutterite groups who reported these kinds of problems.

- **The reported success of the HSHC workshop accessed by participants in the focus group with Hutterite parents and caregivers.** Participants in this group offered high praise for this workshop and information they shared about care for their young children's oral health seems consistent with information presented in the workshop (i.e., they may have taken up what they learned into their parenting practices). It would be helpful to know whether or not the workshop was particularly effective for this group; if so, understand why and build on that to improve practice.

Encouragingly, the activities described above are consistent with MCP/HSHC's philosophies and, in some cases, already encompassed in activities and approaches already underway at MCP and HSHC. These include:

- Working collaboratively through existing channels and with existing programs
- Equipping community members and service providers to share information on ECC prevention
- Translating resources into additional languages
- Using anticipatory guidance, i.e., providing key information that corresponds to particular stages of child development.