

Child Oral Health Promotion: Stakeholder Engagement and Resource Stocktake

Report commissioned by the Health Promotion Agency

July 2015

Project commissioned: April 2015

Final report received: July 2015

Provider: Allen and Clarke Policy and Regulatory Specialists Limited

ISBN: 978-1-927303-57-3 (online)

Citation: Allen and Clarke Policy and Regulatory Specialists Limited (2015). Child Oral Health Promotion Initiative: Stakeholder Engagement and Resource Stocktake Report. Wellington: Health Promotion Agency.

This document is available at: www.hpa.org.nz/research-library/research-publications

Any queries regarding this report should be directed to HPA at the following address:

Health Promotion Agency
Level 4, ASB House
101 The Terrace
Wellington 6011

PO Box 2142
Wellington 6140
New Zealand

Date of Publication July 2015

COMMISSIONING CONTACTS COMMENTS:

The Health Promotion Agency (HPA) commission was managed by Megan Chapman, Manager Child and Family Health, and Rebecca Whiting, Senior Health Promotion Project Manager, as part of HPA's work to support the Ministry of Health with the formative development of the Child Oral Health Promotion Initiative to improve oral health preventive behaviours and practices among pre-school children.

The key aim of this new initiative is that families and whānau enjoy the benefits of improved oral health for themselves and their children through regular tooth brushing and early enrolment with, and routine attendance at, Community Oral Health Services.

HPA's exploratory work, including this stakeholder engagement and resource stocktake, will inform the development of the Child Oral Health Promotion Initiative and any future messaging and promotions. Along with this project, HPA has also conducted a review of current evidence and talked to families and whānau of pre-school children (qualitative and quantitative consumer research).

HPA will provide a summary of the exploratory work and recommendations to the Ministry of Health for consideration alongside their own operational policy work to determine the most effective procurement and distribution of toothbrushes and toothpaste.

ACKNOWLEDGEMENTS:

HPA would like to thank the many people who gave up their time to participate in this work and share their experiences, opinions, insights and resources.

REVIEW:

This report has not undergone external peer review.

COPYRIGHT:

The copyright owner of this publication is the HPA. HPA permits the reproduction of material from this publication without prior notification, provided that fair representation is made of the material and the HPA is acknowledged as the source.

DISCLAIMER:

This research has been carried out by an independent party under contract or by instruction of the HPA. The views, observations and analysis expressed in this report are those of the authors and are not to be attributed to the HPA.

ALLEN+CLARKE

**ORAL HEALTH PROMOTION INITIATIVE
STAKEHOLDER ENGAGEMENT & RESOURCE
STOCKTAKE**

**For
Health Promotion Agency**

April 2015



Acknowledgements

Allen + Clarke is grateful to Health Promotion Agency, Ministry of Health and New Zealand Dental Association for their support in planning and undertaking the stakeholder consultation process. In addition, we would like to thank oral health sector and other stakeholders for their enthusiastic participation in the consultation process and in particular agency representatives who mobilised their networks and hosted consultation meetings.

CONTENTS

EXECUTIVE SUMMARY	5
PART ONE – BACKGROUND	8
INTRODUCTION	8
APPROACH	8
Stakeholder consultations	8
Resources stocktake	9
PART TWO – STAKEHOLDER CONSULTATIONS	11
OVERVIEW	11
PRIORITISATION OF ORAL HEALTH	12
Profile in the health sector and among communities	12
Integration with general health and wellbeing	12
Cost of nutritious food/healthy eating and toothbrushes and toothpaste	12
IDENTIFYING THE RIGHT AUDIENCE/S	13
CHOOSING THE “MOMENT”: MESSAGE DELIVERY SETTINGS	13
Home	14
Education	14
Community	15
Clinical	15
CLARITY, CONSISTENCY AND SIMPLICITY OF MESSAGING	16
Importance of clear and consistent communication	16
Simplicity of messaging	17
ENSURING DELIVERY OF MESSAGES IS APPROPRIATE	17
The messenger is as important as the message	17
Establishing relationships of respect and trust is essential	17
SELECTING THE “RIGHT” FORMAT FOR THE MESSAGING	18
BARRIERS, CHALLENGES AND GAPS	18
Assumptions and experiences that negatively influence behaviour	18
Confusing and inaccurate messaging undermine effort	19
Money, “busyness” and prioritisation of competing needs	19
Transport, transience and access to services	20

Challenges for recent migrants	20
PART THREE - STOCKTAKE OF RESOURCES	21
OVERVIEW	21
Target audiences	22
Delivery of messages	23
Language and imagery	23
How resources are used	23
INFORMATION GAPS AND NEEDS	24
Targeting resources by age and stage of life	24
Effectiveness of and need for more interactive resources	24
PART FOUR - STRATEGIC CONSIDERATIONS	25
OVERVIEW	25
DISTRIBUTION OF TOOTH BRUSHES AND FLUORIDE TOOTH PASTE	25
POLICY CONTEXT AND ENABLING ENVIRONMENT	25
SUSTAINABILITY OF INTERVENTIONS	26
WORKFORCE CAPACITY, CAPABILITY AND TRAINING	26
APPENDICES	27
APPENDIX ONE – PARTICIPANT INFORMATION SHEET	27
APPENDIX TWO – DISCUSSION GUIDE	28

EXECUTIVE SUMMARY

Publicly-funded oral health services are available free of charge for children in New Zealand from birth to 18 years of age. The 2009 New Zealand Oral Health survey, the most recent national study, found an overall improvement in the oral health of New Zealanders. However, the survey also highlighted disparities by ethnic group and level of socio-economic deprivation. More recent data indicates that these inequities still persist.

The Ministry of Health is developing a new initiative to promote and improve oral health preventive behaviours and practices, particularly tooth brushing, among pre-school children. A central component of the initiative is the targeted distribution of toothbrushes and fluoride toothpaste, together with supportive messaging to preschool children and their families and whānau.

This report describes findings from the oral health sector stakeholder engagement process and stocktake of resources. The information gathered through these processes is part of a wider scoping exercise designed to inform development of this initiative and any messaging and promotions to improve oral health preventive behaviours and practices among pre-schoolers, their parents' families and whānau.

Stakeholders welcomed the opportunity to participate in this consultation process. They are generally optimistic about the concept of a national oral health promotion initiative. They are also enthusiastic about the prioritisation of oral health and the potential for increased public awareness of, and understanding about, the connection between oral health and general health and wellbeing.

Where stakeholders expressed caution or concern it tended to relate to issues beyond the scope of this report. However, many of these are important strategic and contextual considerations. Stakeholder comments related to the importance of introducing a sustainable initiative, with clearly defined objectives and measurable outcomes. They are particularly concerned that the toothbrushes and paste are provided to families most in need, and all that members receive the brushes and paste. They consistently highlighted the role of economic and social barriers in preventing good oral health outcomes particularly for Māori and Pacific families and whānau. They also emphasised that achieving improved oral health outcomes requires continual reinforcement of clear, consistent messages and a range of strategies on multiple fronts to engage the target audiences.

The stakeholder engagement process identified key considerations for designers of a national oral health promotion initiative. Stakeholders shared experiences of interventions that have succeeded and failed in their communities and highlighted key characteristics of successful interventions. The resource stocktake process identified examples of well-used and popular resources. Stakeholders also shared examples of the resources they use and what does and doesn't work and identified resource gaps.

The findings in this report are framed by common themes and five key questions that emerged as a result of these two processes. These key questions will need to be addressed as part of the initiative design process (see Diagram 1 Key Questions, below). The text that follows provides an overview of stakeholders' insights into how a new national oral health promotion initiative might be designed to promote and improve oral health preventive practices among pre-school children.

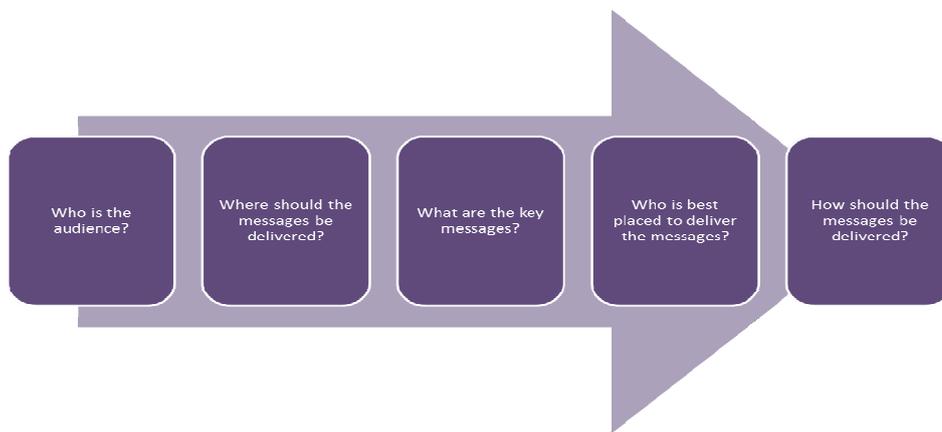


Diagram 1 Key Questions

Identifying the “right” audience/s

Māori and Pacific pre-schoolers are significantly more likely to have caries and poor oral health than the general population. As such, there was a consensus among stakeholders that Māori and Pacific pre-schoolers (and other vulnerable children), and their parents’, families and whānau should be prioritised in the planning and implementation of the initiative.

Stakeholders emphasised the importance of oral health promotion messaging that is targeted and engaging for pre-schoolers, parents, siblings, grandparents and other caregivers, expectant mothers and whānau.

In addition, stakeholders noted that oral health and other health service providers and trainees should be considered in the campaign development. As experts and potential advocates with the capacity to influence people in the communities where they work, service providers must be willing to adopt and own the campaign messages to ensure national consistency.

Choosing the “moment”; message delivery settings

Stakeholders recommended maintaining a multi-layered platform of messaging targeting audiences through a variety of channels. There is a clear connection between the target audience, the level of detail in the messages, and settings in which they are communicated. Around New Zealand oral health messages are currently delivered in four key settings:

- **home** - outreach service providers, and electronic and online communications such as television, radio and the internet
- **education** - early childhood centres including Kōhanga Reo and Pacific early childhood services, and antenatal classes
- **clinical** - dental clinics, mobile dental units, hospitals, and other health environments
- **community** - events, community groups, and churches.

Stakeholders emphasised that messaging in variety of settings and using a range of mediums can broaden their reach and achieve engagement of families and whānau who may not interact with some services. In addition, communicating with people in a range of venues serves to reinforce the messaging.

Clear and consistent messages

Stakeholders consider clear and consistent messaging as crucial to the success of any oral health promotion initiative. They emphasised the importance of an initiative using messages that are easy to understand and consistently reinforced by all health service providers, not just oral health specialists.

There is a “hierarchy” of messages currently used around New Zealand. The five basic messages focus on actions for good oral health behaviour. These include:

- Brush twice per day (with fluoride toothpaste)
- Spit don't rinse
- Eat healthy snacks and avoid sugar
- Water and milk are the best drinks
- Dental care is free for under 18s

Choosing the messenger

Stakeholders stressed the importance of the selection of the right messenger/s. For many, their experience suggests some communities will not take messages seriously unless they come from a trusted source, or someone they can identify with. Many service providers, especially those working with Māori and Pacific communities, invest a lot of time developing relationships to effectively engage the target families and whānau. Intervention success depends on trust, understanding, and reciprocity. The stakeholders emphasised the importance of enlisting community leaders and “champions” to achieve engagement.

Selecting the “right” format for messaging

There is a broad consensus among stakeholders that successful oral health promotion requires multiple engagement strategies with messaging delivered via a range of channels. Stakeholders identified the need for more interactive resources and suggested there is an excess of passive material. The resource stocktake confirms there is vast array of written material such as pamphlets, information booklets, and fliers which are considered the least effective means of engaging people. Stakeholders also emphasised the importance of culturally appropriate resources, particularly in Māori and Pacific languages and tailored for the audience using colour and, for some audiences, humour.

PART ONE – BACKGROUND

INTRODUCTION

Publicly-funded oral health services are available free of charge for children in New Zealand from birth up to 18 years of age. The 2009 New Zealand Oral Health survey, the most recent national study, found an overall improvement in the oral health of New Zealanders. However, the survey also described disparities by ethnic group and level of socio-economic deprivation. More recent data indicates that these inequities still persist.¹

The Ministry of Health intends to develop a new initiative to promote and improve oral health preventive behaviours and practices, particularly tooth brushing, among pre-school children. The key aim of the initiative is that families and whānau enjoy the benefits of improved oral health for themselves and their children through regular tooth brushing and early enrolment and routine attendance at Community Oral Health Services. A central component of the initiative is the targeted distribution of toothbrushes and fluoride toothpaste, together with appropriately supportive messaging to preschool children and their families and whānau. To inform the development of this initiative and any messaging and promotions, the Health Promotion Agency (HPA) is leading some exploratory work. At the same time, the Ministry is also separately working to determine the most effective way of purchasing and distributing toothbrushes and toothpaste.

This report describes the findings of stakeholder holder consultations and a stocktake of resources undertaken by Allen + Clarke in collaboration with HPA.

APPROACH

The findings from the stakeholder consultations and resource stocktake are presented as a high level thematic analysis. The report is designed to assist HPA gain a better understanding of the challenges and barriers to achieving more equitable oral health outcomes for all New Zealanders. Further, it identifies the key characteristics of a successful national oral health promotion campaign focused on promoting increased rates of effective tooth brushing among pre-schoolers. This includes the type of messaging required and strategies for successfully engaging the target audiences.

Stakeholder consultations

The Ministry of Health and HPA supplied a stakeholder list including oral health promoters throughout New Zealand. Stakeholders also recommended a number of additional contacts to participate in the consultations. Allen + Clarke undertook an initial analysis to identify and select a range of stakeholders in a mix of rural and urban locations to participate in the consultations. Consultation locations were selected to allow a diverse range of participants to attend

¹ Community Oral Health Data available at: <http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/oral-health-data-and-stats/age-5-and-year-8-oral-health-data-community-oral-health-service> (accessed May 2015)2013

roundtable discussions and included: Tokoroa, Tauranga, Rotorua, Christchurch, Dunedin, Kerikeri, Auckland, Wellington, Masterton and the Hutt Valley.

Māori and Pacific service providers were prioritised for engagement and participation in the consultations on the basis that there is a concentration of need in these communities. Consultations included a range of service providers including: oral health promoters, maternal and child health, nurses, Well Child/Tamariki Ora providers, primary health organisation representatives, Māori and Pacific Health service providers, Plunket, early childhood educators, university lecturers, oral and dental clinicians/therapists, the New Zealand Dental Association, Te Ao Mārama, and relevant Ministry of Health staff.

Prior to the consultations stakeholders were provided with background information and outlining the consultation process (see Appendix One: Participant Information Sheet). Approximately eighty individuals participated in the consultation process. The consultations included twenty stakeholders from Māori trusts, fifteen from Pacific trusts and thirty two DHB representatives. The consultation process also included discussions with the New Zealand Oral Health Clinical Leadership Network Group and Māori Service Providers Quality Improvement Group (QIG) convened by the Ministry of Health.

Participants were invited to introduce themselves, and share information about their role and experience. Introductions were followed by relatively informal and unstructured discussions to ensure maximum engagement and allow the participants to freely describe successful programmes, and barriers, challenges and needs (see Appendix Two: Discussion guide). Where necessary participants were prompted with the following question:

What do you and your communities need to promote better oral health outcomes for pre-schoolers, and increase preschool tooth brushing?

Roundtable discussions were supplemented by unstructured interviews with a small number of stakeholders and telephone interviews (two) and written responses to questions (one organisation) were provided by stakeholders who were unable to engage face to face.

The findings from the draft report were presented to HPA and representatives from the Ministry of Health as part of a roundtable discussion. This report captures comments and issues raised during this session.

Resources stocktake

Allen + Clarke conducted an internet based search for New Zealand focused dental and oral health care resources targeted primarily toward infants children and adolescents aged 0-18 years' old in May 2015. This search identified a variety of easily accessible resources including materials available on the Ministry of Health, Health Education and New Zealand Dental Association websites.

Stakeholders also provided copies of locally developed resources during the consultation process. Many also cited examples of resources developed in other regions and internationally that they routinely use in the course of their work. Stakeholders were invited to provide additional details of the resources they currently use to support development of the resource matrix.

The resource summary is presented in a matrix documenting the following information:

- the scope and focus of available information

- current oral health messaging
- medium/audience/coverage/evidence
- date the resource was developed, and revised
- standalone/campaign based resources

It is important to note that the stocktake captured easily accessible resources and those provided by stakeholders. The list is indicative of the range and type of information available and includes examples of national and locally developed resources. Notably, the search did not focus on standalone healthy eating and nutrition materials. It is understood that good nutrition is a component of optimal oral health but the scope of the search was limited to resources specifically targeting oral health. We did include dietary information resources provided to us by stakeholders who are using them for the purpose of oral health promotion in the stocktake. A summary matrix of resources has been provided to HPA on a USB device along with electronic copies of resources identified during the stocktake. In addition, a file of hard copy resources collected from stakeholders has been provided to HPA.

PART TWO – STAKEHOLDER CONSULTATIONS

OVERVIEW

Stakeholders were largely optimistic about the proposed oral health initiative including the distribution of tooth brushes and paste. Importantly, the opportunity to raise the profile of, and increase the focus on good oral health was seen as a step in the right direction. They freely shared their experiences implementing and supporting existing initiatives such as supervised brushing in early childhood education centres (ECEs) and World Oral Health Day events. They were invited to reflect on factors contributing to the success of such initiatives and provided examples where past initiatives proved unsustainable or ineffective.

Where stakeholders expressed caution it related to the importance of introducing a sustainable initiative, with clearly defined objectives and measurable outcomes. They were particularly concerned that the distribution of toothbrushes and paste targets families most in need, and includes all family members. They emphasised that achieving improved oral health outcomes requires continual reinforcement of clear consistent messages and a range of strategies on multiple fronts to engage the target audiences. Hard to reach families and whānau outside the health service system are a clear priority.

The narrative that follows is presented around key questions and common themes. It highlights characteristics of successful interventions and strategies for effective engagement and hard to reach populations as identified by the stakeholders.

There was a high degree of consistency in the views expressed by stakeholders during the consultation process. Stakeholders described a range of resources and strategies and pathways they use to successfully engage with the communities they serve. They note effective oral health promotion requires a multi-layered platform of nuanced messaging appropriate to target populations and communities. The Overarching Themes are summarised in Diagram 2, below.

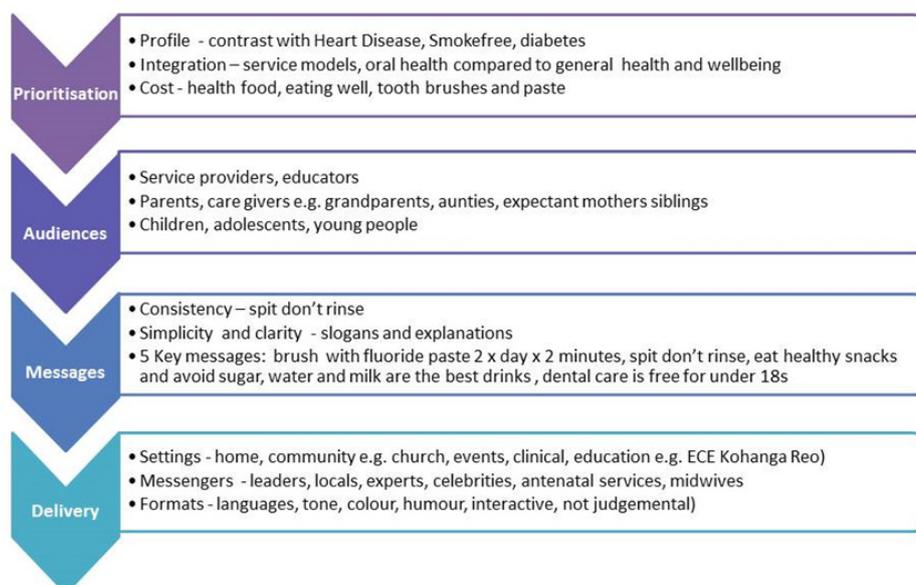


Diagram 2 Overarching Themes

PRIORITISATION OF ORAL HEALTH

Profile in the health sector and among communities

There is a perception that oral health suffers from a low profile and therefore is not prioritised. A number of stakeholders mentioned the difficulty in making oral health “sexy” enough to capture public attention. They also felt that prioritisation of good oral health practices suffer from the myth of a “second chance” driven by the belief that baby teeth are not important because they are replaced by adult teeth.

Stakeholders suggested a range of strategies to increase the profile of oral health nationally and within their communities. These included identifying a celebrity to be the national “face” of oral health; creating local campaigns supported by local champions; and messaging that better explains how oral health is linked to long-term health outcomes.

Integration with general health and wellbeing

Stakeholders acknowledged the risk of people feeling bombarded by health messages but also expressed frustration at low levels of awareness regarding the impact of poor oral health on general health and wellbeing, and economic and social outcomes.

Many stakeholders noted existing service delivery models can contribute to the false separation of issues. Some suggested that perceptions might be shifted by re-framing oral health messages emphasising “plaque is bacteria” harmful to health, “dental disease” is preventable and the mouth is “the gateway to the body”.

Some stakeholders suggested that collaboration between different health services could improve service delivery, raise the profile of oral health, and emphasise the relationship between oral health and total health and wellbeing. This mode of thinking is reflected in the health curriculum at the University of Otago, where students from different health degrees, including oral health and medical students, work together in service delivery teams.

In addition, many stakeholders suggested services such as Well Child/Tamariki Ora providers and general practices are established and effective pathways for engaging families and whānau and as such have an important role in promoting good oral health practices. Stakeholders provided examples where these services have already adopted this practice, but it is not consistently employed and is a missed opportunity to increase oral health promotion coverage.

Cost of nutritious food/healthy eating and toothbrushes and toothpaste

For many families the cost of nutritious food, toothbrushes and paste and dental care act as barriers to good oral health practices. Almost all stakeholders spoke of how families are forced to prioritise needs and carefully allocate scarce resources. Many also mentioned the reality that providing one child in a family with a toothbrush and paste risks doing damage as families are forced to share brushes therefore transmitting caries. A number of stakeholders indicated that poor oral health is “another thing” to add to the list of issues where families in lower socioeconomic communities are told or feel they are failing.

Nevertheless, stakeholders noted that parents, family and whānau want to do the best by their children and if the “why” and “how” of good oral health is explained in easy to understand terms they are more likely to engage in good practice.

IDENTIFYING THE RIGHT AUDIENCE/S

When discussing the target audience for the initiative stakeholders were keen to note that while the messaging needs to be consistent nationally, resources need to address a range of audiences using language/s and mediums appropriate informed by characteristics, priorities and levels of awareness and understanding.

While it is anticipated the initiative will focus on increasing tooth brushing and improving oral health outcomes among pre-schoolers, children cannot be targeted in isolation. Stakeholders also emphasised the importance of targeting and engaging people of influence who can make a compelling case for the prioritisation of oral health and support modelling of good practice and engagement of the primary target groups. Identified audiences include:

- Children, adolescents, and young people
- Parents and other caregivers e.g. grandparents, aunties, and siblings
- Service providers e.g. GPs and early childhood educators
- Expectant and new mothers
- Church and other community leaders and elders.

Stakeholders noted when parents and caregivers become aware of the issues they are usually keen to improve both their own and their children's oral health and this can have a powerful influence on behaviour and practices.

CHOOSING THE "MOMENT": MESSAGE DELIVERY SETTINGS

The context or setting where oral health messages are delivered is an important factor in community engagement. Identified settings for oral health promotion messaging included:

- **home** - outreach service providers, and electronic and online communications such as television, radio and the internet
- **education** - early childhood centres including Kōhanga Reo and Pacific early childhood services, and antenatal classes
- **clinical** - dental clinics, mobile dental units, hospitals, maternity wards, and other health environments
- **community** - events, community groups, marae, and churches.

Stakeholders noted that the audience, messages, and settings in which they are communicated are all closely linked. To a large extent the setting determines the appropriate messenger. For example, providing oral health care messages to parents when children are in surgery for treatment of dental caries is considered by some as the wrong setting while others considered is a powerful moment and good opportunity to engage families and whānau.

Equally, many stakeholders mentioned successfully engaging new mothers in discussions about oral health. However, others noted the period immediately after childbirth can be an overwhelming time when mothers receive a wide range of advice much of which is likely to be lost as they adjust to the challenges of motherhood.

The settings for oral health messaging are discussed in more detail in the information that follows.

Home

In the home, Well Child/Tamariki Ora nurses, Plunket, or community workers might be involved in oral health promotion. Currently the Well Child/Tamariki Ora schedule (to which Plunket is also subject) includes oral health as one of 64 components. While practice varies, many stakeholders indicated that oral health messaging is first provided at five months, with “lift the lip” information delivered at nine months. They emphasised the importance of making this consistent nationally.

Some stakeholders suggested that Well Child/Tamariki Ora and Plunket nurses are natural candidates for delivering tooth brushes, tooth paste, and oral health information, as they have existing relationships with pre-schoolers and their families and have access to high need groups. Other were concerned Well Child/Tamariki Ora and Plunket nurses are expected to deliver information and support on a large number of subject areas and are often forced to prioritise competing needs thereby risking lost or underemphasised oral health messages.

Messages may also be delivered through the radio, television or internet-based resources and other technology. Some stakeholders already use local Māori and Pacific language radio stations to effectively deliver oral health messages, and others suggested that delivering messages through television advertising or social media may be effective. Many stakeholders discussed developing “apps” suitable for children, such as educational games or tooth brushing songs. While many stakeholders noted that almost every family had access to the internet and owned a smartphone or tablet, a number cautioned that some very high need families do not have access to these devices or the internet.

Education

In many regions oral health promotion for pre-schoolers and their parents is directed through early childhood centres, including Kōhanga Reo and Pacific early childhood education centres. Initiatives include: brushing programmes, lift the lip checks, and competitions and messages are delivered by oral health promoters visiting ECEs, and/or early childhood educators. Some ECE providers also reported establishing policies restricting or prohibiting fizzy drinks and “packets” in lunches and other practices to promote healthy eating and good nutrition associated with oral health.

Stakeholders reported that oral health promoters and other health professionals provide training and support ECE educators to help them implement centre-based oral health programmes in many regions. However, stakeholders also noted these programmes do not reach children not enrolled in ECE, many of whom are the most vulnerable to poor oral health. This is an especially important consideration for Pacific children, with reportedly lowest rates of ECE attendance in New Zealand with 85.4 percent of five year olds having attended ECE².

Stakeholders praised supervised brushing programmes as an effective way to educate children about brushing, contribute to development of positive oral health habits, and ensure that high needs pre-schoolers in these centres are brushing at least once per day. Unfortunately logistical considerations such as student/educator ratios and the need for brushing to be supervised to promote effective practices and ensure infection control mean programmes can be difficult to

² Education and Pacific Peoples in New Zealand available at:http://www.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress-education/early-childhood-education.aspx (accessed June 2015).

establish and sustain. Student/educator ratios also impact on capacity of providers to ensure effective supervision for brushing. Some stakeholders cited examples where initiatives such as these had failed due to staff turnover and pressure to prioritise and balance responsibilities. In some instances, stakeholders reported challenges with respect to receiving consent for children to participate in tooth brushing activities.

Community

Some stakeholders described hosting and attending community events such as health expos and cultural festivals, where they provide families with oral health information and resources. Others attend parent groups and antenatal classes, or host coffee groups and workshops to deliver key messages. Stakeholders said these interactions can be very successful, but others noted challenges encouraging parents, especially those from high need families, to attend.

Some Pacific service providers deliver messages through Pacific churches, and encourage community leaders to offer a respected and authoritative voice and support oral health messages. This is viewed as an effective way to engage with Pacific communities, in a setting where people are receptive to the information shared.

Annual events based campaigns such as World Oral Health Day (March), Colgate Oral Health Month (June) and National Oral Health Day (November) all provide a setting for general and targeted community initiatives. However, some stakeholders suggested multiple and competing national initiatives put pressure on priorities and limited resources and potentially diminish overall impact.

Clinical

In a clinical setting, messages might be delivered by dental therapists, dentists, hygienists, general practitioners, practice nurses, midwives or paediatricians. Stakeholders in clinical positions; including dental therapists, dentists, and a general practitioner; expressed frustration that they have very little time to focus on promoting preventative behaviours. For clinicians role definition and performance expectations are primarily focused on therapeutic work. However, many reported that they try to share oral health messages during and after dental examinations and treatments, and that their clinics distribute resources to patients, usually in the form of pamphlets and information sheets. There is also an ongoing concern that often by the time pre-schoolers are seen by a dental therapist significant damage has already been done.

There was some discussion around reaching families through other health services settings such as GP clinics. In addition, at least one region has negotiated with the local hospital to access the antenatal ward and speak to new parents about oral health. Some stakeholders believe this is an effective model because it allows information to be given before babies begin teething and allow time for families to develop good health oral health habits. Other stakeholders cautioned that new parents are often overwhelmed with information, and are more likely to be concerned with messages on feeding and sleeping. Similarly, some stakeholders suggested delivering information on oral health for children from 0-5 years through midwives as part of the messaging on good oral health during pregnancy. Again, there are mixed views on whether this would enable key messages to reach mothers before teething occurs, or if it would result in 'information overload'.

At least one stakeholder suggested that hospital waiting rooms be utilised as a setting for communicating oral health messages to parents while their children are being operated on. It was suggested that this messaging could be in the form of a video or through face to face interaction with a staff member. Most clinical settings we visited had resources in the waiting areas, with most of these being pamphlets, fliers, information sheets, and posters.

CLARITY, CONSISTENCY AND SIMPLICITY OF MESSAGING

Importance of clear and consistent communication

The need to maintain consistency of oral health messages was raised by all stakeholders. The majority of stakeholders reported using five key oral health messages as the basis of their engagement with all community members. These are:

- Brush twice a day (with fluoride toothpaste)
- Spit don't rise
- Eat healthy snacks and avoid sugar
- Water and milk are the best drinks
- Dental care is FREE for under 18s.

These key messages were commonly supplemented with additional information including:

- Not putting children to bed with bottles
- Using a smear of fluoride toothpaste
- Limiting sugar and if you have to consume it do so as part of a meal
- Not sharing tooth brushes
- Not kissing children on the mouth
- Not sharing eating utensils
- Allowing teeth time to "rest" between meals.

The oral health promoters that participated in the consultations tended to be well networked and many reported routinely engaging with other service providers such as early childhood educators, Well Child/Tamariki Ora and Whānau Ora services. Initiatives included delivering training, information sessions and demonstrations and resources to ensure accuracy and consistency of messaging.

Stakeholders were invited to comment on the need for people delivering the messages to be dedicated oral health professionals. While many believe oral health professionals have an important role, they are enthusiastic about other service providers who regularly interact with pre-schoolers and their families and whānau being involved in the delivery of oral health messages. For example, DHB staff in a couple of regions held "train the trainer" sessions with ECE educators, GPs, and Well Child/Tamariki Ora nurses in which they shared information and taught them how to perform "Lift the Lip".

Simplicity of messaging

The key messages are well established but many noted the importance of backing these up with additional information and explanation for parents and caregivers. This is especially the case for parents struggling to understand the importance of and benefits from prioritising oral health. Many stakeholders used short catchy phrases such as “spit don’t rinse” and “still the drill” to simplify messages and make the memorable.

One stakeholder explained that even if they did not have a comprehensive knowledge of key oral health messages, almost all parents are aware that tooth brushing needs to be practiced regularly, and foods high in sugar are harmful to teeth. It was suggested that to encourage behaviour change parents must understand why these messages are important, and the short, medium, and long term effects of good oral health practices.

The “Perfect Māori Teeth” presentation is an example of a strategy promoted in Northland as a way of demonstrating that Māori were once famed for their good teeth. The presentation is used to send a positive message and is considered an antidote to common misconceptions that good oral health is unachievable. It focuses on demonstrating to parents and care givers that bad teeth are not genetic or a foregone conclusion.

ENSURING DELIVERY OF MESSAGES IS APPROPRIATE

The messenger is as important as the message

Stakeholders emphasised the importance of identifying the “right” messenger/s to successfully engage communities and families and promote behaviour change. They described a range of strategies they use to engage people including mobilising community leaders in support of health promotion initiatives. The rationale for this approach is reinforcing experts’ information using respected people of influence to communicate oral health messages.

Among the stakeholders there was popular support for identifying a national face (identity) or creating a mascot for oral health across New Zealand. A number of stakeholders referenced the involvement of rugby league player Shaun Johnson in the “dental fitness” campaign implemented as part of National Oral Health day in 2014 as an example.

Establishing relationships of respect and trust is essential

Investing in communities to establish trust and respect was a consistent theme throughout the consultations. Stakeholders described lengthy engagement processes supported by messaging provided in a range of formats as essential to the success of programmes.

Others talked about seeking a commitment from parents, caregivers, and ECE providers before providing resources and toothbrushes and paste as important for the process of engagement. This “principal of reciprocity” was identified by one stakeholder as an essential element of promoting continued engagement and change, particularly among Māori and Pacific communities. One stakeholder suggested the process of handing out toothbrushes and paste without setting expectations around good oral health practices potentially “devalued” the commodity. This was explained in terms of the “value” people place on something you can get for free and the risk of sending a message that oral health is someone else’s responsibility.

SELECTING THE “RIGHT” FORMAT FOR THE MESSAGING

The majority of stakeholders highlighted the importance of developing a multi-layered platform of messages targeting a range of audiences. For stakeholders, resource development is a continuous process of adapting materials to suit the context and audience.

They emphasised the importance of brightly coloured resources, such as stickers, magnets and books, targeting parents and caregivers and children. Interactive resources such as videos, DVDs, story books, YouTube, songs, television, games and tooth brushing demonstrations are important for promoting learning and engagement. Campaigns based on fictional characters such as Dr Rabbit and Buzzy Bee are appealing to pre-schoolers.

The majority of stakeholders consider pamphlets as a waste of time often ending up unread in the bin, especially if they have a lot of writing or use technical language. Others reported turning one page brochures into fridge magnets to increase the possibility of the information being used e.g. Free Dental services. Some stakeholders include mazes and colouring in activities in their pamphlets to promote interest. Other stakeholders used pictures of recognisable local faces, landscapes and landmarks to make the resources relevant to the community and to engage the audience in the content. Resource development can be a burden on time and resource but stakeholders considered the process essential for effective communication.

All stakeholders identified the importance of providing the key messages in a range of languages. One group noted using the local te reo Māori dialect is important for some communities. Some stakeholders also suggested culturally relevant framing of messages, for example, applying the Māori concept of Te Whare Tapa Whā to engage Māori families.

Stakeholders also noted the need for the appropriate use of humour and contextually and culturally appropriate themes to reach the target communities. They are acutely aware that for many families their first engagement with oral health therapists is when they are already in pain and require highly invasive treatment. The lingering characterisation of dental clinics as the scary and uncomfortable “murder house” may further exacerbate this problem, with this attitude being passed down from older generations. The need to develop resources that adequately communicate the importance of oral health and preventive care without perpetuating fear is important.

BARRIERS, CHALLENGES AND GAPS

Stakeholders highlighted the range of economic, structural and knowledge barriers to effectively engaging families and whānau and improving in oral health outcomes.

Assumptions and experiences that negatively influence behaviour

Many stakeholders indicated individual and community awareness about the importance of oral health for general health and wellbeing are increasing but that there is still work to be done. Primarily, understanding how to manage oral health at each age and stage of life and how good oral health links to health outcomes later in life tend to be poorly understood. Some people mistakenly assume good oral health is genetically determined and therefore unattainable for some. As noted previously parents and caregivers with bad teeth often incorrectly assume their own experience determines outcomes for their children/grandchildren and that there is nothing they can do to improve their oral health.

Accompanying the notion of unattainable “beautiful” smiles is the persistent view that going to the dentist is unaffordable. While adult dental treatments and care can be expensive, stakeholders emphasised the importance of better communicating the message that dental care for New Zealanders from 0-18 is free. A number of stakeholders also suggested the availability of free dental care through school dental services means families can mistakenly assume oral health is not an issue, and that services are not available until children start school.

At least a few service providers also suggested parents and caregivers need to be encouraged to take more responsibility for their children’s oral health. Historically the school dental clinic system did not require parents to attend their child’s appointments. Some DHBs insist or strongly encourage parents to accompany children to appointments but stakeholders suggested this practice is not consistent and many children still attend the clinics alone. Stakeholders noted this approach can create the perception parents do not need to take responsibility for the oral health of their children. As one stakeholder pointed out “no parent would send their young child to a doctor’s appointment unaccompanied so why should they go to the dentist alone”. Stakeholders suggested this situation to be addressed as part of a wider cultural change.

Confusing and inaccurate messaging undermine effort

Many stakeholders talked about the need for active and interactive resources and reported having to make do with materials that are not quite right, for example the Colgate “No more nasties” video. The video appeals to children but promotes rinsing after brushing which is not consistent the “spit don’t rinse” message.

Messaging on toothpaste packaging was also raised as a concern. Currently Colgate’s full strength fluoride toothpaste with images such as Spiderman on the pack is labelled “suitable for children 6 years+”. Stakeholders reported confusion among parents and caregivers about what this means and if there is a risk from using this paste with younger children. In addition, stakeholders noted some families are still fearful that fluoride can damage teeth and therefore messaging does not refer to fluoride toothpaste. One stakeholder recounted the experience of having to extract the teeth of a child who was following the advice to brush twice daily but with toothpaste not containing fluoride.

Money, “busyness” and prioritisation of competing needs

Almost all stakeholders emphasised that income inequality and poverty are determinants of oral health. Families need to have the means to purchase toothbrushes and toothpaste regularly and for all family members to engage in effective oral health promotion practices. For many this is not a priority. Diet and nutrition are essential to good oral health but purchasing fresh fruit and vegetables is expensive compared to highly processed and sugary food products and many families find it difficult to afford/prioritise nutritious options.

Stakeholders also noted for many parents issues such as working long hours and/or multiple jobs and shift work to make ends meet means that supervising tooth brushing for the young ones is difficult. This can be exacerbated in large families in which there are numerous children to care for and organise. Others reported that many parents say brushing in the morning in particular is a challenge as they rush to get the family out the door. For some it was a case of once a day is a realistic goal.

Transport, transience and access to services

While enrolments in oral health services are high, for many families arranging transport to appointments is a challenge reflected in high rates of “did not attend”. In rural and regional locations in particular the family car is used by the person travelling to work and appointments during business hours are beyond their reach. Stakeholders noted strategies to remove this barrier include providing pick-up services and accessing mobile clinics but noted the resourcing implications of this approach.

High levels of transience among families most in need of services also impacts on outcomes as children are lost to follow-up despite concerted efforts of community service sector workers. Discussions with stakeholders revealed that some record keeping systems were better able to respond to this problem than others, with stakeholders in one region reporting that they were still using a paper based system which resulted in children getting lost or “falling through the cracks”.

Challenges for recent migrants

Service providers reported low rates of oral health awareness among recent migrants. Suggested explanations included lack of exposure to oral health messages or conversely exposure to different messages in their home country. Some stakeholders suggested for recent migrants easy access to unhealthy foods such as fizzy drinks, novel in their home country is appealing and also that they don't know how to access oral health services. In addition, giving children “treat foods” high in sugar is often perceived as a demonstration of love and affection for children. Sweet foods can also be used as a form of behaviour management to reward or placate children. While this is not unique to new migrants, stakeholders suggested it is of particular concern among this population.

PART THREE - STOCKTAKE OF RESOURCES

OVERVIEW

A range of resources are freely available on the Ministry of Health and Health Education websites. Hard copy versions or resources are available for purchase in many instances. Downloadable resources are available local (e.g. NZDA and DHB) and international websites (e.g. Colgate, International Dental Federation). The majority of resources identified online are passive i.e. pamphlets and posters and focus on key oral health messages identified by the stakeholders. Resources available on these websites address a range of topics, are easy to find and include publication dates. Some brochures and pamphlets are available in multiple languages but the majority are English language only.

Many resources appear to be developed by DHBs and other oral health promoters. This was confirmed by stakeholders who reported developing their own resources to use in their communities. Resources developed regionally and locally are more likely to be interactive and include messages and imagery appropriate to the community in which they are used and often include contact information for local dental services.

The resources identified during the stocktake largely target children and parents and on rare occasions educators. The stocktake includes 93 passive, 39 active and 9 interactive resources. Of these, passive resources such as posters, brochures, and information cards produced regionally or available through dental websites are most common. Videos embedded on oral health websites and on YouTube are also quite prevalent.

The majority of resources identified during the stocktake are less than five years old. This may reflect the approach to the stocktake which included a targeted internet search and inviting stakeholders to share resources they currently use. The messaging is largely consistent across resources. This reflects the fact many resources are associated with oral health campaigns such as 'Let's Talk Teeth' and 'Healthy Smiles' implemented nationally by New Zealand Dental Association (NZDA) and Ministry of Health, and locally by District Health Boards (DHBs) and Public Health Offices (PHOs).

Many stakeholders noted they already have access to some toothbrushes and fluoride paste and that these are important resources in and of themselves. As a resource they provide a pathway for engaging people in a discussion about oral health. They reported receiving these from a variety of funding sources, programmes and activities and distributing these for people in the communities where they work. The balance of resources and how they are classified is reflected in Diagram 3 below:

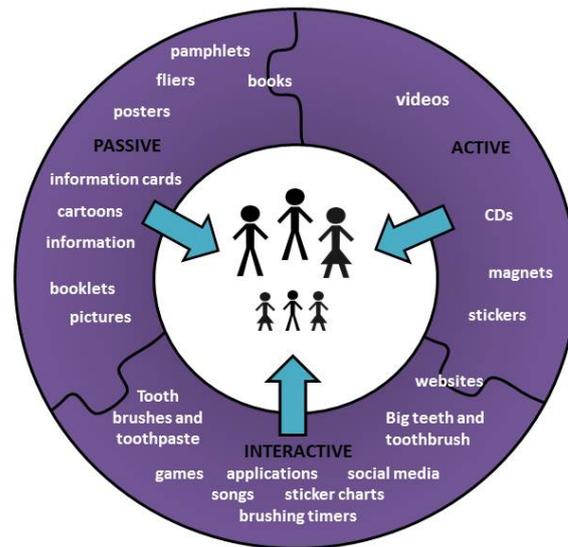


Diagram 3 Resource map

Target audiences

Oral health messages are designed to target both children and their parents, with the objective of promoting healthy dental habits from an early age. In addition they focus on “enforcement” throughout childhood and adolescence, and encouraging enrolment with a dentist. Some resources specifically target parents, some children, while others are designed to appeal to both.

As the main national resource providers the Ministry of Health and NZDA target all ages and audiences. In the Ministry’s case there is the ‘Let’s Talk Teeth’ campaign which targets parents, children and teens from age 0-17. In addition, the New Zealand Dental Association (NZDA) developed the ‘Healthy Smiles’ resources targeting 0-18 year olds and adults. In some instances, messaging is targeted by age range for example, infants (0-3) young children (3-5) children (5-12) and teens (13-18). However, the majority take a broad brush approach using simple messaging applicable for 0-18’s. This is consistent across all sources and mediums.

The primary messages focus on appropriate dental hygiene and diet. This includes effective tooth brushing, flossing and inspection, information about dental products, such as brushes, and fluoridated toothpaste, and diet recommendations including reducing intake of sugary foods, and increasing intake of healthy, teeth friendly alternatives.

Therapeutic messages are directed primarily toward parents. These include pictures and diagrams of stages of decay, from no decay to severe decay. These are often accompanied by information for when to seek dental or medical help. There are a small number of resources targeting pregnant mothers. These have the dual purpose of promoting messages to prevent poor oral health during pregnancy and informing expectant mothers of key oral health messages for babies.

Resources providing guidance and contact details for enrolling children for free dental care are common. These often targeted all children aged 0-18, but also specifically at focus age groups, such as children under five. This message is often accompanied by the relevant dental care information for the age group. Resources available at a local level direct people to their local

dental clinics, whilst national resources provide national 0800 number such as 0800 TALK TEETH.

Delivery of messages

Resources aimed at both children and parents alike are brightly coloured and contain little text. In nearly every instance they are bullet pointed with succinct information, or numbered steps for good oral health. These are often accompanied by graphics, instructional diagrams and/or pictures. Children's resources often present images of oral health related mascots, such as cartoon teeth and mouths.

The tone of the resources is instructional and informative. Their general purpose is to communicate and instruct by employing clear and straight forward English. However, there are also resources detailing various levels of disease in children's teeth. These resources primarily target parents, and employ "scare tactics". Essentially, the purpose of the pictures is to alert parents to the levels of dental decay that can occur in a child's mouth. These types of resources are designed to accompany specific interventions aimed at service providers such as ECE educators, Well Child/Tamariki Ora nurses and other community sector service providers. They include "Lift the Lip" training sessions to identify dental decay, Mighty Mouth brushing training with ECE educators, and CDs explaining oral health and brushing techniques to ECE educators.

Language and imagery

Some nationally developed resources (e.g. from Health Ed) are available in Māori and Pacific Island languages, and English. A few resources from DHBs (e.g. Taranaki and Southern) are available in Māori reflecting the practice of developing and translating resources locally. However, the majority of information is available only in English including more complex information that provides explanations for why oral health is important and how it impacts on overall health and wellbeing.

The majority of the resources include images of children reflecting a variety of ethnicities. This is consistent across nearly all resources where either photos or cartoons of children are present. This suggests the resources are intended to appeal to a wide variety of children.

Resources also tend to be brightly coloured and include illustrations rather than photos, with cartoon teeth a common theme. Many use purple tones as the "recognised" colour for oral health. A number of locally developed resources provided by stakeholders include images of community members.

How resources are used

Stakeholders provided examples of resources they currently use (usually locally developed). In addition they described a range of approaches to using the resources. Largely, resources such as pamphlets are used when engaging children, parents, caregiver, families and whānau in a variety of settings. For example, stakeholders provided pamphlets as part of targeted education and information sessions or during clinic visits after demonstrations.

Stakeholders are very conscious of not just providing information or toothbrushes and paste without providing explanation of wider oral health issues. Stakeholders prefer face to face

interactions to support the delivery of key messages and also noted that often when the resources are in English they provide translation into language during discussions with families.

INFORMATION GAPS AND NEEDS

Targeting resources by age and stage of life

Stakeholders suggested resources targeting children by age and stage of life are important. They highlighted the importance of materials focusing on oral health care from 0-1 year. Many recommended providing information focusing on teething and emphasising the acceptability of practices such as “smearing” fluoride toothpaste on baby teeth rather than brushing. There was a strong view from stakeholders that parents and caregivers need to be engaged before children turn one and that messaging can and should change focus as they grow.

Oral health is currently discussed with parents at the five month Plunket and Well Child/Tamariki Ora checks but some stakeholders are concerned this is too late. Some infants, especially Māori and Pacific, begin teething as early as three months. It was suggested key messages need to be delivered earlier and to the whole family, as families require time to become “orally fit” before their child start teething.

Effectiveness of and need for more interactive resources

The majority of resources identified during the stocktake are “passive” text based resources. These were largely downloadable written resources, or accessible via websites. Active resources available online include videos and websites. Interactive resources are less common and include smartphone/tablet applications belonging to international companies such as Colgate. There is a lack of New Zealand based, and focused oral health resources in these mediums highlighting an opportunity for further future resources to be developed.

The Ministry of Health, HPA and NZDA have established online platforms where such resources could be easily accessed by the public. Interactive or video based resources could be developed to shift the focus away from text based resources and promote increased engagement.

The stocktake considered documenting if resources were pre and post tested with the target audiences and their effectiveness evaluated but this was beyond the scope of the work. However, none of the resources identified were referenced and websites do not include information on testing for effectiveness in terms of engaging the target audiences.

The effectiveness of and a preference for interactive resources was emphasised by many of the stakeholders and many reported creating their own resources such as games and sticker charts aimed at preschool children. Many also highlighted their interest in evaluating their interventions including the supporting materials but lack the resources to do so.

PART FOUR - STRATEGIC CONSIDERATIONS

OVERVIEW

This section includes issues raised by stakeholders that are outside the scope of work. It describes a range of wider strategic considerations that may impact on the effectiveness on the initiative and influence decision making on the final approach.

DISTRIBUTION OF TOOTH BRUSHES AND FLUORIDE TOOTH PASTE

Stakeholders emphasised the importance of providing brushes to all members of the family to encourage role modelling behaviours and ensure tooth brushes are not shared. One stakeholder recommended brushes be provided in a range of colours to avoid confusion over which brush belongs to whom. A few stakeholders suggested key messages are printed on the tooth brushes and/or toothpaste. Others recommended distributing brushes marked with recognisable characters to create a connection between brushing and something children enjoy.

As the affordability is a significant barrier for some families, stakeholders recommended selection of affordable brand brushes and paste distributed through the initiative. This is intended to promote sustainability and promote the perception that good oral health is affordable and attainable.

POLICY CONTEXT AND ENABLING ENVIRONMENT

Stakeholders suggested policy and programme changes that might support intervention effectiveness and promote overall improvements in oral health outcomes. These suggestions are useful for informing the development of the current oral health initiative. They are listed below for HPA's information. Consider:

- introducing an extra Well Child/Tamariki Ora check dedicated to oral health to enable nurses to spend more time discussing the key messages at a time when the information is not competing with other health related priorities;
- providing free dental care for expectant mothers to assist them to improve their own oral health outcomes, understand the importance of oral health and develop good practices they can model for their children;
- increasing the number of FTE oral health promoters and/or funding for dentists and other oral health therapists to spend more time discussing key oral health messages and preventive practices with patients, rather than focusing on the “drill and fill”;
- establishing a national database to facilitate tracking and sharing of oral health information and contact details, possible linking with other health and social services to avoid families being lost to follow-up;
- supporting regional and local oral health initiatives by providing resource and capability to evaluate programmes and activities;

SUSTAINABILITY OF INTERVENTIONS

Stakeholders were positive about the four year funding period for the oral health initiative reflecting their belief that it creates an opportunity to do something meaningful. However, many also recounted experience from past brief and suddenly discontinued initiatives, short-term funding cycles and service limiting contracts resulting short term gains rather than sustainable outcomes. Stakeholders emphasised that to achieve long term behaviour change, oral health messages need to be delivered consistently across a long period of time. They considered this important for fostering habits in individual children and their families, and also for raising the profile of oral health in New Zealand and entrenching behaviours and key messages in families and whānau so that they are passed to future generations.

WORKFORCE CAPACITY, CAPABILITY AND TRAINING

Many oral health promoters are responsible for a wide range of health promotion activities. As such understanding workforce capacity is an important part of the decision making around distribution for toothbrushes and paste. Stakeholders noted there is a tendency to expand their scope of services and increase responsibilities of individual workers without providing additional funding or resources to support delivery.

Similar to other community health sector services, the workforce is ageing, and highly feminised which may be a barrier to engaging some sectors of the community and undermine efforts to support prioritisation of oral health. In addition, services often rely on part time workers responsible for communities spread over large geographical areas and spend a significant amount of time travelling. Clinicians/therapists are under pressure to provide a wide range of corrective procedures and as such have little time to dedicate to promoting preventive behaviours.

These characteristics mean stakeholders are reliant on other frontline service providers to promote oral health. They already routinely network with community nurses and workers, Well Child/Tamariki Ora providers and early childhood educators to engage parents and carers of preschool aged children and promote good oral health and many reported providing train the trainer services to counterparts from other services. They achieve a high degree of engagement illustrated by examples such as early childhood education services establishing supervised brushing programmes. However, it is important to recognise the role these strategies play in making interventions effective.

APPENDICES

APPENDIX ONE – PARTICIPANT INFORMATION SHEET



Child Oral Health Promotion Initiative



Kia Ora koutou, Talofa lava, Kia orana, Malo e lelei, Fakaalofa lahi atu, Bula vinaka, Malo ni, Halo ola keta, Mauri, Fakatalofa atu, Greetings.

The Ministry of Health intends to develop a new Child Oral Health Promotion Initiative (the Initiative) to improve oral health preventive behaviours and practices, particularly tooth brushing, among pre-school children. A central component of the Initiative is targeted distribution of free toothbrushes and fluoride toothpaste, together with appropriately supportive messaging to preschool children and their families and whānau. To inform the development of the Initiative, the Health Promotion Agency (HPA) is leading some exploratory work.

As well as talking to parents, families and whānau, we also want to talk to you, the oral health sector, to gain a better understanding of your work and enable your input into development of the Initiative. HPA has commissioned Allen + Clarke to jointly facilitate engagement with the oral health sector.

HPA’s exploratory work will be provided to the Ministry of Health to help inform their next steps for the Initiative. The Ministry is also separately working to determine the most effective way of purchasing and distributing toothbrushes and toothpaste. The Ministry will consider both pieces of work in informing their next steps.

Your input will help ensure our work builds on successful work already happening, is evidence informed, and supports you in your work to improve oral health outcomes for young children.

We anticipate we will include a mix of small group discussions and one-to-one conversations with a range of oral health professionals. An indicative format follows.

Part A: Who we are	<ul style="list-style-type: none"> • Introduce the work – who is HPA and Allen + Clarke team, roles and responsibilities • Overview of this project and the process
Part B: What you do	<ul style="list-style-type: none"> • Introductions by participants (roles/responsibilities) • Describing the work of your service/s in particular oral health promotion activities you are involved with
Part C: Improving oral health	<ul style="list-style-type: none"> • Influencers, motivators and barriers to improving oral health status • Lessons and challenges reaching families with young children and changing behaviour • Identifying practical, actionable strategies – what could be done? • What support do you need (in terms of health promotion)? • Identifying current effective programmes and resources
Part D: Wrap up	<ul style="list-style-type: none"> • Wrap up • Process for feeding back to you and involving you in the next steps

APPENDIX TWO – DISCUSSION GUIDE



Facilitators Discussion Guide Oral health initiative consultations



WELCOME FORMALITIES

Session opening and welcome by hosts, response and introductions by HPA (handover to A+C).

Part A: Introductions (approx. 10 min)	<ul style="list-style-type: none">• Introduce the work – who is HPA and <i>Allen + Clarke</i> team, roles and responsibilities• Overview of this project and the process• Introductions by participants (roles/responsibilities)• Describing the work of your service/s in particular oral health promotion activities you are involved with
Part B: Improving oral health (approx. 70 min)	<ul style="list-style-type: none">• Influencers, motivators and barriers to improving oral health status• Lessons and challenges reaching families with young children and changing behaviour• Identifying practical, actionable strategies – what could be done?• What support do you need (in terms of health promotion)?• Identifying current effective programmes and resources
Part C: Wrap up (approx. 10 min)	<ul style="list-style-type: none">• Wrap up• Process for feeding back to you and involving you in the next steps

PART A: INTRODUCTIONS

Who we are:

- HPA (lit review, talking to parents and the oral health sector and other key stakeholders).
- A+C (assisting with stakeholder consultation and stocktake of resources)

Housekeeping:

- 1.5 hour session (we will have some time to talk after if people are keen)
- Our role is to listen, responsibility is to accurately capture the range of views people present (making notes, not taping, synthesis of information, not identifying individual views)
- We will prompt and ask to keep conversation flowing as needed
- We reached out to stakeholders individually discussed the consultations, their willingness to participate, enquired after networks we should engage and provided the information sheet, follow-up included providing the consultation schedule
- As the service providers/managers engaging with the community, your contributions to the process are essential
- Our goal is to provide a forum where participants feel comfortable sharing their ideas and opinions and listening to others, and that all have the opportunity to speak/contribute

- Appreciate time - value and respecting ideas and discussion (HPA/A+C engagement approach)

Scope of the discussion:

- As you are aware we are undertaking exploratory work to inform development of a new Child Oral Health Promotion Initiative.
- The focus of the Child Oral Health Promotion Initiative is to improve oral health preventive behaviours and practices, particularly tooth brushing, among pre-school children.
- There are two parts to this initiative – the distribution of toothbrushes and toothpaste (the details of which are being explored by the Ministry of Health), and tools, resources, messages to support the initiative (which is where HPA comes in).

PART B: IMPROVING ORAL HEALTH

Overarching question:

What do you and your community need to provide better oral health outcomes for pre-schoolers, and increase preschool tooth brushing?

Consider:

- What absolutely has to happen?
- If there were no restrictions, what would you see as working?
- What's the most important thing given that toothbrushes and toothpaste will be distributed and that we can't change existing service delivery or funding?
- What's worked or is working really well in your community (or elsewhere don't have to have been directly involved) and why, for example
 - networked/linked up,
 - well resourced,
 - integrated in community,
 - at a local or national level?
- What's been tried and hasn't worked in your community (or elsewhere don't have to have been directly involved) and why?
- HPA is a national organisation with expertise in marketing communications and working with the health sector, and whose role it is to equip/enable the sector and help the public – where would you see HPA's role? What could HPA do? What would you say to HPA?

PART C: Wrap up, next steps, thanks and close

Thanks to all participants for attending and sharing. The process from here...

Consider:

- Timeline for consultation and reporting (due end July)
- Further opportunities to contact us and provide input: oralhealth@allenandclarke.co.nz³
- Report back to participants in what format.⁴
- All participants will be emailed the report from this consultation, along with the final literature review, any reports from research conducted with parents and caregivers. This is only the start of the process and HPA hope they will continue to be part of the journey.
- HPA will be compiling the literature review, our conversations with you, and the research conducted with parents and caregivers into a recommendations report to MOH in August/September.

³ Dedicated email address

⁴ Offer to share full report (?) ask to participants to identify interest in receiving it at the consultation – perhaps a sign-in sheet on arrival and tick to confirm.