RECAP SARPHATI EXPLORE 4 | Oral health in children

Sarphati Amsterdam organizes Sarphati Explore, a meeting platform for researchers, healthcare professionals, policy makers and other stakeholders on specific themes. Together we aim to explore possibilities for future research and collaborations on different topics within Sarphati Amsterdam. By creating a network of experts in a certain field, we can work towards more impact within the academic world, healthcare and society. The fourth edition on 7 April 2022 covered the topic of oral health in children. This edition started with several interesting in-depth presentations discussing the theme from different perspectives:

1. **Introduction: oral health of young children living in Amsterdam**
2. **The way to inclusive and more effective oral health care**
3. **BrushHour: an initiative to improve oral health among young people in Amsterdam**

Presentations 1 and 2 were discussed in parallel sessions in an interactive setting. In this summary we will share the highlights of these interactive sessions.

SESSIE 1 Exploring collaborations within Sarphati Amsterdam for addressing the syndemics in oral health and general health in children

Syndemics is a conceptual framework where anthropology, sociology and health sciences meet (Merrill Singer, 2009). It is a systems approach to population vulnerability. It aims to decipher mechanisms through which health of vulnerable populations is undermined. It is connected to health risks with health outcomes under conditions of social inequality. Many factors can generate health risks and influence disease clustering and amplify disease burden, such as: biological, psychological, sociological, behavioural, political, economic and cultural factors. With syndemics temporal patterns are mapped, such as clusters, accumulation and cascades. It could be a cascade of risks, for instance poverty, poor education, substance dependency and unemployment, which increases the burden. Syndemics quantifies the health consequences of identifiable disease interactions and the social, environmental, or economic factors that promote such interaction and worsen disease. Everything may rapidly fall apart if we stick to the traditional approach. It is not enough to simply have questionnaires. It is important to work with all sectors of the healthcare environment of children.

If we are to decipher mechanisms which undermine health of vulnerable population, what will be the place of dental disease risks and oral health? Who can and will include them? When, where and how? First you need to know where to find your target population and how to best reach them in an effective way. It is important to include children and families that can benefit and often need it most. In general it is a challenge for both research and for healthcare to reach these vulnerable populations. We need to find the support infrastructure of the people that are still missing. Longitudinal birth cohorts exist. But they are often set up from a health perspective. Do birth cohorts exist from a more social perspective or cohorts that do not include health data? Is it possible to use a social cohort and add health data? Midwifery sciences also have cohort studies. The syndemics approach is possible within the Sarphati Cohort, by developing a sub-cohort study from a social perspective to collect data that can also be linked to healthcare data and questionnaire data already collected for the Sarphati Cohort. We need a strategy beyond the health sciences arena. Meta health uses a systems approach and will make efforts to reach the people and see what their needs are. A bottom up approach, by starting small scale and gaining insights to figure out what should be scaled at a later time and figure out what people need to participate and to be involved better.

Multi-disciplinary research and participatory research is needed. It is important to identify which disciplines should be involved, such as: social departments, faculty 'maatschappij & gedragswetenschappen', organizations that work in local communities. The findings of syndemic research are relevant for health policy, so it is important to translate findings to policy and include policy makers. Health economy is also very important.

A long term strategy for recruitment and engagement is important to establish, especially for the more vulnerable population. It is important to think about what these population can gain from participation. 'What's in it for them', is an important question to think about in everything you do. For this you need another mechanism. For instance by providing things or services for the group of people you would like to include. A kind of social interaction of investment and return. The response may increase with the use of interactive apps. For specific groups incentives will not help to include and engage them. We need to analyse who we are missing, what they need and what the environment is of these people. For some groups you may have to provide things such as a phone. This can be a very effective incentive for people that do not have a phone. Think outside of the box when it comes to incentives. Sometimes an incentive should be something other than you would expect. But also think more out of the box when it comes to your recruitment strategy. Add components that are missing, but may help to reach people. Address their need and try to help them, and then involve them in the research. It is important to build trust.

SESSION 2 The road to more effective and inclusive oral healthcare

Together with experts from different disciplines we discussed how we can work towards more inclusive and effective oral healthcare. How can we work together to improve the oral health of children growing up in families dealing with circumstances that make them vulnerable?

We looked at this from different perspectives: healthcare professionals, the family, the living environment and policy.

A better collaboration between healthcare professionals and inclusivity were key points of the discussion. If we truly want to be more inclusive, it is important for us as healthcare professionals to be on the same page. The collaboration between the Parent and Child Teams (OKT) and oral healthcare can be improved. This is not only the responsibility of the dentist, but also of other healthcare professionals.

Idea: an experiment with healthcare insurance: free oral health for parents in an experimental setting.

But are the costs the real issue? Or do other factors play a role? Research shows that parents are often not aware of the financial compensations that are available. But it is an accumulation of things. Shame plays a role, because parents can not afford it or they themselves have bad teeth and do not visit the dentist. Not everyone makes use of preventive oral healthcare, some only visit the dentist if they are in pain. Sometimes cultural and language barriers also play a role.

Stigma can get in the way of treatment. Can we all ease up on this a little? Must teeth be cavity free, white, straight and perfect? Trust is important to reach children and to keep them engaged. The experience must be positive. The situation must allow for this in the interaction.

How can we reach children? How can we make sure that the school dentist has access to every (pre)school? More and more schools are refusing the dentist. Although this is not on a large scale, we do notice that the willingness of schools to take part is declining. At secondary schools there is

no oral healthcare at all. This should be expanded. For this it is important to promote dental healthcare, to be able to increase the reach. Opportunity lies in the coverage of Youth Health Care (GGD), as they provide care for all children.

Idea: oral healthcare students can provide dental health education (Trammelant in Tandenland) at schools in collaboration with the GGD. Would it not be best to deploy students that will work in preventive care later on? On the other hand it is very important to create this social awareness in the education of oral healthcare students. Public oral healthcare should be part of the curriculum. It should also be more appealing for dentists to provide care to children. Dentists should take a good look at themselves, but it could be more appealing if bonuses are provided.

Within Sarphati Amsterdam and the Sarphati Cohort we can contribute to the development of (experimental) research, for example within the large project METAHEALTH. We would love to hear any ideas you may have for this.

The personal responsibility of parents was also discussed extensively. Personal responsibility is very important in The Netherlands. However this is does not work for every family. For instance, some families struggle to set limits on sweets or find it hard to improve tooth brushing. You can encourage parents, but many face barriers they can not overcome. We can not only rely on personal responsibility. Governments also have a responsibility, besides the individual, the dentist the school, the Parent and Child Teams (OKT). Knowledge, money and environment are important in making healthy lifestyle choices for people dealing with more vulnerable situations. You will have to provide this for them first. If you choose to rely on personal responsibility, you will have to accept that people will make completely different decisions. Trust is very important! At the moment we see a shift from personal responsibility to a focus on structural change.

The living environment is very important, as young children can not take personal responsibility. If you are repeatedly exposed to unhealthy behavior due to nudging, can you speak of a personal choice? You can't beat that by providing information. A systems approach is increasingly used to tackle public health problems. This means we will not only try to change behavior on an individual level by traditional health education and parenting. We won't achieve anything if we do not also change structural factors. This provides opportunities for oral healthcare.

The GGD takes responsibility, but does not have sufficient recourses to intervene in daily life. Has the corona crisis not shown that more could be done? A lot more can be done in times of crisis. For example, this is more difficult when it comes to a sugar tax. As a local GGD you should take responsibility in setting the agenda for things like this, but the effectiveness is limited.

Trust was repeatedly mentioned in the discussion. A positive message: distrust at a higher level, towards institutions, can be diminished by gaining trust at a lower level by building personal connections. This provides an opportunity for dentists.

Take home message: get rid off fast food chains, get dentists in, but educate the dentists first!

Setting up a follow up meeting to come to specific ideas and to see how we can proceed would be a great start. What is the most urgent thing to invest in? Is there (Sarphati Cohort) data that you want on this? How could Sarphati Amsterdam support in all of your ideas? We would like to hear from you! You are more than welcome to share any questions or ideas with us via info@sarphati.amsterdam.