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Building space for children's voices

The added value of participatory and creative approaches for child-centred integrated obesity care

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Building space for children's voices: The added value of participatory and creative approaches for child-centred integrated obesity care

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ABSTRACT

Background: Paediatric obesity is increasing across the globe. In search for solutions, it is important to engage children, as they have their own unique perspectives on what it means to be a child with obesity within their sociocultural context. Though this is increasingly acknowledged, the question remains how to meaningfully engage children in paediatric obesity care as they are often in an unequal position in relation to adults.
Aim: In this study, we reflect on what can be learned from a participatory research approach to improve child-centred paediatric obesity care.
Design and methods: We reflect on four years of participatory research with children and care professionals to understand the mechanisms that facilitated child participation within the research process. Secondly, we reflect on how these lessons relate to care practices. We conducted qualitative content analysis on the data gathered, including interviews, observations and working sessions with children and care professionals.
Results: We identified three elements that facilitated child participation: (1) adopting a participatory *attitude*, (2) connecting to children's *living environment* and (3) *doing* activities together. This helped to build trusting relationships and gain in-depth understanding of what works well and why.
Conclusion: Our findings underscore the significance of building communicative spaces where children's voices can be articulated at their own pace, about issues of their own choice, based on their own experiences.
Practical implications: Working together with children as knowledgeable partners in paediatric obesity care can improve care delivery and provide solutions that better reflect their everyday realities and needs.
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Introduction

Paediatric obesity has increased dramatically over the past decades worldwide (WHO, 2023). The consequences are broad, with issues at multiple levels, including health issues impacting morbidity and mortality in adulthood (Ling et al., 2022). Children living with obesity face the negative effects of bullying, both perpetration and victimisation, resulting in multiple social, educational and mental problems (Ling et al., 2022; Newson et al., 2024). Increasing the complexity of tackling obesity further, it is also connected to interacting ecological and economic systems. Overall, this defines obesity as a wicked problem requiring solutions that change system dynamics. To fully understand the complexity of paediatric obesity, it is increasingly acknowledged that the perspectives of children themselves are necessary (Halberstadt et al., 2023; Sijben et al., 2018). Incorporating children's perspectives based on their lived experiences is critical to understanding the impact of paediatric obesity on their lives and developing interventions and policies that are more in line with their personal needs and living environment (Concincion, van Houtum, Verhoeff, & Dedding, 2024). McMellon and Tisdall (2020) report that children and young people offer unique and indispensable perspectives necessary for a greater understanding of social realities, and furthermore, for

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questioning the fundamentals of academic knowledge production. Scholars showed that (young) children are knowledgeable about their own bodies and lives and should be invited as experts of their own lifeworlds and as agents of change (i.e. Aussems et al., 2020; Cudjoe et al., 2022).

In the Dutch model of integrated care, children and parents are at the centre of an approach that goes far beyond just weight management, with a focus on complexity at multiple levels, such as psychological wellbeing, lifestyle factors and family dynamics (e.g. skills to manage challenges, offering the necessary support to address these challenges) (Koetsier et al., 2021). In this approach, youth healthcare nurses are in the role of coordinating professionals (CPs). Characteristic of this care approach is the coordination of all activities around children with paediatric obesity and the provision of support to make lifestyle changes (Koetsier et al., 2021). However, how CPs can put this processual approach into practice and how they could engage children and parents is not well known. As Lim (2017) describes, heeding the silent partner, children are often in a position of unequal power in relation to adults. Gabe et al. (2004) describe that in order to explore family perspectives in providing care, three actors – the child, the parent(s) and health service professionals – are necessary, but this also makes conversations more challenging.

The UN Convention on the Rights of the Child states that children have a right to form and express their own views freely in a manner of their own choosing, concerning all matters affecting them (United Nations, General Assembly, 1989, Article 12). While Eriksson (2023) report that evidence-based methods to enable children to participate in dialogues with adults and thus form and express their views freely in decisions regarding their lives are still scarce, there are inspiring examples in participatory research in which scholars have successfully managed to enable child participation in relation to health and care (e.g. Alderson, 2006; Aussems et al., 2022; Christensen & Prout, 2002; Dedding, 2009). The debate on how to communicate with youth and enable their participation is extensive and ongoing (see e.g. Eriksson, 2023; Facca et al., 2020). Scholars report on building communicative spaces, referring to the 'ideal speech situation' of Habermas (2003), as a starting point for genuine participation. Communicative spaces are spaces where children and young people feel comfortable and safe, where they can speak freely and are listened to, enabling equitable and discursive speech to take place (Bevan, 2013; Dedding et al., 2021). However, the daily practice of obesity care for children and young people poses many challenges in terms of communicating with children and their families due to difficulties in adherence to lifestyle interventions and a care system under increasing pressure.

Participatory action research (PAR), stemming from a critical emancipatory perspective (Freire, 1970), provides a way to implement the rights of children and young people to express their opinions, influence solutions relevant to their lives and thus to participate (Shamrova & Cummings, 2017). Cornish et al. (2023, p.2) define PAR as "a collaborative, iterative, often open-ended and unpredictable endeavour, which prioritises the expertise of those experiencing a social issue and uses systematic research methodologies to generate new insights". PAR enables all stakeholders to critically reflect on power and relations of dependence, engage in self-reflection, develop knowledge, learn together and take action to induce change (Dedding et al., 2021). In this current study, we aim to reflect on and understand how PAR practices could add value to obesity care practices by answering the following question: *How could participatory action approaches (attitudes and methods) facilitate child participation within paediatric obesity care?* Based on four years of close work together with children with paediatric obesity, we reflect on what can be learned from the research process to improve child-centred paediatric obesity care. We focus on children living with paediatric obesity in disadvantaged neighbourhoods, where the issues related to overweight and obesity accumulate (Municipality of Amsterdam, 2019).

Methods

In this study, we followed a qualitative descriptive approach to reflect on how child engagement and participation were facilitated and established during the research process, and how this can relate to care practices. Qualitative content analysis was conducted to provide a structured, focused examination of the content and its meanings. We reflect on the research approach and the data generated from the whole research process, which included a literature review, participatory observations during health consultations with youth health care nurses, and interviews and working sessions with children, in order to learn how PAR practices could add value, not only for research but also for obesity care practices.

Setting

In Amsterdam, providing expert advice beneficial to children's and young people's health is the responsibility of youth healthcare, with a focus on providing prenatal guidance, health information, immunisation, and health screening and monitoring, identifying care needs, and providing support to children (and their families) in their own neighbourhood. Youth healthcare professionals have an important role in signalising the development of overweight and obesity, coordinating obesity care and providing support to families to make sustainable lifestyle changes (de Laat et al., 2019; Koetsier et al., 2021). This specific coordinating role is practiced by youth healthcare nurses ('coordinating professionals' or CPs) and is fully imbedded in the Dutch national model of integrated care for childhood overweight and obesity (Halberstadt et al., 2023).

The entire research process was conducted before, during and after the COVID-19 pandemic (2019–2023). The children in this study all live in Amsterdam Southeast. This area was chosen because of its exceptional diversity and the prevalence of paediatric obesity, and the fact that policymakers and care providers feel that tailored care is especially necessary for this group (Municipality of Amsterdam, 2019). The thirteen children that participated in the working sessions were born to first generation migrant parents and thus had diverse cultural backgrounds: (African) Surinamese, Pakistani, Afghan, Caribbean and Ghanaian (see Concincion, van Houtum, van de Vorst, et al., 2024; Concincion, van Houtum, Verhoeff, & Dedding, 2024). They were aged between six and thirteen years during the research and all of them were living in the Amsterdam Southeast district. The prevalence of overweight or obesity in children (aged 10 years) in the Southeast district is 33 %, which is the highest of the city (Municipality of Amsterdam, 2019). Amsterdam Southeast consists of neighbourhoods where relatively many people are disadvantaged in terms of the intersecting characteristics of poverty, education and participation (van Koperen et al., 2018). Many residents have feelings of unsafety in the neighbourhood due to crime and many do not feel heard, seen or understood by professionals and policy officers (Municipality of Amsterdam, 2019). A stacking of all these characteristics can make children living in households in this neighbourhood extra vulnerable.

Participatory action research

Acknowledgement of the value of PAR, the methods of which focus on experiential knowledge generated and constructed through real lifeworld experiences, is growing (Dedding et al., 2021). PAR can help children and young people in disadvantaged positions to explore, describe and share their lifeworlds and daily experiences and how they are influenced by multiple structures (e.g. health, social, mental, economic and political), and to strengthen children's and young people's agency by enforcing their ability to intervene throughout these structures and report problems essential to them (e.g. Aussems et al., 2020; Sarti et al., 2018; Shamrova & Cummings, 2017). In our study, we conducted

participatory observations within the care setting and living environments of children to understand contextual dimensions such as (family) space, living environment, (social) activities, interactions, time and emotions. We used, among others, a draw, write and tell interview technique in working sessions with children, which is a creative research method (engaging, participatory, familiar and non-threatening) for exploring children's experiences (Angell et al., 2014). Furthermore, we conducted walk-a-longs, consisting of walking individually with children, as well as an organised group session to validate and deepen our findings.

Ethical considerations

Ethical approval was attained for the entire research process from the Medical Ethical Review Committee of the Amsterdam University Medical Centers, the Netherlands (METC; reference number W20_552). Beyond the generic ethical principles that apply to all research, we also followed the ethical principles for participatory health research (ICPHR, 2022). Children and their parents received verbal and written information about the study and had a fortnight to decide if they wanted to participate and, if so, on what conditions. It was highlighted in every session that participation was voluntary, that withdrawal from the study was possible at any time without reporting a reason and without any consequences in terms of the quality and continuation of obesity care. All children gave verbal consent and the written informed consent was signed by one parent. We use pseudonyms in order to protect children's anonymity.

Double role of the researcher

During the entire research process, the main researcher (SC), a Black female with a Caribbean background, also worked as a youth healthcare nurse. This unique double position enabled her to engage with youth healthcare nurses, to observe care practices and interactions with children and their families, and to work over a longer period of time together with children living in a disadvantaged neighbourhood. In these observations, we could discern the differences between the youth healthcare setting and the participatory approach of the study. In this article, when we use the word 'researcher' we are referring to the main researcher (SC). The fragments from the reflexive diary were written by the main researcher in the first person ('I'). When we refer to 'we', we are indicating the entire research team (SC, LvH, AF & CD).

Data analysis

The data consisted of fieldnotes, detailed field reports, transcripts, verbatims of interviews and the reflexive diary kept during the four-year research process. The prolonged engagement with nurses, children and their families, member checking, reflective journaling, and discussion within the research team helped to establish credibility (cf. Lincoln & Guba, 1985). Following Krippendorff's (2022) practical guide for conducting qualitative content analysis, we inductively analysed how a trusting relationship with children was built and what was needed so that children felt invited to share their perspectives and the life experiences that are important to them. We immersed ourselves in the context and lifeworld of the children to reveal both the depth and meaning in children's utterances (Lindgren et al., 2020; Özden, 2024).

Findings

In this section, we describe how children's participation was facilitated in the research process. We identified three key elements that facilitated child participation in the research process: (1) *adopting a participatory attitude,* (2) *connecting to children's living environment and* (3) *doing activities together.* We describe these elements separately and reflect on how the findings relate to and might benefit obesity care practices, followed by some key observations of the interactions between children, parents and nurses in the care setting.

Children's contribution in obesity care

In general, youth healthcare is based on monitoring the health and wellbeing of children, whereby children and their parents are invited through letters to come to a clinic during health consultation hours. Integrated obesity care for children is imbedded in this setting. During the participatory observations, it was observed that most consultations consisted of an enquiry led by the youth healthcare nurse to evaluate how the family was managing in terms of implementing healthy lifestyle activities. In these consultations, many questions asked by the youth healthcare nurses were closed-ended questions in which children could only answer with 'yes' or 'no'. There were also categorical questions, such as 'how are you?' and 'how are things at school/home?' and questions related to healthy behaviours such as 'did you manage to do your exercises?' and 'how did your sport lesson go?' These types of questions work as an impediment to engaging children in meaningful dialogues. The contribution of children was consequently very limited. Frequently, the dialogue was guided by the nurse or parent(s), often resulting in silent and passive children. Furthermore, dialogues between parent(s) and nurses were conducted while sitting on opposite sides of a computer desk. In all cases, children sat next to their parents opposite to the nurse. The nurse asked questions mostly to the parent(s). When a question was asked directly to a child and the child did not respond immediately, parents helped their child to answer, resulting in the child falling silent again. Fig. 1 illustrates the differences observed between youth healthcare practice and participatory approaches, and highlights the three identified elements (participatory attitude, connecting to children's living environment and doing activities together), that can facilitate child participation.

Adopting a participatory attitude: inviting children as knowledgeable agents

In the working sessions with children, the attitude of the researcher was found to be key to inviting children into dialogue. This attitude stemmed from the notion that children are knowledgeable about their own lives. This was supported by a respectful, empathetic, open, non-judgmental, supportive and encouraging attitude. This started with the way children were invited to take part in the study. The researcher invited children to participate *as partners* in the research process, not just as a source of information. In analysing the data, we found that repeating that children are knowledgeable was important for the children. Children would nod and smile and say that they were not used to being asked about their opinion. It empowered children to speak aloud; they felt invited to react and ask questions. A respectful, empathetic, open, non-judgmental attitude was required to respectfully and slowly explore the concerns children had, such as mourning a family member, feeling alone and missing their peers. It took time to encourage children to get acquainted with their role as an experience expert. In the beginning, children were often silent, or their answers were short and often non-verbal (e.g. nodding, looking away). After the researcher repeatedly demonstrated that she really wanted to understand and that she appreciated and acknowledged what was meaningful for them, they became more willing to share the full range of their lived experiences. The children reacted to this acknowledgement by speaking more freely and leading dialogues towards themes on their own accord e.g. feeling bored, falling back into unhealthy eating patterns. This encouraged the researcher to step further out of her comfort zone, to let go of her own agenda and to follow children's lead and pace, while providing and supporting a non-threatening environment for children to gently participate in a way of their own choosing.

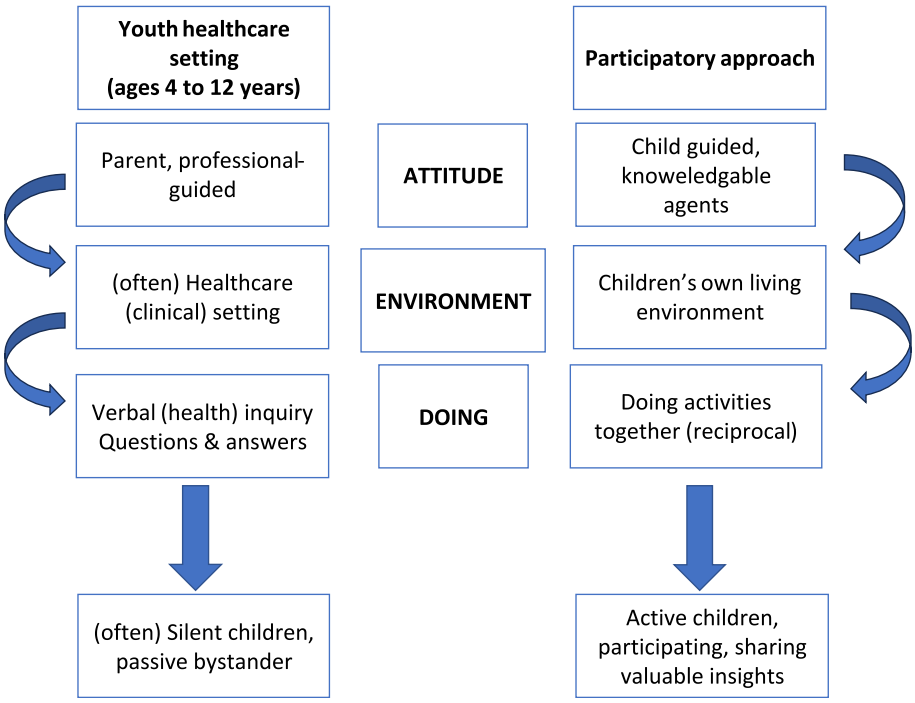

Fig. 1. The differences observed between youth healthcare practice and participatory approaches, and the three elements that can make a difference in facilitating child participation.

Environment: connecting to children's own living environment

A second key element we identified was connecting to children's living environment. It was significantly different when the researcher met with children in their own environment, compared to during the consultations hours in a clinical setting.

> I ring the bell at the front door and I am let in by Joe himself. I take off my shoes and leave them at the front door. Joe recognises me and says *"Hi teacher*[3]*". I say: "Hi! Now the roles are reversed. You always come to my consultation hours at the office, now I come to your house"*. Joe has to laugh at this and walks into the living room, presenting me to his mom sitting on the couch (Field report 2022, Joe, 10y).

Connecting to children's living environment provided a deep understanding of their daily activities and living situation, and interactions with their parents and culture. As the example shows, this starts at the front door: Joe is well aware that the roles are reversed and that he is in an important position to show his home and family to the visiting researcher. Connecting with the environment is, however, more than visiting Joe's house. Joe is of Surinamese descent. When entering Joe's house, the researcher took off her shoes and left them at the front door, as is customary in Surinamese culture. The same went for washing hands, since hygiene is very important for the Surinamese community. Taking the customs of the family and culture into account enabled the researcher to connect; to let parent and child know that she respects what is important to them, without saying it out loud. Joe and his mom felt free to share their experiences based on a trusting relationship. This enabled Joe to share topics that he had been unsure about for a long time, such as food portion size. Because the researcher was in his own home, Joe was able to demonstrate what he believed to be a small plate or a full plate of food:

> I ask him what he means by small plate and he walks to the kitchen to grab the plate in question. He hands me a standard breakfast plate: *"Look at this one, this is small"*, he says. I explain that this is a normal plate for breakfast and that it is adequate for his age. Joe has to laugh at this. He thinks the plate is small, implying that his daily portion of breakfast will not fit on the breakfast plate (Field report 2022, Joe, 10y).

This seemingly small example illustrates how valuable insights can be easily overlooked or not shared in a clinical setting during consultation hours. During a walk-along, we identified similar findings on the importance of connecting with children in their own living

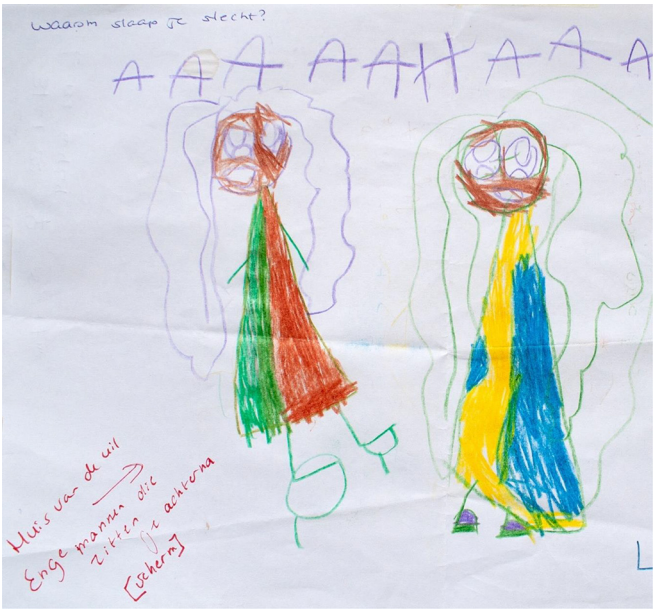

Fig. 2. Leilah's drawing of scary zombie images chasing her in her mind (6 years old, 2023).

[3] At the time of this interaction, Joe had known the researcher for approximately two years in her role as a youth healthcare nurse at the youth healthcare centre in his neighbourhood, and was used to calling her 'teacher'.

environment. Connecting to children's frame of reference is important to understand their daily struggles, facilitate opportunities for them to share their views and acquire a deep understanding of what they value.

> I walk with Ted in his neighbourhood. He shows me where he takes his sport lessons. As he does this, his face becomes sad. He is afraid to play sports in a group of children and he is also afraid of pain during exercise. He says he is embarrassed. Ted explains*: "I can't do all the exercises there [health club], like doing a handstand during gymnastics"*. His mother's support is important to him and helps him, but getting there together is not possible, as it is too far from his home and too expensive for the two of them to go by bus every week. His mother also has to take care of his other siblings. He has to go to sports class alone, and this demotivates him from going. Ted shares*: "As a result, I often don't go at all"* (Fieldnotes walk-along 2021, Ted, 12y).

This example illustrates how Ted shared sensitive and personal information, and at the same time provided many practical openings to help him.

Connecting to children's environment can also mean connecting to their community. For the research, the researcher visited a local African church congregation in the children's neighbourhood, on the request of the pastors, to provide education on child health and development. Approximately 30 women and their children participated during the women's conference organised in the church. A result of this local visit was that the pastor felt respected and heard: "*You can't believe how difficult it is to find a highly educated black female researcher or youth healthcare professional willing to come to church and talk to us about good health and child-development"* (Field report, 2021). When the researcher afterwards asked the mothers what was different about the information she had provided in the education versus the information they usually received from youth healthcare professionals, a mother explained*: "You take the time to come to us in church and give a lot of examples of situations. Most of the time they don't understand us"*. Another mother added: *"You are a highly educated woman of colour. Most of the professionals are white and they don't understand"* (Field report, 2021). If mothers do not feel understood, this has consequences for the information they share, but also for how they might encourage their child to speak up and share personal information within the care setting. The example also shows how significant it was that the mothers in this community could identify with a female professional of a similar background who could empathise with the struggles and experiences they had (i.e. parenting, struggles with healthy eating, making ends meet on little income).

Doing: doing activities together with children

The researcher used different techniques to talk with the children, such as drawing, writing, walking and playing. All these techniques allow children to 'do' something or be in 'action' while communicating, instead of just answering questions. Doing activities together with children lowers the threshold for children to express themselves and increases opportunities to share personal or sensitive topics of their own choosing. It enables and facilitates children to speak freely without feeling the pressure to make eye contact with the researcher. In addition, we observed that it was beneficial that the children had a choice in how they wished to communicate with adults. Some children wanted to go for a walk in their neighbourhood, others wanted to draw or to play a game. Having a range of participatory and creative methods increases the chance that a child can express him-, her- or themselves in different ways.

Having experienced the advantages of doing activities together, the researcher introduced a draw, write and tell activity during consultation hours.

> I ask Leilah, *"Why do you sleep so badly?"* I have crayons and markers and paper sheets on my desk. Leilah picks up some crayons and starts drawing. She does not look at me. I remain silent and observe. She draws figures of men, she says she sees them in her head every time she lies in bed. She says, *"Scary men, they are chasing you" [Fig. 2.]*. Through the drawing, I notice that she is scared at night and hardly sleeps. Her mother recognises the zombies from a television program: "*I didn't know she found this scary and slept so badly because of it"* (Fieldnotes participatory observations, 2023, Leilah, 6Y).

It turned out that Leilah watched this television program daily after school at her grandmother's house, where she was taken care of while her mother and father were working. Since her grandmother had a physical impairment, she could not walk far or go outside to the playground, decreasing opportunities for Leilah to be physically active after school. Leilah shared that for this reason, she got bored quickly and thus watched TV until her parents got off from work. This small example illustrates the mechanisms and underlying causes behind inactivity and disturbed sleeping patterns that negatively influence achieving a healthier lifestyle.

In a second example of *doing activities together*, the researcher placed a numerical scale on the floor of the consultation room, which she used to invite children to indicate how they were feeling (Fig. 3). This five-point scale was made together with the children. The two extremes were represented by a depiction of a sad face and a happy face. Children could then choose which number indicated best how they were feeling. The numbers 2,3 and 4 were the most insightful because they provided an opportunity for the researcher and the children to find words for how they felt. Another benefit we identified was that children could move around the room during this activity (and thus did not have to sit across from the researcher), making the consultation more playful and meaning that they could choose for themselves whether or not to look the researcher in the eye.

The final example shows how *doing activities together with children with paediatric obesity* can also take place within a group. The researcher asked children what they wanted to do, and together the children decided to go to an indoor playground – a location they knew and found fun. This activity enabled the researcher to spend informal time with them in a joyful environment. In consultation with the children, play was interspersed with exploration of the themes that they valued. Moreover, while they were playing, the researcher and the children's mothers could engage in meaningful dialogues themselves. The mothers asked many questions and reacted to what they had heard their children say to the researcher. We conclude that having this extra (unexpected) time with the mothers, apart from their children, was beneficial for the relationship of trust and allowed us to attend to

Fig. 3. A numerical scale to playfully explore children's feelings.

the parents' questions and concerns, which they had not dared to share in the consultation room.

Fig. 1 summarises the above-described key elements for child participation that might be beneficial to youth healthcare practice. It is important to emphasise that obesity care practice in youth healthcare is not as fixed as Fig. 1 might suggest. For example, nurses do incorporate home visits when coordinating care and they do sometimes speak with children without their parents present. Children 12 years and older are allowed to visit consultation hours without their parents, with parental consent, and some nurses work in schools and speak to children individually during breaks. Nevertheless, most contact with children is during consultation hours in a youth healthcare services setting with their parents present. Important to note is that the three elements enhance each other, as the following example of Joe shows:

> I sit on the floor in Joe's living room and Joe comes and sits next to me. He grabs the crayons and starts to make a drawing. I explain to him what we are going to do. Joe says*: "I can't draw very well"*. I say that I can't draw well either and I explain that the drawing itself is not necessarily important, but that it is about what he wants to share and what is important to him. Joe starts drawing his house and speaks freely about what he wants to draw (Field report, 2022, Joe, 10y).

Drawing a picture together was not the only key to engaging Joe to speak freely and share his knowledge. Another dimension was space. Sitting together with the researcher on the floor, experiencing that the researcher made time to listen, being encouraged to think about what was important to him (instead of a professional-guided agenda), and being able to share it in front of his mother were also elements beneficial to meaningful dialogue.

The learning effect of participatory action research on parents and youth healthcare

Interestingly, the three key elements also had a learning effect on parents and youth healthcare practice. For parents, it was new that the researcher wanted to talk to their children individually, with them nearby but not actively involved in the dialogue. This approach made them reflect on how they listened to their child, and what they possibly forgot to ask their child. For instance, the mother of Leilah was amazed by how freely her daughter spoke during play. The researcher used building blocks and construction toys to play with Leilah, while having a conversation with her about school (Fig. 4). This way of speaking during play made it possible for Leilah to speak freely about things that were hard at school. Leilah's mother took a picture of this moment to remind herself that this is a way that can help her to communicate with her child.

Another example is that Joe's mother was surprised to hear how important gaming is for her son. She was startled when we looked at Joe's drawing. She said: *"He does indeed game a lot"*. By reflecting on the drawing, she gained insight into the amount of time he actually spent gaming and the interaction between gaming and eating. She observed all the places in the house where Joe sits when he is gaming and also that he is always eating something when he is gaming. In parallel, Joe was encouraged to explain why he was gaming so much.

An essential element to engaging children in activities is that there is trust between the researcher and parents. It is imperative to connect with parents first and invest in a trusting relationship, as they are the primary caregivers and important to their children. Trust is a prerequisite to create space to also work with children alone, with their parent present but out of earshot. The latter is important as it allows children to feel more comfortable to share their own experiences and struggles. A parent shared:

> *I'm happy that you take time for us and not only take weight and height measurements or talk about how much candy she eats. When I come here [health consultation hours], they only weigh and take her height, but I need help, somebody to think with me what to do. She is older now so I don't know what is good for her (Fieldnotes during consultation hours, mother, 2022).*

Fig. 4. Leilah (6 years old) constructing a castle while sharing her experiences (2023). *photograph placed with permission.

Another mother explained why it is important to connect with parents on dimensions such as background and culture. She indicated that she is of Antillean descent and was very happy that the researcher comes from Curaçao. She said: *"Luckily we have you. When I came here [health consultation hours], I thought that they would not understand us. Now it's nice that there is someone who knows and understands our culture"* (Fieldnotes during consultation hours, mother, 2022). Because this parent could identify herself with the researcher and find recognition, it made it easier to talk about topics that are sensitive within the culture and community and can cause struggle. To gain a better situated sense of what children and their parents value, it is imperative to connect with parents, their culture and the community in order for them to feel respected and acknowledged and thus be able to trust and share their feelings and needs.

The PAR approach also had a learning effect on youth healthcare practice. During the research process, preliminary results were shared with the team of youth healthcare professionals, enabling reflection on the findings and how they relate to existing goals and practices, such as reaching out to targeted families. It resulted in a substantiation and strengthening of existing lines of action such as outreach work, district-oriented work, tailored care and integral work with network partners. Furthermore, the preliminary results helped to explore pathways to design electronic health records that are more in line with the lifeworld and perspectives of children and parents. Specifically, the team of youth healthcare professionals in the Amsterdam Southeast district began to experiment and evaluate building space to work in a more child-centred, outreaching and lifeworld-oriented way in obesity care. Youth healthcare professionals who recognised themselves in the participatory approach of working together with children felt acknowledged and encouraged to inspire others with their experiences of participatory approaches.

Discussion

Building space for children's voices is essential to comprehending the complexity of paediatric obesity and becoming more effective in communicating with children to develop and shape care in line with their needs and circumstances. The aim of this study was to reflect on and understand how participatory research approaches could add value to obesity care practices for children, particularly those living in disadvantaged neighbourhoods. Based on our findings, we discerned three key elements: (1) adopting a participatory *attitude*, (2) connecting to children's *living environment* and (3) *doing* activities together. Typically, we observed that the contribution of children in dialogue with adults in obesity care practice was limited. Frequently the dialogue was guided by the youth healthcare nurse or parent(s), often resulting in silent and passive children. We reflected on the attitude of the researcher and found this to be key to inviting children into dialogue. This stemmed from the notion that children are knowledgeable, followed by a respectful, empathetic, open, non-judgmental, supportive and encouraging mindset. Furthermore, connecting to children's own living environment provided a deep understanding of their daily activities and living situation, and encouraged interactions with their parents and culture. We also identified that doing activities together, such as drawing, writing, walking and playing, allowed children to 'do' something or be in 'action' while they were communicating, instead of simply answering questions. Doing activities together with children lowered the threshold for children to express themselves and increased opportunities to share personal or sensitive topics of their own choosing.

The benefits are not only reserved to increasing child, parent and community participation. Through the parallel learning effect of PAR, concepts in Dutch youth healthcare policy such as outreach work and neighbourhood-oriented work were valorised and reinforced with practical examples that can help youth healthcare nurses attune to families and deliver tailored child-centred care. Nevertheless, within the reflection process we found tensions relating to implementing the key elements.

First, it is necessary to be critical about the position of children within policy. It is important that their position as knowledgeable actors is clarified, and that concrete pathways for how to strengthen their position are given. Consistent with Habermas' (2014) conceptual communicative action, which is aimed at achieving understanding in relationships (e.g. connecting, reinforcing and empowering competencies and skills), our study underscores the need to explore how children's voices are heard. Building and creating communicative space for children to set their own issues in the agenda is crucial. In our study, the rather broad concept of communicative space was explored empirically and in relation to children. Building this space together with children, in which the threshold was low for children to express themselves, increased opportunities for them to share personal or sensitive topics, such as feeling sad or bored, or experiencing daily struggles with motivation. Concincion et al. (2023) also found that personal or sensitive themes are often shared if parents were not present. Therefore, it is important to be aware that building a communicative space requires a certain amount of attention, time, skills, tact and trust (see also Concincion, van Houtum, Verhoeff, & Dedding, 2024).

Second, in order to connect with children and their parents within their own living environment, it is imperative to establish a trusting relationship. This requires long-term commitment from all parties involved. During the analysis, it became clear that the amount of time the researcher invested in the participatory and creative approaches could be a real challenge in the current structure of the Dutch set-up of integrated obesity care for children. In daily practice, insufficient time, continuous changes in infrastructure and limited financial recourses are perceived as barriers in need of improvement (van der Voorn et al., 2022). Nevertheless, it is important to note that for some children, even a simple activity was sufficient to increase their participation and engagement within the existing youth healthcare infrastructure.

Third, we emphasise that the connection with the living environment is crucial, especially for families that are underserved in obesity care practice. This requires awareness among youth healthcare nurses of the sociocultural context in relation to cultural values and habits. It can be challenging for nurses to connect with many different cultural backgrounds, not to mention the difficulty of language barriers. The majority of youth healthcare nurses in the Netherlands belong to a unilateral group consisting of white highly educated females. Reflexivity is necessary to remain aware of one's own privileges and of the experiences and voices that are overlooked or not fully recognised (Verdonk et al., 2019). There are multiple social identities such as ethnicity, gender, sexual orientation, social-economic status and disability that intersect at the micro level of individual experiences (Bowleg, 2012). However, it is also important to recognise that this is constantly asked of children and families the other way around: to come to a clinical setting where the majority of the professionals are white, Dutch-speaking and from a different socio-economic status. Professionals thus need to demonstrate cultural sensitivity, or at least an awareness that it is difficult for both parties – children/families and professionals – to connect and understand each other.

Lastly, we want to address the fact that researchers and healthcare professionals have made themselves too dependent on written and verbalised competencies. To begin with, there are questions about the readability levels of health questionnaires or consent forms (Simonds et al., 2017). For instance, written (online) health questionnaires for adolescents in secondary education are widely used in youth healthcare in the Netherlands. Hahnraths et al. (2021) describe the following associated limitations, such as a relatively high percentage of 'do not know' responses and the number of questions asked during questionnaire administration, indicating comprehension problems. As for younger children, their parents mostly receive health information in written form, which excludes parents with a more practical education and those with lower (health) literacy. It is important that children have multiple ways of expressing themselves and can thus participate in the decision-making processes affecting them.

Strengths and limitations

Reflecting on our research work allowed us to become aware of the parallels between research and care, and how both fields can benefit from each other. We gained valuable insights into pathways that could improve care for children with paediatric obesity. All participating children came from the district of Amsterdam Southeast; these children face enormous challenges – they have the highest prevalence of paediatric obesity in the whole municipality of Amsterdam, and are largely characterised by low socio-economic status – and yet are underserved in research and care. These children have a broad variety of cultural backgrounds – including Surinamese, Pakistani, Afghan, Caribbean and Ghanaian – and belong to a seldom heard community. As a group of stakeholders, they are seldom asked questions and are seldom given the opportunity to name their lived reality and needs as they know and experience them (Dedding & Aussems, 2024). Working with these seldom heard children was only possible because of the dual position of the main researcher (SC). Reflexive examination of the positionality of the researcher was conducted continuously within the research team. For example, the fact that the researcher is a Black female with a Caribbean background could have influenced child and parent participation positively. This underscores the need for healthcare professionals to reflect more often on their own positions, because there is still a need for better-culturally-tailored interventions (Verhoeff & Coutinho, 2010). Our study is limited in the sense that it is an initial exploration of how participatory approaches can benefit obesity care practice. This should be explored further and evaluated with children, their parents and professionals.

Conclusion

Children have unique perspectives on what it means to be a child with obesity within their sociocultural context and the mechanisms that lie beneath the struggles they experience every day. However, it is a challenge in daily obesity care to facilitate children's participation and enable them to express themselves about issues of their own choice and based on their own experiences. Going to the next level in obesity care practice for children, healthcare professionals should be equipped with practical participatory and creative methods, to be able to build and facilitate communicative spaces for all children, as well as ensure that children play a more active role in developing solutions and tailoring care.

Implications for paediatric nursing practice

Nurses that work in paediatric healthcare are likely to encounter silent children and young people. Working together with children as knowledgeable partners in care can improve care delivery and provide solutions that better reflect their everyday realities and needs. It is imperative that healthcare practices invest in long-term trusting relationships with families, and facilitate time and skills development (i.e. participatory and creative methods) for nurses, in order to work together with children in obesity care.

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Ethics approval statement

The research study design was assessed and approved by the recognised Medical Ethical Review Committee of Amsterdam University Medical Centers (METC; reference numberW20_552).

Patient consent statement

Children and their parents were informed about the entire research process. They received verbal and written information and had two weeks' time to decide if they wanted to participate. During the research process, it was highlighted that participation was voluntary, and withdrawal from the study was always possible, without needing to give a reason.

CRediT authorship contribution statement

Siegnella Concincion: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Christine Dedding:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Methodology, Formal analysis, Data curation, Conceptualization. **Arnoud Verhoeff:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Methodology, Formal analysis, Data curation, Conceptualization. **Lieke van Houtum:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Data availability

Data presented in this study are not available to access, post or share. Due to the young age of the children that participated in the study and the unique position of the researcher/corresponding author, children and parents were assured that the raw data would remain confidential and would not be shared.

Declaration of competing interest

The authors declare no potential conflict of interest.

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