

A Comprehensive Understanding of Parental Roles in the Oral Health of Children Aged 5–12 Years in Government and Private Schools in Bhopal – A Comparative Study

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Abstract

Background: Oral health in children is significantly influenced by parental awareness, behavior, and sociodemographic factors. According to the World Health Organization, oral health inequalities are unjust and preventable, often reflecting disparities in parental knowledge and socioeconomic status. Despite ongoing health promotion efforts, early childhood caries remains highly prevalent. While schools play a key role in education, lasting impact requires active parental involvement. This study compares the roles and awareness of parents in government and private schools in Bhopal to better understand their influence on children's oral health and to support more inclusive, family-centered strategies. **Materials and Methods:** A descriptive cross-sectional study was conducted among parents of children aged 5–12 years studying in government and private schools in Bhopal. A pre-validated online questionnaire was distributed through Google Forms to assess parental roles in children's oral health. Permission was obtained from school authorities, and informed consent was taken from all participants. Data were collected over 2 months and analyzed using Statistical Packages of Social Sciences version 29, with $P \leq 0.05$ considered statistically significant. **Results:** A total of 240 parents participated, equally split between government ($n = 120$) and private ($n = 120$) schools. Among them, 48.3% were mothers, 44.2% fathers, and 7.5% caregivers. Half of the families were nuclear, while 35.8% were joint. Socioeconomically, 39.2% were upper middle class, 29.2% lower middle, and 23.3% upper lower class. Brushing twice daily was more common among private school children (54.5%), whereas 75% of those who rarely brushed were from government schools. Only 21.7% of parents provided fluoride toothpaste—96.2% of them from private schools. Regular oral hygiene education was reported by 71.4% of private school parents versus 28.6% of government school parents. All parents who scheduled 6-monthly check-ups were from private schools; all who never did were from government schools. Belief in the oral–general health link was stronger among private school parents (61.7% vs. 38.3%). Government school parents preferred public dental care and often relied on home remedies, whereas private school parents favored private clinics and showed greater involvement in preventive oral health measures. **Conclusion:** The study revealed significant differences in parental awareness and oral health practices between government and private school parents, influenced by socioeconomic factors and access to care. Private school parents showed greater involvement and knowledge, whereas government school parents faced financial and awareness-related barriers. These findings highlight the need for targeted, school-based oral health initiatives and accessible education programs to bridge gaps and promote equitable oral health outcomes among children.

Keywords: Children, Government schools, Oral health, Parental role, Preventive behavior, Private schools.

INTRODUCTION

In their recent Global Oral Health Action Plan, the World Health Organization (WHO) defined oral health inequalities as “differences in oral health status that are avoidable and deemed to be unfair, unacceptable and unjust”. The high prevalence of oral diseases during childhood poses a serious global health threat.^[1] Pediatric age represents a crucial phase for the development of an individual from the very 1st months of life, and it represents a key stage in which individuals can

effectively intervene with adequate health promotion policies since parents could be unprepared for this delicate role.^[2]

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Parents are responsible for their child's oral health care.^[3] According to the health beliefs model, the oral health status among children can be determined by the beliefs of their guardians. Parents' oral health behaviors, knowledge, and attitudes can directly affect the number of caries and the level of gum health among children by influencing their oral health behaviors.^[4]

Parents play a key role in their kids' lives, thus their understanding toward oral health is important. The management and prevention of dental health concerns, on the whole, demand a significant amount of time and effort, self-awareness, and intervention. Children should visit a dental clinic for an oral health assessment within 1 year of birth, as per the Australasian Academy of Paediatric Dentistry recommends. Parents' education and understanding of the need for early dental care at home may be greatly aided by the dental professionals.^[5] The WHO advocates integrating oral health promotion into school activities and curricula. Effective programs often require reinforcement at home, primarily by mothers.^[6] Parents with higher levels of education are more likely to have the knowledge and skills necessary to effectively communicate with their children about the risks associated with certain behaviors.^[7] Appropriate guidance on oral hygiene is vital for growing children, and schools are the best centers for effective implementation of dental health promotion programs because they are easily accessible to children. Furthermore, children are more receptive, and information on health promotion can be delivered and nurtured, thereby allowing them to develop good dental health behaviors that last a lifetime.^[8] Early childhood is a period for parents to be good role models for their children. Children learn their first knowledge and behavior about their oral and dental health from their parents at a younger age and then from their educators at school, and they try to simulate. Positive behavior acquisition about dental health learned at a young age facilitates permanent habits about teeth brushing and good nutrition for life.^[9]

The study aimed to explore and compare parental involvement in the oral health of children aged 5–12 years studying in government and private schools in Bhopal. The objectives were to assess differences in parental supervision and participation in daily oral hygiene practices and dental visits between the two school types, and to identify key challenges faced by parents in maintaining their children's oral health, with a focus on the influence of socioeconomic and educational factors.

MATERIALS AND METHODS

Ethical clearance for the study was obtained from the Institutional Ethics Committee of Peoples Dental Academy, Bhopal, with IEC No. IEC/2025/200/009. The study protocol, including the aim and objectives, was submitted for review and approved by the research and ethics committee of the institution. Informed consent was obtained from all participants before data collection. Participants were informed about the nature and purpose of the study and assured that their responses

would remain confidential. The online questionnaire included a consent form, and only those who agreed to participate could proceed with the survey.

A cross-sectional comparative study was conducted in government and private schools across Bhopal City. Parents of children aged 5–12 years were approached through these schools to participate by filling out a questionnaire. The setting enabled a comparative understanding of parental roles in children's oral health across different school types. Parents from both types of schools were invited to participate in the study to obtain a comprehensive understanding of their roles in maintaining and promoting their children's oral health. The study employed a convenience sampling design. The study population consisted of parents of children aged 5–12 years enrolled in government and private schools in Bhopal.

A total of 240 parents participated in the study, with 120 from private schools and 120 from government schools. Participants were approached through schools and were informed about the study objectives. Participation was voluntary, and questionnaires were not identified by name or code to maintain anonymity and confidentiality. Parents were included if they had children within the specified age group, were willing to participate, and completed the questionnaire. Those with children outside the 5–12-year age range, unwilling to participate, or who submitted incomplete responses were excluded from the study.

A cross-sectional, pre-validated questionnaire was distributed online through Google Forms to parents of children aged 5–12 years enrolled in government and private schools in Bhopal. Permission was obtained from the respective school authorities to conduct the study. Informed consent was obtained from all participants before data collection. Participants were informed about the nature and purpose of the study and were assured that their responses would remain confidential. The questionnaire included a digital consent form, and only those who agreed to participate could proceed. Data collection was carried out over 2 months using the online mode exclusively to gather information on parental roles in children's oral health. The questionnaire included seven sections: (1) demographic details (9 items), (2) oral health habits and practices (6 items), (3) routine dental check-ups (3 items), (4) knowledge and attitudes toward children's oral health (5 items), (5) parental role in oral health maintenance (4 items), (6) awareness regarding common dental problems in children (5 items), and (7) challenges in managing children's oral health (2 items).

Statistical analysis

The data were subjected to statistical analysis with the consultation of a statistician. The data so obtained were compiled systematically. Statistical analysis was done using the Statistical Packages of Social Sciences (version 29, Chicago, Inc., USA). The result of the data was obtained using frequency distribution.

RESULTS

The questionnaire was distributed to 240 participants, yielding a 100% response rate. Among them, 44.2% were fathers, 48.3% mothers, and 7.5% caregivers. Half of the participants belonged to nuclear families, 14.2% to two-generation families, and 35.8% to joint families. Socioeconomic status distribution showed 3.3% from the upper class, 39.2% upper middle class, 29.2% lower middle class, 23.3% upper lower class, and 5.0% lower class. Children were nearly equally distributed across school types, with 50.8% attending government schools and 49.2% private schools (Table 1).

In terms of children's oral hygiene practices, 57.5% brushed once daily (46.4% from government, 53.6% from private schools), 36.7% brushed twice daily (54.5% government, 45.5% private), 2.5% brushed more than twice daily (66.7% government, 33.3% private), and 3.3% brushed rarely (75% government, 25% private). Parental supervision during brushing was always practiced by 41.7% (36% government, 64% private), sometimes by 36.7% (52.3% government, 47.7% private), and never by 21.7% (76.9% government, 23.1% private) (Table 2).

Only 21.7% of parents reported using fluoride toothpaste (3.8% government, 96.2% private), while 39.2% did not (66% government, 34% private), and 39.2% were unsure (61.7% government, 38.3% private) (Table 3). With regard to dietary habits, 25% of children consumed sugary foods more than once a day (76.7% government, 23.3% private), 23.3% once a day (46.4% government, 53.6% private), 34.2% occasionally (31.7% government, 68.3% private), and 17.5% rarely (57.1% government, 42.9% private). When asked about educating their children on oral hygiene, 40.8% of parents did so regularly (28.6% government, 71.4% private), 35.8% sometimes (53.5% government, 46.5% private), and 23.3% did not (85.7% government, 14.3% private). Regarding tongue hygiene, 70.8% acknowledged its importance (37.6% government, 62.4% private), 3.3% did not (100% government), and 25.8% were unsure (80.6% government, 19.4% private).

When assessing dental visit frequency, 8.3% visited a dentist every 6 months (100% private), 12.5% annually (13.3% government, 86.7% private), 61.7% only when problems occurred (51.4% government, 48.6% private), and 17.5% had never taken their child to a dentist (100% government). Common reasons for not visiting included high cost (30.8%), belief that it is unnecessary without symptoms (25.8%), lack of time (10.8%), fear or anxiety (10.8%), and lack of awareness (10.8%). Financial constraints were reported predominantly by government school respondents (86.5%), whereas the belief that dental visits were unnecessary was more common among private school respondents (87.1%) (Table 4).

In terms of dental care provider preference, 45% visited government dentists (88.9% government school), 30.8% private dentists (100% private school), and 24.2% had no preference. When asked if oral health affects overall health,

Table 1: Demographic characteristics of study participants

Variables	Responses	n (%)
Your relationship with the child?	Father	106 (44.2)
	Mother	116 (48.3)
	Caregiver	18 (7.5)
	Total	240 (100)
Type of family	Nuclear family	120 (50)
	2 generation family	34 (14.2)
	Joint family	86 (35.8)
	Total	240 (100)
Socioeconomic status	Upper class	8 (3.3)
	Upper middle class	94 (39.2)
	Lower middle class	70 (29.2)
	Upper lower class	56 (23.3)
	Lower class	12 (5)
	Total	240 (100)
Type of school your child attends	Government school	122 (50.8)
	Private school	118 (49.2)
	Total	240 (100)

Table 2: Frequency distribution of government and private school parents about supervising their child's brushing

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
Do you supervise your child's brushing?	Always	100 (41.7)	36 (36)	64 (64)	0.000
	Sometimes	46 (52.3)	42 (47.7)	88 (36.7)	
	Never	40 (76.9)	12 (23.1)	52 (21.7)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

Table 3: Frequency distribution of government and private school parents about providing their child with fluoride toothpaste

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
Do you provide your child with fluoride toothpaste?	Yes	52 (21.75)	2 (3.8)	50 (96.2)	0.000
	No	94 (39.2)	62 (66)	32 (34)	
	Not Sure	94 (39.2)	58 (61.7)	36 (38.3)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

67.5% said yes (38.3% government, 61.7% private), 10% said no (50% each), and 22.5% were unsure (88.9% government). Regarding the age of first dental visit, only 1.7% had visited before age 1, 5.8% between 1–3 years (both 100% private), 15% between 4–6 years (11.1% government, 88.9% private), 22.5% after 6 years (44.4% government), while 55% had never visited (71.2% government). When asked about the importance of dental visits even in the absence of visible problems, 34.2% agreed (19.5% government, 80.5% private), 25.8% disagreed (61.3% government), and 40% were unsure (70.8%

Table 4: Frequency distribution of government and private school parents about reasons for not taking their children for routine dental check-ups

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
If you do not take your child for routine dental check-ups, why not?	Lack of time	26 (10.8)	2 (7.7)	24 (92.3)	0.000
	Dental care is too expensive	74 (30.8)	64 (86.5)	10 (13.5)	
	My child does not need dental care unless there is an issue	62 (25.8)	8 (12.9)	54 (87.1)	
	Fear or anxiety about visiting dentist	26 (10.8)	20 (76.9)	6 (23.1)	
	Lack of awareness	26 (10.8)	16 (61.5)	10 (38.5)	
	Lack of time and my child does not need dental care unless there is an issue	8 (3.3)	0 (0)	8 (100)	
	Lack of time and lack of awareness	2 (0.8)	0 (0)	2 (100)	
	Lack of time and dental care is too expensive	4 (1.7)	2 (50)	2 (50)	
	Fear or anxiety about visiting dentist and lack of awareness	2 (0.8)	0 (0)	2 (100)	
	Lack of awareness and dental care is too expensive	4 (1.7)	4 (100)	0 (0)	
	All of the above	6 (2.5)	6 (100)	0 (0)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

government). About 64.2% considered baby teeth important (37.7% government, 62.3% private), 15% did not (61.1% government), and 20.8% were unsure (84% government). Awareness about fluoride's role in preventing decay was low, with only 24.2% responding positively (100% private), while 40% said no (60.4% government), and 35.8% were unsure (74.4% government) (Table 5).

Parental involvement in ensuring oral health routines was reported as very involved by 27.5% (72.7% private), moderately involved by 35.8% (55.8% government), minimally involved by 26.7% (56.3% government), and not involved by 10% (83.3% government). Limiting sugary intake was strictly followed by 39.2% (59.6% private), occasionally by 37.5%, and not at all by 23.3% (78.6% government). Reminding children to brush daily was done by 46.7% (67.9% private), sometimes by 25.6%, rarely by 15.8%, and never by 12.5% (80% government). Only 31.7% always encouraged rinsing after meals (86.8% private), 28.3% sometimes did (52.9% private), and 40% never did (83.3% government). When managing dental pain, 12.5% gave pain relief medicine (53.3% government), 31.5% visited a dentist immediately (71.1% private), 11.7% waited to see if the pain subsided, and 33.3% used home remedies (77.5% government). Smaller proportions used combinations of remedies and actions. In case of dental trauma, 32% rinsed and checked for damage (53.8% private), 41.7% visited a dentist (62% private), 5% attempted to reinsert the tooth (66.7% government), and 20.8% took no action unless pain occurred (80% government) (Table 6).

Recognition of dental caries was primarily through black/brown spots (58.2% government), pain while eating (24.2%), sensitivity (15%), and bad breath (3.3%). Regarding the frequency of foul-smelling breath in children, 9.2% of parents reported that their child has it regularly, with a higher proportion from private schools (63.6%) compared to government schools (36.4%). Occasional bad breath was reported by 20.8% of parents, almost equally distributed between government (48%) and private schools (52%). Rare occurrences were noted by

Table 5: Frequency distribution of government and private school parents about awareness of the benefits of fluoride in preventing tooth decay

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
Are you aware of the benefits of fluoride in preventing tooth decay?	Yes	58 (24.2)	0 (0)	58 (100)	0.000
	No	96 (40)	58 (60.4)	38 (39.6)	
	Not Sure	86 (35.8)	64 (74.4)	22 (25.6)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

11.7%, more from private schools (64.3%). The majority, 58.3%, stated that their child never has bad breath, with more responses from government school parents (57.1%) than private (42.9%) (Table 7).

Bruxism was reported every night in 8.3% (80% private), occasionally in 19.2%, rarely in 11.7%, and never in 60.8% (61.6% government). Barriers to maintaining children's oral health included financial constraints (35.8%, 95.3% government), lack of knowledge (16.7%, mostly private), time constraints (15.8%, mostly private), and the child's refusal to cooperate (15.8%). Combinations of challenges were also reported, with most combinations showing higher proportions among government school respondents for financial constraints, and private school respondents for knowledge and time issues. To improve their child's oral health, 18.3% suggested affordable dental care (77.3% government), 14.2% wanted more information (100% private), 6.7% preferred child-friendly dental services (100% private), and 8.3% cited needing more time (80% private). Government oral health programs were recommended by 27.5% (75.8% government), and 5% favored all listed options equally (50% from each school type). Combinations of support needs were reported with similar distribution trends.

Table 6: Frequency distribution of government and private school parents regarding their responses to dental injury management in children

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
If your child accidentally hits their teeth or knocks one out, what do you do?	Rinse the mouth with water and check for damage	78 (32)	36 (46.2)	42 (53.8)	0.000
	Take them to the dentist immediately	100 (41.7)	38 (38)	62 (62)	
	Try to put the tooth back in place	12 (5)	8 (66.7)	4 (33.3)	
	Do nothing unless they complain of pain	50 (20.8)	40 (80)	10 (20)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

Table 7: Frequency distribution of government and private school parents reporting bad breath in their children

Questions	Responses	Total (%)	Government school (%)	Private school (%)	P-value
Does your child often have foul-smelling breath (bad breath)?	Yes, regularly	22 (9.2)	8 (36.4)	14 (63.6)	0.079
	Sometimes	50 (20.8)	24 (48)	26 (52)	
	Rarely	28 (11.7)	10 (35.7)	18 (64.3)	
	Never	140 (58.35)	80 (57.1)	60 (42.9)	
	Total	240 (100)	122 (50.8)	118 (49.2)	

Finally, comparison of knowledge scores revealed significantly higher mean scores among mothers (8.77 ± 3.90) and fathers (8.49 ± 4.43) than caregivers (4.22 ± 3.49 ; $P < 0.001$). Joint families showed higher scores (9.51 ± 4.10) compared to nuclear (7.53 ± 4.19) and two-generation families (8.00 ± 4.33 ; $P = 0.004$). A clear socioeconomic gradient was observed, with the upper class scoring highest (11.25 ± 2.54) and the lower class lowest (1.50 ± 4.26 ; $P < 0.001$). Importantly, parents of private school children had significantly higher scores (10.93 ± 2.98) than those of government school children (5.77 ± 3.75 ; $P < 0.001$) (Table 8).

DISCUSSION

Parental involvement significantly influences children's oral health, especially between ages 5–12. As primary caregivers, parents shape oral hygiene habits, dietary choices, and dental visit routines. Strengthening their knowledge and practices can play a key role in preventing oral diseases such as dental caries. Interventions targeting parents can promote long-term oral health in children. Early engagement may also reduce the future burden of dental issues. The study maintained a balanced distribution of participants across key demographic variables. Fathers, mothers, and a small proportion of caregivers participated, ensuring diverse parental perspectives. Various family structures—nuclear, joint, and two-generation—were represented, along with a range of socioeconomic backgrounds. Equal representation of children from government and private schools allowed meaningful group comparisons and minimized demographic bias.

Parental supervision of brushing differed notably between groups; more private school parents always supervised brushing, while occasional or no supervision was more frequent among government school parents. According to Chandak and Chahande, most parents in their survey knew to brush their children's teeth with a toothbrush and toothpaste, and 81.73% were aware of brushing twice daily—an improvement over a

Table 8: Comparison of mean knowledge of government and private school parents about knowledge and attitudes toward children's oral health

Characteristics	Mean±SD	t value or F value	P-value
Your relationship with the child			
Father	8.49±4.43	9.70	0.000
Mother	8.77±3.90		
Caregiver	4.22±3.49		
Type of family			
Nuclear family	7.53±4.19	5.704	0.004
2 generation family	8.00±4.33		
Joint family	9.51±4.10		
Socioeconomic status			
Upper class	11.25±2.54	29.89	0.000
Upper middle class	10.53±3.25		
Lower middle class	8.22±3.66		
Upper lower class	5.71±4.04		
Lower class	1.50±4.26		
Type of school your child attends			
Government school	5.77±3.75	11.75	0.000
Private school	10.93±2.98		

previous study where only 61.2% guided their children on twice-daily brushing as part of personal hygiene.^[5]

The use of fluoride toothpaste was notably higher among private school parents, whereas many government school parents either did not provide it or were unsure about its use. Government school parents also reported more frequent sugary food and drink consumption by their children. Regular parental education on oral hygiene and awareness of tongue cleaning was more common in private school groups. According to Nasirzadeh *et al.*, a significant positive correlation was observed when parental health literacy was considered, highlighting its influence on children's oral health behavior.^[10] Routine dental visits were also more common in private school

children, while government school parents often visited only during problems or avoided visits altogether.

Regular dental visits were associated with better oral health in children, as supported by Nasirzadeh *et al.* and Olak *et al.*^[11,12] Government school parents cited cost and lack of awareness as major barriers, while private school parents mentioned lack of time. Service preferences also differed—government school parents leaned toward public services, whereas private school parents favored private clinics. These contrasts underscore the need for targeted strategies to improve oral health awareness and access in both groups.

Parental understanding of the connection between oral and general health was higher among Private schools compared to those from government schools. Hugar *et al.* emphasized that an optimal diet—low in carbohydrates, rich in non-vegetable fats, adequate in protein, and micronutrient-dense—can significantly help prevent dental caries and improve both periodontal and overall oral health.^[3]

These findings highlight the need to include balanced dietary practices in parental oral health education, as diet directly impacts children's oral health. Hamasha *et al.* reported that many parents understood the link between primary and permanent teeth, and between oral and general health.^[13] However, delayed first dental visits were common in both groups, especially among government school parents. Hamasha *et al.* and Winnier *et al.* found that most parents were unaware of the ideal age for a child's first dental visit or the significance of plaque.^[13,14]

Awareness about baby teeth and fluoride's role in preventing decay was higher among private school parents, while many government school parents were unaware or uncertain. Private school parents also showed greater involvement in their child's oral care. Chandak and Chahande reported that 66.35% of parents knew about fluoride, but only 54% understood its role in preventing caries, contrasting with findings by Bamba *et al.*^[5,15] These disparities highlight the need for better parental education, especially in government school settings.

Parental practices regarding diet, hygiene, and dental care varied significantly. Private school parents were more consistent in limiting sugary snacks, encouraging rinsing after meals, and promptly seeking dental care for pain or trauma. In contrast, government school parents showed lower engagement and often relied on home remedies. Recognition of cavities and symptoms such as pain and sensitivity was higher among private school parents. Foul breath reports were similar in both groups, while teeth grinding was more noted by private school parents. Key challenges for government school parents included financial issues, limited knowledge, and uncooperative children, whereas private school parents sought better information and child-friendly services. Unemployment and lower education levels of parents were linked to poorer oral health.^[16-18] These findings underscore the need for targeted oral health interventions based on socioeducational differences.

Limitations

The study's generalizability is limited due to the use of convenience sampling, which may not represent all parents of government and private school children in Bhopal. Unequal sample sizes between the two groups may have influenced comparisons. In addition, reliance on self-reported data without clinical verification may introduce response bias, with parents possibly overstating positive behaviors or giving socially desirable responses.

CONCLUSION

The study revealed significant differences in parental roles and oral health practices between government and private school respondents in Bhopal. Private school parents showed greater awareness, involvement, and preference for private dental care, while government school parents faced financial and access barriers, often relying on home remedies. Awareness of early dental problems and preventive practices was higher among private school parents. Key influencing factors included maternal involvement, joint family structure, and socioeconomic status. These findings highlight the need for school-based dental programs and targeted awareness initiatives to address disparities and promote equitable oral health care among children.

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