

Knowledge and Practices for Early Childhood Caries Prevention among Parents of the Children Visiting King Abdulaziz University Pediatric Dental Clinics, Kingdom of Saudi Arabia

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ABSTRACT

Aim: Children's oral health maintenance is influenced by their parents' knowledge and behaviors. Therefore, the aim of this study was to assess the knowledge and practices among parents for prevention of early childhood caries (ECC) in children.

Materials and methods: This cross-sectional study interviewed the parents visiting the Pediatric Dental Clinic in King Abdulaziz University, Faculty of Dentistry (KAUFD), from January 1, 2018 to December 31, 2018. The questionnaire was drafted based on the recommendations on strategies for ECC prevention by the American Academy of Pediatric Dentistry in 2018.

Results: Of the 549 parents, 283 responded. The mean knowledge score for caries prevention was 2.29 (standard deviation = 1.26) out of 10. In addition, 13.8% of participants scored zero. Knowledge questions that showed the highest correct responses were those associated with fluoride application. However, only 96 (24.4%) participants were aware of fissure sealants, 48 (17%) participants knew that fissure sealants are applied to sound teeth, 35 (12.4%) participants knew the correct age of the first dental visit, and 157 (55.5%) participants practiced snacking between meals. Mothers showed significantly higher mean knowledge score compared with fathers ($p < 0.001$). In addition, the number of dental visits significantly correlated with the mean parental knowledge score ($p < 0.05$).

Conclusion: Parental dental knowledge and practices were not satisfactory. Anticipatory guidance should be reinforced by oral healthcare providers on each dental visit. In addition, pediatricians and physicians could be involved in improving parental dental knowledge.

Clinical significance: This study reported the level of knowledge and awareness of parents visiting the Pediatric Dental Clinic in KAUFD. It could be used as a reference for future community services and caries prevention programs conducted by oral healthcare services for children to prevent ECC.

Keywords: Cross-sectional study, Knowledge, Parents, Practice.

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INTRODUCTION

Dental caries is an infectious process involving the breakdown of the tooth enamel.¹ Extensive dental caries influences the health and well-being of young children.² Despite preventive methods, dental caries is highly prevalent worldwide.^{3,4} Children are susceptible to caries, which is multifactorial in origin, as soon as the first tooth erupts.⁵ Early childhood caries (ECC) is a serious dental public health problem in Saudi Arabia. A systematic review in 2013 found that the prevalence of ECC is high and varies with geographic location across Saudi Arabia. The national prevalence is 80% for primary dentition.⁶

Children's oral health maintenance is influenced by the parent's knowledge and behaviors. Children under the age of 5 years generally spend most of their time with the parents, especially the mother.⁷ Therefore, the aim of this study was to assess the knowledge and practices for ECC prevention among parents of children with dental caries visiting the Pediatric Dental Clinic in KAUFD.

MATERIALS AND METHODS

Subjects

This cross-sectional study was performed in the Pediatric Dental Clinic at KAUFD, Jeddah, Saudi Arabia. It included all parents of children who attended the pediatric dental clinics between

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January 1, 2018 and December 31, 2018. The inclusion criteria were (1) healthy children, (2) age ≤ 16 years, (3) at least one visit to a pediatric dentistry resident or specialist, and (4) at least one carious lesion. The exclusion criteria were (1) comprehensive dental treatment under general anesthesia, (2) no dental treatment, (3) visit to clinics other than the Pediatric Dental Clinic at KAUFD, and (4) no carious lesions.

Methods

Approval for this study was obtained from the ethics committee of KAUFU (089-09-18). Parents of the children who met the inclusion criteria (549 parents) were interviewed via telephone by four dental students for 10–15 minutes to complete a questionnaire. Face validity of the questionnaire was performed by two consultants with 20 parents, and the questionnaire was modified accordingly. The questionnaire was drafted based on the recommendations on strategies for ECC prevention by the American Academy of Pediatric Dentistry (AAPD) in 2018. The questionnaire included demographic data of the child and parent, socioeconomic factors (family income, parental education, and parental occupation), and hospital factors (number of dental visits).

Statistical Analysis

The results included descriptive information of the population, which is expressed as number and percentage. The Chi-square test was used to compare the categorical variables, with a significance level of 0.05. In addition, for each question regarding knowledge that was answered correctly, the participant was awarded a score of 1. Thus, the total knowledge score ranged from 0 to 10. Ordinal regression analysis was performed to assess the adjusted association of demographic predictors and sociodemographic predictors (parental occupation, parental education, and family income) with the dependent factor (knowledge score) reported as *p* value and 95% confidence interval (CI).

RESULTS

A total of 283 parents (51.5% response rate) participated in the study. The number of fathers and Saudi citizens were 150 (53%) and 225 (79.5%), respectively. The number of parents with male and female children were 137 (48.4%) and 146 (51.6%), respectively. The mean age of children was 8.6 [standard deviation (SD) = 2.54] years. In terms of educational level, 164 (58%) of the fathers and 142 (50.2%) of the mothers held a bachelor's degree or higher (Table 1). The mean knowledge score for ECC prevention was 2.29 (SD = 1.26) out of 10. In addition, 13.8% of the participants scored zero. Knowledge questions that showed the highest correct responses were those associated with the duration of professional fluoride application [172/283 (60.8%)] and the appropriate amount of toothpaste recommended in children aged 3–6 years [151/283 (53.4%)]. Only 96 (24.4%) participants were aware of fissure sealants, and only 48 (17%) participants knew that it should be applied to sound teeth. In addition, 35 (12.4%) participants knew that the first dental visit should be at the age of 6–12 months. Regarding dietary sugar intake, 67 (23.7%) and 157 (55.5%) participants fed sugary snacks to their children immediately after meals and between meals, respectively. Moreover, 172 (60.8) and 140 (49.5%) participants performed *ad libitum* breastfeeding and bottle feeding, respectively, until the age of 2 years (Table 2). Mothers showed significantly higher mean knowledge score compared with fathers (*p* < 0.001). In addition, parents with higher monthly income (*p* = 0.04), educational level (*p* = 0.047), and number of dental visits showed significantly higher mean knowledge score (*p* = 0.008; Table 3).

Regarding practices for ECC prevention, 188 (66.4%) participants did not take their children to a dentist in the absence of dental problems, 53.4% participants brushed their children's teeth twice a day, and only 21 (7.4%) participants used dental floss for their children (Table 2). The parental educational level and number of dental visits significantly correlated with parental ECC prevention practices (*p* < 0.05; Table 4).

Table 1: Sample demographic data and characteristics (*n* = 283)

Variable		<i>n</i> (%)	
Gender	Male	137 (48.4)	
	Female	146 (51.6)	
Nationality	Saudi	225 (79.5)	
	Non-Saudi	58 (20.5)	
Who answered the questionnaire	Father	150 (53.0)	
	Mother	133 (47.0)	
Father education level	Illiterate	7 (2.5)	
	Primary/intermediate	31 (11.0)	
	High school	81 (28.6)	
	University or higher	164 (58.0)	
Mother education level	Illiterate	5 (1.8)	
	Primary/intermediate	38 (13.4)	
	High school	98 (34.6)	
	University or higher	142 (50.2)	
Father occupation	Not working	3 (1.1)	
	Retired	15 (5.3)	
	Private sector	102 (36.0)	
	Government	83 (29.3)	
	Military	33 (11.7)	
	Medical field	13 (4.6)	
	Teacher	31 (11.0)	
	Dentist	3 (1.1)	
	Mother occupation	Housewife	227 (80.2)
		Retired	3 (1.1)
Private sector		15 (5.3)	
Government		7 (2.5)	
Teacher		22 (7.8)	
Medical field		5 (1.8)	
Dentist		4 (1.4)	
Family income/month		Less than 7,000 SAR	77 (27.2)
		8,000–10,000 SAR	90 (31.8)
		11,000–16,000 SAR	69 (24.4)
	More than 16,000	47 (16.6)	
How many children do you have?	1–2 children	61 (21.6)	
	3–4 children	139 (49.1)	
	More than 5	83 (29.3)	
Did your child receive any dental treatment before coming to the pediatric specialty clinic?	Yes	124 (43.8)	
	No	159 (56.2)	
Number of treatment session	One	25 (8.8)	
	Two	20 (7.1)	
	Three	41 (14.5)	
	Four	42 (14.8)	
	More than 4	155 (54.8)	
Type of program	Intern	49 (17.3)	
	Masters and PhD	151 (53.4)	
	Board	75 (26.5)	
	Faculty	8 (2.8)	
Sources from which parents obtained the knowledge of oral care methods	Dentist	242 (85.5)	
	Edubook	16 (5.7)	
	Social media	111 (39.2)	
	Friends	9 (3.2)	
	Pediatrician	15 (5.3)	
	Magazine	6 (2.1)	
	TV	22 (7.8)	
	GP	3 (1.1)	



Table 2: Distribution of participants based on the responses to questions regarding knowledge and practices

Question	Answers	Prevalence (%)
Knowledge questions		
At what age should the child have the first dental visit?	6–12 months*	35 (12.4)*
	2 years	63 (22.3)
	3 years	49 (17.3)
	4 years	26 (9.2)
	5 years	51 (18)
	I do not know	59 (20)
Do you know what are pit and fissure sealants?	Yes*	96 (24.4)*
	No	214 (75.6)
On what pit and fissure sealants should be applied?	Caries teeth	15 (5.3)
	Sound teeth*	48 (17.0)*
	I do not know	220 (77.7)
When should dental flossing be begun?	When there is contact between the teeth*	43 (15.2)*
	3 years old	17 (6.0)
	6 years old	112 (39.6)
	I do not know	111 (39.2)
What is the amount of toothpaste that should be applied for children aged 3–6 years?	Smear or rice-size	16 (5.7)
	Pea size*	151 (53.4)*
	Full-length brush	43 (15.2)
	I do not know	73 (25.8)
What is the amount of toothpaste that should be applied for children under the age of 3 years?	Smear or rice size*	76 (26.9)*
	Pea size	112 (39.6)
	Full-length brush	25 (8.8)
	I do not know	70 (24.7)
Should a child receive topical fluoride every 6 months?	Yes*	172 (60.8)*
	No	40 (14.1)
	I do not know	71 (25.1)
When should sugary and cariogenic food be given to the child?	Any time	55 (19.4)
	With meals*	67 (23.7)*
	Between meals	157 (55.5)
When should <i>ad libitum</i> breastfeeding be stopped?	Before going to bed	4 (1.4)
	6 months (after eruption of first primary molar)*	25 (8.8)*
	1 year	35 (12.4)
	2 years	172 (60.8)
	I do not know	51 (18.0)
When should bottle feeding be stopped?	1–1.5 years*	67 (23.7)*
	2 years	140 (49.5)
	3 years	37 (13.1)
	4 years and more	7 (2.5)
	I do not know	32 (11.3)
Parental practices questions		
When do you take your child to visit a dentist?	Rarely	17 (6.0)
	If pain or trauma	188 (66.4)
	Every 3–6 months*	78 (27.6)*
How many times your child brushes teeth?	No brushing	46 (16.3)
	Once/day	86 (30.4)
	2 or more per day*	151 (53.4)*
Do you use dental floss for your child?	Yes*	21 (7.4)*
	No	139 (49.1)
	I do not know what dental floss is	123 (42.5)

*Correct response

Table 3: Ordinal regression analysis showing the adjusted association of sociodemographic predictors and number of dental sessions with the dependent factor (mean knowledge score)

Predictors	Mean knowledge score/10 (SD)	Adjusted p value	95% confidence interval
Gender			
Male	2.22 (1.71)	0.948	0.416 to –0.444
Female**	2.36 (2)		
Which parent answered the questionnaire?			
Father	1.87 (1.57)	<0.0001*	–1.564 to –0.584*
Mother**	2.77 (2.04)		
Family income/month			
Less than 7,000 SAR	2.06 (1.712)	0.115	–1.717 to 0.188
8,000–10,000 SAR	1.91 (1.458)	0.118	–1.507 to 0.178
11,000–16,000 SAR	2.14 (1.556)	0.04*	–1.601 to 0.036
More than 16,000**	3.62 (2.558)		
Father education			
Illiterate	0.71 (0.756)	0.047*	–3.686 to 0.028
Primary and intermediate	2.06 (1.692)	0.27	–1.365 to 0.382
High school	1.99 (1.609)	0.336	–0.951 to 0.324
Bachelor and higher**	2.55 (1.988)		
Mother education			
Illiterate	1.00 (1.000)	0.337	–3.878 to 1.065
Primary and intermediate	1.63 (1.364)	0.151	–1.477 to 0.227
High school	2.02 (1.592)	0.369	–0.835 to 0.317
Bachelor and higher**	2.70 (2.069)		
Paternal professionalism			
Dentist	7.67 (0.58)	0.006*	1.029–6.064
Private	2.25 (1.96)	0.155	–1.61 to 0.255
Government	2.22 (1.62)	0.139	–1.766 to 0.246
Military	1.97 (1.45)	0.65	–1.929 to 0.329
Medical field	2.23 (1.74)	0.126	–2.475 to 0.305
Teacher	2.16 (1.21)	0.069	–2.231 to 0.082
Retired**	2.83 (2.75)		
Maternal professionalism			
Dentist	7.75 (0.957)	0.033*	0.121–2.849
Retired	0.67 (1.155)	0.033*	–4.952 to –0.207
Private	2.40 (2.165)	0.821	–1.117 to 0.878
Government	2.00 (1.826)	0.145	–2.517 to 0.371
Teacher	2.82 (1.842)	0.97	–0.897 to 0.929
Medical field	4.40 (2.793)	0.301	–0.811 to 2.636
Housewife**	2.12 (1.660)		
Number of treatment sessions			
One	1.60 (1.354)	0.008*	–1.885 to –0.284
Two	2.95 (2.114)	0.485	–0.557 to 1.173
Three	1.68 (1.572)	0.001*	–1.841 to –0.497
Four	1.86 (1.945)	0.003*	–1.618 to –0.329
More than 4**	2.60 (1.868)		

*Significant at 0.05

**Reference

The bold values are the significant values

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Table 4: Distribution of included parents with correct responses based on their demographic data, socioeconomic status (parental education, profession, and income), and treatment session characteristics (number of visits and history of previous treatment)

Variable	When do you take your child to dentist?		How many times your child brushes?		Do you use dental floss for your child?	
	Correct answers	p value, OR and (95% CI)	Correct answers	p value, OR and (95% CI)	Correct answers	p value, OR and (95% CI)
Child gender						
Male	39/137 (28.46%)	0.741, 1.09 (0.544–1.543)	109/137 (79.56)	0.065, 0.547 (0.959–3.481)	10/137 (7.29%)	0.940, 0.966, (0.425–2.520)
Female**	39/146 (26.7%)		128/146 (87.67)		11/146 (7.5%)	
Who answered the questionnaire?						
Father	36/150 (24%)	0.183, 0.68 (0.866–2.467)	121/150 (80.66%)	0.136, 0.612 (0.853–3.135)	11/150 (7.33%)	0.953, (0.422–2.502)
Mother**	42/133 (31.5%)		116/133 (87.2%)		10/133 (7.52%)	
Family income/month						
Less than or equal to 7,000 SAR	13/77 (16.88%)	0.156, 0.531 (0.222–1.27)	62/77 (80.5%)	0.2, 0.492 (0.166–1.457)	7/77 (9.1%)	0.778, 0.84 (0.25–2.816)
8,000–10,000 SAR	26/90 (28.88%)	0.88, 1.063 (0.485–2.33)	73/90 (81.1%)	0.726, 1.24 (0.37–4.16)	5/90 (5.56%)	0.285, 0.494 (0.136–1.08)
11,000–16,000 SAR	26/69 (37.6%)	0.264, 1.58 (0.71–3.532)	60/69 (86.95%)	0.697, 0.794 (0.248–2.54)	4/69 (5.797%)	0.135, 0.354 (0.09–1.38)
More than or equal to 16,000 SAR	13/47 (27.6%)		42/47 (89.36%)		5/47 (10.64%)	
Mother educational level						
Illiterate	1/5 (20%)	0.566, 0.522 (0.057–4.8)	5/5 (100%)	0.81, a	0/5 (0%)	0.928, a
Primary/intermediate	5/38 (13.1%)	0.025*, 0.316 (0.116–0.863)	29/38 (76.3%)	0.055, 0.41 (0.165–1.02)	6/38 (15.79%)	0.101, 2.475 (0.838–7.312)
High school	26/98 (26.5%)	0.331, 0.754 (0.426–1.33)	77/98 (78.57%)	0.035*, 0.466 (0.229–0.947)	5/98 (5.10%)	0.543, 0.71 (0.24–2.145)
University or higher**	46/142 (32.3%)		126/142 (88.7%)		10/142 (7.04%)	
Father education level						
Illiterate	0/7 (0%)	0.02*, 0.033 (0.002–0.59)	7/7 (100%)	0.002*, a	1/7 (14.29%)	0.555, 1.94 (0.216–17.32)
Primary/intermediate	4/31 (12.9%)	<0.001, 0.073 (0.024–0.22)	21/31 (67.7%)	0.021*, 0.36 (0.151–0.858)	3/31 (9.68%)	0.74, 1.245 (0.333–4.65)
High school	20/81 (24.69%)	<0.001, 0.161 (0.088–0.29)	69/81 (85.18%)	0.97, 0.986 (0.465–2.09)	4/81 (4.94%)	0.391, 0.603 (0.19–1.93)
University or higher	54/164 (32.9%)		140/164 (85.36)		13/164 (7.93%)	
Mother professionalism						
Dentist	3/4 (75%)	0.059	4/4 (100%)	0.703, a	0/4 (0%)	0.831, a
Retired	3/3 (100%)	0.056*	3/3 (100%)	0.83, a	0/3 (0%)	0.73, a
Private sector	7/15 (46.6%)	0.0576, 2.61 (0.906–7.52)	12/15 (80%)	0.709, 0.779 (0.21–2.9)	1/15 (6.67%)	0.907, 0.882 (0.109–7.12)
Government sector	2/7 (28.57%)	0.836, 1.193 (0.335–6.32)	6/7 (85.7%)	1.17, 1.168 (0.14–9.992)	1/7 (14.29%)	0.772, 0.097 (0.097–6.18)
Teacher	5/22 (22.7%)	0.805, 0.877 (0.31–2.485)	18/22 (81.8%)	0.82, 0.876 (0.28–2.74)	2/22 (9.091%)	0.267, 2.47 (0.5–12.196)
Medical field	1/5 (20%)	0.795, 0.746 (0.082–6.81)	4/5 (80%)	0.825, 0.779 (0.085–7.168)	0/5 (0)	0.935, a
Housewife**	57/227 (25.1%)		190/227 (83.7%)		17/227 (7.49%)	
Father professionalism						
Dentist	3/3 (100%)	0.021*	3/3 (100%)	0.511, a	0/3 (0)	0.972, a
Private sector	29/102 (28.4%)	0.706, 1.341 (0.29–6.14)	88/102 (86.27%)	0.141, 2.42 (0.75–7.833)	5/102 (4.90%)	0.314, 0.412 (0.074–2.31)
Government	27/83 (32.5%)	0.086, 3.86 (0.827–17.993)	66/83 (79.5%)	0.5, 1.49 (0.468–4.768)	6/83 (7.23%)	0.583, 0.623 (0.115–3.38)

Contd...



Contd...

Variable	When do you take your child to dentist?		How many times your child brushes?		Do you use dental floss for your child?	
	Correct answers	p value, OR and (95% CI)	Correct answers	p value, OR and (95% CI)	Correct answers	p value, OR and (95% CI)
Military	5/33 (15.15%)	0.69, 1.429 (0.248–8.23)	27/33 (81.8%)	0.43, 1.73 (0.445–6.735)	3/33 (9.090%)	0.817, 0.8 (0.121–5.29)
Medical field	2/13 (15.38%)	0.727, 1.45 (0.177–11.94)	12/13 (92.3%)	0.19, 4.616 (0.47–45.39)	0/13 (0%)	0.376, a
Teacher	10/31 (32.2%)	0.113, 3.81 (0.73–19.869)	28/31 (90.3%)	0.112, 3.59 (0.743–17.346)	5/31 (16.13%)	0.63, 1.538 (0.266–8.89)
Retired**	2/18 (11.1%)		13/18 (72.2%)		2/18 (11.11%)	
Number of treatment sessions						
More than four	37/155 (23.9%)	(0.196, 2.3 (0.65–8.12)	86/155 (55.5%)	0.078, 2.2 (0.923–5.3)	15/155 (9.7%)	0.37, 2.5 (0.32–20.38)
Four	17/42 (40.5%)	0.02*, 4.98 (1.287–19.32)	28/42 (66.7%)	0.017*, 3.56 (1.26–10.04)	2/42 (4.8%)	0.88, 1.2 (0.1–13.9)
Three	17/41 (42.5%)	0.017*, 5.19 (1.337–20.18)	23/41 (56.1%)	0.116, 2.27 (0.82–6.3)	3/41 (7.3%)	0.59, 1.895 (0.54–19.28)
Two	4/20 (20.0%)	0.46, 1.83 (0.351–9.35)	5/20 (25.05%)	0.43, 0.59 (0.16–2.176)	1/20 (5.0%)	0.87, 1.263 (0.074–21.54)
One**	3/25 (12.0%)		9/25 (36.0%)		1/25 (4.0%)	

OR, odd ratio; CI, confidence interval

*Significant at 0.05

**Reference

^aOdd ratio and confidence interval could not be calculated as there were cells with zero value

The bold values are significant values

DISCUSSION

Parental knowledge and practices play an important role in preventing oral diseases and improving dental health in children. In addition, maintenance of oral health is initially a parental responsibility, which later involves both parents and children.⁸ In this study, the parents' mean dental knowledge score was low. This was similar to studies performed in Saudi Arabia^{9–11} and other countries.^{7,12} In addition, mothers scored significantly higher (2.77 ± 2.04) compared with fathers (1.87 ± 1.57). This could be because mothers usually accompany children to dental visits and are more involved in their children's healthcare. Accordingly, Pani et al.¹³ reported that mothers' perception of their children's oral health-related quality of life (HRQoL) was higher compared with fathers.

Similar to a previous study,⁹ the highest parental knowledge mean score was reported in questions associated with fluoride application. However, 75.6% of participants was not aware of pit and fissure sealants. In addition, only 12.4% of participants was aware that the first dental visit should be made within 6–12 months of tooth eruption. Relatively similar findings have been previously reported.^{7,10,14,15} This suggests the importance of increasing parental awareness regarding the first dental visit and fissure sealants.

Moreover, although AAPD reported that frequent consumption of sugar-containing snacks or drinks (e.g., juice, formula, soda) between meals increased the risk of caries, more than half the parents (55.5%) believed that sugary and cariogenic foods are better consumed between meals than at the end of meals.¹⁶ This finding is important, as the role of sugary and cariogenic foods in the etiology and initiation of caries is crucial.¹⁷

Regarding baby feeding, most parents thought that *ad libitum* breastfeeding should be stopped at the age of 2 years. However, AAPD reports that *ad libitum* nocturnal breastfeeding should be avoided after the first primary tooth begins to erupt.¹⁸

Parental behavior training on oral hygiene practices is important, as healthy practices develop early in life, during childhood, and continue to adulthood, with numerous oral and general health benefits.¹⁹ However, most participants in this study reported that their children brushed teeth two or more times a day. This apposed the reports on school children in Jizan, Saudi Arabia, where most children brushed irregularly.²⁰ This could be explained by Theunissen et al.²¹ who reported that in most cases, children report significantly poor oral HRQoL, motor function, cognitive function, and physical complaints compared with their parents, though reports of both child and parents were valid.

In addition, more than half the participants (66.4%) took their children to dental visits only when there was pain or trauma. In another study in Riyadh, less than one third (28%) of the participants made dental visits for their children in the absence of pain.⁹ However, AAPD guidelines advise early and regular dental visits for early detection of caries, reinforcing and motivating parents regarding the importance of oral hygiene.⁸

Similar to previous studies,^{22,23} this study also found an association between socioeconomic status and the level of parental dental knowledge and practices. Parental knowledge and behavior were significantly associated with the frequency of dental visits, similar to other studies reporting that changing a behavior needs multiple reinforcements and extended duration.^{24–26} Therefore, it is important to reiterate anticipatory guidance at each dental visit. Moreover, this study suggested that the lack of parental awareness followed the same pattern as the lack of pediatricians' awareness. Studies have shown pediatricians lacked awareness regarding the frequency of dental visits and fissure sealants. However, knowledge was better regarding fluoride application and sugar cariogenicity.^{15,27–29} In addition, Anand et al.³⁰ reported that children are consulted by physicians more than 10 times before the age of 3 years.³⁰ This suggests that the key to imparting parental education

is to establish dental awareness programs for pediatricians, family physicians, and general practitioners. Therefore, future awareness campaigns are necessary for dental caries prevention for all those involved in children's healthcare. This was previously recommended by Al-Shalan et al.¹⁰ in Riyadh and Sabbagh et al.¹⁵ in Jeddah. However, the efforts put since then do not seem satisfactory.

This study reported the level of knowledge and awareness of parents visiting the Pediatric Dental Clinic in KAUFJ. It could be used as a reference for future community services and caries prevention programs conducted by oral healthcare services for children. However, a limitation of this study is that it did not investigate the reason for dental visits, the treatment involved, and whether anticipatory guidance was provided in the dental visits. Further studies with greater sample size and from other dental healthcare services are recommended to measure parental knowledge and practices after the children undergo a full dental treatment, and a comparison should be made with the findings of this study.

CONCLUSION

Parental dental knowledge and practices were not satisfactory. Anticipatory guidance should be reinforced by oral healthcare providers, on each dental visit. In addition, the role of pediatricians and physicians could be critical in improving parental dental knowledge.

CLINICAL SIGNIFICANCE

This study reported the level of knowledge and awareness of parents visiting the Pediatric Dental Clinic in KAUFJ. It could be used as a reference for future community services and caries prevention programs conducted by oral healthcare services for children to prevent ECC.

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