International Journal of Community Medicine and Public Health
Sharief GSD et al. Int J Community Med Public Health. 2024 Aug;11(8):3094-3100
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20242169

Original Research Article

Assessment of parents' oral health related behaviours and its relationship with oral health status of the children aged between 6-12 years in Davangere city: a cross-sectional survey

Gazala Sulthana D. Sharief*, Sapna B.

Department of Public Health Dentistry, Bapuji Dental College and Hospital, Davangere, Karnataka, India

Received: 24 May 2024
Accepted: 02 July 2024

***Correspondence:**
Dr. Gazala Sulthana D. Sharief,
E-mail: gazalasulthana486@gmail.com

ABSTRACT

Background: It is widely acknowledged that the behaviour of parents affects their children's health. This study aimed to evaluate the relationship between oral health behaviour of parents and oral health status of their children aged between 6-12 years.
Methods: A cross-sectional survey was conducted among 420 parent-child dyads with children aged between 6-12 years. A self-designed proforma was used for recording the sociodemographic details, with a questionnaire to assess parents' oral health-related behaviours followed by clinical examination of the children for their oral health status. The Chi-square test, spearman's correlation test and binary logistic regression analysis were applied by considering Statistical significance at $p<0.05$.
Results: The majority of the parents reported of having good oral health-related behaviours (60.2%). When children's oral health status was assessed, more than half of the children had low caries experience (62.5%), showed a milder form of gingivitis (96.2%) and good oral hygiene status (57.4%). No statistically significant association was found between parents' oral health-related behaviours with the children's oral health status.
Conclusions: Parents' oral health-related behaviours did not influence the children's oral health status.

Keywords: Child oral health, Dental caries, Parents' oral health behaviours

INTRODUCTION

Practice leads to habits and habits lead to a change in behaviour. Young children learn fast by observing adults, listening to people they love and admire, and following the action of loved ones such as parents, as they are the primary model for behaviour. Parents are instrumental in shaping children's character and health behavioural practices. Learning begins at home and mothers are the first and the best teacher. It is also widely acknowledged that the behaviours of parents, and in particular mothers, affect their children's health.[1-3] It is also same with the oral health that the role of parents is very important because they are the main caregivers or suppliers of oral health to their children.

Today's parents are busier than those in past decades. Parents who are preoccupied with more immediate and pressing issues may be less likely to follow preventive oral health behaviours for themselves or for their children. Due to this parental disregard, an unfortunate pattern of delay in seeking treatment exists, leading to worsening children's oral health.[4] Dental care professionals accept that efforts to improve parental oral health behaviours to reduce the risk of caries and poor oral health among their children.[2]

According to the centres for disease control and prevention (CDC), middle childhood and early adolescent age (6-12 years) bring dramatic changes in an individual's life. It is also considered as a transition

period from mixed to permanent dentition. During this period oral hygiene is poor not only because of the carefree age and emotional stresses of the child but also due to dietary factors, oral hygiene practices, shedding of deciduous teeth and eruption of permanent teeth.[5]

Many studies have been conducted worldwide to assess the oral health status of different age groups of children. But only handful of studies have assessed the influence of parents' oral health related behaviours on the oral health status of 6-12 years aged children. Insight into this will help us to plan for prevention and intervention strategies to improve children oral health outcomes and better quality of life. Hence the study was planned to assess the parents' oral health-related behaviours and its relationship with the oral health status of the children aged between 6 to 12 years in Davangere city.

Research question

Is there a relationship between parent's oral health-related behaviours with the oral health status of their children aged between 6-12 years?

METHODS

An observational, descriptive, cross-sectional survey was conducted among parent-child dyads, with children aged between 6-12 years visiting for the first time to department of pedodontics and preventive dentistry.

Sample size calculation (n)

Prevalence of dental caries among the middle age group between 6 to 10 years (69%) 6 was considered to calculate the sample size for the present study. The sample size was determined by fixing the type I error (α) at 5% and type II error (β) at 20%, maintaining the power of the study at 80%. It was calculated using the formula, $N=4pq/l^2$, considering the allowable error (L) of 5%, sample size of 342.24 was obtained which was rounded off to 350. Anticipating the non-response to an extent of 20%, the sample size was increased accordingly. The sample size for the present study was: n=420 (parent-child dyad). A non-probability-consecutive sampling technique was adopted until the required sample size was achieved. Ethical approval was obtained from the Institutional Ethical Review Board before the start of the study (Ref. No: BDC/Exam/574/2020-21).

Inclusion criteria

Healthy children with no known chronic medical conditions and not diagnosed with any behaviour or cognitive disease who were aged between 6-12 years and able to sit and cooperate for clinical examination (no history of phobias related to the dental setting). If there was more than one child in a family aged between 6 to 12 years who visited the dental hospital, only one child was included in the study by choosing a child from the lottery method. When both parents accompanied the child, then the single parent who provided the written informed consent, and child assent and who had the knowledge of reading either English or Kannada (local language) were invited to participate in the study on their voluntariness.

Exclusion criteria

Children with special healthcare needs were identified and excluded using the CSHCN survey screener (Children with Special Health Care Needs).[7] Since they might be at higher risk for dental caries, owing to poor muscular coordination and muscular weakness that could hinder their regular oral hygiene practices.[8]

Data collection

Recording of socio-demographic characteristics

Socio-demographic details related to parents and children were recorded using 12 questions in both open and close-ended. Data was collected by asking the parent who volunteered to participate in the study.

Assessment of parents' oral health-related behaviours using a self-structured questionnaire

Based on previous studies in the literature, the questionnaire was self-designed to collect information regarding parents' oral health-related behaviours which contains 13 closed-ended questions.[2,9,10]

Validity and reliability of the translated version of parents' oral health-related behaviour questionnaire

For the assessment of parents' oral health-related behaviours, the questionnaires were adopted from the studies in the literature.[2,9,10] Necessary modifications were made to the questionnaire. Later the questionnaire was checked for validity and reliability. An acceptable validity (content validity index, S-CVI=0.87) and reliability (Cronbach's alpha=0.80) was obtained for the scale.

Training and calibration

The primary investigator was calibrated for the clinical examination, Kappa statistics were applied to compute the intra-examiner reliability. The kappa coefficient scores were 0.88, 0.94 and 0.92 for DMFT/deft index (decayed, missing, filled teeth/decayed, extracted, filled teeth), MGI (modified gingival index) and OHI-S (oral hygiene index- simplified) respectively. These values reflected a high degree of conformity in observations.

Scheduling of survey

The time period set for the data collection was almost for 8 months, from March 2022 to October 2022. The survey was scheduled to meet the parents and their children aged

between 6 to 12 years visiting the department of pedodontics and preventive dentistry on feasible working days.

Method of administration of survey questionnaire

The parents who voluntarily signed informed consent to participate in the study were made to sit comfortably in the waiting area of the pedodontia department. The procedure and purpose of the study were explained to them by the primary investigator. They were given a questionnaire related to parents oral health related behaviours either in English or Kannada language according to their preference. It was supervised by a trained assistant of the primary investigator. Concurrently, the child was subjected to an oral health examination to assess the current oral health status by the primary investigator.

Assessment of oral health status of the children

Dental caries was assessed using DMFT/deft index with WHO modified criteria.[11-13] Gingival health was assessed using the Modified Gingival Index.[14] Oral hygiene status was assessed using the oral hygiene index- simplified (OHI-S), for permanent dentition and simplified oral hygiene index for deciduous and mixed dentition.[15,16]

Statistical analyses

The data obtained was compiled systematically in a Microsoft excel sheet and subjected to statistical analyses using Statistical Package for Social Science (SPSS) software version 20. The significant level was fixed at $p<0.05$. Descriptive statistics were generated in terms of frequencies, percentages, mean and SD. Chi-square test to assess the association between the categorical variables. Spearman's correlation was used to assess the correlation of categorical variables. Binary logistic regression was used to check the relationship between independent variables (sociodemographic characteristics and parents oral health related behaviours) with the dependent variables (caries experience, gingival status and oral hygiene status of children).

RESULTS

A total of 420 parent-child dyads visiting the department of Pedodontics and preventive dentistry were approached to collect the data as per the determined sample size. The mean age of the children was 8.8±2.0. Female children were more in number (54.8%) compared to males (45.2%). The majority of the children had one sibling (45.2%), followed by no siblings (26.2%), two siblings (22.6%), three siblings (3.6%), four siblings (1.7%) and five siblings (0.7%). Most of the children in the present study were studying in private schools (78.6%) than in public schools (21.4%). About 50% of the respondents were from the upper middle socioeconomic class, 23.8% from the upper lower, 22.9% from the lower middle, 2.4% from the lower class and 1% from the upper class.

Table 1: Distribution of participants based on the responses to oral health-related behaviours.

Questions	Responses	N (%)
1. Frequency of tooth brushing	Twice/more daily	221 (52.6)
	Less than twice daily	199 (47.4)
2. Frequency of dental visits	Regular dental visits	160 (38.1)
	No regular dental visits	260 (61.9)
3. Reason for visiting the dentist	Check-ups mainly	27 (6.4)
	In trouble mainly	393 (93.6)
4. Consumption of snacks in between meals	Never	128 (30.5)
	One/more daily	292 (69.5)
5. Habit of smoking	No, never	347 (82.6)
	Yes, in the past/present	73 (17.4)
6. Duration of tooth brushing	Three minutes	26 (6.2)
	Less than three minutes	394 (93.8)
7. Frequency of replacing toothbrush	Three months/less	228 (54.3)
	Never, until it cannot be used	192 (45.7)
8. Method of tooth brushing	Circular/vertical	291 (69.3)
	Horizontal/irregular	129 (30.7)
9. Use of dental floss	Yes	2 (0.5)
	No	418 (99.5)
10. Time of tooth brushing	Before/after breakfast	408 (97.1)
	At irregular time	12 (2.9)
11. Type of toothbrush	Soft-bristled	411 (97.9)
	Medium/hard bristled	9 (2.1)
12. Supervision of child's brushing	Yes	293 (69.8)
	No	127 (30.2)
13. Insisting the child for two times brushing	Yes	355 (84.5)
	No	65 (15.5)
Behaviours score	**Mean±SD**	**Range**
	7.0±1.8	3-13

Almost half of the parents had the habit of brushing twice or more daily (52.6%) when compared to brushing less than twice daily (47.4%). More than half of the parents were not in a habit of regular dental visits (61.9%) when compared to parents having regular dental visits (38.1%). More than three fourth of the parents visited the dentist only when there was any trouble (93.6%). Regular dental checkups were preferred by 6.4% of the parents only. About 69.5% of parents were in a habit of consuming snacks once or more daily between meals. But, 30.5% never consumed snacks in between meals. More than

three fourth of the parents were not in a habit of smoking (82.6%) when compared to few with a history of smoking either in past or present (17.4%). The majority of the parents brushed their teeth for less than three minutes (93.8%), and only a few were in a habit of brushing for about three minutes (6.2%). Around half of the parents were in a habit of replacing their toothbrush every three months (54.3%), when compared to 45.7% of the parents who had the habit of replacing it when they felt it cannot be used (45.7%).

About 69.3% of the parents brushed their teeth in circular/vertical strokes, and brushing through horizontal/irregular strokes was followed by 30.7% of the parents. About 99.5% of parents never used dental floss as an oral hygiene aid but, 0.5% were in the habit of using it. Most of the parents brushed their teeth usually before or after breakfast (97.1%), but few had the habit of brushing their teeth irregular time (2.9%). A soft-bristled toothbrush was used by 97.9% of the parents, while 2.1% preferred using a medium/ hard bristled toothbrush. More than half of the parents were in the practice of supervising their child while brushing (69.8%) when compared to parents who were not (30.2%). Majority of the parents in the present study insisting their child two times brushing (84.5%) (Table 1).

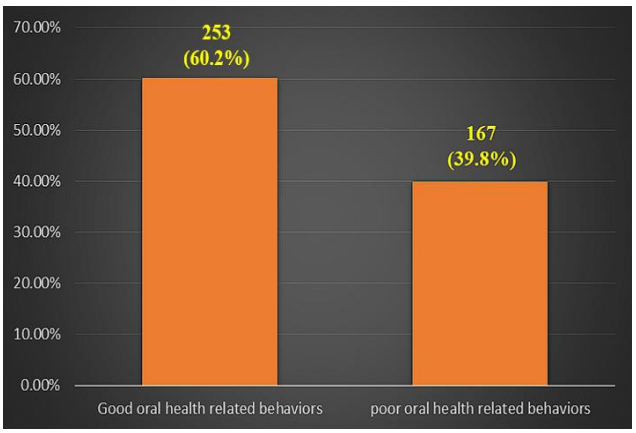

Figure 1: Category of parents based on their oral health-related behaviours.

Based on the responses provided by the parents to the self-administered oral health-related behaviours questionnaire, parents were categorized into having poor/ good oral health-related behaviours by taking the mean oral health-related behaviour score as a reference. Almost 60.2% had good oral health-related behaviours. Poor oral health-related behaviours were noticed among 39.8% of the parents (Figure 1).

When assessed for the children oral hygiene status, more than half of the children had low caries experience (62.5%). High and no caries experience was seen among 19.2% and 18.1% of children respectively. When the gingival status of the children was assessed using the modified gingival index (MGI), 96.2% showed a milder form of gingivitis, 3.3% with moderate gingivitis and a severe form of gingivitis was seen in 0.5% of the children. When the oral hygiene status of the children was assessed using the oral hygiene index- simplified (OHI-S) for permanent and mixed dentition, the majority of the children had good oral hygiene status (57.4%), followed by fair oral hygiene status (30.2%) and 12.4% had poor oral hygiene status (Figure 2).

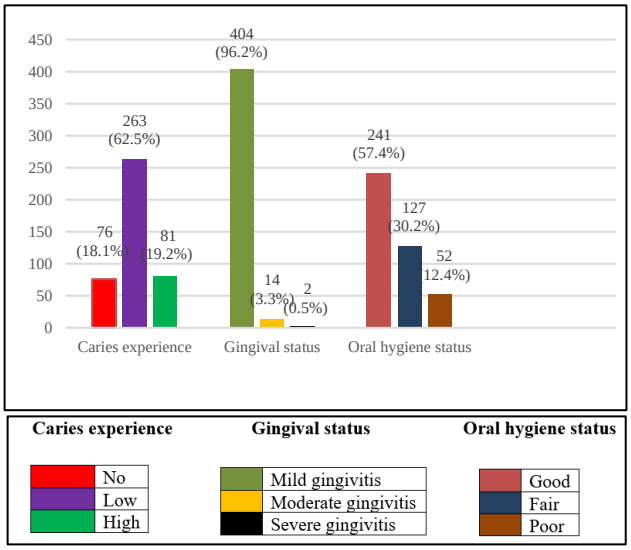

Figure 2: Children oral health status.

The association between parents' oral health-related behaviours and the children's caries, gingival and oral hygiene status was not found to be statistically significant (χ^2=0.519, p=0.471), (χ^2=0.036, p=0.850) and (χ^2=1.380, p=0.240) respectively. A weak positive, non-significant correlation was found between parents' oral health-related behaviours and the children's caries (rho=0.035, p=0.473) and gingival status (rho=0.009, p=0.851). However, a weak inverse, non-significant correlation was found between the parents' oral health-related behaviours and the oral hygiene status of the children (rho=-0.057, p=0.241) (Table 2).

To identify the predictors for the children's oral health status, factors like parents' occupation, education, gender, parents' oral health-related behaviours, socioeconomic status, number of siblings, type of school, and gender of the child were included in the model. The dependent variables were dichotomized as caries present/absent, gingivitis present/ absent, good/poor oral hygiene status. Among all the predictor's mothers' education level was a statistically significant predictor of a child's oral health status with the odds ratio (OR) of 2.931, p<0.05 (Table 3).

Table 2: Association between parents' oral health-related behaviours and children's oral health status.

Parents' oral health-related behaviours	Caries status		Total	χ^2 value	P value	Rho value	P value
	Caries absent	Caries present					
Poor	33 (19.7)	134 (80.2)	167 (39.7)				
Good	43 (16.9)	210 (83.0)	253 (60.2)	0.519	0.471	0.035	0.473
Total	76 (18.0)	344 (81.9)	420 (100)				
Parents' oral health-related behaviours	**Gingival status**						
	Gingivitis absent	**Gingivitis present**	**Total**				
Poor	161 (96.4)	6 (3.59)	167 (39.7)				
Good	243 (96.0)	10 (3.95)	253 (60.2)	0.036	0.850	0.009	0.851
Total	404 (96.1)	16 (3.8)	420 (100)				
Parents' oral health-related behaviours	**Oral hygiene status**						
	Good	**Poor**	**Total**				
Poor	90 (53.8)	77 (46.1)	167 (39.7)				
Good	151 (59.6)	102 (40.3)	253 (60.2)	1.380	0.240	-0.057	0.241
Total	241 (57.3)	179 (42.6)	420 (100)				

Table 3: Binary logistic regression analysis showing the relationship between independent variables with the dependent variables.

Variables	OR (95% C.I.)		
	Caries experience	Gingival status	Oral hygiene status
Father occupation			
Professionals	1	1	1
Unemployed	1.161 (0.409-3.297)	0.302 (0.036-2.547)	1.527 (0.700-3.330)
Mother occupation			
Professionals	1	1	1
Unemployed	0.776 (0.241-2.495)	5.522 (0.779-39.161)	1.412 (0.713-2.796)
Father education			
Graduates	1	1	1
Illiterates	1.077 (0.307-3.778)	1.001 (0.204-4.906)	0.911 (0.372-2.227)
Mother education			
Graduates	1	1	1
Illiterates	*2.931 (1.008-8.524)	3.124 (0.593-16.454)	1.377 (0.781-2.429)
Socio economic status			
Upper class	1	1	1
Lower class	1.116 (0.517-2.411)	2.395 (0.480-11.961)	0.694 (0.371-1.297)
Siblings			
No or one sibling	1	1	1
More than one sibling	1.120 (0.624-2.010)	0.540 (0.167-1.749)	1.260 (0.798-1.991)
Type of school			
Private	1	1	1
Public	1.281 (0.693-2.368)	1.913 (0.402-9.093)	1.035 (0.636-1.683)
Gender of child			
Male	1	1	1
Female	1.530 (0.929-2.522)	1.847 (0.628-5.433)	1.125 (0.763-1.661)
Gender of parent			
Male	1	1	1
Female	0.761(0.431-1.346)	0.404 (0.148-1.105)	1.092 (0.714-1.671)
Parents oral health-related behaviours			
Good oral health-related behaviours	1	1	1
Poor oral health-related behaviours	1.342 (0.782-2.304)	1.547 (0.507-4.725)	0.770 (0.510-1.164)

*p value <0.05.

DISCUSSION

Parents are the primary social force influencing child development in the childhood years. During the age period of 6-12 years, the biological, cognitive, emotional or social changes transform children's bodies, environment and minds. When adolescents, if this period is not attuned to their needs and emerging independence, they can lose confidence in themselves and slip into negative behaviour patterns.[17-19] Taking this into consideration, early detection and intervention targeting parental oral health behaviours and practices may be beneficial in the prevention of oral health problems among the children. Hence the present study strived to investigate the relationships between parents' oral health-related behaviours with the oral health status of 6-12 years old children.

In the present study, for parents with poor oral health-related behaviours, 80.2% of their children had caries and 19.7% were caries-free. This could be attributed to the parent's behaviour of visiting the dentists only during trouble, their habit of snacking once/more daily between meals, brushing for less than three minutes a day and of not using dental floss. However, it was not found to be statistically significant. Among the parents with good oral health-related behaviours, 83% of their children had caries and 16.9% were caries-free. Since this study has relied on parents' self-reports of their oral health-related behaviours, the absolute levels of oral health behaviours might be biased by under or over-reporting due to socially desirable responses.

Parents with good oral health-related behaviours, 59.6% of their children had good oral hygiene status and 40.3% had poor oral hygiene status. Gingivitis was absent among 96% of children and only 3.95% had gingivitis. This could be due to the major proportions of parents in the present study having good oral health related behaviours (60.2%). This could also be attributed to the fact that the majority of the parents had the habit of brushing twice or more daily (52.6%), brushing teeth before or after breakfast (97.1%), replacing toothbrushes every three months or less (54.3%), brushing in circular or vertical strokes (69.3%), using of soft-bristled toothbrush (97.9%). our study findings were in line with the study done by Chand et al, Bozorgmehr et al, Viana et al, where, parents' oral and dental health behaviour influenced the children's dental and oral health status.[1,2,20]

Among the parents with poor oral health-related behaviours, 53.8% of their children were found to be with good oral hygiene status and 46.1% with poor oral hygiene status. 96.4% of the children with no gingivitis and 3.59% had gingivitis. These results are contradicting the evidence of the previous literature. This can be credited to the fact that the majority of the children in the present study were pursuing their education in private schools, where the teachers may be imparting or inculcating some good oral hygiene behaviours to children in the classrooms rather than their own parents. Furthermore, the enforced curriculum in the schools might have provided enough information to children which could have been modified and improved their health behaviours which in turn might have improved their oral hygiene status in the present study. These statements can be substantiated by using the study done by Gautam et al where they stated that children who attend private schools have good oral hygiene than those who attend public schools.[21] They also revealed that there will be a decreased risk for calculus and plaque formation among children belonging to private schools. This might be because of the supervision of the teachers during their lunch time and instructions to gargle their mouths after the meal. These are the additional conclusions which supports our investigatory findings.

The present study is of its first kind to assess the influence of parents' oral health related behaviours on the oral health status of the children belonging to the transitional period (6-12 years) in Davangere city, Karnataka, India. Use of validated self-administered questionnaire aided to the internal validity of the present study. Training and calibration of primary investigator for doing clinical examination with a high degree of conformity in observations minimized the intra-examiner variability.

This study has some limitations. The use of cross-sectional design limited the causality. Therefore, further longitudinal studies would help in understanding the causal relationships. As oral health-related behaviours are socially desirable, it is possible that parents could have over-reported these behaviours. The study subjects represented a convenience sample of parent-child dyad carried out in a single centre catering to urban areas, which may not represent the entire parent population at large. Hence, there may be chances of potential selection bias. Assessment of children's gingival status by the visual examination method might have created subjective errors in the interpretation.

CONCLUSION

Majority of the parents reported of having good oral health-related behaviours. When children's oral health status was assessed, more than half of the children had low caries experience, showed a milder form of gingivitis and good oral hygiene status. Parent's oral health related behaviours did not show any influence on their children's oral health status.

ACKNOWLEDGEMENTS

The authors are thankful to the expert panelists for validating the research tool and training and calibrating the primary investigator for clinical examination. Special thanks to the parent-child dyads for being a part of the research.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee (Ref. No.: BDC/Exam/574/2020-21)

REFERENCES

1. Chand S, Chand S, Dhanker K, Chaudhary A. Impact of mothers' oral hygiene knowledge and practice on oral hygiene status of their 12-year-old children: A cross-sectional study. J Indian Assoc Public Health Dent. 2014;12:323-9.
2. Bozorgmehr E, Hajizamani A, Malek Mohammadi T. Oral health behavior of parents as a predictor of oral health status of their children. ISRN Dent. 2013;1(1):1-6.
3. Okada M, Kawamura M, Kaihara Y, Matsuzaki Y, Kuwahara S, Ishidori H, et al. Influence of parents' oral health behaviour on oral health status of their school children: an exploratory study employing a causal modelling technique. Int J Paediatr Dent. 2002;12(2):101-8.
4. Menon I, Nagarajappa R, Ramesh G, Tak M. Parental stress as a predictor of early childhood caries among preschool children in India. Int J Paediatr Dent. 2013;23(3):160-5.
5. Bhardwaj VK. Dental caries prevalence in individual tooth in primary and permanent dentition among 6-12-year-old school children in Shimla, Himachal Pradesh. Int J Health Allied Sci. 2014;3:125-8.
6. Mehta A. Trends in dental caries in Indian children for the past 25 years. Indian J Dent Res. 2018;29(3):323-8.
7. Davidoff AJ. Identifying children with special health care needs in the National Health Interview Survey: a new resource for policy analysis. Health Serv Res. 2004;39(1):53-71.
8. Patidar D, Sogi S, Chand Patidar D. Oral health status of children with special healthcare need: a retrospective analysis. IJCPD. 2022;15(4):434-7.
9. Sarnat H, Kagan A, Raviv A. The relation between mothers' attitude toward dentistry and the oral status of their children. Pediatr Dent. 1984;6(3):128-31.
10. Wilson A, Brega AG, Batliner TS, Henderson W, Campagna EJ, Fehringer K, et al. Assessment of parental oral health knowledge and behaviors among American Indians of a northern plains tribe. J Public Health Dent. 2014;74(2):159-67.
11. Peter S. Essentials of preventive and community dentistry. 7th edition. New Delhi: Arya (Medi) Publishing house; 2022:746-751.
12. Mean number of decayed, missing and filled permanent teeth (mean DMFT) among the 12-year-old age group. Indicator metadata registry details. The global health observatory. World Health Organization, 1999. Available at: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3812. Accessed on 14 December 2022.
13. Gruebbel AO. A measurement of dental caries prevalence and treatment service for deciduous teeth. Acta Odontol Scand.1944;163-8.
14. Lobene RR, Weatherford T, Ross NM, Lamm RA, Menaker L. A modified gingival index for use in clinical trials. Clin Prev Dent. 1986 ;8(1):3-6.
15. Greene JC, Vermillion JR. The simplified oral hygiene index. J Am Dent Assoc. 1964;68:7-13.
16. Rodrigues CR, Ando T, Guimarães LO. Simplified oral hygiene index for ages 4 to 6 and 7 to 10 (deciduous and mixed dentition). Rev Odontol Univ Sao Paulo. 1990;4(1):20-4.
17. Positive parenting tips for Healthy Child Development. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/child-development/positive-parenting-tips/index.html. Accessed on 2 December 2022.
18. Eccles JS. The development of children ages 6 to 14. Future Children. 1999;9(2):30-44.
19. De Figueiredo CR, Dias FV. Families: Influences in Children's Development and Behaviour, from Parents and Teachers' Point of View. Psychol Res. 2012;2(12):693-705.
20. Viana DA, Utami SP. Parent's oral and dental health behavior as predictors of children's oral and dental health status. DENTA. 2022;16(1):13-20.
21. Gautam N, Kushwaha A, Chandak A, Yadav Y, Upadhyay S. Oral health status among children between the ages of 12 and 15 attending government and private school systems in Bareilly City. J Dent Health Oral Res. 2022;3(2):1-11.

Cite this article as: Sharief GSD, Sapna B. Assessment of parents' oral health related behaviours and its relationship with oral health status of the children aged between 6-12 years in Davangere city: a cross-sectional survey. Int J Community Med Public Health 2024;11:3094-100.