

Knowledge, Attitudes, and Practices in Oral Health among Families with Preschool Children in an Urban Poor Community in Metro Manila

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Abstract

The knowledge, attitudes and practices in oral health of families with preschool Filipino children of selected communities in urban Metro Manila were explored. One hundred thirty-two randomly selected children were examined and interviewed as well as their parents. Results were correlated with parents' educational attainment. Results revealed that parents had adequate knowledge in oral health, had desirable attitudes but practices were not congruent with them. Moreover, the parents' considerably high educational attainment does not correlate with the knowledge, attitudes, and practices in oral health of their families. The results may be used in developing programs that may educate parents of the growing urban poor in Metro Manila on how to better attend to the oral health care of their children.

Keywords: *Oral Health, Knowledge, Attitudes, Practices*

Introduction

During the World Health Organization's Thirtieth World Health Assembly in May 1977, it was decided that the main social target of governments and the World Health Organization in the following decades should be for all citizens of the world to attain by the year 2000 "a level of health which will permit them to lead a socially

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and economically productive life.” This goal is commonly known as “Health for All by the Year 2000.” (WHO, 1985)

“Health for All essentially targets all people to have a quality of life that will allow them to work productively and to participate actively in the community where they belong. It means that health is either promoted or undermined in the areas where people live and work. They will be made to realize that they have the power to shape their lives and the lives of their families, free from the avoidable burden of disease and aware that ill-health is not inevitable.” (WHO, 1998)

Oral health occupies low priority among the different government projects. There is limited or sometimes lack of dental supplies and materials and an acute shortage of dental human resources in government-run facilities. Dentists can hardly go farther than their workstations because of the lack of budget for their transportation. Efforts in providing dental health education as a preventive measure of oral/dental problems are negligible (Mission, 2000). The insufficient budgetary allocation is a huge stumbling block in the effective and efficient delivery of oral health services in the country. In fact, in the proposed P1.05 trillion (*US \$25.1223 billion*) Philippine national budget for 2006, the government is allotting P10.58 billion (*US \$ 252.53402 million*) for the Department of Health. This converts to 33 centavos (*US\$ 0.01*) daily for the health care of each Filipino. The allocation is way below the World Health Organization prescription that countries set aside at least 5 percent of their gross national product for health (Esguerra, 2005).

It is not only the government that should be mentioned to be at fault. Many people neglect oral health and they do not routinely follow the relatively simple oral hygiene practices that are necessary in maintaining a healthy mouth. Rationale behind this is probably a very simple one. People who neglect their mouths are not greatly concerned about the matter and therefore are not sufficiently moved to do otherwise (Ambrose, 1963). Families, especially those belonging to the low income groups, may also lack the means to focus on their health. It is easy to comprehend the reason behind the importance of prioritization of the eradication of the more serious medical diseases since they may be severely infectious and potentially fatal problems. However, they forget that they may also be suffering from chronic and social diseases

that are highly preventable but can easily pose a threat to the health of the individual if left without appropriate action. Dental caries is one example.

It is therefore not surprising that the Department of Health's 1998 survey revealed 94.4 percent prevalence of dental caries on temporary teeth. A fact which further proves the lack of concern of parents and the neglect of children on their oral health.

Statement of the Problem

This study aimed to identify the present oral health situation of families living in an urban poor community. Through an investigation of their knowledge, attitudes and practices in oral health care, the study specifically had the following objectives:

1. Determine the knowledge, attitudes and practices in oral health of parents of preschool children;
2. Determine whether the educational attainment of parents correlated with their knowledge, attitudes, practices in oral health and the oral health status of the preschoolers.

The study hopes to contribute to the development of programs and policies that will help focus the attention on the oral health of the people. As a dental health professional and Family Life and Child Development student, the researcher's goal is to help improve the overall condition of health of the people. While focus on the prevention and control of medical conditions truly require prioritization, oral health should not be left behind.

Review of Related Literature

Oral health

Although the mouth or oral cavity makes up only a very small portion of the human body, its state of health has many implications for the health of the rest of the body.

The primary teeth, popularly known as baby teeth, are far more important to the child's future oral health than parents may imagine. Healthy and well-maintained

primary teeth aid in the general growth and development of the young child. Basic principles of pediatric dentistry would list the following specific functions of sound primary teeth:

1. provide a proper chewing surface until about age 12 to 13 allowing for the efficient mastication of food important for proper body growth and brain development;
2. help the young child produce correct pronunciations aiding in speech formation and development;
3. maintain a normal facial profile by providing support to the developing bones and muscles of the face;
4. preserve jaw space and guide the eruption of permanent teeth in its rightful position in the developing mouth thereby preventing any dental complications, such as malocclusion, which may lead to bigger health problems in the future;
5. also, enhance the young child's personality by promoting self-confidence --- an important factor for a good state of mental health; and
6. allow for the avoidance of infection and concomitant pain and suffering contributing to the overall well-being of the child.

(M.O.Villarico, Pediatric Dentistry lecture, July 2002)

Oral diseases can cause functional limitations on the performance of daily activities. Aside from physical pain and psychological discomfort, they can affect eating habits, social interactions, self-esteem, and productivity at work and in school (Dental Health Service, 2001). Different levels of oral status had different impacts on people's daily life. The worse the oral status the worse the subjective impact on the individual's general performance of activities and work, perceived appearance, eating habits and perceived comfort. Pain and discomfort are common sequels of dental and oral diseases which impose a significant burden on the family and the community.

Dental diseases, as a source of infection, may lead to death. It is one of its many possible complications if left unattended. In the 1991 Philippine Health Statistics, septicemia or blood poisoning has been identified as the eighth leading cause of death among Filipinos in all ages. Bacteriologic evidence suggests that the microorganisms in an infected structure in the mouth or oral cavity is similar to the organism impli-

cated in cases of septicemia. Majority of the cases susceptible to these are individuals whose mouths were classified as being in poor condition. Despite these facts, majority still does not consider oral diseases as life threatening and therefore often ignored (Dental Health Service, 2001).

Interest in Health

All interests have two aspects, the cognitive and the affective. The cognitive aspect is based on concepts which children develop about their areas of interest (Hurlock, 1978). For instance, the cognitive aspect of a child's interest in the dental visit is based on his concepts of the dentist. If he thinks of the dentist as a friend who will help take care of his teeth and provide a pleasant experience in the visit, his interest in the dental visit will be very different than if it was based on concepts of the dentist who is always giving injections and pulling out teeth in order to inflict pain and suffering.

Concepts that make up the cognitive aspect of interests are based on personal experiences and what is learned in the home, school, and community and from the different forms of mass media. If children's needs are satisfied, then interests are developed. As long as the benefits persist, interests stay. Sadly, interest in health does not satisfy personal needs as long as children are healthy or suffer from no troublesome ailments. Therefore, children are seldom interested in health practices (Hurlock, 1978).

The affective aspect of the concepts that make up the cognitive part is the emotional reactions expressed as attitudes toward the activities that interests give rise to. For example, a pleasant first dental exposure may encourage a child to view dental visits as positive experiences. This helps him establish a good relationship with the dentist and will help develop favorable attitudes toward dental visits. Because the dental experience is pleasant, the interest in oral health care is strengthened. On the other hand, any unpleasant dental experience with a dentist or any other health professional can and often does lead to unfavorable attitudes that may weaken the interest in oral health care.

Children's motivation to brush their teeth in order to have good oral hygiene

comes from having favorable attitudes toward the dentist and dental visits. It also helps to see parents, siblings and other significant persons moved by the same motivation, which is strengthening the interest in the particular behavior or attitude object.

Children's interest in health shows a predictable pattern. Most children take good health for granted and resent parental attempts to safeguard their good health. Unless children were sick, they would have little interest in health. Learning in this aspect is due more to social pressures from peers and adults. If parents do not take the responsibility upon themselves in the supervision of measures to maintain good health in their children, such as tooth brushing, interest will not develop.

Health Situation in the Philippines

Three decades after the World Health Organization launched "Health for All 2000", the Philippines is presumed to be far from the goal of ensuring equal health status for all Filipinos irrespective of socio-economic status and place of birth. By the year 2000, the supposed target year for the movement, figures presented by the Community Medicine Foundation were discouraging already.

Examples that oral health is one of the least concerns of Filipinos are as follows: "the World Health Organization cites the Philippines as one of the countries in South-east Asia where oral cancer is a common occurrence; the Community Medicine Foundation confirmed that ninety-eight percent of Filipinos suffer from dental caries and fifty percent suffer from various gum diseases; at the age of twelve, most Filipino children have six decayed, missing or filled teeth due to caries" (Mission, 2000).

What contributed further to the problem, according to a Community Medicine Foundation paper, is the inadequacy of the public dental health system. As of 1997, the dentist-to-population ratio is 36,000 Filipinos for every government dentist.

Health and Filipino Parents

In Filipino families, mothers usually assume the sole responsibility of raising children. Different factors may influence her independence in making decisions for the children especially when it comes to child-rearing practices. One of the primary influences may be the level of educational attainment.

In McGuire & Popkin's study, higher levels of education are associated with better health and nutrition (as cited in Beray, 1998). Educated individuals are likely aware of the value of medical care, participate in early consultation and practice preventive medicine. Hence, more educated mothers will likely have healthier families because they have better information on the optimal allocation of health resources. In addition, the decision processing will probably be done deliberately and independently (Beray, 1998).

“For those in the low-income group and possessing a limited amount of knowledge, a mother will not take the illness seriously when first noticed. Rather, a mother would try to give some form of aid or treatment first. It is not just the length of illness but also the degree to which a sick person is perceived to be suffering which determines perceived gravity and eventual action of the mother” (Tan, 1987).

On the aspect of decision-making among urban poor mothers when it comes to health care intervention for their children, Tupasi, Miguel, Tallo, et.al in their 1987 study discussed the limitation in urban mothers' knowledge about the disease leading to inappropriate action i.e., low rate of public health service utilization (as cited in Bagasao, 1991). On the other hand, the decision to self-medicate or consult a traditional healer was affected by financial constraints, availability of the health facility and the satisfaction that mothers got from the rapport they had with the healer. The choice depended on their confidence in the ability of the person to give the right cure. It also noted that the mothers' perception of the nature of illness appeared equally important. For instance, cough was seen as natural, ordinary and less life threatening than diarrhea so that giving home remedies was an acceptable practice among mothers (Bagasao, 1991).

Facts are that the Philippines has an oral health situation characterized by an increase in the prevalence of dental caries, gum diseases and oral cancer. The results of the 1978 National Epidemiological Survey showed that children aged twelve had dental caries prevalence rate of 95.5 percent and gum disease prevalence of 54.3 percent. Urban communities showed a mean index of 6.67 at age 12 in comparison to 6.0 mean oral health index of rural communities based on the 1995 National Monitoring Evaluation survey of oral health depending on the number of decayed, missing

and filled teeth (Dental Health Service, 2001). All these figures points to Filipinos having poor prospects when it comes to oral health. And as oral health continues to take a backseat, people will unknowingly compromise their quality of life as a result of their poor oral health.

Present knowledge, attitudes and behavior towards oral health, whether desirable or not, is because of the transfer of knowledge, attitudes and behavior of the older generations to the younger generations. Parents, in order for their children to have a fighting chance that will prevent disease initiation and progression in the face of limitations, should invest in the formation of the right knowledge, attitudes and practices towards oral health.

Conceptual Framework

In Figure 1, the researcher presents a conceptual perspective on one factor that may affect the oral health condition of urban poor families. Since Filipino families put a heavy premium on becoming educated as a most aspired achievement in life, it was interesting to see how the level of educational attainment of parents (independent variable) affected the formation of knowledge, attitudes and practices in oral health (dependent variable) --- one of the least prioritized concerns of Filipinos. Data about the parents' knowledge, attitudes and practices in oral health was validated through an intraoral examination, which provided a view of the preschoolers' current oral health status.

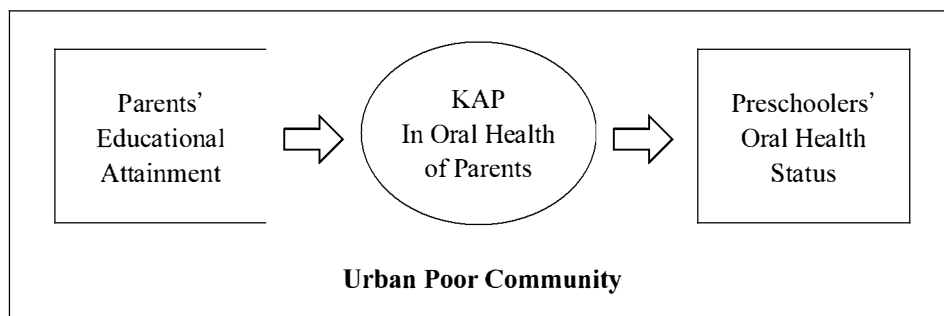


Figure 1. the conceptual framework

Operational Definitions

Knowledge—a nine-item test in the interview schedule on the basic concepts, ideas, and principles that are held and believed to be true information on oral health matters by participants of the study

Attitude—it is a significant ten-item questionnaire forming part of the interview schedule for parents, which dealt with the manner of acting, feeling or thinking that revealed one's disposition or opinion towards oral health

Practice—a significant seventeen-item test for parents which formed part of the interview schedule that included the habitual or customary performance of oral health care measures claimed to be followed by the participants of the study on a regular basis

Satisfactory Oral Health—condition of well-being of the teeth according to the set specific oral health goals as outlined by the World Health Organization in its program called "Health For All 2000"

Family—a group of individuals who are related by blood and or living together in one household unit and members of the selected urban poor community

Preschooler—a child who is 5-6 years old, and belonging to a family residing within the vicinity of the selected urban poor community

Parent—biological or adoptive parent, relative or caregiver of the preschooler and is in charge of the overall well-being of the preschool child

Urban Poor Community—a concentration of low-income settlers with an average declared combined family income not exceeding thirty three thousand pesos (US \$700.93) per month.

Delimitations of the Study

The study was limited to the selected three day care centers and three districts in Payatas, Quezon City, an urban poor community in Metro Manila. Gathering of attitudes and practices data was done merely through an interview schedule. The inability to conduct other measures that will corroborate actual attitudes and practices in oral health limits the accuracy of results and conclusions.

The evaluation for satisfactory oral health status of the teeth was confined to the set specific oral health goals of the World Health Organization's "Health for All 2000" program. It only focused on the presence or absence of dental caries in the preschooler participants in order to check on whether this can be correlated with the parents' educational attainment.

Methodology

Research site

Payatas is famous as a garbage-dumping site for most parts of Quezon City in Metro Manila. It has a population of 200,000 or ten percent (10%) of the city's 2005 estimated population with the number of households reaching 70,000 and has the fastest growing population in the city.

Sampling

Simple random sampling via the raffle method was utilized. Preschooler participants came from the enrollment lists of three preschools -- Bahay Pangarap, Lupang Pangako and Molave Day Care Centers -- and the district nutrition scholar's lists from three areas -- Sierra Madre Street, Mt. Apo Street and Gravel Pit Road. Those belonging to the 5-6-year-old age range qualified for the study. The respective parent or caregiver of each preschooler automatically became a respondent of the study. There were eleven participants included from each day care center and district resulting to a total number of sixty-six preschoolers, and the respective parents/guardians of the selected preschoolers making up sixty-six parents. Total number of participants involved in the study is one hundred thirty-two.

Instrumentation

1. Interview Schedule for Parents. The pre-tested questionnaire included subjects that dealt with ideas and concepts of the dentist and dental visits, and specific knowledge, attitude and practices concerning the respondents' oral health and hygiene.
2. Oral Assessment Chart for Intraoral Examination. This instrument recorded

actual findings of the researcher regarding the oral health profile of the respondents as reflected by the condition of the hard tissues (teeth). It is considered a standardized dental recording system commonly used in most dental schools and dental practices in the Philippines.

Data collection procedure

Data collection was finished in seven (7) full working days. Assistance in data collection came from five dentists who underwent training for this particular part of the research through calibration measures conducted by the researcher. Each selected family who participated in the study had a particular schedule for the data collection. The researcher facilitated the gathering of information from the parents and their preschool children. After completion of each interview with the parent, child respondents underwent an intraoral examination for the assessment of the health status of their teeth.

Data analysis procedures

Frequency distributions and percentages provided a better understanding of the demographics and the knowledge, attitudes and practices in oral health of families with preschool children living in an urban poor community.

Correlation analyses used were the following: Analysis of Variance (ANOVA), Spearman correlations and Chi-square.

Results and Discussion

Parents' knowledge in oral health

A viable scoring system was devised for the 'knowledge' part. For every correct answer, the respondent garnered one point. For an item that presented a follow-up question, both the main and follow-up questions needed adequate and satisfactory answers in order to qualify for one point. The actual score for every respondent was computed. The rating scale used for the participants' knowledge in oral health had three categories: POOR (correctly scoring at least one out of nine items), FAIR (correctly scoring at least four out of nine items) and GOOD (correctly scoring at

least seven out of nine items). Each participant's knowledge on oral health was then evaluated. The total score for every participant was entered into a category which rated their level of knowledge in oral health. Therefore based on the acceptable and satisfactory answers which the parents provided in the 'knowledge' aspect of their interview, they were perceived to have knowledge being GOOD, FAIR, or POOR when it came to oral health.

Table 1 provides the parents' computed scores and their respective ratings for their knowledge in oral health. A respondent must get a score of nine (9 of 9) to obtain a perfect score. As shown in Table 1, 30 parents got a score of eight (8 of 9) while 4 parents got the lowest score of six (6 of 9); 13 parents got seven correct answers (7 of 9) and 19 parents obtained perfect nine scores (9 of 9). Majority was able to reach high/vocational school (59.1%); some reached elementary (33.3%); and a few went to college (7.6%).

Table 1. *Distribution of Computed Scores and Ratings of Parents for their Knowledge in Oral Health*

Educational Level	FAIR	GOOD			TOTAL	Percentage (n=66)
	6 of 9	7 of 9	8 of 9	9 of 9		
Elementary	2	3	10	7	22	33.3
High Sch/Vocational	2	9	16	12	39	59.1
College	0	1	4	0	5	7.6
TOTAL	4	13	30	19	66	100

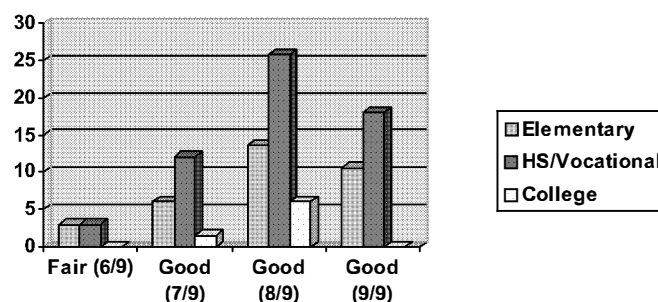


Figure 2. Shows the distribution of parents' oral health knowledge ratings based on their educational attainment

In terms of knowledge in oral health, although majority of parents or 94 percent were able to provide acceptable and satisfactory responses to the knowledge questions, there is no sufficient statistical evidence that the mean knowledge levels of parents are different across educational levels. Therefore, parental knowledge in oral health does not rely on their level of educational achievement.

As presented in Table 2, using Analysis of Variance (ANOVA), it can be said that there is no statistical evidence that the mean knowledge level of parents are different across educational levels. The p value is 0.923. The level of significance is 0.05. The p-value must be equal to or less than 0.05 to be considered significant. Therefore, there is no relationship between oral health knowledge and educational achievement of parents.

Table 2. *Crosstabulation of Parents' Oral Health Knowledge and Education*

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.121	2	0.061	0.080	0.923
Within Groups	47.818	63	0.759		
Total	47.939	65			

Parents' attitudes in oral health

Parental attitudes pertaining to oral health generally yielded the following outcome:

1. The top three health care providers that they enumerated were doctor (74.2 percent), dentist (39.4 percent) and nurse (22.7 percent).
2. Seventy-one and two tenths percent admitted to being afraid of the dentist.
3. Forty and nine tenths percent would visit the dentist only in the presence of a symptomatic problem while 25.8 percent claimed to do regular dental visits.
4. Eighty-nine and four tenths percent believed in the need for twice a year dental check-ups.
5. Ninety-seven percent is convinced that children's teeth should be cared for primarily to prevent the onset of pain and to have a good-looking set of teeth.
6. On the matter of the choice of action concerning the presence of tooth decay

that is not painful yet, 45.4 percent would simply ignore it, 27.3 percent would plainly do tooth brushing of the affected area, and 19.7 percent would readily have it extracted.

7. If parents had the choice to have the dental cavity treated, majority (42.2 percent) would have it done when it becomes painful already while a few (21.2 percent) would claim to do it when money becomes available.
8. As to the kind of dental treatment, an overwhelming 80.3 percent preferred extraction to maintaining the tooth with a filling.
9. Parents understood that a tooth infection could be life threatening (81.8 percent).

Parents' practices in oral health

Parents' practices in oral health have the following results:

1. Forty-three and nine tenths percent brushed their teeth twice a day and 39.4 percent brushed their teeth thrice a day.
2. Common toothbrush brands available in their community are Colgate, Oral B and Springmaid and the main reason behind their toothbrush choice is actually the price, with most of them (78.9 percent) preferring toothbrushes in the 0.00 to 30.00-peso (*US \$0.00 to 0.70*) price range.
3. Most parents said that they change toothbrushes every two months and those toothbrushes would usually have unruly bristles or merely look broken when they perceive it as time to change.
4. The common tools that they use to aid them in removing interdental food debris are toothpick (57.6 percent), matchstick and thread (16.7 percent each).
5. Common toothpaste brands available in their community are Colgate, Close-up, Hapee and Beam and reasons behind their toothpaste choice are good taste, perceiving it as nice, and simply being used to it. Nevertheless, the price still played an important role in toothpaste selection with most of them (68.2 percent) preferring toothpastes in the less-than-ten-peso (*less-than-US \$0.23*) price range.
6. Many parents (68.2 percent) practice substitution for toothpaste when the need

arises.

7. Ninety-two and four tenths percent has been to a dentist and the most common reason for the dental visit is to have a tooth undergo extraction.
8. Generally, parents would be aware that a dental problem exists if they experience pain (63.6 percent), see a cavity (12.1 percent), have bad breath (10.6 percent), and or feel a canker sore (9.1 percent).
9. They would decide to go see a dentist mainly because pain is already present (74.2 percent).
10. Seventy-five and eight tenths percent of parents have yet to bring their 5-6-year-old children for a first dental visit.

Educational attainment and parents' knowledge, attitudes and practices in oral health

Only a few attitudinal responses of the parents --- those about fear of the dentist, twice a year check-ups, caring for children's teeth, and perception of tooth infection as life threatening --- underwent correlation analysis and proved to be independent of their level of education. One attitude, however, exposed a significant relationship with parental education. When it came to the treatment choice between filling and extraction, elementary-level parents and high school-level parents would rather remove the tooth/teeth concerned than save it through a dental restoration. On the other hand, majority of college-level parents opted to save rather than remove tooth/teeth.

Table 3 reveals that extraction is the treatment of choice for majority of parents --- 90.9 percent from elementary-level parents, 79.5 percent and 40 percent from high school-level parents and college-level parents respectively. These data also supported chi-square analysis findings which showed that a significant association exists between the parents' choice of dental treatment and their level of education ($p=0.0348$).

Correlation analysis on parent practices in oral health also discovered that responses to aspects like frequency in oral cleaning, switching to new toothbrushes, substitution for toothpaste, and dental visits do not have any connection with their educational attainment.

Table 3. *Distribution of Parents' Responses to the Question: If you have a painful cavity, what will be your treatment of choice – filling or extraction?*

Parent's Response	Parent' Education						TOTAL	%
	Elementary	%	High School	%	College	%		
Filling	2	9.1	8	20.5	3	60.0	13	19.7
Extraction	20	90.9	31	79.5	2	40.0	53	80.3
TOTAL	22	100	39	100	5	100	66	100

*chi-square = 6.716, df = 2, p = 0.0348 (sig)

Educational attainment and preschoolers' oral health status

One of the objectives of the study was to determine if the level of educational attainment of parents is associated with the oral health condition of their preschool children. Results revealed that the mean knowledge of parents in oral health is similar across the varying educational levels and that there is no association between this same knowledge of parents and their children's oral health status. Therefore, it follows that the children's oral health status is also independent of the parents' level of education (refer to Figure 3).

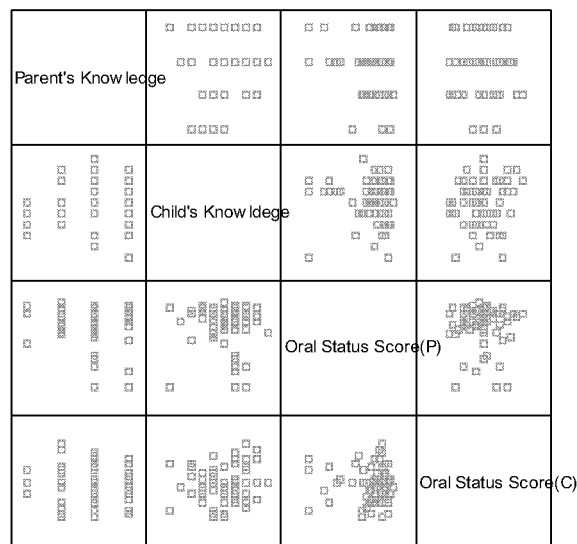


Figure 3. A scatter plot of the sample showing the different variables

Conclusion

Most urban poor parents were able to prove that their knowledge in oral health is sufficient and satisfactory for the health benefit of their families. As for the attitudes towards oral health by the parents, it is encouraging that there are positive aspects such as acknowledgement of the dentist as a health care provider, adequate oral hygiene awareness, belief in twice a year dental check-ups and the need to care for children's teeth. On the other hand, what was reportedly practiced went against their abovementioned desirable attitudes. These included dental visits dictated only by painful symptoms and the preference of interventional over preventive and conservative dentistry -- critical practices that persist even though they know that possible dental complications could be fatal. It also does not help that they admit to being fearful of the dentist.

Generally, the level of educational attainment of parents belonging to urban poor families did not have an impact on the type of knowledge, attitudes and practices in the oral health of their families. With the help of correlation analysis, the study was able to provide supplementary evidence that educational achievement did not help obtain knowledge, attitudes and practices that are desirable for the oral health of their families.

Moreover, the level of educational attainment of parents was not associated with the oral health condition of their preschool children.

Recommendations

Parents must be willing to invest in the health of their families. They may be equipped with adequate knowledge and desirable attitudes that can help improve their oral health but proper application is lacking. Government and non-government organizations should try to employ strategies that can facilitate the motivation of individuals and families to improve their health and eventually their quality of life.

For preschools, daycare centers and public schools include an oral health pro-

gram that can be a significant part of the school curriculum. Stress on the importance of healthy nutrition and sufficient hygiene information that will especially uplift knowledge, attitudes and habits for oral health. Provide innovations in their school calendar, such as sponsoring oral health fairs by the local dental chapter, which will actively promote oral health care. A Presidential Decree recognizes every February as National Dental Health Month in the country – celebrate it by allotting special activities related to oral health care. Establish tie-ups with non-government groups and health associations that have the capability to provide necessary aids and services that will fill up or enhance already existing programs pertaining to oral health. Tooth brushing should be incorporated as a regular part of daily school activities preferably timed every after meal breaks and fluoride mouth rinsing every three months. Lastly, school officials should be strict with the implementation of at least a once-a-year dental check-up of all its students. And to make sure that parents address the dental needs of their children, incorporate dental health as part of the annual school clearance requirements that children must pass before being allowed to move up to the next grade level.

The key is to focus on prevention instead of intervention. Schools are a good venue to disseminate vital oral health information and conduct preventive and interceptive dentistry. Public and private individuals, via a multi-sectored approach, must affect reforms that will start at the grassroots level – from the smallest government units and youngest members of the communities – that will ultimately ripple towards the achievement of better oral health conditions contributing to a much desirable quality of life even for urban poor families.

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