



Effect of Controlled Social Media Oral Health Interventions Using Storytelling and Text-Based Education on Knowledge, Practice, and Satisfaction of Mothers with Toddlers: A Clinical Trial

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Article Info	ABSTRACT
Article type: Original Article	Objectives: This study aimed to examine the impact of social media oral health interventions, using storytelling and text-based education, on the knowledge, practice, and satisfaction of toddlers' mothers.
Article History: Received: 06 Jun 2025 Accepted: 10 Dec 2025 Published: 08 Jun 2026	Materials and Methods: This controlled clinical trial was conducted in 2020 and involved 118 Iranian mothers with toddlers who were active Instagram users. The participants were randomly assigned to two groups storytelling (n=35) and text-based education (n=83). After two weeks, the mothers' knowledge (n=8 questions), practice (n=7 questions), and satisfaction (n=5 questions) were assessed using an online questionnaire. The Mann-Whitney test and generalized linear model were used for statistical analyses (alpha=0.05).
* Corresponding author: Department of Community Oral Health, School of Dentistry, Tehran University of Medical Sciences, Tehran, Iran Email: smohebbi@tums.ac.ir	Results: The mean scores of knowledge, practice of mothers regarding their children, and their practice regarding themselves were 34.71 ± 6.85, 10.54 ± 5.05, and 8.65 ± 1.84 in the storytelling group, and 34.87 ± 6.80, 10.32 ± 3.97, and 9.18 ± 1.76 in the text-based education group, respectively. Of all, 71.4% of those in the storytelling group and 72.3% of the text-based education group described the received content as very good. Mothers' knowledge ($P=0.002$, $\beta=0.094$) and practice regarding their children ($P=0.041$, $\beta=0.099$) were directly correlated with their satisfaction. The satisfaction score was significantly lower in mothers with a higher educational level ($P=0.003$, $\beta=-1.3$). Conclusion: While mothers displayed a relatively desirable level of knowledge, their oral health practice fell short. However, it is worth noting that mothers expressed high satisfaction with both interventions. Hence, online learning should be considered and promoted alongside traditional methods to effectively accelerate oral health practices. Implementing these methods over an extended period will help establish more sustainable effects. Keywords: Controlled Clinical Trial, Health Education, Dental, Mothers, Social Media
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INTRODUCTION

The American Academy of Pediatric Dentistry, the American Dental Association, the American Public Health Association, and the American Academy of Pediatrics currently recommend that all children must have their first dental visit within their first year of life [1, 2]. This recommendation is based on the fact that dental caries is already prevalent among 3-year-old children, making them more susceptible to future caries [3]. It is essential to start oral healthcare during infancy when dental caries have not yet caused tooth damage, oral health habits have not yet been established, and all dental caries prevention measures are readily accessible [4].

Toddlers are not mentally, physically, or functionally receptive to health education, and this age range represents a critical period for directing health education efforts toward parents. During this stage, children and parents take their initial significant steps in shaping behavior and perception, eliminating risk factors, and preventing potential oral diseases [5]. Therefore, mothers, as the primary caregivers of toddlers, play a pivotal role in establishing a positive attitude towards oral health in their children from infancy. This role can be realized through effective education [6]. Providing oral health advice in dental offices is a standard method for health education by professionals. The effectiveness of traditional training methods in dental offices is a debated topic. Kotha et al. [7] reported that conventional training methods did not have a significant efficacy in enhancing knowledge and practice among the target population. Moreover, this educational approach requires an in-person visit to the office, while many toddlers never visit dental offices at a young age. Even in countries with efficient public health systems, the first dental visit is postponed until 2 years of age. In the United Kingdom, only 30% of children visit a dentist before the age of 2 years, whereas in Canada, this figure rises to 44.5% [8]. A study conducted in Brazil showed that 11.7% of the population had never seen a dentist; among them, 47.9% were under 4 years of age [9]. Individuals sometimes neither seek dental

care to receive essential oral health education nor engage in future follow-ups. Hence, it is crucial to establish an alternative method of knowledge enhancement to provide parents of very young children with essential oral health information, emphasizing the importance of early dental visits.

E-learning or online learning is “an educational method that provides easy access to all required educational content for learners by information technology.” The interaction between learners and teachers can be enhanced by considering learners' motivation and acceptance and utilizing a user-friendly medium [10]. Over the past two decades, social media has significantly developed across all age groups. They serve as a user-friendly tool that provides an interactive environment for people. As of October 2020, there were 4.5 billion Internet users worldwide, with over 4 billion actively engaging with social media [11]. Instagram is extremely popular among Iranians, and Iran ranks seventh in the world in terms of Instagram usage, with 24 million active members [12]. A 2020 report revealed that most Instagram users were females and those aged 25-34 years [13]. As a social media platform, Instagram enables users to share their daily routines, information, and emotions mainly through pictures and videos. Employing diverse educational methods is essential for promoting effective learning. One such method, storytelling, has long been a powerful platform for teaching and conveying concepts. Beyond entertainment, storytelling is a potent educational tool that shares experiences in today's world [14]. Stories present events through words and images, tapping into emotions and providing contextual meaning. As a result, they are often more vivid and memorable than mere facts [14]. Audiovisual content, including animation, is a contemporary educational method that benefits people irrespective of their academic background and socio-economic status, making it accessible and enjoyable for a broad audience [15]. Research indicates that this approach provides faster learning and, in combination with practical

application, is more effective than other methods [16]. The amalgamation of storytelling with animation provides the advantages of both media and modernized narratives, thus enhancing their appeal and acceptance among the public.

Since the COVID-19 pandemic, interest in using tools for distance education has increased and there is evidence that they can be more effective, engaging, and interesting [17, 18]. However, it should be noted that the effectiveness of e-learning depends on the methods used and the target population [19]. This study investigated the impact of oral health educational interventions delivered through social media on the knowledge, behavior, and satisfaction of mothers of toddlers and compared the effectiveness of storytelling and text-based education through an online questionnaire survey.

MATERIALS AND METHODS

Study design and participants:

A single-blind, parallel-group controlled clinical trial with a 1:2 allocation ratio was conducted in 2020 among mothers of children aged 1–3 years. The study was approved by the Medical Ethics Committee of Tehran University of Medical Sciences (IR.TUMS.DENTISTRY.REC.1399.110) and registered in the Iranian Registry of Clinical Trials (IRCT20131102015238N4).

The study population comprised mothers of children aged 1–3 years who were active Instagram users and followed two popular Iranian online shop pages for children. Potential participants were invited through stories published on these pages. Mothers who were interested in participating were provided with information about the study objectives and procedures and were enrolled after providing written informed consent.

Sample size:

According to the results of a previous study [20], Using a two-sample t-test with the assumption of equal variances option in the Power Analysis and Sample Size application, version 15, and considering $\alpha=0.05$, $\beta=0.2$, a mean knowledge score of 13.1 and 14.3 in the storytelling and text-based educational

groups, respectively, and a standard deviation of 2.0, the minimum required sample size was estimated to be 33 in the storytelling group and 66 in the text-based educational group, considering a 1:2 ratio. Considering a 5% potential attrition rate, the final sample size was increased to 35 in the storytelling group and 70 in the text-based educational group, respectively. This was the minimum sample size, and there was no limit on the number of participants based on the number of mothers interested in participating in the study.

Randomization and allocation concealment:

Participants were randomly allocated to one of two educational intervention groups using a computer-generated randomization procedure. The allocation ratio was 1:2, with participants assigned to either the storytelling intervention or the text-based educational intervention. The unequal allocation ratio was selected for ethical considerations, as the text-based approach had greater supporting evidence and was considered a more established educational approach [21].

Two Instagram accounts were created for the two intervention groups. After randomization, each participant received the link to only one of the two educational pages.

Interventions:

Three episodes of 1 to 2 minute serialized animated stories with audio-visual content were produced, along with 14 text-based slides that contained text and related pictures. These materials conveyed the same educational messages about the importance of children's teeth, early dental visits for children, feeding practices, toddlers' oral self-care, transmission of cariogenic bacteria from mother to child, and oral hygiene tips for mothers (Fig. 1). The animation series depicted the experiences of individuals from two fruit symbol families, each representing contrasting approaches to health and well-being one depicting a healthy family and the other an illness-prone family), featuring family members of varying age groups. Designing characters, voice acting, and graphic design were executed by a team of experts, along with delivering specific training tailored for the relevant age group, encompassing oral



Fig 1. Samples of educational content: A) text-based education, B) storytelling education.

health messages and recommendations. In the healthy family, the characters included celery as the mother, apple as the father, and tangerine and sour cherry as the children. Meanwhile, in the illness-prone family, the characters featured lollipop as the mother, soda pop as the father, and sugar dispenser and cheese puffs as the children. The desired two-dimensional animation was prepared by the motion graphic method. The related scenarios were drafted after collecting evidence-based scientific content from the American Academy of Pediatric Dentistry's oral health policies and recommendations [22], and the animations were subsequently produced. The animations were reviewed and revised based on feedback from two oral health experts and a pediatric dentist. Additionally, two uneducated mothers provided their comments on the animations.

Outcomes:

The primary outcome was mothers' oral health knowledge regarding their children's oral health, assessed using the knowledge section of the study questionnaire two weeks after the intervention.

Secondary outcomes included mothers' oral health practices regarding their children, mothers' oral health practices regarding themselves, and mothers' satisfaction with the

educational program, all assessed two weeks after the intervention.

Data collection and measurement:

A questionnaire was developed based on a previously validated questionnaire [20]. It consisted of four sections: demographic characteristics (5 questions), oral health knowledge (8 questions), oral health practices (7 questions, including 4 questions regarding mothers' practices for their children and 3 questions regarding mothers' own practices), and satisfaction with the educational program (5 questions).

The content validity of the questionnaire was assessed using a combination of quantitative and qualitative methods. The questionnaire was reviewed by eight faculty members specializing in oral health and pediatric dentistry. Their comments regarding grammar, wording, item allocation, and scaling were considered, and modifications were made until consensus was reached. Items with a content validity index greater than 0.78 and a content validity ratio greater than 0.70 were retained. Of the initial 13 knowledge questions, five were excluded because they did not meet the predefined content validity criteria [23] (Appendix 1).

Blinding:

The study was conducted using a single-blind design. Participants' group assignments were coded, and the researchers, outcome evaluators, and statistical analysts were blinded to group allocation during outcome assessment and analysis.

Statistical analysis:

Data analysis was carried out using SPSS version 21 (SPSS Inc., IL, USA). Quantitative variables were expressed as mean and standard deviation, while qualitative variables were reported as percentage and frequency. The correct answers to the questions on mothers' knowledge about children's oral health were scored five, and otherwise (including "I do not know") were scored zero. The range of scores for each question on mothers' practices and satisfaction was 0 to 5. The mothers' oral health knowledge, mothers' practices regarding their children, mothers' practices

regarding themselves, and satisfaction scores of each mother were computed as a total sum of scores obtained from each question. The normality of the knowledge, practice, and satisfaction scores was assessed using the Shapiro–Wilk test. As the scores were not normally distributed, between-group comparisons were performed using the Mann–Whitney U test. Generalized linear models were also used to assess the effect of the educational intervention on the study outcomes. Statistical significance was defined as a two-sided P value < 0.05.

Interim analysis and stopping guidelines:

No interim analysis was performed, and no formal stopping guidelines were applied because the study involved a short-term educational intervention and outcomes were assessed at a single prespecified follow-up point.

RESULTS

Participant characteristics:

Mothers were between 22 and 41 years (mean age = 30.58 ± 5.92 years). All participants completed the questionnaire, and there were no missing data. There were 83 participants in the text-based education group, and 94% of them had university education. There were 35 individuals in the storytelling group, 91.4% of whom had university education. Figure 2 shows the CONSORT flow diagram of the study.

Primary outcome: Knowledge score:

Table 1 shows the mothers' responses to eight knowledge questions in the two intervention groups. After the intervention, the mean

knowledge score was 34.71 ± 6.85 and 34.87 ± 6.80 out of 40 in the storytelling and text-based education groups, respectively. The highest percentage of correct answers in the storytelling group was 97.1%, which was related to the question about the time of first primary tooth eruption, and 97.6% in the text-based group, which was related to the question about how often children should visit a dentist.

Secondary outcomes: Practice and satisfaction:

Table 2 shows answers to questions on mothers' practice regarding their children, and Table 3 shows answers to questions on mothers' practice regarding themselves. The results showed that 31.7% and 22.9% of the storytelling and text-based education groups always used fluoride toothpaste for their children, respectively (Table 2). Nearly 34% of mothers reported brushing their teeth twice daily or more in both groups (Table 3). Also, 17% of mothers in the text-based education group consumed sweet snacks three times a day or more, compared to 14% in the other group (Table 3).

Regarding satisfaction, 97% of the participants viewed the story content, while 90% of the participants in the text-based education group read the texts. In the storytelling group, 71.4% of the participants had a very good opinion about the approach (options included 'very good,' 'good,' 'bad,' 'very bad,' and 'no idea'). Similarly, 72.3% of the mothers selected the 'very good' option in the text-based education group (Table 4).

The mean score of the mothers' practice

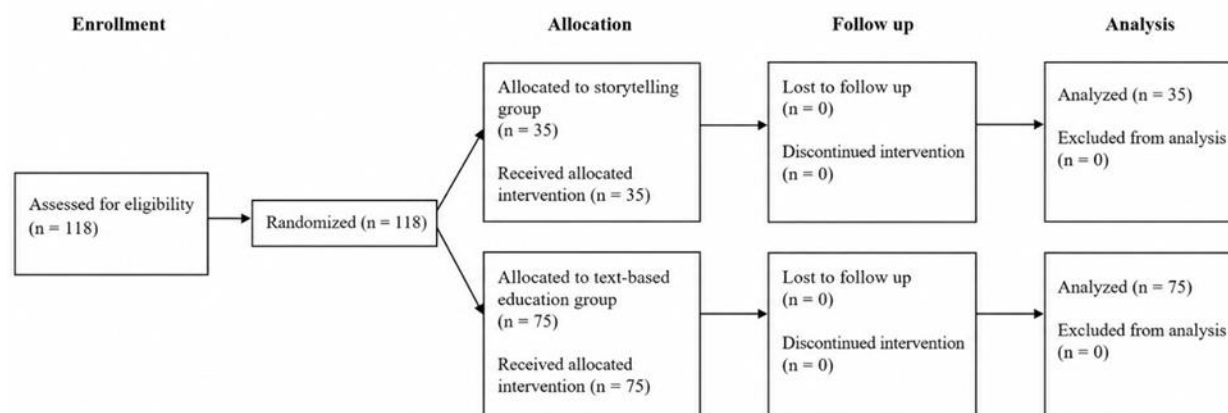


Fig 2. CONSORT flow-diagram of the study.

Table 1. Percentage of mothers' (n=118) correct responses to the knowledge questions after the intervention in the storytelling and text-based education groups

Questions	Story telling group (n=35); n (%)	Text-based education group (n=83); n (%)
1- At what age does the first primary tooth erupt?	34 (97.1%)	78 (94%)
2- How many primary teeth does a 3-year-old child have?	28 (80%)	67 (80.7%)
3- When should children have their first dental visit?	28 (80%)	61 (73.5%)
4- How often a day should toddlers brush their teeth, at least?	32 (91.4%)	73 (88%)
5- How much toothpaste do toddlers need for tooth brushing?	31 (88.6%)	71 (85.5%)
6- How often should toddlers visit a dentist?	33 (94.3%)	81 (97.6%)
7- Which one is correct about the iron drops?	27 (77.1%)	78(94%)
8- Which one is correct about sugar consumption and infancy habits?	30 (85.7%)	70 (84.3%)

Table 2. Frequency percentage of mothers' (n= 118) responses to mothers' practice questions regarding their children after the intervention in the storytelling and text-based education groups

Questions	Story telling group (35 participants); n (%)	Text-based education group (83 participants); n (%)
1- Who brushes your child's teeth?		
He/she doesn't brush his/her teeth, yet.	8 (22.9%)	9 (10.8%)
Himself/herself	1 (2.9%)	2 (2.4%)
Himself/herself under supervision of adults	12 (34.4%)	36 (43.4%)
Adults	14 (40%)	36 (43.4%)
2- How often does your child brush his/her teeth?		
Irregularly or never	8 (22.9%)	9 (10.8%)
Once a week	1 (2.9%)	5 (6%)
Several times (2-3 times) a week	5 (14.3%)	11 (13.3%)
Once a day	12 (34.3%)	41 (49.4%)
More than once a day	9 (25.7%)	17 (20.5%)
3- How often does your child eat sweet snacks or beverages (cold or warm)?		
Three times or more per day	6 (17.1%)	8 (9.6%)
Around two times per day	11 (31.4%)	36 (43.4%)
Once a day	5 (14.3%)	16 (19.3%)
Occasionally or not every day	7 (20%)	13 (15.7%)
Rarely	6 (17.1%)	10 (12%)
4- Do you use fluoridated toothpaste for your child?		
Always	13 (31.7%)	19 (22.9%)
Most of the time	1 (2.9%)	6 (7.2%)
Occasionally	3 (8.6%)	15 (18.1%)
Never	11 (31.4%)	37 (44.6%)
I don't know	7 (20%)	6 (7.2%)

Table 3. Percentage of mothers' responses (n=118) to the questions regarding their own practice after the intervention in the storytelling and text-based education groups

Questions	Storytelling group (35 participants); n (%)	Text-based education group (83 participants); n (%)
1- How often do you brush your teeth?		
Irregularly or never	3 (8.6%)	4 (4.8%)
Once a week	2 (5.7%)	3 (3.6%)
Several times (2-3 times) a week	3 (8.6%)	5 (6%)
Once a day	15 (42.9%)	42 (50.6%)
More than once a day	12 (34.3%)	29 (34.9%)
2- Do you use fluoridated toothpaste?		
Always	25 (71.4%)	55 (66.3%)
Most of the time	3 (8.6%)	-
Occasionally	5 (14.3%)	9 (10.8%)
Never	2 (5.7%)	19 (22.9%)
3- How often do you eat sweet snacks or beverages (cold or warm) between meals?		
Three times or more per day	6 (17.1%)	12 (14.5%)
Around two times per day	8 (22.9%)	17 (20.5%)
Once a day	7 (20%)	16 (19.3%)
Occasionally or not every day	8 (22.9%)	26 (31.3%)
Rarely	6 (17.1%)	12 (14.5%)

Table 4. Percentage (frequency) of mothers' (n=118) responses to the satisfaction questions after the intervention in the storytelling and text-based education groups

Questions	Storytelling group (35 participants); n (%)	Text-based education group (83 participants); n (%)
1- Have you seen the received content?		
Yes	34 (97.1%)	75 (90.4%)
No	1 (2.9%)	8 (9.6%)
2- Was the content straightforward and intelligible?		
Very much	26 (74.3%)	60 (72.3%)
Much	8 (22.9%)	19 (22.9%)
Moderate	1 (2.9%)	2 (2.4%)
A little and very little	0	2 (2.4%)
3- Was the content attractive and intelligible?		
Very much	21 (60%)	53 (63.9%)
Much	8 (22.9%)	22 (26.5%)
Moderate	4 (11.4%)	6 (7.2%)
A little and very little	2 (5.7%)	2 (2.4%)
4- How much did the content change your child's oral health behavior?		
Very much	14 (40%)	34 (40%)
Much	13 (37.1%)	25 (30%)
Moderate	8 (22.9%)	23 (27.7%)
A little and very little	0	1 (1.3%)

Table 4 Cont'd**5- what do you think about the content in general?**

Very good	25 (71.4%)	60 (72.3%)
Good	9 (25.7%)	21 (25.3%)
Weak and very week	1 (2.9%)	1 (1.2%)
No idea	0	1 (1.2%)

regarding their children was 10.54 ± 5.05 and 10.32 ± 3.97 out of 20 in the storytelling and text-based education groups, respectively. The mean score of the mothers' practice regarding themselves was 8.65 ± 1.84 in the storytelling group and 9.18 ± 1.76 out of 15 in the text-based education group. There were no significant differences between the two groups' mean scores of knowledge and mothers' practice regarding their children and mothers' practice regarding themselves (Table 5).

Factors associated with knowledge, practice, and satisfaction scores:

Regarding the association between mothers' satisfaction scores and other variables, the generalized linear model

results indicated no significant relationship with maternal age or children's gender ($P > 0.05$). However, mothers with a higher educational level had significantly lower satisfaction scores ($P = 0.003$, $\beta = -1.3$, Table 5). Furthermore, higher satisfaction scores were significantly correlated with higher scores of knowledge ($P = 0.002$, $\beta = 0.094$) and mothers' practice regarding their children ($P = 0.041$, $\beta = 0.099$, Table 6). The association between the knowledge score and mothers' practice regarding their children and themselves was not statistically significant ($P > 0.05$). Mothers of boys reported significantly higher scores in their self-care practice than mothers of girls ($P = 0.002$, $\beta = 0.99$).

Table 5. Mean and standard deviation of mothers' knowledge, mothers' practice regarding themselves, mothers' practice regarding their children, and satisfaction after the intervention in the storytelling and text-based education groups

Variable	Storytelling group	Text-based group	P value
Knowledge	Mean=34.71 SD=6.85	Mean=34.87 SD=6.80	0.898
Practice regarding themselves	Mean=8.65 SD=1.84	Mean=9.18 SD=1.76	0.348
Practice regarding their children	Mean=10.54 SD=5.05	Mean=10.32 SD=3.97	0.848
Satisfaction	Mean=14.85 SD=2.36	Mean=14.80 SD=2.49	0.935

Statistical analysis by the Mann-Whitney test.

Table 6. Generalized linear model of factors associated with the satisfaction score

Variable	β	Std. Error	95% confidence interval	P value
Mothers' education	-1.300	0.44	-2.1 to -0.45	0.003
Knowledge	0.094	0.03	0.033 to 0.154	0.002
Mothers' practice regarding themselves	-0.038	0.11	-0.269 to 0.193	0.700
Mothers' practice regarding their children	0.099	0.04	0.003 to 0.195	0.041
Age of mothers	0.023	0.037	-0.051 to 0.096	0.544
Gender of children	0.075	0.42	-0.760 to 0.910	0.860

DISCUSSION

This study assessed the effect of social media-based oral health interventions using storytelling and text-based education on mothers' knowledge, practice, and satisfaction with toddlers. Both interventions improved the participants' knowledge but only moderately enhanced their practice. Moreover, the mothers expressed high levels of satisfaction with both interventions.

Our results demonstrated that oral health education delivered through Instagram moderately impacted oral health practices. A study conducted in Thailand demonstrated significantly improved oral health practice scores among caregivers of children aged 6 to 36 months who received social media-based oral health education compared to traditional education [24]. However, it should be mentioned that the education period in their study lasted 6 months, but our follow-up period was only 2 weeks. Previous research has shown that more extended follow-up periods and reinforcement play crucial roles in the effectiveness of oral health education [25, 26].

The results of the present study showed a high level of satisfaction in both intervention groups. Since e-learning is flexible and can adopt various formats, it is often preferred over conventional methods, especially in situations requiring in-depth practical or contextual education [10].

The results of the present study demonstrated a significant correlation between the knowledge and practice scores and overall satisfaction. Oral health knowledge and the ability to manage one's health status give individuals a sense of empowerment [27]. A previous study found that social media can enhance empowerment in healthcare by influencing social support. Social support is a complex concept encompassing different types of assistance, such as advice and information, emotional backing, practical help, and social companionship [28]. This empowerment is significantly associated with healthcare consumers' satisfaction [29].

Our study found that mothers with higher levels of education had lower satisfaction

scores. This aligns with findings from other studies in Iran, which also reported lower satisfaction with health services among more educated individuals. This phenomenon may be attributed to their higher expectations from these services [30, 31]. A study evaluating user satisfaction with primary care in a small Brazilian city highlighted that a low level of education can impact how individuals perceive health problems. This low level of education may result in a compromised judgment of the care they receive [32].

Our findings indicated no statistically significant differences in knowledge, practice, and satisfaction scores between the two intervention groups. This result contradicts the findings of an earlier study on primary school girls in Yazd, Iran, which compared the effectiveness of indirect storytelling-based oral health education with the direct education method. The results also showed a significant increase in knowledge, attitude, and practice scores in the intervention group (storytelling education) compared to the control group (direct education) [33]. This may be attributed to the larger sample size, diverse age groups, and the fact that stories tend to be more engaging for children [34], and our participants were adult mothers.

Sarwer-Foner et al. [35] examined the effects of a conventional educational method on oral health behavior versus combining traditional techniques with digital technology. This study revealed no significant difference in toothbrushing frequency between the two groups. This contradicts the results of the present study, which showed that less than 30% of the participants' children brushed their teeth twice a day after an educational intervention via social media compared to the conventional education group. However, the frequency of dental flossing increased significantly in the mixed education group compared to the conventional education group in the study by Sarwer-Foner et al. [35]. Sarwer-Foner et al. [35] concluded that oral health education through social media can be effective in conjunction with traditional education. Therefore, while oral health education through social media may be

insufficient, its effectiveness can be enhanced when combined with traditional methods.

Strengths and Limitations:

Our study added to the current literature on oral health education for mothers of toddlers. It indicated that innovatively integrating traditional storytelling into modern technologies leads to enhanced acceptance and satisfaction with the educational approach. Nevertheless, this study had several limitations. The follow-up period in this study was relatively short. Therefore, it is recommended that future research consider longer follow-up periods and extended education durations and include children from different age groups and mothers of toddlers from diverse economic, social, and educational backgrounds. Furthermore, a post-test questionnaire was used in this study, and there were no baseline knowledge, practice, or satisfaction scores. Pretest questionnaires increase the chance of leading questions, leading to repeat testing bias [36]. Random allocation of the participants to the intervention groups had the potential to provide two similar groups in baseline characteristics [23].

While social media provides several benefits, research highlights distinct drawbacks, such as increased workload, expectation of a constant online presence, rise of unprofessional behavior, privacy violations, and a shift in the patient-practitioner relationship toward unprofessionalism [13]. While these disadvantages should be considered, the approach should not be rejected. The most effective strategy appears to be a balanced use of traditional and digital methods, utilizing the strengths of both approaches.

CONCLUSION

Oral health education via social media in storytelling and text-based forms can be considered a suitable approach to educate toddlers' mothers. However, to better impact knowledge and practice in oral health, it is essential to recognize its limitations and utilize it alongside traditional methods.

CONFLICT OF INTEREST STATEMENT

No conflict of interests to declare

GENERATIVE AI IN SCIENTIFIC WRITING

Artificial intelligence (AI) was not used in the preparation of this manuscript.

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