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Review Article

Oral health status and oral healthcare system in India: a narrative review

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ABSTRACT

India's National Oral Health Programme (NOHP) was launched in 2014 to strengthen oral health services, however, a consolidated evaluation of its implementation and progress remains limited. Therefore, we aimed to synthesize evidence on India's oral disease burden and oral health system progress (NOHP) from 2014 to 2025. A comprehensive search was conducted in PubMed, Embase, Google Scholar, and government websites (August-October 2025). We included all study designs, reports and programme documents (2014-25), excluding non-oral health and non-English/non-full text articles. Data extraction covered major dental conditions, and programme domains were mapped using WHO health-system building blocks. Findings were narratively summarised, NOHP'S funding mapped using QGIS 3.28, and study quality appraised using SANRA checklist. Dental caries prevalence ranged from 19.6% to 94% (mean DMFT/DMFT: 0.4-2.8). Gingivitis affected 46.6% of the population and periodontitis was 51% (≥15 years). Partial edentulism ranged 13.4-100% and the complete edentulism was 5.3-90.5%, with national estimates of 61.9% and 7.2% (≥45 years), respectively. Orofacial clefts occurred at a rate of 0.9 per 1,000 births, with 50-60% of cases being cleft lip and palate. India reported 143,759 new oral cancer cases in 2022 (ASR: 9.9/100,000). Programme improvements included PHC-level dental units, tobacco cessation centres, mobile-dental vans, screening collaborations (NTCP, NP-NCD, RBSK), school dental programmes and dental amalgam phase-down. Despite 3.7 lakh dentists, rural availability remains low (1:25000). Two Centres of Excellence and three National Resource Centres were established, alongside the national oral health policy draft. India has strengthened oral health services (OHS) under NOHP, yet gaps persist in coverage, funding, oral health information management system (OHIMS) and workforce distribution. Stronger primary-care integration, expanding preventive services and unified OHIMS are essential for equitable OHS.

Keywords: National oral health programme, Oral health system, India

INTRODUCTION

The world heath assembly's (WHA) 2023 oral health agenda outlines the 80-80-80-90-50 targets that countries should achieve-universal access to essential service, oral health services in primary care, operational national oral health policies, phase down of dental amalgam and policies to reduce sugar intake, respectively by 2030.[1] Yet oral health remains neglected globally despite its strong link between overall health, quality of life, and social well-being.[2] In India, oral diseases such as caries, gingivitis, periodontitis and oral cancer remains highly prevalent and contribute significantly to impaired quality of life, financial burden and premature mortality.[3,4]

Despite advances in dental education and private sector growth, access to affordable and equitable oral care in India remains limited, particularly in rural and underserved areas.[5-7] To address these gaps, the Government of India (GoI) launched the National Oral Health Programme (NOHP) in 2014-15 under the National Health Mission (NHM) to strengthen oral health promotion, prevention, and service delivery.[8] Since then, dental care units were established from primary health care (PHC) to district hospital level, along with financial support for manpower, equipment, capacity building and IEC (Information, Education and communication). Other key initiatives include, the establishment of Tobacco Cessation Centres (TCCs) in dental institutions, resource centres, piloting pit and fissure sealant programme, drafting of national oral health policy, formulation of revised operational guidelines, setting up of Mobile dental units, phasing down the use of dental amalgam and observance of World oral health day.[9] However, significant challenges persist, including limited-service delivery, uneven workforce distribution, inadequate financing, need for unified Oral Health Information Management System (OHIMS), and governance gaps.[6-10] Although India has achieved an optimal dentist-population ratio (~2.6:10000 vs. WHO's reference 1:7500), unequal distribution and low service utilization continue to limit effective oral health care access.[11] In this context, a comprehensive assessment of the burden of oral diseases in India is needed to document the current oral health status and also describe the performance of the oral health programme over the past decade (2014-25). Existing studies have focused on specific issues such as diseases prevalence and the service access gaps. To our knowledge, no review has examined the structural progress of India's oral health system since the launch of the NOHP. This narrative review addresses this gap by synthesizing evidence from published literature and publicly available reports, to access the current scenario, identify key challenges, and propose future recommendations.

Study design

Our narrative review focused on the evolution of oral health status and the system (NOHP) in India from its implementation in 2014 to 2025.

Search strategy

A comprehensive literature search was conducted across multiple databases (PubMed, Embase, google scholar, government website and reports) from August 2025 to October 2025. We used PICO framework to collect the evidence using key words (Table 1).

Table 1: Search strategy developed using the PICO framework.

Component	Description
PICO framework	Population (P): Indian population regardless of age and gender
	Intervention (I): Changes in the programs, or policies related to oral health implemented in India over the past decade
	Comparator (C): Oral health status and oral healthcare system in India (2014)
	Outcome (O): Current situation of oral health status and oral healthcare system in India (2025), including changes over the past decade
Search terms	"Oral health", "oral condition", "dental caries", "gingivitis", gum disease", "periodontal health", "periodontitis", "oral cancer", "oral habits", "oral health promotion", "health policy", "oral health system", "oral health coverage" and "India"

Inclusion and exclusion criteria

We included all study designs, national or regional health reports, and India's oral health related laws and regulations. Studies on Indian populations were included irrespective of age, gender or region. We excluded perspectives, commentaries, letter to the editor, conference abstracts, non-English literature articles without full text, and those not addressing oral health status or system.

Study selection

CS and KPO conducted the literature search, imported all records into Rayyan and duplicates were removed. Three independent reviewers (CS, KPO and SPA) screened title and abstract, followed by full text screening based on predefined eligibility criteria and discrepancies were resolved through discussion.

Data extraction and synthesis

The predefined extraction datasheet (Excel spreadsheet) was used to extract information from the included articles based on eligibility criteria. Key indicators included, prevalence of major dental conditions (caries, gingivitis, periodontitis, edentulism, cleft lift and cleft palate and oral cancer). Programme related domains were mapped using World Health Organization (WHO) health system building block framework (workforce and service delivery, health information system, financing including out-of-pocket expenditure (OOPE)) and the progress of NOHP (2014-2025). The findings were narratively summarized and NOHP's funding for the last four year

(financial year of 2022-2023 to 2025-2026) were visualized in a choropleth map using QGIS version 3.28.

The results were presented under two domains namely oral health status and programme level assessment since the implantation of NOHP in 2014, as outlined below.

Dental caries

Based on the eligibility criteria, 14 studies were conducted in India between 2014 and 2025, and the reported prevalence of dental caries ranged from 19.6% to 94% among adults aged ≥45 years (Nationwide survey) and preschool children (3-6 years, Ladakh).[12,13] Among children, prevalence varied from 25.8% in Chhattisgarh to 83.4% in Odisha.[14,15] The mean (SD) of DMFT/DMFT scores ranged from 0.4 to 2.8 (SD: 1.0-4.4), indicating considerable variation across age groups and geographical regions (Table 2).[16,17]

Gingivitis and periodontitis

Studies consistently showed that over half of the population had gingivitis and periodontitis (Table 3). The pooled prevalence of gingivitis was 46.6% (95% CI: 37.8-55.5) and periodontitis was 51% (95% CI: 41.9-60.1) among individuals aged ≥15 years, indicating gingivitis was more common among children and adolescents, and periodontitis was more prevalent among adults and older populations.[18-20]

Edentulism (partial and complete)

The prevalence of partial edentulism and complete edentulism ranged from 13.4 to 100% and 5.3 to 90.5%, respectively.[21,22] The Nationwide survey data indicated that partial edentulism was more than complete edentulism, with prevalence rate of 61.9% and 7.2%, respectively among older adults (≥ 45 years) (Table 4).[23]

Cleft lip/palate

The reported incidence of orofacial clefts in India was 0.9 per 1000 live births in 2022.[24] Across studies, cleft lip with palate was the most frequently observed anomaly (approximately 50-60% of total cases) followed by isolated cleft palate (20-30%) and cleft lip alone (15-25%).[25,26] The study conducted in Wardha, Maharashtra, provided a detailed classification, reporting that left unilateral cleft lip (30.8%) and palate (30.8%) was the most common type, followed by bilateral clefts (22.5%) and right unilateral forms (17.2%) (Table 5).[27]

Table 2: Prevalence of dental caries in India, 2014-2025.

Author and year	Study area	Age group (years)	Sample size (N)	Caries prevalence (N, %)	DMFT/DMFT/DEFT (mean±SD)
Subhojit et al 2025[12]	Nationwide	≥45	65562	12,871 (19.63)	NA
Prabakar et al, 2016[16]	Chandigarh	3-17	4493	2126 (47.3)	DMFT: 0.41±1.02 DFT: 1.06±1.20
		3-5	86	35 (40.7)	-
		5-10	2524	1419 (56.2)	-
		11- 5	1739	600 (34.5)	-
		15-17	144	72 (50)	-
Mohanty et al 2024[17]	Odisha	6-14	419	215 (60)	DMFT: 1.72±29 DEFT: 2.78±4.4
Tamchos et al 2025[13]	Ladakh	3-6	402	378 (94)	NA
Barjatya et al 2020[49]	Indore	3-5	640	410 (64.1)	NA
Nagarajappa et al 2020[50]	Bhubaneswar, Odisha	12-15	800	485 (60.6)	NA
Das et al 2019[15]	Odisha	General	1412	1177 (83.4)	NA
Sukumar et al 2025[51]	Tamil Nadu	>60	881	339 (38.5)	NA
Jeseem et al 2025[52]	Kerala	5-15	1158	NA	DMFT: 0.72±1.3 DMFT: 1.85±2.7
Sharma et al 2019[53]	Himachal Pradesh	2-6	2,859	1561 (54.5)	NA
Marya et al 2017[54]	Haryana	5-15	400	304 (76)	NA
Chevvuri et al 2022[14]	Chhattisgarh	Up to 6	360	93 (25.83)	NA
Chugh et al 2018[55]	Odissa	Up to 6	425	201 (47.29)	NA
Ragnenkar et al 2023[56]	Goa	3-5	386	181 (47)	DMFT: 2.0±2.9

NA: not available, SD: standard deviation, DMFT: decayed, missing, and filled teeth and deft: decayed, extracted, and filled teeth (deciduous).

Table 3: Prevalence of gingivitis and periodontitis in India, 2014–2025.

Author and year	Study area	Age group (years)	Sample size (N)	Prevalence N (%)	
				Gingivitis	Periodontitis
Subhojit et al 2025[12]	Nationwide	≥45	65562	NA	9323 (14.3)
Chacko et al 2023[58]	Kerala	20-79	1285 Rural: 725 Urban: 560	NA	644 (50) rural: 396 (61.4) urban: 228 (35.5)
Rekha et al 2020[59]	Karnataka	11-18	1340 rural: 670 urban: 670	1115 (83.2) 582 (86.9) 533 (79.6)	NA
Shishirendu et al 2022[60]	Nationwide	≥45	65562	7238 (11.1)	NA
Athar et al 2022[61]	Greater Noida	18-79	512	NA	418 (81.6)
Sujatha et al 2015[62]	Bangalore	30-60	40	NA	32 (80)
Kumar et al 2017[19]	Telangana	11-12	1539	1422 (92.40)	NA
Balraj et al 2024[20]	Urban and rural India	≥18	1049	NA	839 (80)
Chandrashekar et al 2020[63]	SRMA	≥15	92219	42974 (46.6) (95% CI: 37.8-55.5)	47301 (51) (95% CI: 41.9-60.1)
Vijayta et al 2014[64]	Bhopal	12-15	1100 Rural: 560 Urban: 540	Overall: 645 (58.2) Rural: (63.2) Urban: (54)	NA
Selvaraj et al 2021[65]	Tamil Nadu	>18	288	NA	121 (42)
Nidhi et al 2021[66]	Uttarakhand	6-19	1400	1120 (80.8)	NA
Sandip et al 2022[67]	West Bengal	20-64	2220	NA	2132 (96)
Gopalankutty et al 2020[68]	Kerala (tribal)	>20	360	264(73.3)	84.2% (95% CI 75.5 - 92.8)

NA: Not Available, CI: Confidence Interval, and SRMA: Systematic Review and Meta-Analysis.

Table 4: Prevalence of edentulism in India, 2014-2025.

Author and year	Study area	Age group (years)	Sample size (N)	Prevalence N (%)	
				Complete edentulism	Partial edentulism
Shishirendu et al 2022[23]	Nationwide	≥45	65562	4719 (7.22) (95% CI: 7.02-7.42)	40440 (61.87) (95% CI: 61.50-62.24)
Manimaran et al 2017[22]	Tamil Nadu	30-60	1000	NA	1000 (100) Kennedy's class I: 100 (10) kennedy's class II: 160 (16) kennedy's class III: 540 (54) kennedy's class IV: 200 (20)
Deepa et al 2019[69]	Uttar Pradesh	35-74	1200	Overall: 64 (5.3) Rural: 32 (5.8) Urban: 29 (4.8)	Overall: 621 (51.8) Rural: 315 (52.5) Urban: 306 (51)
Vaddi et al 2024[70]	Tamil Nadu	>60	437	44 (10.1)	316 (72.3)
Ranjana et al 2025[21]	Puducherry	> 60	328	297 (90.5)	253 (13.4)
Satvika et al 2025[71]	Haryana	18-60	507	137 (27.02)	370 (72.98)
Javed et al 2017[72]	Tamil Nadu	18-80	3000	NA	1462 (48.7)
Sen et al 2018[73]	Maharashtra	35-74	500	110 (22)	390 (78)
Bharman et al 2022[74]	Assam	20-40	1540	Overall: 471 (30.6) Rural: 227 (29.7) Urban: 242 (31.4)	

Table 5: Community- and hospital-based studies on cleft lip and palate in India, 2014-2025.

Author (year)	Study area	Setting (community/ hospital)	Age group (years)	Sample size (N)	Incidence / prevalence (N, %)	Classification details	Side-wise distribution (N, %)
Dara et al (2022)[24]	Chandigarh	Hospital	Infants	48	0.97/1,000 live births	Group 1:8 (16.6%) Group 1(A): 10 (20.8%) Group 2(A): 28 (58.3%)	Left-sided: 15 (46.9%) Right-sided: 13 (40.6%)
Vinus et al (2023)[75]	Wardha, Maharashtra	Hospital	NA	1600	NA	-	Right unilateral cleft lip and palate: 224 (17.2%) Left unilateral cleft lip and palate: 401 (30.8%) Bilateral cleft lip and palate: 294 (22.5%) Cleft of right lip and alveolus: 78 (5.9%) Cleft of left lip and alveolus: 114 (8.7%) Cleft of both lips and alveolus: 27 (2.1%) Cleft palate only: 103 (7.9%) Cleft of anterior hard palate: 5 (0.4%) Cleft of only soft palate: 20 (1.5%) Cleft of only uvula: 6 (0.5%) Cleft of soft palate and uvula: 20 (1.5%) Cleft of orofacial region: 8 (0.6%)
Datta et al (2025)[76]	Bihar	Hospital	<5 years	100	NA	Group I: cleft lip (n=18) Group IA: cleft lip and alveolus (n=6) Group II: cleft palate (n=46) Group III: cleft lip with cleft palate (n=30)	Unilateral cleft lip (n=14) Bilateral cleft lip (n=2) Unilateral cleft lip and alveolus (n=6) Complete cleft palate (n=10) Unilateral cleft palate (n=4) Bilateral cleft palate (n=6)
Vijaya et al (2017)[27]	Andhra Pradesh	Hospital	≤15	137	NA	NA	Right side: 17 (12.4%) Left side: 23 (16.8%) Middle:16 (11.7%) Both side: 51(37.2)
Vijay et al (2019)[25]	Himachal Pradesh	Hospital	Up to 40	926	NA	Cleft lip and palate: 486 (52.5%) Cleft palate: 243 (26.2%) Cleft lip:197 (21.3%)	Isolated cleft palate: 226 (24.4%) Left-sided cleft lip with palate: 209 (22.5%) Bilateral cleft lip with palate: 157 (16.9%) Right-sided cleft lip with palate: 120 (12.9%) Left-sided cleft lip only: 115 (12.4%) Right-sided cleft lip only: 60 (6.5%) Bilateral cleft lip only: 22 (2.4%) Submucous cleft palate: 17 (1.8%)

Continued.

Author (year)	Study area	Setting (community/ hospital)	Age group (years)	Sample size (N)	Incidence / prevalence (N, %)	Classification details	Side-wise distribution (N, %)
Prabakaran et al (2019)[26]	Salem, Tamil Nadu	Hospital	1-9	1643	NA	-	Primary cleft palate: 492 (29.9%) Primary lip nose, unilateral: 458 (27.9%) Lip nose revision: 298 (18.2%) Alveolar bone graft: 137 (8.3%) Primary lip nose, bilateral: 94 (5.7%) Fistula repair: 87 (5.4%) Primary lip nose, unilateral + primary cleft palate: 29 (1.8%) Secondary cleft palate: 21 (1.3%) Other procedures: 16 (1.0%) Primary lip nose, bilateral + primary cleft palate: 7 (0.4%) Fistula repair + alveolar bone graft: 2 (0.1%) Primary lip nose, unilateral + other: 2 (0.1%)
Shaikh et al (2020)[77]	Gujarat (tribal population)	Community	NA	496	NA	NA	Unilateral cleft lip, (n=223) Total patients: (n=223) Tribal patients: (n=158) Bilateral cleft lip, (n=57) Total patients: (n=57) Tribal patients: (n=27) Lip revision, (n=4) Total patients: (n=4) Tribal patients: (n=0) Cleft palate – total vs tribal population Group 3 palate (cleft lip and palate), (n=102) Total patients: (n=102) Tribal patients: (n=40) Group 2 palate (isolated cleft palate), (n=82) Total patients: (n=82) Tribal patients: (n=38) Overall palate cases, (n=184) Total patients: (n=184) Tribal patients: (n=78)

Oral cancers

Data from the National Cancer Registry Programme (NCRP), covering 29 population-based cancer registries (PBCRs), showed the highest oral cancer incidence in central India (Bhopal), with 64.8% in males and 37.2% in females (70 years), followed by the western and northeastern regions (58.4%) (60 years).[28] Tongue cancer was the leading subsite, highest among northern males (58.4%) (60-69 years) and northeastern females (37.2%) (70-75 years).[28]

The hospital-based registries reported 70,793 oral cancer cases (74.8% of males). The highest incidence of tongue cancer occurred among males aged 45-49 years (13.9%) and females 50-54 years (15%).[29] The world Cancer Research Fund (2022), reported 143759 new oral cancer cases, with age-standardized incidence rate (ASR) of 9.9 per 100,000 (male:14.7; female: 5.0).[30]

The projections estimates lip and oral cancer in men will rise from 131,414 (2026) to 163,224 (2036).[31] A recent systematic review and meta-analysis (SRMA) reported pooled prevalence of leukoplakia (6.7%), oral submucous fibrosis (4.5%), lichen planus (7.5%), erythroplakia (2.5%), palatal lesions in reverse smokers and nicotine palatini (11.5%).[32]

Health workforce and care delivery

A total 32 state dental councils compile report says, India has 3.7 lakhs registered dentist as of 2025.[33] Despite having over 300 dental colleges producing ~30,000 BDS graduates annually, the workforce distribution remains highly inequitable, with high concertation in urban areas. India requires ~1.86 million dentists to serve its 1.4 billion population, the rural dentist-population ratio remains challenging (ranges from 1:250,000 to 1:50,000).[33-35] In India, dental care service are delivered through both the government (Figure 1) and private sector (PS). However, the PS continues to dominate curative services, while preventive and promotive oral healthcare service remains weak within the public health system.

Health information systems

India is gradually strengthening its oral health information system. The national platform eDantSeva, launched by CDER-AIIMs and Ministry of Health and Family Welfare (MoHFW), mainly serves as an educational and facility mapping tool rather than a real time data system. In 2021, under Ayushman Bharat Digital Mission (ABDM), the Ayushman Bharat Health Account (ABHA) IDs were piloted in selected Union Territories to enable sharing of digital health records, including dental data and later expanded nationwide.[36]

Several institution-based systems such as the Dental Health Informatics System (DHIS) and private platforms (denSMART and Dentobees) focus on clinical or academic record-keeping but lack national integration. India's PBCR and Hospital-Based Cancer Registry (HBCR) under ICMR-National Centre for Disease Informatics and Research (NCDIR) provides essential oral cancer incidence, and outcome data.[29-37] The only national oral health survey was conducted in 2002-03 by the Dental Council of India (DCI) and MoHFW (Ministry of Health and Family Welfare), with no subsequent national surveys.[38] However, LASI Wave-1 (2017–19) provides national estimates on tooth loss and periodontal disease among older adults.[39]

Health financing (NOHP)

The NHM's (National Health Mission's) funding for the NOHP from 2022-23 to 2025-26 showed moderate variation across states (Figure 2).[40] Total allocation increased from rupees 83.6 crores in 2023-24 to 130.3 crores in 2024-25, followed by a slight decline to 119.1 crores in 2025-26, the four years, Andhra Pradesh, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu and Uttar Pradesh consistently received higher allocations than other states. Among the Union territories, Delhi received highest funding, followed by Jammu and Kashmir, Ladakh Lakshadweep and Puducherry, indicating stable financial support of oral health activities under NHM (Figure 3).

Out of pocket expenditure

Indian government spending health expenditure of GDP (Gross Domestic Product) increased from 1.13% to 1.84% and general government expenditure on health increased from 3.94% to 6.12% of g between 2014-15 and 2021-22, respectively.[41]

Despite reduction in the out of pocket expenditure (OOPE) from 62.6% in 2014-15 to 39.4% in 2021-22, studies showed about 50% of people still avoid dental treatment due high cost, which ranges from INR (Indian Rupee) 2000-5000 per person (Table 6).[42-44]

Progress of the NOHP (2014–2015)

The NOHP launched in 2014 its Initial phase, focused on establishing the basic infrastructure for service delivery by setting up dental care units at selected district and sub district level.[45] IEC materials were also developed and disseminated to promote the oral hygiene among school children and communities. Common procedure provided in public health facilities includes oral health counselling, scaling, restorations (temporary or permanent fillings, pit and fissure sealants), extractions, and minor surgical procedures.[9] Other major procedures are usually carried out at tertiary care level such as root canal treatments, teeth alignment (orthodontic corrections), prosthetic rehabilitation for missing teeth and oral and maxillofacial surgeries.[9]

The NOHP collaborates with other national health programmes by addressing shared risk factors of oral and non-communicable disease (Figure 4). It works with the

National Tobacco Control Programme (NTCP) to establish Tobacco Cessation Centres (TCCs) in dental institutions and NOHP's dental units to provide tobacco cessation counselling.[9] It also partners with National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) for oral cancer screening and sugar-reduction counselling in NCD clinics.[9] Under school health programme of Rashtriya Bal Swasthya Karyakram (RBSK), children are screened for dental caries and congenital oral conditions (cleft lip and palate).[46] Several states including Puducherry, Delhi, Karnataka and Andhra Pradesh, operate mobile dental vans to deliver preventive and curative services in underserved rural areas. Capacity-building initiative for dental surgeons, programme managers, and auxiliary staff have also been conducted to strengthen preventive and promotive services.[47] In states such as Gujarat and Kerala, oral health counselling has been integrated into MCH services (Maternal and Child Health programme) under RMNCAH+N (Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition) framework, with antenatal clinics educating pregnant women on oral health and its implications for maternal and neonatal outcomes.[48] Monitoring and evaluation (ME) are conducted at district and state levels by designated NOHP nodal officers using standardized reporting from PHCs, CHCs, District Hospitals and state NOHP cells to assess performance, service delivery, quality assurance, and gaps.9Under NOHP, two Centre of Excellence (CoEs) and three National Resource Centres (NRCs) were established to strengthen the oral health research, training and service delivery in India.[9] The CoEs includes the National Centre of Excellence for the Implementation of NOHP by Centre for Dental Education and Research-All India Institute of Medical Sciences, which supports programme planning, implementation, monitoring and provides technical guidance to states, and the National Institute of Research and Referral for Higher Dental Studies (NaRRIDS), New Delhi, which serves as an apex centre of advanced dental research, specialised referrals, clinical training and development of evidence-based guidelines.[9]

The three NRCs are the National Resource Centre for the Oral Healthcare of Children and Elderly, PGIMER (Postgraduate Institute of Medical Education and Research), Chandigarh, focusing on training, research and clinical protocol for paediatric and geriatric care; the National Resource Centre for Oral Potentially Malignant Disorders (OPMDs), Lady Hardinge Medical College (LHMC), New Delhi, which specialises in capacity building for early detection, diagnosis and management of OPMDs; and the National Resource Centre for Tobacco Cessation and Oral Health (NRC-OH-TC), MAIDS (Maulana Azad Institute of Dental Sciences), New Delhi, which provides technical supports for tobacco cessation service, develop counselling protocols, trains providers and promotes integration of cessation service with oral health care.[9]

Quality assessment

We assessed the methodological quality of the narrative review using the Scale for the Assessment of Narrative Review Articles (SANRA). Each of the six items was rated on a 0–2 scale (maximum 12). Our review fulfilled all six items with a total score of 12, indicating high methodological rigor.

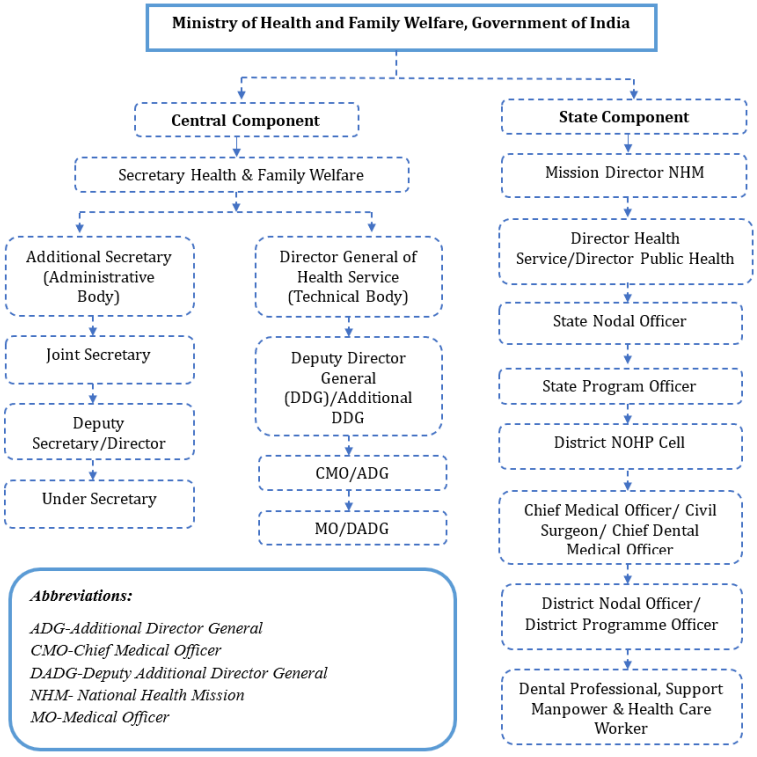

Figure 1: Organisational structure of NOHP.

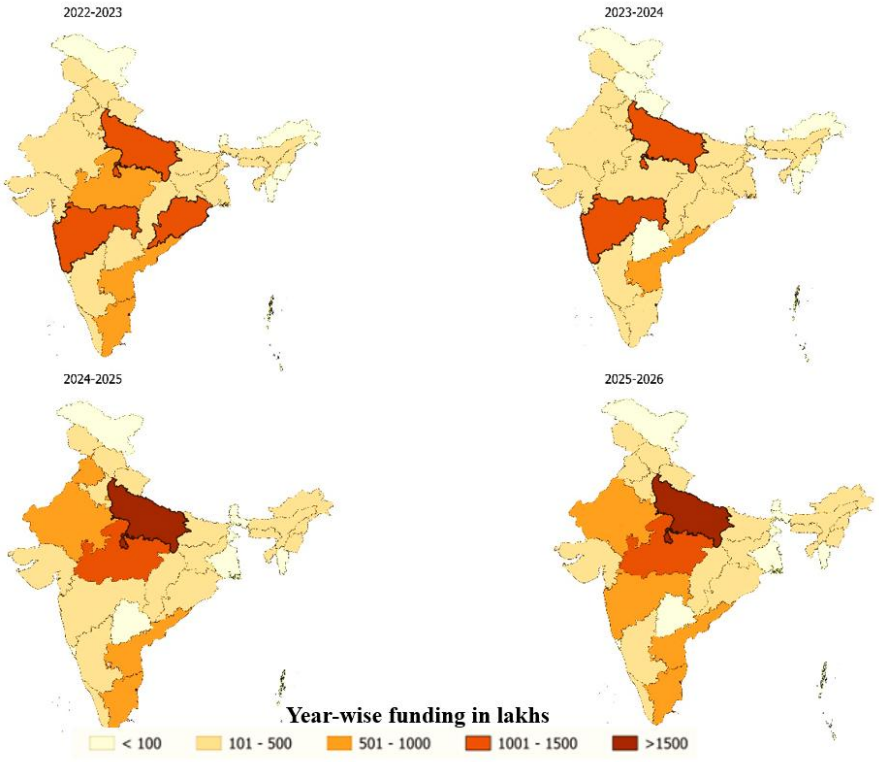

Figure 2: Year-wise funding received under the national oral health programme, 2022–2026 (in lakhs).

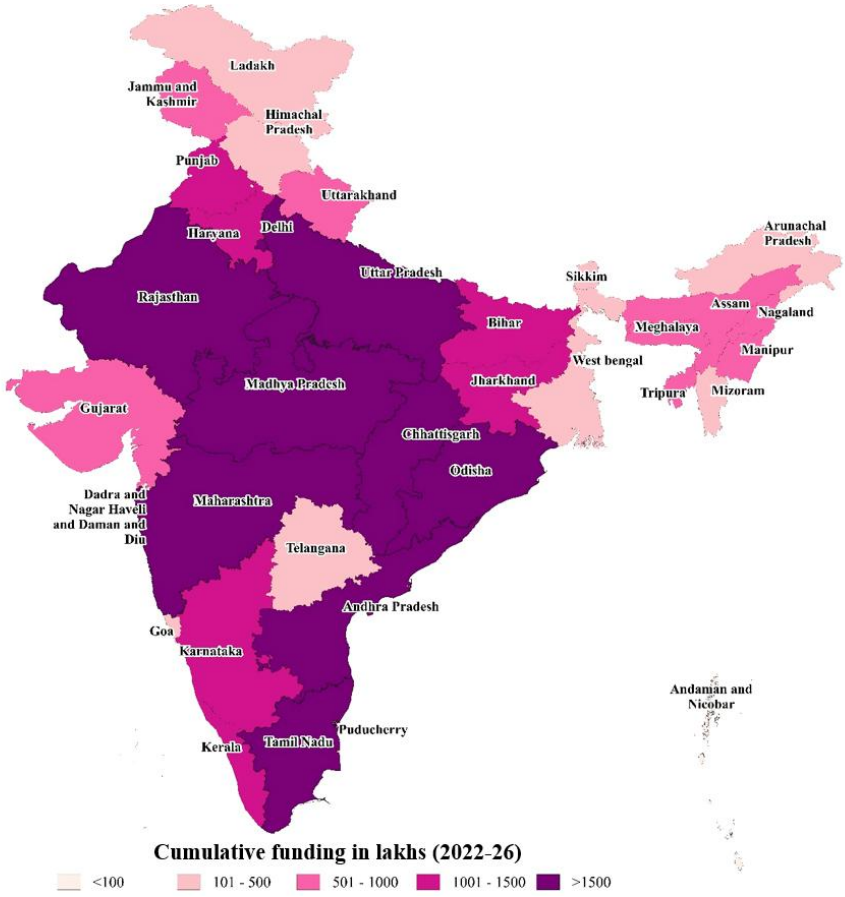

Figure 3: Cumulative funding received under the national oral health programme, 2022-2026 (in lakhs).

Table 6: Out-of-pocket expenditure and catastrophic dental health expenditure related to dental conditions in India.

Author (year)	Study area	Study population	Age group (years)	Sample size (N)	Proportion of OOPE/CDHEN (%)	Expenditure on oral health care
Meenal et al (2013)[78]	Tamil Nadu	Adults people visiting public and private sector	≥18	500 public (n=250) Private (n=250)	OOPE Public (median INR ~ 100) Private (median INR ~ 1825)	Public sector: free of cost private sector: INR ~5488.2/year (the total costs of dental care in the private sector in a year were 50 times greater than the cost spent by the patients in public sector.)
Verma et al (2018)[44]	Chhattisgarh	Head of the household	NA	860	OOPE- mean±SD: INR 2254.28±4868.01	Annual expenditure on dental care (oral hygiene aids+ dental treatment) for the last one year Mean±SD: INR 4368.16±5140.31
Nobelika et al (2020)[43]	Tamil Nadu	Sanitary workers	≥18	246	CDHE -15.4%	Money spent on dental care (past 1 year): 67.5% did not spend on dental care (not applicable). 94.3% spent less than ₹1000. 0.4% spent ₹1000–₹5000. 5.3% spent more than ₹5000. Money spent on dental medication (past 1 year): 83.3% spent less than ₹500. 5.7% spent ₹500–₹2000. 11.0% spent more than ₹2000.
Syamkumar et al (2022)[42]	Kerala	General	NA	500	OOPE Mean±SD: INR 2500±4868	INR: ~2500±4868 (per person and/or family member in last 1 year)

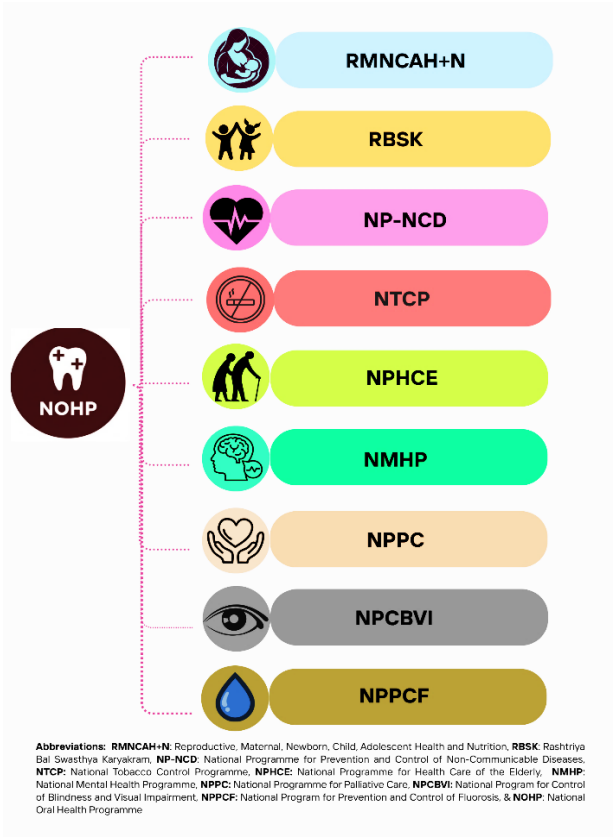

Figure 4: Collaboration of the national oral health programme with other national programme.

DISCUSSION

The current review synthesizes evidence from national and regional published literature (2014-25), government reports and website, showing substantial variation in the burden of oral diseases across the states, age groups, and genders. Evidence remains fragmented and outdated, with no national oral health survey conducted after 2002-03, indicating urgent need for a comprehensive nationwide survey covering all the states and union territories to accurately estimate the disease prevalence, treatment seeking behavior and service delivery patterns across the healthcare levels (Sub-centers, PHCs, CHCs, DHs). Gaps in routine data systems were also identified. Although selected dental indicators are included in HIMS and platform such as eDantSeva exist, reporting remains inconsistent and fragmented across public, private and institutional providers. Establishing a unified digital repository (OHIMS) or expanding mandatory reporting through eDantSeva, would enable the systematic recording of services including best practices, resource utilization, and facilitate periodic monitoring by a National Steering Committee. Strengthening the referral and tracking mechanism, particularly for oral cancer from PHCs to higher centers, would further improve the continuity of care. To improve the oral health awareness and programme visibility, days/ months of oral health importance can be observed across India. Several positive developments under NOHP were observed, including the establishment of dental units, TCCs, mobile dental vans, and collaboration with national programmes such NP-

NCD, NTCP, and RBSK (Figure 4). The pit and fissure sealant pilot programme can be evaluated and scaled nationally to reduce the childhood caries. National or regional resource centres for other areas of oral health can be established across the country. Despite India having more dentist than the WHO recommendation, workforce distribution remains highly inequitable across urban-rural settings. Creating equitable dental workforce across the regions and dedicated dental surgeon post at all healthcare levels as per the IPHS (Indian Public Health Standards) norms, supported by trained auxiliary staff would strengthen the primary level oral health care services, including oral health education, tobacco cessation counselling and periodic capacity building. Posting of dental specialists at district level facilities can improve the range of advanced oral healthcare services.

Although funding allocation to NOHP have increased gradually, state-level variability persists. Consistent financial support is needed to expand services in underserved regions, including mobile dental vans and public private partnerships. Outsourcing denture fabrication to accredited labs and collaborating with NGOs can improve the access to rehabilitation service and reduce the OOPE, which remains high for dental care. As per World bank data, India's total health expenditure (3.31% of GDP) remains low and OOPE (45.98%) moderately high compared with other South Asian countries, suggesting limited financial risk protection for dental service. While certain secondary and tertiary dental procedures are covered under schemes such as PM-JAY (Pradhan Mantri Jan Arogya Yojana), comprehensive oral health insurance is still lacking.

Programme monitoring and evaluation remains limited at national and state levels, emphasising the need for regular programme evaluation to track progress and identify gaps, accompanied by region specific action plans, undertaking implementation researches and Health Technology Assessments. Standardized School Dental Health programme guideline with clear achievable goals, objectives and service package are also required for uniform implementation. Release of Oral Health Policy and the development of an implementation framework for NOHP are essential to strength the programme and to achieve WHA's targets. Formation of state advisory bodies by identifying state-level leaders from public health institutions, dental and medical colleges to work in collaboration with the NOHP state nodal officer can further facilitate regional momentum. Integration with other national programmes should be expanded to build on existing collaboration and maximise the shared risk-factor approaches.

Strength and limitation

The strengths of this review is this being the first attempt to systematically examine India's oral health system progress since the launch of the NOHP utilizing evidences from both peer-reviewed studies and government reports. It adopts a comprehensive scope by covering both oral disease burden and health system framework of the programme. Furthermore, the use of the PICO framework and SANRA quality assessment adds to the methodological rigor and reliability of the findings. However, certain limitations must be acknowledged. As a narrative review, the findings are subject to publication bias and may not capture all unpublished programme evaluations. In addition, the lack of nationally representative data on burden of disease and other data limits the ability to quantify exact changes in prevalence over time. Considerable variability in state-level implementation and reporting also makes it difficult to generalize findings across the country.

CONCLUSION

Overall, this review indicates that India has made meaningful progress in strengthening its oral health services through NOHP, yet significant gaps persist in service coverage, data systems (reporting and monitoring), funding, workforce distribution, and programme governance. Strengthening the integration of oral health in primary care, expanding preventive, curative and rehabilitative services, improving financial protection, developing unified data sharing and monitoring system (OHIMS) are essential for achieving equitable and affordable oral health, there by meeting the national and global targets by 2030.

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