Mobile Dental Clinics as a Strategy for Adolescent-Health in India: A Systematic Review of Accessibility, Feasibility, and Health Outcomes

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Abstract

Background: Oral health problems, such as dental caries, gingivitis's, malocclusions, and complications due to poor oral hygiene practices, are a significant burden in the adolescent population of India. Despite the high prevalence of these preventable conditions, lack of access to dental facilities persists particularly in rural regions, urban informal settlements, and socioeconomically disadvantaged communities. In response to these gaps, mobile dental clinics have been introduced in India as an outreach-oriented service delivery approach intended to extend oral healthcare access to under-served adolescent populations (Petersen, 2018; Peres et al., 2019; World Health Organization, 2022).

Objective: This review aims to systematically examine existing evidence on mobile dental clinics as an adolescent-health strategy in India, with particular emphasis on access to care, delivery of preventive services, feasibility of implementation, and observed health-related impacts among adolescents.

Methods: A systematic narrative review of peer-reviewed literature, programmatic evaluation literature, and policy literature from the years 2000 to 2025. The literature search was conducted on the following sources: the PubMed/www.PMC.org search engine, peer-reviewed literature indexed on Scopus publications, and literature on the Government of India health programs. Eligible materials described mobile dental clinic initiatives implemented in India with relevance to adolescents or school-based populations. Given substantial heterogeneity in study designs, interventions, and outcome measures, findings were synthesized thematically using a qualitative approach.

Results: The reviewed evidence suggests that mobile dental clinics improve accessibility of oral health screening and basic dental care for adolescents, especially within the school and community settings. School-based mobile dental clinic programs had high levels of oral health screening, increased detection of undiagnosed oral problems, enhanced oral health awareness, and positive acceptability among the adolescents (Jain et al., 2023). Economic and operational assessments conducted within the Indian settings suggest that mobile dental clinics are indeed economical and logistically feasible, especially when integrated within dental colleges and government health programs (Chavan et al., 2021; Bala et al., 2023). However, certain issues continued to exist, such as lack of continuity of care, incomplete referral follow-up, workforce constraints, and concerns regarding long-term sustainability (John et al., 2023; Patil et al., 2016; Kotha et al., 2018).

Conclusions: Mobile dental clinics are an important part of strategies for adolescents and for improving access to preventive and primary oral health care. They can be most effectively implemented as part of school health care programs and can be beneficial with proper referral services and aligned with existing public health infrastructure. Future research and scaled-up

efforts can be improved with better evaluation strategies and focusing on outcomes for adolescents (Ministry of Health and Family Welfare, 2018; Ministry of Education, 2018).

Keywords: mobile dental clinics, adolescents, oral health, India, school health, access to care

Introduction

Perhaps one of the most vital ages in the human life cycle is adolescence. This age is characterized by rapid bodily development and maturation. Practices and behaviors that take root during this age tend to extend into later life. Yet one area of human concern and well-being—the concern for oral health—is either overlooked in discussions and policies pertinent to the welfare and health of adolescents. This neglect tends to occur despite the established relationships between oral health and nutrition, communication, socialization, self-esteem, and quality of life. Oral health problems during adolescence have the potential to create short- and long-run morbidity (Kumar et al., 2018; Sheiham, 2006).



Fig. 1. Conceptual illustration representing oral health care delivery supported by mobile and technology-enabled service platforms.

In the Indian scenario, a lot of adolescent morbidity exists and relates to oral health, and it primarily includes untreated cases of dental caries, periodontitis, malocclusion, and many other disorders related to improper practices related to oral health and hygiene. In reality, these cases associated with oral health in many adolescents remain either unidentified or undertreated until they reach severe stages and have significant subsequent sequelae like pain, infections, and disabilities, which affect basic day-to-day functioning like eating, speaking, and sleeping, and also related to learning and education among school-going adolescents, as lack of concentration related to oral health troubles has been implicated among them.

In addition to having physical expressions, oral health problems in youths may have serious psychosocial undertones. Dental appearance, misalignment, and visibly untreated disease can influence self-image, peer interactions, and social participation. Since adolescents experience greater sensitivity in matters pertaining to looks and acceptance, it is likely that any oral health conditions will impact on embarrassment, stigma, or staying away from social gatherings. These psychosocial dimensions further underscore the importance of addressing oral health as a central component of adolescent health rather than as a narrowly clinical issue.

Despite the preventable nature of many oral diseases, there is limited use of dental care among Indian adolescents. A range of structural and systemic barriers contributes to this pattern. Geographic inaccessibility of dental facilities continues to be a major constraint, particularly in rural areas, tribal regions, and densely populated urban settlements with limited public services. The dental structures provided by the Indian government are dispersed mostly in urban areas. On the contrary, while the number of dental setups in India is high, especially in urban areas, they are inaccessible to many Indians who are considered low-class because of high costs and inaccessibility. Consequently, routine preventive dental visits are uncommon among adolescents, and care is often sought only in response to acute symptoms (Gambhir et al., 2014; Prinja et al., 2015).

Financial considerations add to the hurdles that exist in accessing oral care. In India, dentistry is supported through out-of-pocket payments, and oral health is still not covered under government-funded schemes for health. For poorer segments, oral health is considered low on the list after many other priorities. This has led to a delay in diagnosis and worsening of oral disease in adolescents.

A further challenge lies in the limited integration of Oral health care when it comes to the health of the adolescents. Since the school environment is an optimal setting for the implementation of health initiatives among the population of the youth, the preventive dental screening and oral health carries out the health initiative sometimes through conducting health awareness campaigns. Additionally, the aspect of little knowledge on the importance of dental health among the youth contributes to reduced demand for the health initiative of oral health care.

Collectively, these details indicate an obvious divide between the needs of orals health for the age group in the country and the delivery of the same in India. To cater to the needs of closing the divide in the above area, there has been an emerging trend towards outreach approaches.



Fig. 2. Conceptual framework illustrating key barriers to healthcare access, including knowledge gaps, geographic isolation, cost constraints, cultural practices, trust deficits, language barriers, and provider-related factors.

The mobile dental clinics could be one such model that has come up. These clinics are basically fully equipped vehicles that possess the capability to provide basic dental care. These dental clinics have the intention to take dental health to schools and communities. Mobile dental clinics have the versatility to conduct health screening procedures for teeth. These dental clinics are capable of performing basic curative procedures for dental problems. These clinics particularly suitable for adolescent populations with limited prior exposure to dental care (Patil et al., 2016; Kotha et al., 2018; Bashir et al., 2020).

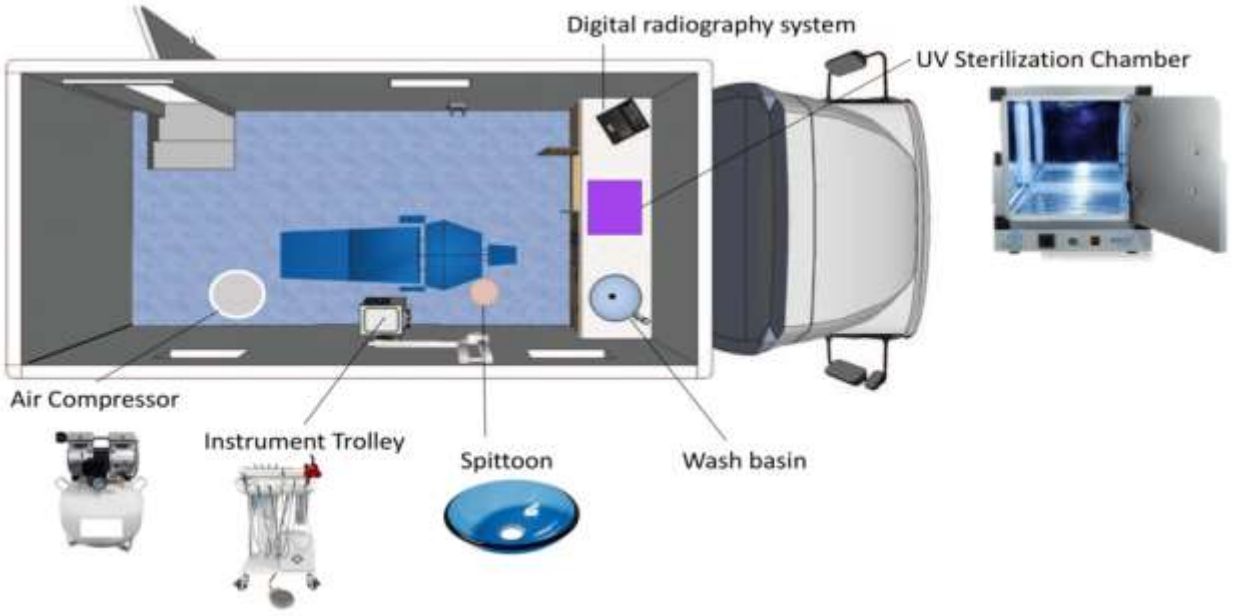


Fig. 3. Conceptual representation layout of a mobile dental clinic showing diagnostic, treatment, and infection-control components, including radiography, sterilization, and patient care areas.

The deployment of mobile dental clinics aligns with public health principles emphasizing accessibility and equity. The fact that it delivers services within schools or communities means that it reduces the concept of indirect costs for families. Additionally, it is crucial since it aids in achieving a high coverage rate since it provides services to adolescents within schools. It should be noted that in some Indian environments, the dental clinics are the first encounter for adolescents when it comes to accessing oral healthcare (Kshirsagar et al., 2025; Bala et al., 2023).
In terms of adolescent health, there are some other benefits provided by the mobile dental clinics. The adolescent phase is a significant phase in which health education and counseling can play a profound role because, at this age, the person starts taking more significant decisions in terms of health. Oral hygiene practices, diet, and staying away from harmful substances are some aspects in which the mobile clinics impart training while running these dental programs.

Mobile dental clinics have been established in India under various institutional settings such as dental colleges, government health departments, NGOs, and public and private partnerships. The range of services and intensity might differ according to the intent and availability. Even though mobile clinics have been recognized to be a promising new endeavor for improving oral health care access, there exist certain concerns about long-term feasibility and health outcomes for adolescents.

Currently available literature on the effectiveness of mobile dental clinics for adolescents in India varies in many ways. The literature includes descriptions of projects undertaken for these adolescents, as well as some evaluative studies. However, despite the effectiveness of individual projects aimed at these people, there are no concrete indicators available to determine the effectiveness of these projects as a strategy for the health of these adolescents. This is partly due to a lack of focus on specific indicators for these groups.

In the context of increasing focus on the health of adolescents being incorporated into the health policies of the country, it is important to critically assess the impact of the mobile dental clinics within the same context. It is important to understand the contribution that the clinics make to the issues of accessibility, prevention, viability, and health outcomes within the context of the group. At the same time, it is important to identify the operational issues that affect the same.

In this context, this systematic review seeks to summarize current available evidence on mobile dental clinics as an approach for adolescent health in India. The review will target its focus on how this aspect works in ensuring oral health accessibility, preventive education, feasibility in India, and overall outcomes associated with health. By consolidating available evidence and identifying gaps, this review seeks to inform program design, policy integration, and future research directions related to adolescent oral health in India.

Methods

Study Design

This study was conducted as a systematic narrative review (non-meta-analysis) in accordance with conference-level academic requirements. A narrative synthesis approach was selected due to the substantial heterogeneity across study designs, intervention models, outcome measures, and reporting formats within the available literature on mobile dental clinic initiatives in India. The review aimed to synthesize qualitative and descriptive evidence related to access, service delivery, feasibility, and health-related outcomes among adolescent populations rather than to quantify pooled effect estimates (Craig et al., 2008; Peters et al., 2013).

Data Sources and Search Strategy

A structured and comprehensive literature search was undertaken to identify relevant studies published between **January 2000 and March 2025**. The following sources were systematically searched:

- PubMed/PMC

- Scopus-indexed peer-reviewed journals
- Guidelines, policy documents, and programmatic reports from Government of India health initiatives

Search strategies were adapted to each database and included combinations of the following key terms and their variants:

- "Mobile dental clinic" OR "mobile dental van"
- "Adolescent" OR "school children" OR "youth"
- "India"
- "Oral health outreach" OR "school dental program"

Boolean operators and keyword combinations were used to maximize retrieval sensitivity while maintaining relevance. In addition, the reference lists of all included articles were manually screened to identify further eligible studies that may not have been captured through database searches.

The overall process of literature identification, screening, eligibility assessment, and inclusion is illustrated in **Fig. 4**.

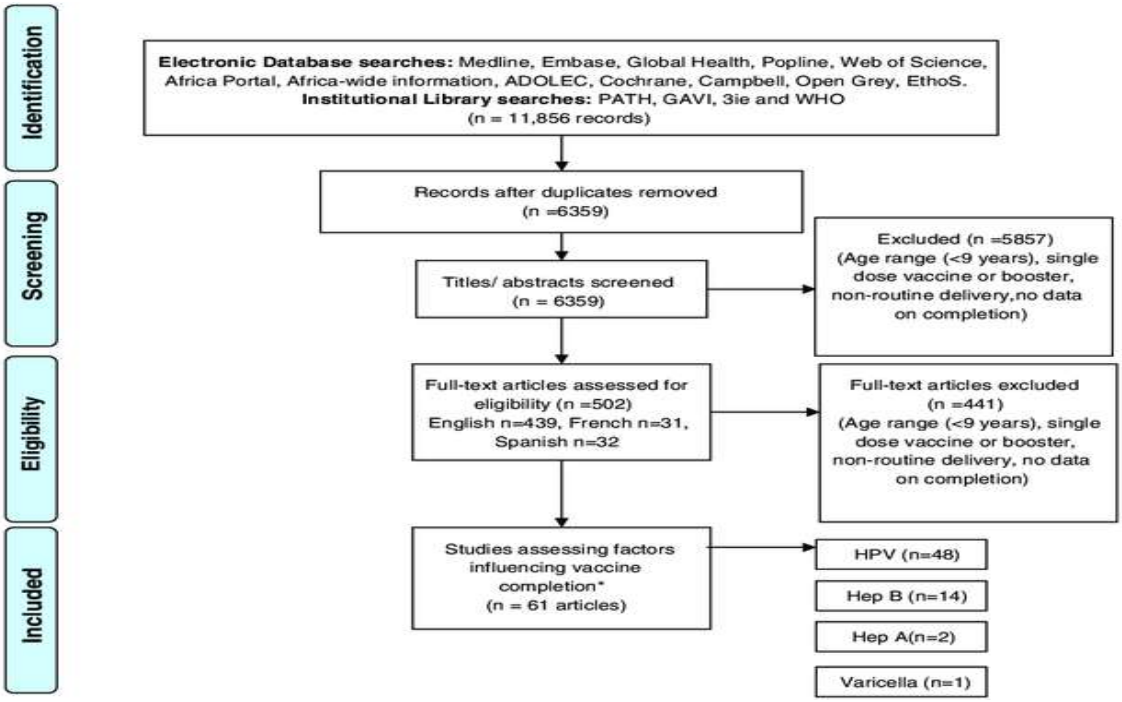


Fig. 4. Conceptual literature search and study selection workflow used in the systematic narrative review of mobile dental clinic interventions.

Inclusion Criteria

Studies and reports were included in the review if they met the following criteria:

- Conducted within the Indian context
- Described mobile dental clinics or van-based dental service delivery models
- Targeted adolescents or school-going populations (aged 10–19 years or school-enrolled children)
- Reported outcomes related to at least one of the following domains:
    - Access to dental care
    - Screening and early detection
    - Preventive or educational interventions
    - Basic curative services
    - Feasibility, acceptability, or operational considerations

Both peer-reviewed publications and relevant programmatic or policy documents were considered to capture a broad range of implementation experiences.

Exclusion Criteria

Studies were excluded from the review if they met any of the following conditions:

- Focused exclusively on adult populations
- Were opinion pieces, editorials, or commentaries without program descriptions
- Were case reports lacking evaluative or outcome-related data
- Did not involve mobile or outreach-based dental service delivery

These exclusion criteria were applied to ensure relevance to adolescent oral health and to maintain consistency in the scope of the review.

Data Extraction and Synthesis

Data from included studies were systematically extracted using a structured framework. Extracted variables included:

- Geographic setting (urban, rural, or mixed)
- Characteristics of the adolescent target population
- Types of services provided (screening, preventive education, preventive care, basic curative care, referral services)
- Reported outcomes related to access, awareness, service utilization, feasibility, and operational challenges

Given the diversity of study methodologies and outcome reporting, a **thematic synthesis approach** was employed. Findings were grouped into key thematic domains, including access to care, preventive and educational service delivery, feasibility and operational viability, alignment with school and adolescent health platforms, and system-level challenges. Quantitative pooling and statistical meta-analysis were not undertaken due to heterogeneity and inconsistent outcome definitions across studies.

Results

Overview of Included Evidence

The body of evidence considered here encompasses a broad spectrum of initiatives involving mobile dental clinics that have been undertaken in various settings within India. The literature considered for this review encompasses studies and reports that concentrated on school-going adolescents and utilized outreach-based forms of dental care delivery. The vast majority of initiatives undertaken considered this review were implemented in either a school-based setting or a community-based setting and concentrated on oral health education and basic oral care instead of specialized oral treatment.

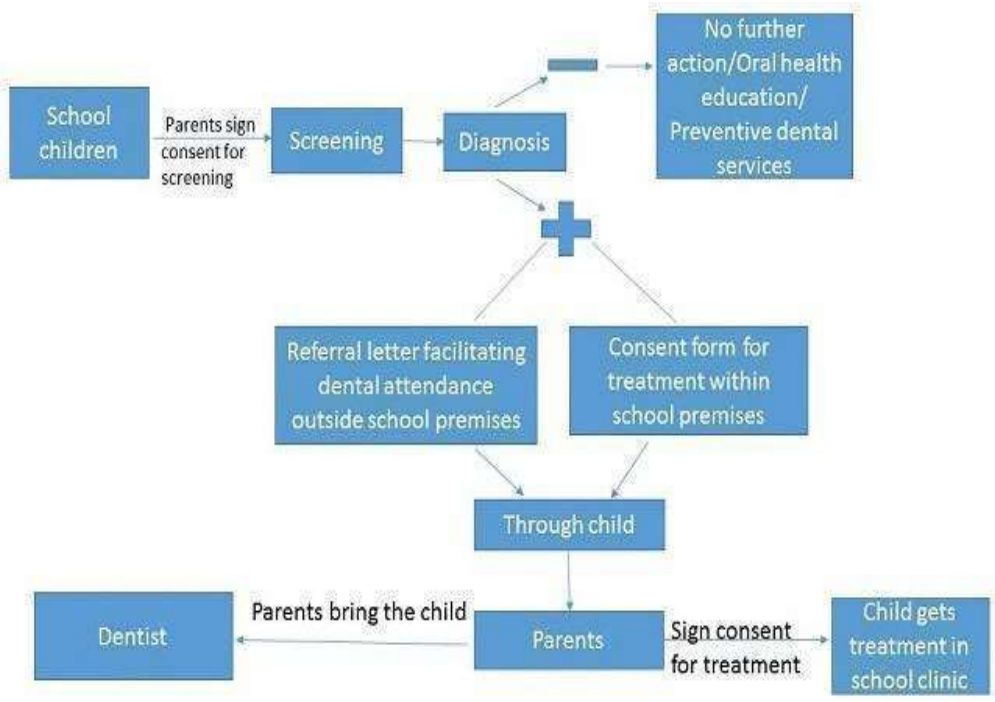


Fig. 5. Conceptual workflow of screening, consent, referral, and treatment pathways in school-based mobile dental clinic programs.

Adolescent Oral Health Needs Uncovered Through Mobile Dental Clinic Programs

Throughout the studies included in this literature review, the adolescents were found to have a huge burden of unmet oral health needs. In most studies, the adolescents were found to have little to no exposure to dental prevention programs. Oral hygiene habits were also found to be poor. These habits were considered to be contributing to disease presence.

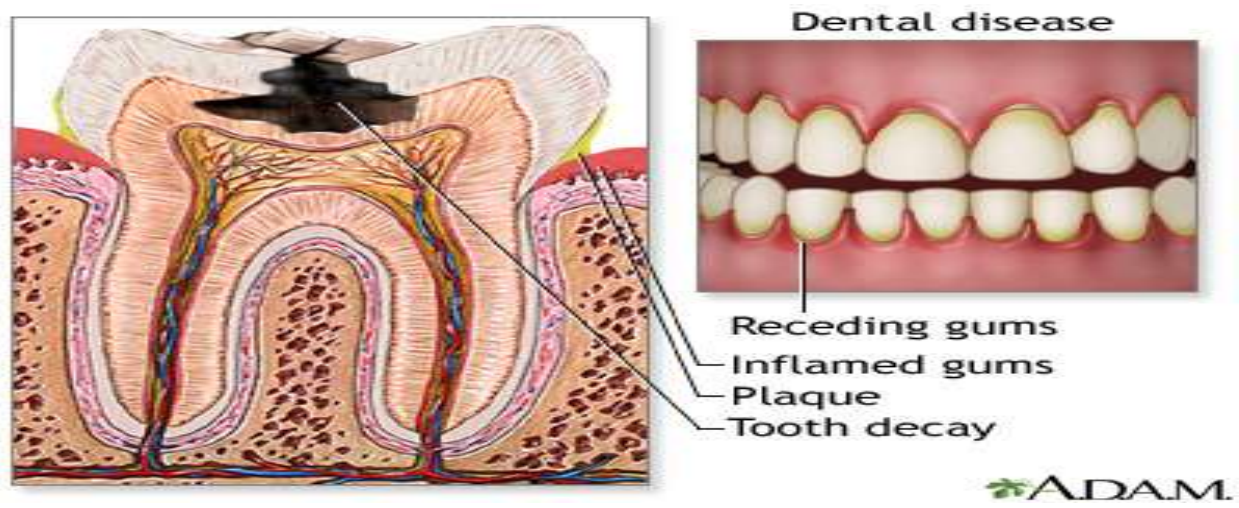


Fig. 6. Conceptual anatomical and schematic representation of dental disease processes, highlighting plaque accumulation, gingival inflammation, receding gums, and tooth decay.

Indeed, the type of experiences encountered in the mobile dental clinic often represented the first kind of professional evaluation for many adolescents. Reports emphasized that oral pain and infection were not uncommon among screened adolescents and were frequently associated with functional limitations, including difficulty eating and reduced classroom concentration. The importance of dental care as it relates to adolescents cannot be overemphasized.

Enhanced Access to Screening and Basic Dental Care

One of the salient and prominent features that were found in the initiatives reviewed is the role of mobile dental clinics. The clinics assisted in increasing access to screening and basic dental services for adolescents. The clinics operated in a manner that eliminated geographic and logistical barriers inherent in conventional dental clinics. The initiatives indicated a high rate of adolescent response to the services offered in school settings.

The mobile dental clinics allowed for the screening of a considerable number of adolescents within a relatively short period of time, which would otherwise go unnoticed for the disorders. Also, the mobile dental clinics used to identify the necessary referrals for the selected number of adolescents who were to receive particular care, which would otherwise not be possible. Not to mention, the use of the mobile clinics would eliminate the limited capacity to seek care on the part of the adolescents due to dependency on caregivers and low prioritization of preventive dental visits.

Preventive and Educational Components of Service Delivery

Besides the screening process, oral health education was also regularly provided as part of these mobile dental services. The educational session could be conducted individually or in group settings. The topics educated during this process included oral hygiene practices like brushing, diet in relation to sugar consumption, as well as tobacco.

The improvements observed include increased awareness and understanding among adolescents regarding oral health after being subjected to mobile clinic interventions. The adolescents were seen to be better informed about basic oral health concepts and displayed optimistic attitudes towards oral health. Even though there were positive outcomes regarding increased knowledge and awareness in both, few research projects followed up on longer-term outcomes to evaluate behavioral change. Therefore, the educational impact of mobile dental clinics is primarily reflected through immediate or short-term indicators rather than long-term outcomes.

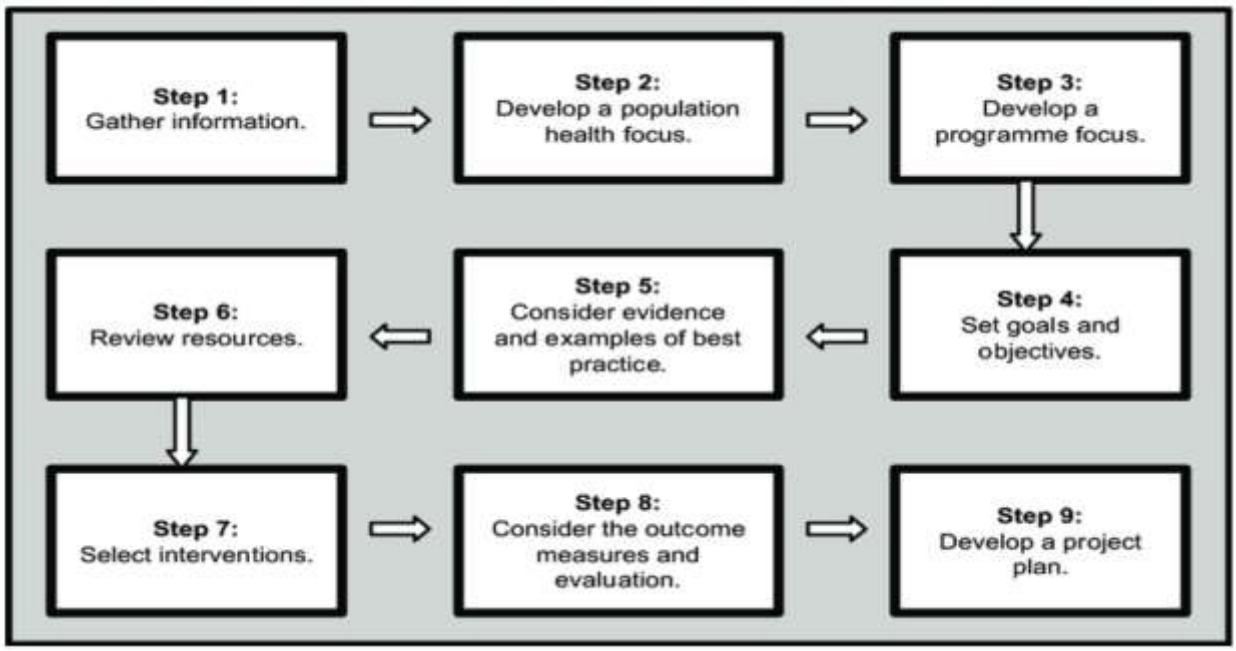


Fig. 7. Conceptual preventive and educational services delivered to adolescents through mobile dental clinic interventions.

Feasibility and Operational Viability in Indian Settings

Findings from participating evaluations indicate that mobile dental clinics are viable from an implementation standpoint in the Indian setting, especially when delivered using an institutional model like dental colleges, government sector schemes, or collaborative efforts involving both. Efficiency advantages in sharing facilities, use of transport, and dental student participation were highlighted.

School visits and coordination with education officials were considered to be contributing factors in improving the logistical workability and continuity of services. Mobile dental clinics were found to be accepted by the adolescent group as well as school and community officials. The cost factor was accounted for mainly in terms of description analysis, and the reports available show that mobile clinics are viable at a reasonable operating cost when incorporated into a larger institutional setup.

Alignment With School and Adolescent Health Platforms

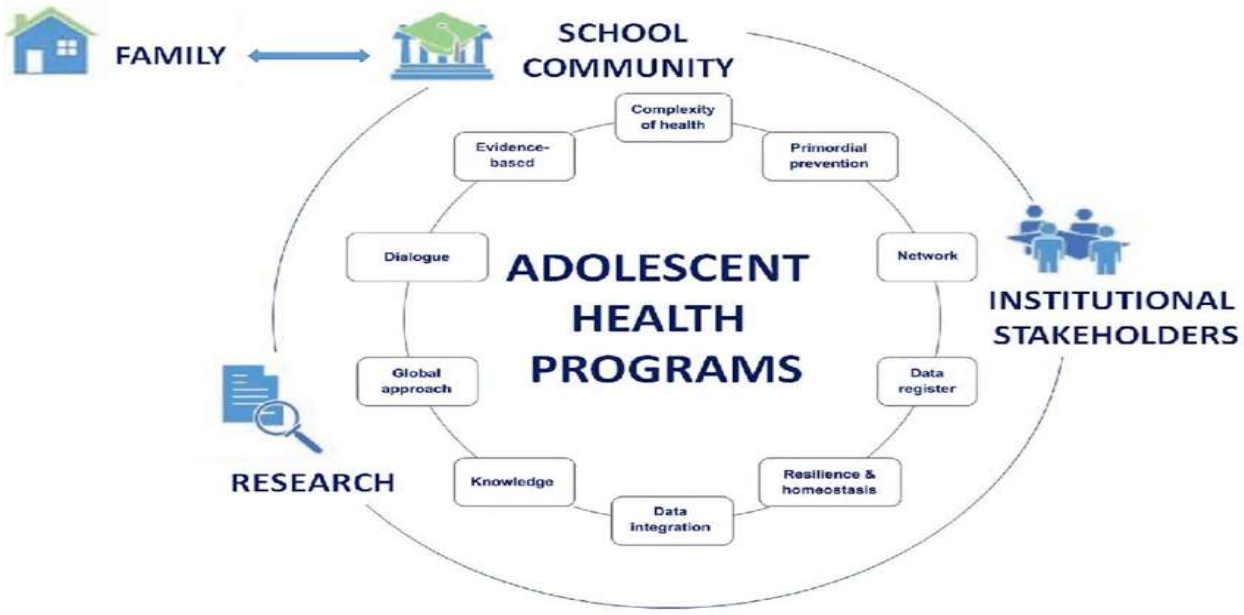


Fig. 8. Conceptual integration of mobile dental clinics within school-based and adolescent health platforms to support continuity of care.

There are some mobile dentists' projects that aligned with existing programs within schools and for adolescents. This is due to the ease of working alongside existing programs within schools and health organizations. Also, some projects that aligned with existing structured programs within schools benefited from established communication channels.

This alignment also facilitated continuity-of-care provisions by integrating oral health efforts with other forms of adolescent health services delivered at schools. While a range of schools adopted different intensity levels for such integration efforts, there were instances where mobile dental clinics became complementary aspects within school health initiatives rather than isolated interventions.

Operational and System-Level Challenges

Even in areas of strength, there have been challenges in mobile dental clinic programs. A significant challenge is that follow-up care is limited to adolescents in need of formal dentistry. The completion of referrals is often made challenging by financial constraints and the availability of support

The availability of the workforce was another area that posed certain challenges, especially to the schemes that had limited numbers of skilled personnel and the academic schedules of the dental institutions. The maintenance of equipment, infection control, and vehicle maintenance were other areas that required constant administrative support. In addition, the systems of documenting the outcome were not always consistent.

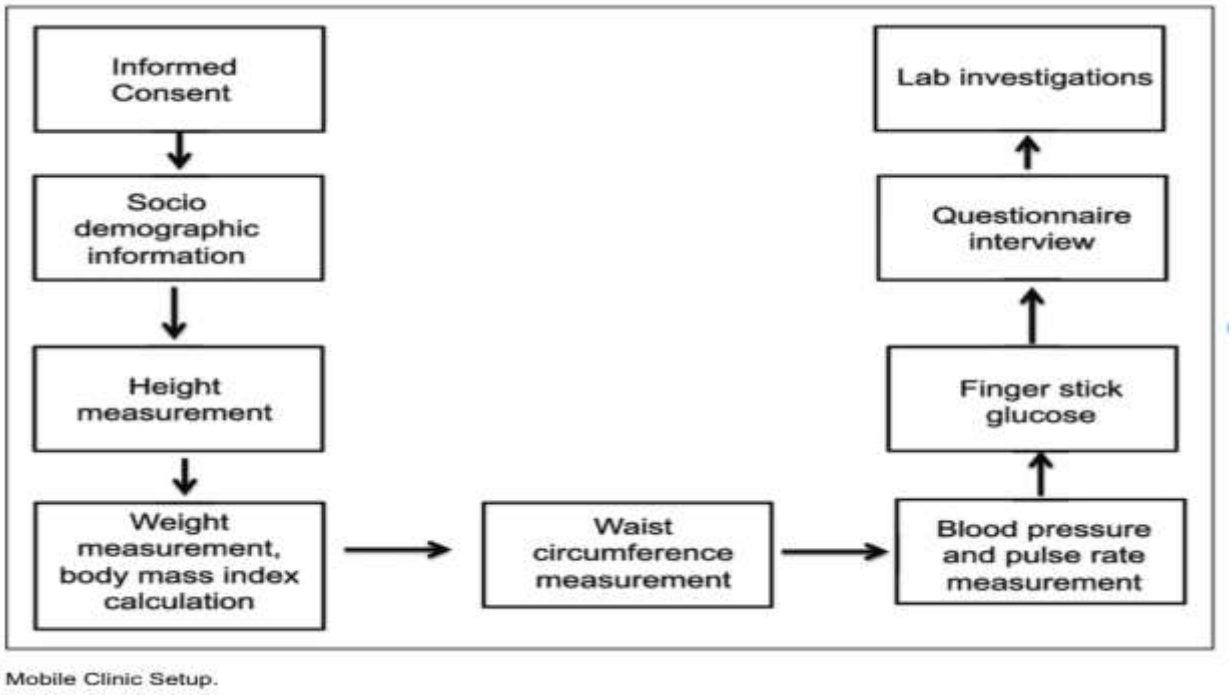


Fig. 9. Conceptual sequential workflow of informed consent, demographic data collection, anthropometric measurements, and basic clinical assessments conducted during mobile clinic visits.

Notably, adolescent-specific outcome indicators were infrequently reported. Most programs focused on service delivery metrics rather than measures capturing behavioral change, psycho-social outcomes, or longitudinal oral health trajectories.

Summary of Result Patterns

Taken together, the reviewed evidence demonstrates that mobile dental clinics consistently enhance access to screening, basic care, and preventive education for adolescents in underserved Indian communities. Although there has been a clear indication of feasibility and acceptability on one hand, there are limitations in the matter of continuity of care as well as outcome measurements

Discussion

This systematic review emphasizes the importance of the role of the mobile dental clinic in being an integral part of an appropriately positioned intervention strategy for adolescents in the Indian setting. A critical analysis of the synthesis of the existing body of evidence reveals the fact that the mobile dental clinic directly addresses the age-old structural issues that have impeded the access of the adolescent population to oral health services. Instead of acting as mere outreach programs, these clinics appear to be an intelligent service-delivery strategy.

A very essential factor that brings about the effectiveness of mobile dental clinics in the Indian setting is the ability to decentralize the point of service delivery. The current facility-based dental

care can limit adolescents' engagement with preventive dental care through travel costs, financial outlay, as well as the use of dental personnel, which largely impose barriers to preventive dental care among adolescents. A decentralized approach as presented in the mobile dental clinics can largely diminish these barriers as the point of service delivery is altered from the facility to the school setting. This is important in the adolescent phase, which is largely characterized by competing educational activities, lack of autonomy in the decision to access care, as well as low prioritization of preventive dental visits. The results obtained from this literature review are also relevant to general models for adolescent health. Adolescents have long been identified as a crucial phase for health outcomes. Health knowledge, attitudes, and practices for adolescents are considered to be consolidated. Health practices performed at such ages have good prospects of impacting long-term outcomes.

Mobile dental clinics offering health screenings and health education services form a platform for engaging with adolescents. This platform can be effectively executed to undertake long-term interactions with adolescents at such a critical phase. From a program implementation perspective, the effectiveness of mobile dental clinics is largely tied to their linkage and integration into and with existing educational and health infrastructure.

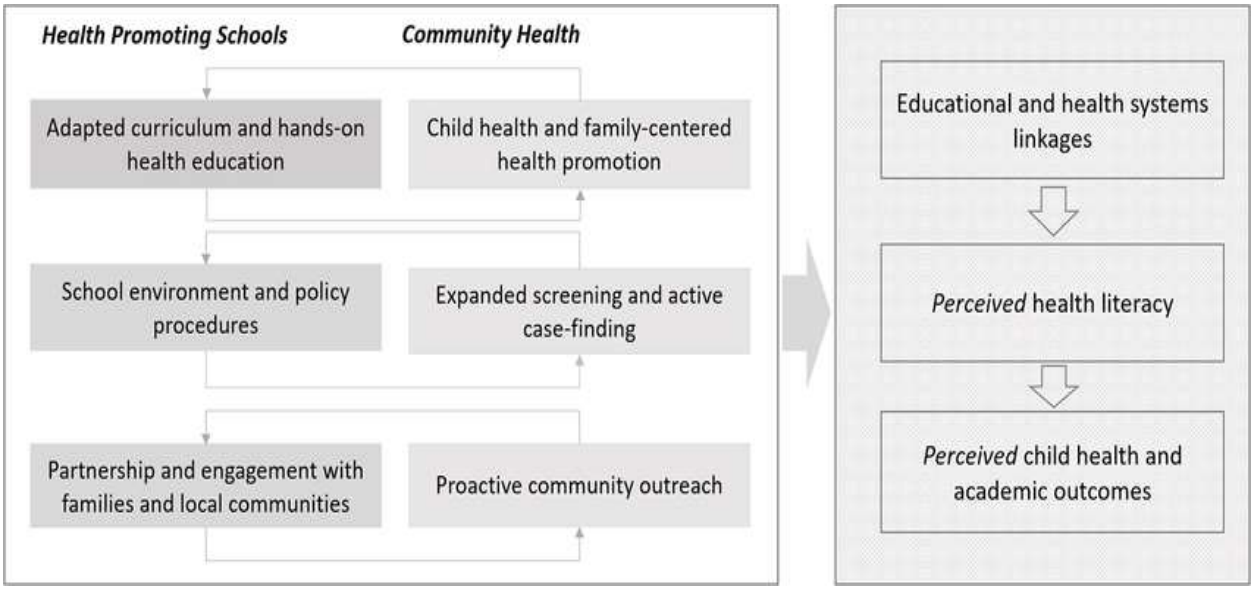


Fig. 10. Conceptual integration of mobile dental clinics within adolescent health and school health systems in India.

School-based delivery helps ensure systematic coverage and helps to facilitate repeated exposure to the target group, thus improving reach and acceptability. Linkage with school health programs and workers helps to ensure that mobile clinics are able to play a part in improving follow-through and referential care and help recall preventing and control various health conditions. Arguments pertaining to equity further support mobile dental clinics as a relevant component of India's oral health care delivery system. Rural and slum-dwelling adolescents and those belonging to low-socioeconomic strata encounter varied obstacles during their pursuit of dental care. Mobility as a defining characteristic of mobile dental care enables programs to strategically target such youth,

and as such, they help close gaps within oral health care as a tool of equity (Petersen & Kwan, 2011; Watt, 2005, Kwan & Petersen, 2005; Kay & Locker, 1996).

Mobile dental care not only acts as an intervention strategy within dental science. Additionally, the literature review brings up the following weaknesses in the current literature that measure the impact in a tempered light. Although mobile dental facilities do manage to be effective in increasing accessibility for screenings and educational components, the ability to facilitate comprehensive care is currently limited. The fact is that patient referral for specialized care is often hindered by the lack of insurance options or physical accessibility to facilities. Consequently, the advantage offered by early detection and intervention may fail to provide lasting benefit. Another important gap in this area is related to the outcomes in terms of adolescent-specific indicators.

Most assessments have relied on service reach, acceptance, or outcomes related to new knowledge only, without much emphasis on behavior change, or transitions in oral health only for young people. This is important because it is difficult to establish how mobile dental clinics have aided in meeting overall adolescent health outcomes. Future assessments will need to adopt different conceptual frameworks, including adolescent development outcomes like self-efficacy. In terms of implications for health policies, the results of this systematic review imply that there should be a vision for mobile dental clinics to be considered essential building blocks for the overall coordination of health care systems for adolescents. Additionally, there should be coordination strategies to ensure the integration of mobile dental clinics within the framework of health promotion programs for adolescents to make meaningful contributions to the improvement of their health status.

In conclusion, mobile dental clinics hold a regionally strategic position within the context of adolescent health care in India. They present an adaptive and contextual solution to overcome barriers to accessibility, improve preventive dental practices, and engage the adolescent population in oral health services. At the same time, it is crucial to acknowledge the significance of these services as a continuum within adolescent oral health care to ensure translation of improvements within accessibility to sustainable improvements within population health outcomes.

Conclusion

Mobile dental clinics represent a practical and contextually appropriate strategy for addressing adolescent oral health needs in India. The evidence synthesized in this review indicates that these clinics improve access to oral health screening, preventive education, and basic dental care, particularly among adolescents from underserved and hard-to-reach populations. By delivering services within schools and community settings, mobile dental clinics reduce geographic and financial barriers, facilitate early identification of oral health problems, and increase service utilization among adolescents who might otherwise have limited contact with formal dental care systems.

In addition to improving access, mobile dental clinics serve an important role in preventive oral health promotion during adolescence, a critical period for establishing long-term health behaviors. Educational interventions delivered through these platforms contribute to improved awareness of oral hygiene practices, dietary habits, and risk factors such as tobacco use. However, the reviewed

literature highlights limitations related to continuity of care, referral completion, and the lack of adolescent-specific outcome indicators. Most evaluations emphasize service reach and short-term knowledge gains, underscoring the need for more comprehensive assessments of behavioral change and sustained oral health outcomes (Watt, 2005; Kay & Locker, 1996).

From a systems and policy perspective, the effectiveness of mobile dental clinics is closely linked to their integration within existing school health and public health frameworks. Programs implemented in collaboration with dental institutions and government health initiatives demonstrate greater feasibility, acceptability, and operational sustainability. Strengthening referral pathways, standardizing outcome evaluation, and embedding mobile dental clinics within broader adolescent health strategies are essential to maximizing their long-term impact (World Health Organization, 2018). Overall, mobile dental clinics offer a flexible and equity-focused approach that can contribute meaningfully to improving adolescent oral health outcomes in India when supported by coordinated implementation and robust evaluation mechanisms (National Health Systems Resource Centre, 2021).

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