

Need Assessment of Oral Health Policy Curriculum: Knowing and Teaching Gaps among Public Health Dentistry Postgraduate Students in India

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Background: India released its second National Oral Health Policy in 2021, nearly four decades after the 1983 draft. However, health policy competence among the dental workforce remains poorly understood. Public Health Dentistry postgraduates, who are most likely to engage in policy work, demonstrate undocumented gaps in curriculum, knowledge, confidence, and involvement.

Material and Methods: A mixed-method, cross-sectional study was conducted. The study combined an exploratory content analysis of syllabi from ten international Master's programs in Dental Public Health with a survey of a convenience sample of 117 postgraduate students in public health dentistry in the 2nd-3rd year, using an expert-validated, adapted 38-item questionnaire distributed via Google Forms. The survey covered sociodemographics, curriculum, continuing dental education, knowledge, confidence (18 items), barriers, future needs, and involvement. We convenience-sampled postgraduates from colleges across five Indian zones.

Results: 62% of postgraduates responded. While 77.2% reported receiving policy teaching, only 50.9% considered it adequate. Mean knowledge scores ranged from 1.54 to 1.79 ("something" to "little"), with 57.9% scoring below "little." Mean confidence was 2.74, with the lowest scores for the CDC framework (2.51) and policy-reform appraisal (2.56). Only 21.1% had held a policy role, whereas 75.4% expressed interest in future involvement and 98.2% supported compulsory policy education. The most frequently cited barriers were "unawareness of opportunities" (77.2%) and "lack of knowledge" (75.4%).

Conclusions: Indian Public Health Dentistry postgraduates show substantial gaps in policy knowledge and teaching but strong interest in structured learning. Curricular revision that incorporates the policy triangle, electives, skill-based training, and visible career pathways is essential for effective training.

Keywords: Curriculum; Dental education; Oral health policy; Content Analysis; Needs assessment; Public health dentistry.

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Introduction

Oral diseases affect approximately 3.5 billion people worldwide and constitute a major non-communicable disease burden, particularly in low- and middle-income countries [1,2]. South Asia, largely due to India, has experienced the most significant increase in disability-adjusted life-years attributable to oral disorders from 1990 to 2019 [3]. Despite this substantial burden, oral health is rarely included in universal health coverage benefit packages, and policy responses have not aligned with epidemiological trends [2,4]. In India, the first National Oral Health Policy (NOHP) was drafted between 1983 and 1986, and an updated version was released in 2021, nearly 4 decades later.

However, awareness and implementation among the dental workforce remain limited [5]. Public Health Dentistry (PHD), the specialty responsible for leading population-level oral health initiatives, serves as the primary locus for policy literacy. The current cohort of postgraduate (MDS) students, who are anticipated to become future leaders, advocates, and policy analysts, has not been formally surveyed for policy knowledge or benchmarked against international peers [6,7]. Therefore, this study conducted a focused needs assessment to identify knowledge and teaching gaps regarding oral health policy among Public Health Dentistry postgraduates in India and to determine enablers for curricular reform. Another objective was also to conduct an exploratory content analysis of Dental public health curricula at the top 10 universities.

Material and Methods

Study design and setting: We conducted a mixed-methods, cross-sectional pilot study from June to November 2021. The study comprised two phases: an exploratory content analysis of curricular documents and a quantitative cross-sectional survey of MDS Public Health Dentistry students in India. The protocol adhered to the Declaration of Helsinki. We obtained informed electronic consent from all respondents before they completed the questionnaire, and we maintained confidentiality. As our study falls under the "Educational Evaluation Exemption," a global norm in which normal classroom/curriculum feedback surveys do not require ethics clearance, it was exempted from ethical clearance.

Content analysis: The MDS Public Health Dentistry course regulations of the Dental Council of India (DCI, 2017) and the publicly available curricula of ten internationally recognized Master's University of California–San Francisco, University of Toronto, Leeds, Boston University, Harvard, Sydney, and Karolinska) were retrieved and analyzed by two independent reviewers (AYB, MB). We mapped items to four predefined domains: skill assessment and community programs; public health practice (delivery, economics, planning); dental public health practice (delivery, payments, evaluation, manpower planning); and clinical and school programs, adapted from the IAPHD competency document.[7]

Questionnaire design and validation: We developed a 38-item self-administered questionnaire in English using Google Forms, including items from the Malik et al. (2017) instrument and the Patel et al. (2011) framework, both adapted to the Indian dental context.[6,8] The instrument addressed seven domains: sociodemographic profile; curriculum and continuing dental education (CDE) (Q1–Q4); knowledge of NOHP-1983, NOHP-2021, the policy process and cycle, policy models, the policy triangle, and the role of actors (Q5–Q11); confidence across 18 policy competencies (Q12–Q29) measured on a five-point Likert scale (0 = completely disagree to 4 = completely agree); perceived barriers to involvement (Q30); future learning needs (Q31–Q33); and involvement and practices (Q34–Q38). A panel of six Dental Public Health experts from across India conducted face, content, and construct validation. The modified Lawshe content-validity ratio was 0.82, and Cronbach's α for the confidence subscale was 0.86, indicating good internal consistency. (**Appendix 1**).

Appendix 1. Questionnaire used in the study		
Section	Items	Response format
A. Sociodemographic profile	Age, gender, religion, family income, occupation, college, year of MDS	Categorical/open-ended
B. Curriculum & CDE	Items 1–4 (Teaching in college for health policy/oral health policy, College regularly conducts CDE on health policy, Attended courses in Health policy, The components covered in health policy/oral health policy curriculum)	Present/Absent; Adequate/Inadequate; multiple choice

C. Knowledge	Items 5–11 (Oral health policy 1983, 2021, Health policy process & cycle, Health policy models & frameworks, Role of Actors in policy making, stage of national oral health policy)	5-point awareness scale / multiple choice
D. Confidence	Items 12–29 (relevance of health policy in Dentistry, examples of dental professionals in health policy, educational and/or career options, competencies that overlap between oral health policy and academics, CDC framework, proposals for reform of public and private players, factors creating conditions for high-	5-point Likert scale

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	quality dental care to be unequally distributed, effectiveness of interventions to lower health care costs while expanding coverage, policy topics relevant to oral health care, national and local policies affect oral health, advocacy opportunities for students and residents, problem amenable to a policy resolution, literature review necessary to write a policy resolution, write a policy editorial, write a policy review)	
E. Barriers	Item 30 - preventing student involvement in health policy roles	Multiple response

F. Future needs	Items 31–33 (Oral health policy teaching and curriculum and which year of dental school)	5-point Likert scale / multiple choice
G. Involvement & practices	Items 34–39 (Involvement past and present, health policy-related work in future and role)	5-point Likert scale / open-ended

Sampling and Data collection: MDS Public Health Dentistry students enrolled in any of the three academic years at recognized dental colleges in India were eligible to participate. In 2020, India had 318 dental institutions; 258 offered postgraduate programs, and 79 offered Public Health Dentistry as a specialization, with 233 postgraduate seats available. Of these 79 institutions, 72 were private, and 7 were government-run. (DCI Portal 2021). The study included a sample of all 2nd- and 3rd-year postgraduates (n=117) in Public Health Dentistry for the study, as oral health policy topics were most common in these years. We distributed the survey link, along with a participant information note and consent statement, via email and WhatsApp. We recruited a volunteer sample from the IAPHD conference registration contact list and included 92 2nd- and 3rd-year students who registered during the study period. We sent a single reminder after two weeks.

Statistical analysis: Data were exported from Google Forms to Microsoft Excel 2019 (Microsoft Corp.,

Redmond, USA) and duplicates were removed; three duplicate records were removed prior to analysis. Categorical variables are presented as frequencies and percentages. Likert-type responses are reported as mean composite scores on a 0–4 scale (knowledge: 0 = nothing to 4 = very knowledgeable; confidence/needs: 0 = completely disagree to 4 = completely agree). For interpretation, mean certainty scores were categorized a priori as low (<2.0), medium (2.0–3.0), and high (>3.0). Free-text responses to Q37 and Q38 were analyzed and grouped into topic-based categories.

Results

Sociodemographic profile and curriculum exposure: Of the 92 students invited, 89 (96.7%) responded, but only 57 completely filled the questionnaire, yielding a response rate of 62.0%, which was used for results tabulation and analysis. Table 1 summarizes sociodemographic and curricular profiles. The mean age was 27.4 years (range 24–40); 46 (80.7%) were women, 32 (56.1%) were in their second MDS year, and respondents represented 52 unique dental institutions across five Indian zones. While 44 (77.2%) reported health-policy teaching in their college, only 29 (50.9%) considered it adequate. CDE programs on policy were available in 56.1% of colleges, and only 42.1% of respondents had attended external policy courses (Table 2). The most frequently covered components included oral health policy in different countries (54.4%), policy evaluation (52.6%), and models/frameworks (52.6%), whereas fewer than half of institutions addressed the policy cycle (40.4%).

Knowledge of oral health policy: Mean self-rated knowledge scores ranged between "something" and "little" across all six policy domains (1.54–1.79 on the 0–4 scale; Figure 1). The lowest scores were observed for the roles of actors in policymaking (1.54) and the policy triangle (1.58). Awareness of NOHP-2021 (1.79) was slightly higher than that of NOHP-1983 (1.61). For the composite knowledge score, 10 respondents (17.5%) were classified as "poor" (mean 0–1), 23 (40.4%) as "fair" (1–2), 21 (36.8%) as "good" (2–3), and only 3 (5.3%) as "excellent" (>3). Regarding the current stage of the national oral health policy (Q11), 20 (35.1%) believed it was in the public domain, 13 (22.8%) thought it was still in draft, 12 (21.1%) thought it was implemented, and only 8 (14.0%) correctly identified policy analysis as the relevant stage.

Confidence across policy competencies: Mean certainty scores across the 18 policy competencies are shown in Figure 3. The overall mean confidence was 2.74 ± 0.71 on the 0–4 scale, denoting a position between "neutral" and "agree." Respondents showed the highest confidence in understanding the relevance

of health policy in dentistry (3.05), discussing policy topics in oral healthcare care (2.89), and identifying drivers of rising oral healthcare costs (2.86). Respondents reported the lowest confidence in describing the CDC framework for policy actions (2.51) and assessing reform proposals for public and private stakeholders (2.56). Only 16 respondents (28.1%) were classified as having "high confidence," while the remaining 41 (71.9%) fell within the medium-to-low range (Table 3).

Barriers, future needs and involvement: Perceived barriers to involvement in health-policy committee roles are presented in Figure 2. The most frequently cited barriers were "unawareness of opportunities" (77.2%) and "lack of knowledge" (75.4%), followed by "absence of guidance and teaching" (47.4%) and "lack of curriculum" (47.4%). Despite these challenges, motivation remained high (Figure 4): 56 of 57 respondents (98.2%) wanted to be taught oral health policy, and an equal proportion agreed that policy teaching should be compulsory in the dental curriculum. Seventeen (29.8%) and fifteen (26.3%) suggested introducing policy teaching in the BDS fourth and third years, respectively. Twelve respondents (21.1%) reported past involvement in a policy role, 20 (35.1%) reported current involvement, and 43 (75.4%) intended to undertake policy-related work in the future. Free-text responses (Q38) clustered around three themes: contributing evidence and need-assessment surveys to policymakers, engaging in policy advocacy and tobacco-cessation programs, and participating in framework formulation and preventive program implementation.

Table 1. Sociodemographic and academic profile of Public Health Dentistry postgraduate respondents (N = 57)

Variable	Category	n (%)
Age (years)	24–25	14 (24.6)
	26–30	36 (63.2)
	31–35	4 (7.0)
	>35	3 (5.3)
Gender	Female	46 (80.7)
	Male	11 (19.3)
Religion	Hindu	47 (82.5)
	Muslim	4 (7.0)
	Christian	1 (1.8)
	Others / not specified	5 (8.7)
Year of MDS	2nd year	35 (61.4)
	3rd year	22 (38.6)

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Geographic zone of college	North	8 (14.0)
	South	10 (17.5)
	East	4 (7.0)
	West	2 (3.5)
	Central	2 (3.5)
	Zone not deducible from college name	31 (54.4)
Occupation of head of family	Professional (medical/dental/engineer/banker)	21 (36.8)
	Business / self-employed	14 (24.6)
	Government service	6 (10.5)
	Retired	7 (12.3)
	Others / not specified	9 (15.8)

Table 2. Presence and adequacy of health-policy / oral-health-policy curriculum and CDE in respondent institutions (N = 57)

Curricular item	Present n (%)	Adequate n (%)	Inadequate n (%)	Not applicable / blank n (%)
1. Teaching of health policy / oral health policy in college	44 (77.2)	29 (50.9)	16 (28.1)	12 (21.1)
2. College regularly conducts CDE on health policy	32 (56.1)	27 (47.4)	8 (14.0)	22 (38.6)
3. Attended courses in health policy outside college	24 (42.1)	20 (35.1)	8 (14.0)	29 (50.9)

Components of policy teaching covered (multiple response, % of N = 57): oral health policy of different countries 54.4%; policy evaluation 52.6%; policy models and frameworks 52.6%; history of oral health policy 50.9%; policy-making process 45.6%; policy cycle 40.4%; other 17.5%.

Table 3. Composite knowledge and confidence categories among respondents (N = 57).

Composite domain	Category (mean score band)	n (%)
Knowledge of policy (Q5–Q10; 0–4 scale)	Poor (0–1)	10 (17.5)
	Fair (1–2)	23 (40.4)
	Good (2–3)	21 (36.8)
	Excellent (3–4)	3 (5.3)
Confidence in policy competencies (Q12–Q29; 0–4 scale)	Low (<2)	2 (3.5)
	Medium (2–3)	39 (68.4)
	High (>3)	16 (28.1)
Future intent (Q31, Q32, Q36; agree + completely agree)	Want oral-health-policy teaching (Q31)	56 (98.2)
	Want compulsory curricular teaching (Q32)	56 (98.2)
	Consider future policy work (Q36)	43 (75.4)
Involvement (Q34, Q35)	Past involvement (agree + completely agree)	12 (21.1)
	Current involvement (agree + completely agree)	20 (35.1)

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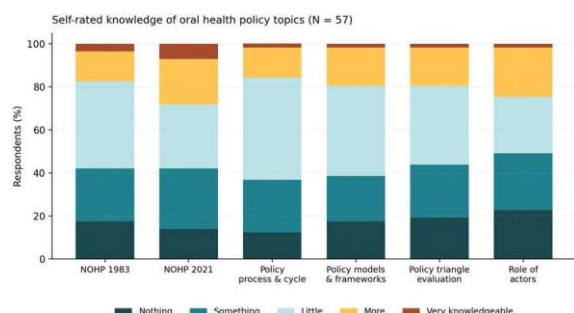


Figure 1. Distribution of self-rated knowledge across six oral-health-policy domains among Public Health Dentistry postgraduates in India (N = 57). Knowledge was rated on a five-point scale from Nothing (0) to Very much knowledgeable (4). Across all domains, the modal response was "little," with fewer than 25% of respondents reaching "more" or "very knowledgeable" on any single topic.

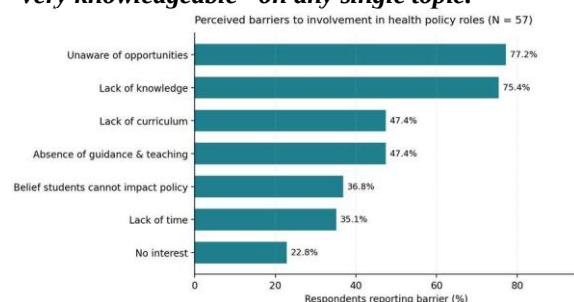


Figure 2. Perceived barriers to involvement in health-policy committee roles among Public Health Dentistry postgraduates (N = 57). Percentages exceed 100% because the item permitted multiple responses. Unawareness of opportunities and lack of knowledge dominate; lack of curriculum and absence of guidance are reported by nearly half of respondents.

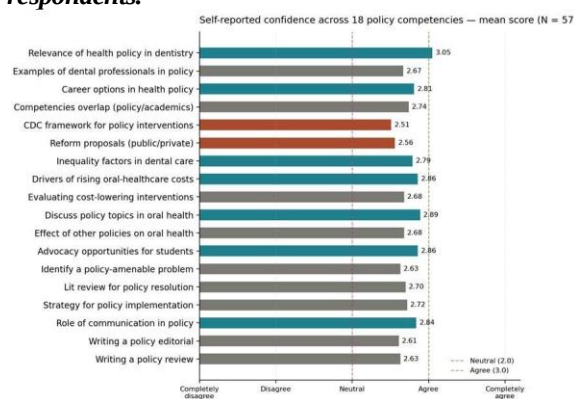


Figure 3. Mean self-reported confidence across 18 policy competencies (Q12–Q29) on a 0–4 scale, where 2.0 = Neutral and 3.0 = Agree. Bars in teal denote mean ≥ 2.75; bars in rust denote mean < 2.60 (weakest competencies); grey denotes intermediate scores. The CDC framework and appraisal of reform proposals were the weakest competencies.

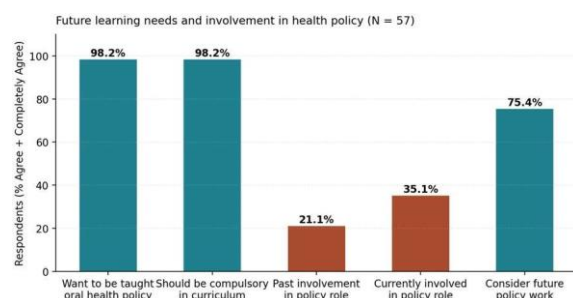


Figure 4. Future learning needs and current involvement of Public Health Dentistry postgraduates in oral health policy (N = 57). Bars show the percentage of respondents who selected "Agree" or "Completely agree." Teal indicates strong endorsement (≥60%); rust indicates limited current engagement.

Discussion: To the best of our knowledge, this needs assessment is the first study to document oral health policy knowledge, confidence, and involvement among Public Health Dentistry postgraduates in India. The evidence shows a consistent pattern: limited formal teaching, modest knowledge and confidence, and notably high learning motivation. This configuration closely parallels findings from medical student populations in the United Kingdom, the United States, and Canada.[6,8,9,10]

Malik et al. (2017) surveyed UK medical students and found that the majority felt underprepared to engage with health policy despite valuing its importance for clinical practice; only a quarter had received formal policy instruction.[6] Emil et al. (2014) identified similar gaps in Ontario and California, where students rated their knowledge of policy systems as poor but expressed strong interest in elective teaching.[10] Walton et al. (2020) demonstrated that even a brief, voluntary policy elective during the COVID-19 pandemic led to measurable gains in confidence and policy literacy, supporting the feasibility of low-cost interventions.[9] The present results expand these observations to the Indian dental context and to a more advanced learner cohort. The finding that nearly half (47.4%) of postgraduates cite "lack of curriculum" as a barrier, despite 77.2% reporting some teaching, implies that current coverage is fragmentary rather than absent. This reflects issues of depth, sequencing, and skill translation rather than simple visibility.

The dominant weakness on the policy triangle (Walt & Gilson's seminal framework of content, context, process and actors) and on the role of actors is especially significant.[11] These are the conceptual scaffolds that allow practitioners to read policies critically, anticipate implementation gaps and engage with stakeholders. Their absence from postgraduate teaching is consistent with our content analysis, which found that the DCI MDS regulations focus heavily on

dental care delivery, planning, and evaluation but engage only superficially with policy analysis and political economy.[12] In contrast, the international Master's programs reviewed treat policy analysis, governance and advocacy as distinct learning units.

Confidence ratings in this study (mean 2.74) fall just below the "agree" threshold, denoting a generally neutral self-appraisal; students neither feel fully competent nor completely unprepared. Such mid-range scores are typical of cohorts familiar with policy concepts yet lacking experiential exposure. Patel, Davis, and Lypson (2011) proposed that progressing medical education in health policy requires pairing didactic teaching with experiential learning, advocacy projects, and visible career pathways.[8] Although the Indian context offers several entry points, such as the National Health Mission, the National Oral Health Program, NITI Aayog, state public health cadres, and the Indian Council of Medical Research, these opportunities remain largely invisible to postgraduates, as reflected by the 77.2% who cite "unawareness of opportunities" as a barrier.

Respondents' high willingness to receive instruction (98.2%) and pursue future policy work (75.4%) is the most actionable finding from this survey. This echoes observations by Shewade et al. (2014) and Garg (2017), who advocated reviving community medicine and public health teaching in India through skill-based, problem-oriented, and elective-driven curricula.[13,14] Lessons from Indian community medicine, such as integration with district health systems, electives, and the creation of a Public Health Council, are directly applicable to Public Health Dentistry.[14] Chandrashekar et al. (2016) similarly recommended repositioning the public health dentist as a "public health" professional, whose competence goes beyond clinical preventive dentistry to include program management, policy advocacy, and health systems analysis.[15] The present data quantify the demand for such repositioning among emerging professionals.

Three implications follow. First, the MDS Public Health Dentistry syllabus must be revised to make health policy a discrete teaching unit anchored on the policy triangle, the policy cycle and the analytical study of NOHP-1983 and NOHP-2021. Second, elective courses, CDE programs, and structured exposure to state oral-health programs should be offered to operationalize skill-based training. [13,14] Third, visibility of career pathways, through a dedicated Indian public-health cadre on the lines of the Indian Administrative, Police, and Forest Services, would translate confidence into involvement. [14,15] With the NDC formation and curriculum revisions expected, this manuscript will act as an evidence

document for the policymakers to frame the Oral health policy-related curricula in India.

Strengths and limitations: Strengths of this study include a multi-zone respondent base, dual-source data (content analysis and survey), use of a previously validated instrument adapted for the Indian dental context, and respondents were drawn from multiple institutions and reported representation across Indian zones. This study should be considered as an exploratory, cross-sectional survey with a descriptive curriculum document review. However, the sampling approach and incomplete geographic classification preclude national representativeness. Limitations include the modest complete-questionnaire response rate ($n = 57$, 62%); however, 89 responded with incomplete questionnaires, suggesting they may be interested in the topic of inquiry but lacked the knowledge to complete it. Self-reported knowledge and confidence (subject to social-desirability bias), and the over-representation of women and second- and third-year postgraduates, may limit generalizability. As a pilot, the study is hypothesis-generating and should be followed by a multi-center study with stratified selection and objective knowledge testing, with an increase in postgraduate programs in Indian Dental Colleges, including 95 that offer PHD (DCI portal, 2025).

Conclusions: Public Health Dentistry postgraduates in India show considerable knowledge and teaching gaps regarding oral health policy, knowledge is at "something to little," confidence is moderate, and past or current policy involvement is negligible. Yet nearly all wish to be taught, and three-quarters intend future policy work. Immediate priorities for translating the second National Oral Health Policy from text into practice include revising the MDS curriculum to make oral health policy a distinct, skill-based teaching unit, introducing elective and CDE programs, and creating a visible Indian public-health-dentistry cadre.

References

1. World Health Organization. Oral health [fact sheet]. Geneva: WHO; 2025 Mar 17. Available from: <https://www.who.int/news-room/fact-sheets/detail/oral-health>.
2. World Health Organization. Global strategy and action plan on oral health 2023–2030. Geneva: WHO; 2024. Available from: <https://www.who.int/news/item/26-05-2024-who-releases-global-strategy-and-action-plan-on-oral-health>.
3. Bernabe E, Marcenes W, Hernandez CR, Bailey J, Abreu LG, Alipour V, et al. Global, regional, and national levels and trends in burden of oral conditions from 1990 to 2017: A systematic analysis for the Global Burden

- of Disease 2017 study. *J Dent Res.* 2020;99(4):362–73.
4. Peres MA, Macpherson LMD, Weyant RJ, Daly B, Venturelli R, Mathur MR, et al. Oral diseases: A global public health challenge. *Lancet.* 2019;394(10194):249–60.
5. Yadav S, Rawal G. The current status of dental graduates in India. *Pan Afr Med J.* 2016;23:22.
6. Malik B, Ojha U, Khan H, Begum F, Khan H, Malik Q. Medical student involvement in health policy roles. *Adv Med Educ Pract.* 2017;8:735–43.
7. Indian Association of Public Health Dentistry. Definition, roles and competencies of public health dentistry specialists. Manipal: IAPHD; 2018. Available from: <http://www.iaphd.org>.
8. Patel MS, Davis MM, Lypson ML. Advancing medical education by teaching health policy. *N Engl J Med.* 2011;364(8):695–7.
9. Walton R, Greenberg A, Ehlke D, Solá O. Development of a health policy elective for medical students during the COVID-19 pandemic: A pilot study. *PRiMER.* 2020;4:29.
10. Emil S, Nagurney JM, Mok E, Prislín MD. Attitudes and knowledge regarding health care policy and systems: A survey of medical students in Ontario and California. *CMAJ Open.* 2014;2(4):E288–94.
11. Walt G, Gilson L. Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy Plan.* 1994;9(4):353–70.
12. Dental Council of India. MDS course regulations, 2017. New Delhi: DCI; 2017. Available from: https://dciindia.gov.in/Rule_Regulation/MDS_Course_Regulations_2017.pdf.
13. Shewade HD, Jeyashree K, Chinnakali P. Reviving community medicine in India: The need to perform our primary role. *Int J Med Public Health.* 2014;4(1):29–32.
14. Garg BS. Teaching/training and practice of public health/PSM/community medicine. *Indian J Community Med.* 2017;42(3):127–30.
15. Chandrashekar J, Vinita S, Joe J. Public health: The true role of public health dentist. *J Indian Assoc Public Health Dent.* 2016;14(3):241–2.
16. Singh A, Purohit BM. Public health policies in India: Status of oral health. *Indian J Community Med.* 2019;44(2):91–4.

17. Goel S, Verma H. Scope of dentists in public health. *Internet J Health*. 2008;9(1):1–6.
18. Shah N, Mathur VP, Kathuria V, Gupta T. Effectiveness of an educational video in improving oral health knowledge in a hospital setting. *Indian J Dent*. 2016;7(2):70–5.
19. Lal S. National oral health care programme: Implementation strategies. *Indian J Community Med*. 2004;29(1):3–5.
20. Ahuja NK, Parmar R. Demographics & current scenario with respect to dentists, dental institutions and dental practices in India. *Indian J Dent Sci*. 2011;3(2):14–8.

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