

Invisibility of oral health in prisons: a scoping review of dental care

Jane Ignácio dos Reis-Marcelino, Vitor Rafael Gomes, Gabriel Alves-Goulart, Luciane Miranda-Guerra

Piracicaba School of Dentistry, Campinas State University (FOP/Unicamp). Piracicaba. Brazil.

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ABSTRACT

Objectives: To map scientific production of dental care in prisons, identifying trends, gaps, and organizational aspects of access.

Material and method: Scoping review in accordance with Johanna Briggs Institute (JBI) and PRISMA-ScR guidelines in MEDLINE, Web of Science (WoS), Latin American and Caribbean Health Sciences Literature (LILACS), and Embase. Primary studies in three languages were included, without time restrictions.

Results: From 28 studies (mostly from Brazil, France, and India), high rates of caries, periodontal disease, and tooth loss prevail under a reactive emergency model.

Discussion: Prison care reflects structural inequities. Initiatives such as tele-dentistry and screening protocols are effective for improving a comprehensive approach. A transition toward a public health logic is necessary to guarantee the right to care within the prison system.

Keywords: dental care; prisoners; oral health; prisons.

RESUMEN

Objetivos: Mapear la producción científica sobre asistencia odontológica en prisiones, identificando tendencias, brechas y organización del acceso.

Material y método: Revisión de alcance siguiendo al Instituto Joanna Briggs (JBI) y PRISMA-ScR (*Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews*) en MEDLINE, Web of Science (WoS), Latin American and Caribbean Health Sciences Literature (LILACS) y Embase. Se incluyeron estudios primarios en tres idiomas, sin restricción temporal.

Resultados: De 28 estudios analizados (principalmente de Brasil, Francia e India), predominan altos índices de caries, enfermedad periodontal y pérdida dental, bajo un modelo reactivo de urgencias.

Discusión: La atención carcelaria refleja iniquidades estructurales. Iniciativas como la teleodontología y los protocolos de triaje son eficaces para mejorar la integralidad. Es necesario transitar hacia una lógica de salud pública que garantice el derecho al cuidado en el sistema penitenciario.

Palabras clave: atención odontológica; prisioneros; salud bucal; prisiones.

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INTRODUCTION

The prison population is a highly vulnerable group in healthcare terms, and the lack of protection can also be in their dental health, which is regarded as a basic feature of comprehensive healthcare¹. Current estimates calculate that there are about 11.5 prison inmates worldwide, with a global average of 145 inmates per 100,000 members of the community, with signs of a constant level of growth in regions such as South America, Western Asia and Oceania².

One aspect of this scenario is a high demand for dental healthcare, which is further aggravated by overcrowding, unhealthy conditions and a lack of infrastructures. These factors impose obstacles on health promotion and prevention and compromise integrated healthcare³.

While some countries have made progress in integrating dental care into primary care systems, socially vulnerable groups such as the prison population still face significant barriers to accessing this type of care. Studies mention high prevalences of dental caries and periodontal disease in this population, with a large proportion of persons who present with unattended dental needs⁴. Such challenges transcend national frontiers, creating a truly international problem that requires structured responses and public policies designed for the prison setting.

Several countries have established regulatory frameworks designed to ensure universal and comprehensive access to healthcare, including the progressive inclusion of dental care as part of the public health system. Brazil's Single Health System (SUS) consolidated this principle by including dental health teams in the family health strategy in the early 2000s⁵⁻⁷. However, persistent structural and organisation limitations on dental care in prisons and what services are available are often limited to emergency procedures. This scenario highlights serious gaps in improvements to health rights and continuity in care, along with persistent and long-standing inequalities that have a disproportionate effect on the prison population. These challenges are not limited to Brazil; they have in fact been documented in prison systems worldwide⁸.

Dental health care in prisons should be regarded as a strategic component in public health that goes beyond restorative care. The need is to include activities for prevention, promotion of self-care and early detection of systemic issues with oral symptoms⁹. Studies that map the organisation, accessibility and effectiveness of prison dental care services are therefore essential for subsidising public policies geared

towards equal and comprehensive care, while contributing to the removal of the long-standing inequalities that define dental care in the prison population¹⁰.

The aim of this study is to map scientific output of the issue of dental healthcare in the prison population, identifying trends, gaps in knowledge and aspects associated with the organisation and access to dental care services, the overall objective being to provide subsidies to improve health policies designed for this group.

MATERIALS AND METHOD

Study design and recording protocol

This study is a scoping review designed in accordance with the methodological recommendations of the JBI¹¹ and the guidelines of the PRISMA-ScR initiative¹². The review was guided under the lead question: "What is the scientific scenario of dental healthcare for the prison population?". The question aligned with the PCC strategy (acronym of: population [of inmates], concept [dental healthcare] and context [prisons]), used to prepare the search strategy^{11,12}. The review was previously registered in the JBI Register and OSF Registries platforms.

Inclusion and exclusion criteria

Primary studies that met the research objectives were selected. The studies were available in English, Portuguese or Spanish and published in scientific journals indexed in the databases of MEDLINE (via PubMed), WoS, LILACS (via the Virtual Health Library) and Embase, with no restrictions on the year of publication.

The decision to include articles published solely in indexed journals was made to ensure a criterion of quality and reliability of sources, since said bases include journals subject to formal editorial evaluation and peer review. Chapters from books, technical reports, monographs, theses, dissertations and bibliographical reviews were not included.

Search strategy for articles

The study was carried out in accordance with the six-stage methodological proposal designed by the JBI¹¹: identification of the subject and formulation of the research question; identification of the relevant studies; selection of studies; categorisation of the extracted data; analysis and interpretation of the results; and presentation of the synthesised knowledge.

A preliminary search was initially carried out in the SciELO database to identify relevant studies and refine the descriptors. A broader and more systematised search was then carried out using a search strategy in the MEDLINE database (via PubMed), WoS (All Collections), LILACS (via the Virtual Health Library) and Embase^{11,13}. The articles found were analysed according to titles, abstracts and indexed terms.

The search strategy^{11,13} was constructed by using Boolean operators and applying them to the intersection of descriptors. To do so, each descriptor was associated to its equivalent terms and previous indexed terms. The operators “OR” and “AND” were used according to the model for the different bases (Table 1). The strategy was reviewed by a librarian with experience in bibliographical research to ensure an adequate fit for the descriptors and operators used.

The data was collected between September and October 2025. The entire search process was documented, including detailed information about the queries made in each database, the logging of excluded articles and the reasons for their exclusion.

Selection of studies and data extraction

After the studies were identified, a screening process was carried out based on readings of the titles and abstracts to select eligible articles for qualitative

synthesis. This process was carried out independently by two authors with the Rayyan (Rayyan®/QCRI/web and app) program¹⁴ in two phases: the first one consisted of reading the title and abstract, then the texts with discrepancies were fully analysed, and consensus meetings were subsequently held. These phases were enough to define the studies that were included. In cases where divergences persisted after discussions between the two reviewers, consultations were held with a third reviewer for a final decision.

The selected articles were organised into a specific file with information such as title, authors, year and country of publication, objectives, methodological design, samples, methods adopted, analysed outcomes, main results and outcomes. The data from the final sample were descriptively analysed, validated by all the authors and organised in a study characterisation table.

RESULTS

The workflow presented here was used to initially identify 90 records in the databases. The duplications were then eliminated and the screening process was completed, the final result being 28 studies that met the inclusion criteria and were included in the scoping review (Figure 1).

Table 1. Search strategy used in electronic databases.

Database	Search strategy
PubMed	((((((((((((((Prisoners[MeSH Terms]) OR (Prisoner[Other Term])) OR (Incarcerated Individuals[Other Term])) OR (Incarcerated Individual[Other Term])) OR (Individual, Incarcerated[Other Term])) OR (Imprisoned Individuals[Other Term])) OR (Imprisoned Individual[Other Term])) OR (Individual, Imprisoned[Other Term])) OR (Inmates[Other Term])) OR (Inmate[Other Term])) OR (Hostages[Other Term])) OR (Hostage[Other Term])) OR (Detained Persons[Other Term])) OR (Detained Person[Other Term])) OR (Person, Detained[Other Term])) AND (Oral Health[MeSH Terms])) OR (Health, Oral[Other Term])) AND (Dental Care[MeSH Terms])) OR (Care, Dental[Other Term])).
LILACS	("Prisoners" OR "Detained Person" OR "Detained Persons" OR "Hostage" OR "Hostages" OR "Imprisoned Individuals" OR "Incarcerated Individuals" OR "Inmates" OR "Person, Detained" OR "Prisoner" OR mh:("Prisoners")) AND ("Oral Health" OR "Health, Oral" OR mh:("Oral Health")).
Web of Science	((((((((((TS=(Prisoners)) OR TS=(Detained Person)) OR TS=(Detained Persons)) OR TS=(Hostage)) OR TS=(Hostages)) OR TS=(Imprisoned Individuals)) OR TS=(Incarcerated Individuals)) OR TS=(Inmates)) OR TS=(Person, Detained)) OR TS=(Prisoner) AND (TS=(Oral Health)) OR TS=(Health, Oral) AND (TS=(Dental Care)) OR TS=(Care, Dental) AND (((TS=(Prisons)) OR TS=(Penitentiaries)) OR TS=(Penitentiary)) OR TS=(Prison) AND TS=(Dentistry)).
Embase	('prisoner'/exp OR 'prisoners':ti,ab,kw OR 'prisoner':ti,ab,kw OR 'incarcerated individuals':ti,ab,kw OR 'incarcerated individual':ti,ab,kw OR 'individual, incarcerated':ti,ab,kw OR 'imprisoned individuals':ti,ab,kw OR 'imprisoned individual':ti,ab,kw OR 'individual, imprisoned':ti,ab,kw OR 'inmates':ti,ab,kw OR 'inmate':ti,ab,kw OR 'hostages':ti,ab,kw OR 'hostage':ti,ab,kw OR 'detained persons':ti,ab,kw OR 'detained person':ti,ab,kw OR 'person, detained':ti,ab,kw) AND ('oral health':ti,ab,kw OR 'health, oral':ti,ab,kw) AND ('dental care':ti,ab,kw OR 'care, dental':ti,ab,kw).

The countries with the highest representation were Brazil (n = 4), France (n = 3), England (n = 3) and India (n = 3), showing a concentration of scientific production in contexts of medium and high admissions, characterised by a larger infrastructure of research and organisation of health services (Figure 2).

The 28 quantitative (n = 22) and qualitative (n = 6) studies presented a wide range of objectives. In general terms, the quantitative studies showed a high prevalence of dental caries (often over 90%), periodontal disease and tooth loss, with high values in the DMFT index (acronym for decayed, missing and filled teeth), a significant presence of untreated caries and a major need for restorative, periodontal and prosthetic treatment.

The studies also reported a high demand for prophylaxis, removal of calculus and prosthetic rehabilitation, as well as a predominance of care focused on emergency treatment and extractions. A number of studies highlighted barriers to access, low service coverage, discontinuities in care and regional inequalities in the availability of dental care.

The qualitative studies highlighted perceived scarcities in care, limited preventive guidance, negative impacts of dental health on quality of life and struc-

tural difficulties in the prison system. Initiatives were also described, such as the implementation of triage protocols, educational models for self-care and experiences with tele-dentistry, with favourable results for organisation of services and increased access (Table 2).

Table 3 shows the main results and outcomes of the studies, offering a synthesised view of the evidence on dental care in prison settings and highlighting patterns of dental morbidity, gaps in care and innovative strategies.

DISCUSSION

The largest amount of research was carried out in Brazil (n = 4), followed by France, England and India (n = 3 each one), which reveals a geographical imbalance in evidence. This pattern matches the historical concentration of scientific production in certain national contexts and limits understanding of the realities in low-income countries, where prison systems often coexist with greater scarcities in the healthcare system. The low representation of such countries imposes limits on a global understanding of the inequalities of dental care in prison. Collective health studies have

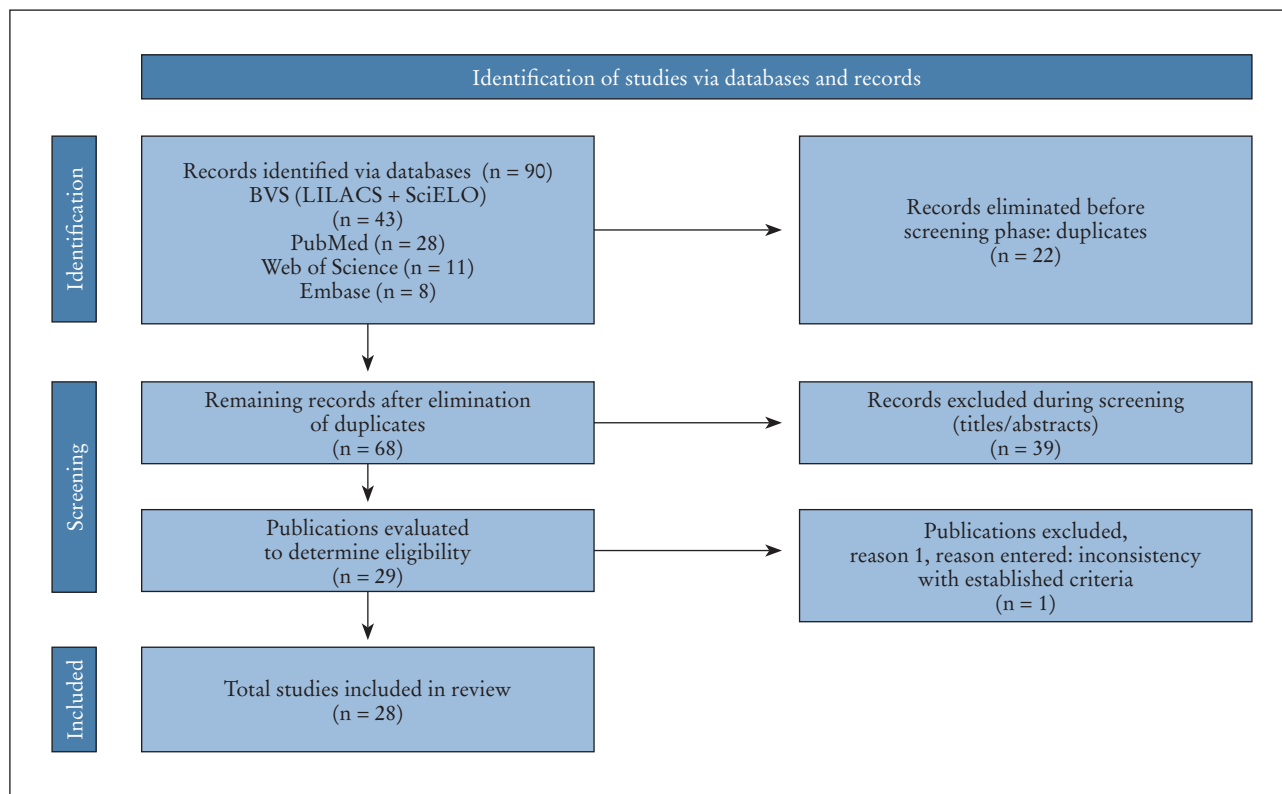


Figure 1. Flow chart of identification, screening and inclusion process of studies in the scoping review.

pointed out that inequalities in healthcare should be interpreted according to structural and social factors that precede imprisonment and influence cumulative increases in vulnerability¹. This perspective reinforces the need to incorporate intersectional analyses that consider ethnic/racial, gender and socioeconomic factors^{30,41,42}.

The findings agree on the existence of persistent structural iniquities, expressed as a high prevalence of caries, periodontal diseases and tooth loss. In different contexts such as Brazil, Saudi Arabia, India and Russia, dental care continues to focus on emergency treatment and tooth extraction, this reinforcing a reactive and fragmented model^{26,30,41}.

This pattern has also been documented in European prison systems. A study carried out in the UK showed a high accumulated need for treatment, high pent-up demand and the more dental extraction procedures than preventive strategies⁴³. The convergence of results in countries with different developmental levels suggests that the logic underlying healthcare in prison responds more to the institutional structure of imprisonment than to economic availability, leading to the reproduction of a healthcare model that focuses on controlling pain and not on comprehensive health promotion.

The lack of integration between levels of care, along with the added problems of overcrowding and operational restrictions common to the prison system, also relegate dental health to a secondary level in comprehensive healthcare^{28,29}. This fragmented approach compromises continuity in care after release and perpetuates previously existing cycles of exclusion from healthcare. The literature agrees that the absence of systematic preventive strategies and integrated protocols aggravates the load of dental diseases amongst this population.

At the same time, initiatives that highlighted possible changes and reorganisation of healthcare were identified. The Cuban experiences, based on participative educational models, showed significant improvements in dental hygiene indicators^{31,34}. These results are linked to health promotion approaches that prioritise autonomy, critical education and co-responsibility in self-care. Tele-dentistry was also identified as a promising instrument for increasing access in contexts with a lack of professionals and logistical barriers^{28,39}. However, implementing these tools requires technological infrastructure, professional training and adequate regulation to iniquities prevent new types of digital exclusion.

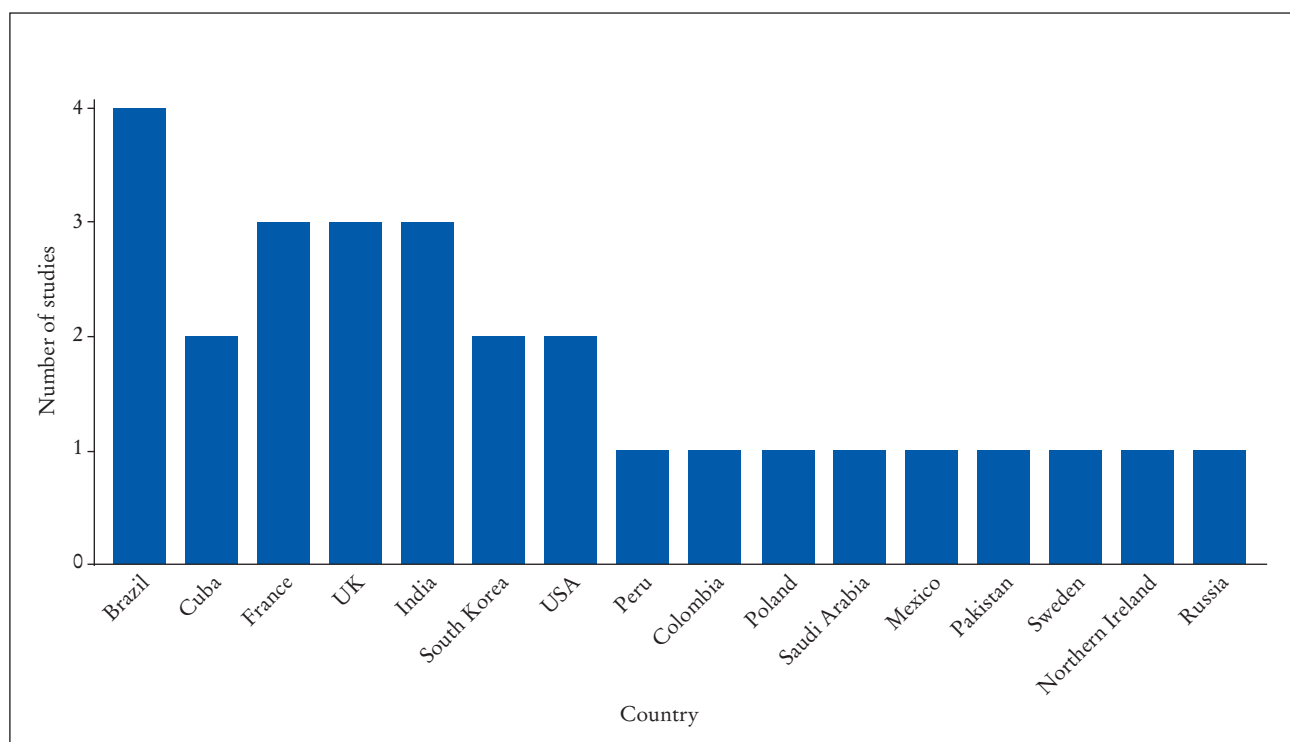


Figure 2. Distribution of studies included in review according to country of origin.

Table 2. Main characteristics of selected studies.

Author/year	Country	Type of study	Objective
Barnes <i>et al.</i> (1987) ¹⁵	USA	Quantitative	Determine the needs for evaluation in preventive dentistry, prophylaxis, elimination of tartar and periodontal treatment amongst inmates recently released from a state prison.
Heidari <i>et al.</i> (2007) ¹⁶	England	Quantitative	Investigate the general state of dental health, the behaviour and needs for dental treatment of temporarily detained persons.
Rocha Buelvas <i>et al.</i> (2010) ¹⁷	Colombia	Qualitative	Apply an academic perspective to evaluate dental health promotion amongst inmates.
Decerle <i>et al.</i> (2012) ¹⁸	France	Quantitative	Determine inmates' dental health in the current prison system, according to observations made in three French prisons.
Reddy <i>et al.</i> (2012) ¹⁹	India	Quantitative	Evaluate the state of dental health and treatment needs of inmates with life sentences and determine the dental health facilities in the central prisons of Karnataka.
Heidari <i>et al.</i> (2014) ²⁰	England	Quantitative	Highlight some of the common medical problems facing dental health professionals when treating inmates in men's prisons in the UK.
Heidari <i>et al.</i> (2014) ²¹	England	Qualitative	Describe a series of cases selected to demonstrate the complex problems posed by male inmates in Her Majesty's Prison, in Brixton (London). It also analyses the establishment of an interprofessional network of primary care relations in a prison setting involving a dentist and other health professionals.
Gray <i>et al.</i> (2014) ²²	Northern Ireland	Quantitative	Develop and test a triage protocol to prioritise dental care needs of patients in a prison setting and include dental health promotion and information about access to services.
Rodrigues <i>et al.</i> (2014) ²³	Brazil	Quantitative	Evaluate tooth loss and the need for prosthetic rehabilitation and the use of dental services amongst inmates.
Oliveira <i>et al.</i> (2015) ²⁴	Brazil	Quantitative	Evaluate the impact of the dental state of health on quality of life related to the dental health of male Brazilian adolescent detainees.
Fadel <i>et al.</i> (2015) ²⁵	Brazil	Qualitative	Explore the relationship between dental health, life trajectory and perceptions of inmates in vulnerable situations.
Singh <i>et al.</i> (2015) ²⁶	India	Quantitative	Evaluate the state of dental health and treatment needs of inmates to enable adequate services to be planned.
Treadwell <i>et al.</i> (2016) ²⁷	USA	Quantitative	Evaluate the barriers affecting inmates' access to dental health care before imprisonment in prison in Georgia.
Giraudeau <i>et al.</i> (2017) ²⁸	France	Quantitative	Discuss the challenges and opportunities for improving dental health in French prisons, especially through tele-dentistry.
Priwe <i>et al.</i> (2018) ²⁹	Sweden	Quantitative	Describe the state of dental health and the associated risk factors in a prison population at the time of entry into prison.
Kondratyev <i>et al.</i> (2019) ³⁰	Russia	Quantitative	Investigate the prevalence of dental diseases and evaluate OHI-S*, DMFT † and CPI‡ indexes amongst prison inmates.
Ley Sifontes <i>et al.</i> (2020) ³¹	Cuba	Quantitative	Evaluate the utility of a dental health education strategy in a Cuban prison.
Sharma <i>et al.</i> (2020) ³²	India	Quantitative	Evaluate the impact of imprisonment on the nutritional state and dental health of male inmates in Jaipur.
Coz <i>et al.</i> (2021) ³³	France	Qualitative	Analyse the perspectives of prison and hospital professionals on improving interprofessional relationships.
Ley Sifontes <i>et al.</i> (2022) ³⁴	Cuba	Qualitative	Design a systemic-procedural model for elderly adults in dental health promotion within in the prison setting.

(continuation)

Table 2. Main characteristics of selected studies (*continued*).

Author/year	Country	Type of study	Objective
Hwang <i>et al.</i> (2022) ³⁵	South Korea	Quantitative	Evaluate dental caries and compare the prevalence of same amongst inmates and the general public.
Pezo Jimenez <i>et al.</i> (2023) ³⁶	Perú	Quantitative	Describe conditions of access to dental health in Peruvian prisons.
Hwang <i>et al.</i> (2023) ³⁷	South Korea	Quantitative	Develop a dental triage system for South Korean prisons.
Haq <i>et al.</i> (2023) ³⁸	Pakistan	Quantitative	Evaluate dental healthcare seeking behaviours and associated factors in the Central Prison of Peshawar.
Fiegler-Rudol <i>et al.</i> (2024) ³⁹	Poland	Quantitative	Highlight the importance of dental health amongst prison inmates and disparities of access.
Gamboa Orozco (2024) ⁴⁰	Mexico	Quantitative	Differentiate between true and false dental emergencies during the SARS-CoV-2 outbreak to optimise triage in the CERESO of Campeche.
Riccioppo <i>et al.</i> (2025) ⁴¹	Brazil	Quantitative	Compare the productivity of dental health teams in prisons during the COVID-19 pandemic to the previous three years.
Shahin <i>et al.</i> (2025) ⁴²	Saudi Arabia	Quantitative	Evaluate dental caries and its predictors in prison in the Eastern Province.

Note. *OHI-S: simplified oral hygiene index; †DMFT: (index of) decayed, missing and filled teeth; ‡CPI: community periodontal index; §SARS-CoV-2: severe acute respiratory syndrome coronavirus 2; ||CERESO: Social Readaptation Centre; ¶COVID-19: 2019 coronavirus disease.

Another recurrent feature is the interconnection between dental health, mental health and social determinants. Prison inmates present worse indicators of general health and a higher prevalence of mental disorders^{16,20,35}. The evidence suggests that chronic pain, tooth loss and nutritional difficulties have a negative impact on quality of life, self-esteem and processes of social reintegration. In structural terms, these conditions should not be understood in isolation, but rather as an expression of accumulated social inequalities¹. Far from correcting these inequalities, prisons tend to deepen them when healthcare is organised in a fragmented and reactive manner.

Finally, there were proposals that reposition dental care in prisons as a strategic area of public health that articulates ethics and human rights. Strengthening primary care, integration with public health networks and implementation of standardised triage protocols are effective instruments for reorganising care.

According to Hwang *et al.*³⁷, the use of adapted triage categories enables better clinical prioritisation to be established along with a more rational allocation of resources. However, the technical reorganisation of a healthcare flow should be accompanied by structural reforms that acknowledge inmates as a subject of legislation. Guaranteed dental care is a concrete indicator of a public commitment to equality in health.

The main strengths of this scoping review include the rigorous application of a systematic methodology based on the PRISMA-ScR guidelines, which ensured transparency, reproducibility and clarity in the process of identifying, selecting and synthesising studies. The study also offers an updated systematisation of international scientific production on dental care in prison settings, enabling the identification of trends, gaps in knowledge and recurrent patterns of inequality that had not previously been integrated from a perspective of public health and human rights.

However, this review does have some limitations. The restriction to certain databases and specific languages may have excluded relevant research carried out in other geographical contexts. Furthermore, the fact that it was a scoping review meant that no formal critical evaluation was conducted on the methodological quality of the studies, which limits the possibilities for assessing the weight of the synthesised evidence. Finally, the heterogeneous nature of the designs, contexts and methodological approaches made it difficult to carry out more in-depth comparisons and identify the causal relations between variables.

Table 3. Main results and conclusions of the studies.

Author/year	Main results	Conclusions
Barnes <i>et al.</i> (1987) ¹⁵	93% required prophylaxis and removal of calculus, and 32% needed periodontal treatment; greater needs amongst the elderly and certain ethnic groups.	Sizeable periodontal demand indicates the need for better planning and distribution of resources in prison dental services.
Heidari <i>et al.</i> (2007) ¹⁶	High prevalence of mental and infectious diseases and high-risk behaviour; scarce dental health with a high percentage of caries and little treatment, focus on emergency treatment.	Temporarily detained inmates present poorer general and dental health than the general population.
Rocha Buelvas <i>et al.</i> (2010) ¹⁷	Serious deterioration of dental health due to poor infrastructure, low prevention and exclusion from health programs.	Promotion should be based on empowerment and recognition of inmates as subjects of legislation.
Decerle <i>et al.</i> (2012) ¹⁸	Period of imprisonment explained greater variability in tooth loss and functional units; greater chewing difficulties in long prison sentences.	Stable levels of oral infection maintained at the expense of a degraded chewing function.
Reddy <i>et al.</i> (2012) ¹⁹	Caries: 97.5%; DMFT*: 5.26; high need for hygiene, restoration and extraction.	Urgent government and organisational attention to improve dental health in prisons.
Heidari <i>et al.</i> (2014) ²⁰	Worse general and dental health than in the general population; high incidence of mental and infectious diseases and smoking.	Prison setting aggravates preexisting conditions and requires integrated services.
Heidari <i>et al.</i> (2014) ²¹	Interdisciplinary network improved information exchange and monitoring of vulnerable patients.	The IRN† improved access and allowed for more focused and effective care.
Gray <i>et al.</i> (2014) ²²	95% received a correct category in triage; 72% were treated in time; evaluation in <72 h for new inmates.	The system improved access and efficiency and reduced waiting times.
Rodrigues <i>et al.</i> (2014) ²³	Average loss of 11.3 teeth; 78.5% required prostheses; extraction was the main reason for treatment.	High dental vulnerability and need for prosthetic rehabilitation.
Oliveira <i>et al.</i> (2015) ²⁴	64% with negative impact on OHRQoL‡; greater impact with untreated caries and longer period of detention.	Untreated caries has a significant effect on quality of life.
Fadel <i>et al.</i> (2015) ²⁵	Limited perception of dental health based on previous trajectories; little influence of prison.	Non-injurious influence of studied condition on dental health.
Singh <i>et al.</i> (2015) ²⁶	Caries: 92.6%; DMFT increases with age; 24.3% with root caries.	High prevalence indicating need for regular dental care.
Treadwell <i>et al.</i> (2016) ²⁷	83% without regular dentist; 66% without insurance; 64% did not attend due to lack of money.	Urgent need to increase coverage and continuity of dental care.
Giraudeau <i>et al.</i> (2017) ²⁸	Tele-dentistry showed a reasonable match; 63% were incorrect but useful diagnoses for emergencies.	Tele-dentistry can improve access to and planning of care.
Priwe <i>et al.</i> (2018) ²⁹	66% with untreated caries; only 4.9% with healthy periodontum; 71% with drug use.	Access very limited and high vulnerability.
Kondratyev <i>et al.</i> (2019) ³⁰	High prevalence of caries (92.4%), periodontitis (55.7%) and dental pulp diseases (87.9%).	Need for public policies designed for prison dental care.
Ley Sifontes <i>et al.</i> (2020) ³¹	Improvement in hygiene (94.5%), information (91.7%) and reduction of risk factors.	Effective strategies with significant improvements in six months.
Sharma <i>et al.</i> (2020) ³²	Association between age and periodontal worsening; No significant differences in DMFT.	Need for structured hygiene and dental care in prisons.
Coz <i>et al.</i> (2021) ³³	Distinctive role of prison dentist; practice separated from other specialities.	Essential for health, self-esteem and social reintegration.

(continuation)

Table 3. Main results and conclusions of the studies (*continued*).

Author/year	Main results	Conclusions
Ley Sifontes <i>et al.</i> (2022) ³⁴	Educational model stimulated health behaviours and self-care.	Systematic integration of improved promotion and health education.
Hwang <i>et al.</i> (2022) ³⁵	Higher prevalence of caries and DMFT in prison inmates than amongst the general public.	Dental health significantly worse; incorporate self-evaluation in examinations.
Pezo Jimenez <i>et al.</i> (2023) ³⁶	Only 67.19% of prisons had dental services; 29 with assigned team.	Basic right of access to dental health is infringed.
Hwang <i>et al.</i> (2023) ³⁷	New more specific and sensitive triage system.	More effective model for improving care in South Korea.
Haq <i>et al.</i> (2023) ³⁸	Dental pain and use of prosthesis associated with lower frequency of visits.	Significant barriers to dental care exist.
Fiegler-Rudol <i>et al.</i> (2024) ³⁹	Greater incidence of oral diseases than in the general population; associated with sentences and bad conditions.	Educational programs and telemedicine can reduce inequalities.
Gamboa Orozco (2024) ⁴⁰	84% were false emergencies; 16% were real.	Relatively adequate control of dental condition suggested.
Riccioppo <i>et al.</i> (2025) ⁴¹	Regional inequalities and predominance of emergencies and extractions.	Low access that was not substantially modified during the pandemic.
Shahin <i>et al.</i> (2025) ⁴²	High prevalence of untreated caries; associated factors: age, sex, nationality and soft drinks.	Preventive measures and regular checkups urgently required.

Note. *DMFT: (index of) decayed, missing and filled teeth; †IRN: interdisciplinary relationship network; ‡ OHRQoL: oral health related quality of life.

CONCLUSIONS

The synthesis of the studies included in this scoping review showed that dental care in the prison system continues to be fragmented, mostly reactive and marked by profound structural inequalities. The high prevalence of dental pathologies amongst inmates reflects not only the scarcity in care, but also the reproduction of logics of social and institutional exclusion. This scenario shows that the right to dental health is still subordinate to a punitive reasoning, in which imprisonment symbolically extends outwards to access to and quality of healthcare.

Despite this state of affairs, innovative experiences were found that offer specific options for change. Educational strategies, standardised triage models and tele-dentistry show potential for reorganising care, pointing the way towards a more equal and humanised type of healthcare. This review also found evidence of scientific and ethical gaps: the scarcity of studies in low-income countries and the limited presence of qualitative and intersectional approaches restrict greater understanding of the complexities of dental health in prison settings.

CORRESPONDENCE

Jane Ignácio Reis Marcelino
 Universidade Estadual de Campinas (Unicamp)
 Cidade Universitária Zeferino Vaz.
 Barão Geraldo. Campinas - SP. Brasil
 E-mail: j264650@dac.unicamp.br

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