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ORIGINAL ARTICLE

Impact of Mobile Dental Clinics on the Quality of Life of Children

Almerinda Cavalcante de Amorim[1], Luciane Zanin[1], Flávia Martão Flório[1]

[1]Department of Preventive Dentistry, Faculty of Dentistry, São Leopoldo Mandic, Campinas, SP, Brazil.

Correspondence: Flávia Martão Flório, Rua José Rocha Junqueira, 13, Ponte Preta, Campinas, SP, Brasil. 13045-755. **E-mail:** flavia.florio@slmandic.edu.br

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ABSTRACT

Objective: To evaluate the impact of mobile dental clinics on the oral health-related quality of life (OHRQL) of children. **Material and Methods:** A longitudinal epidemiological study was conducted with participants from seven mobile dental clinics carried out between May 2019 and January 2020 by the NGO *Missão Sorrisos*. Parents and children who attended the program had their sociodemographic data collected. Both completed the Scale of Oral Health 5 (SOHO-5) self-reported questionnaire before treatment and again 30 days after treatment. **Results:** The improvement in the children's oral health after treatment at the mobile clinics is reflected in the pre-and post-treatment medians measured by the SOHO-5 total score from the children's own reports from the parents' reports. The procedures performed were effective in reducing pain and difficulties in eating, drinking, and sleeping. An improvement in the perception of the children's appearance and self-confidence was reported, both from the perspective of the parents/guardians and the children themselves. The chance of improvement in the perception of the children's oral health was greater for parents (OR=5.96; CI95%: 1.32-26.84) and children (OR=5.76; CI95%: 1.28- 25.95) from families whose main caregiver was not professionally active at the time of the study. **Conclusion:** The mobile dental clinics had a positive impact on the OHRQL of children from the perspective of the participants of the study.

Keywords: Longitudinal Studies; Quality of Life; Dental Caries; Child; Dentistry; Dental Care.

Introduction

Dental caries in both primary and permanent teeth are still a significant health problem in most countries and were among the ten diseases with the highest incidence in 195 countries and territories between 1990 and 2016 [1,2]. The disease affects 60-90% of school-age children and the vast majority of adults [1,3], and although a reduction in the total number of carious lesions has been observed in Latin America and the Caribbean, untreated lesions have increased in these regions [4].

Epidemiological studies conducted in Brazil and other countries have shown that most cavitated lesions in primary dentition remain untreated [5,6], with several factors influencing access to dental care [7]. The population that least seeks public dental treatment is between 5 and 19 years of age [8], and the factor of income plays a decisive role in preventing universal care [9].

Literature shows that caries in advanced stages if left untreated, can lead to aesthetic, functional, and psychological problems that impact daily life and affect the child's growth, weight gain, self-confidence, and socialization. Furthermore, they can affect the learning abilities and daily activities of children and parents [10,11], contributing to a negative impact on their quality of life [12].

Both international [6,13,14] and Brazilian [12,15-17] literature on the impact of conventional dental treatment on the QoL of children is extensive. However, there is no knowledge of studies that have evaluated the impact of dental care delivered by mobile dental clinics, taking the form of specific actions carried out in adapted and mobile spaces, whose social importance both in a Brazilian [18,19] and international [20,21] context has already been established.

Material and Methods

Type and Place of Study

An epidemiological, longitudinal study of a quantitative nature was conducted in Goiânia, the capital of the state of Goiás, located in the Brazilian Midwest, which has a Human Development Index (HDI) of 0.7998. The study was approved by the Ethics Committee for Research in Human under CAEE 29383020.8.0000.5378. All the children who participated in the study signed an Assent Form, and their direct guardians signed a Free and Informed Consent Form.

The socially-funded NGO *Missão Sorrisos* was created in June 2018 and provides free dental care to the population, treating adults and children who need preventive, curative, and or rehabilitative dental treatment, which is carried out by volunteer specialists. The mobile clinics are carried out every month in the most vulnerable regions of the city.

In all, seven monthly mobile clinics were carried out between May 2019 and January 2020, on Saturdays, from 8:00 am to 6:00 pm, and pediatric clinical care was performed by a single specialist.

Sample Characterization and Inclusion and Exclusion Criteria

The convenience sample consisted of all children between 4 and 12 years old who attended the seven mobile clinic groups carried out in the period and who had dental caries at the dentin level, a need for extractions, and/or who complained of pain in the *anamnesis*. To be included in the study, the direct guardians of the treated children had to agree to participate and provide documents proving their familial link with the child, ensuring accuracy in the answers to the questionnaire. The children had to be able to answer the questionnaire without the presence of their parents.

Experimental Design

After training, during screening, two professionals invited the participants of the mobile clinics to participate in the study and were responsible for applying the questionnaires through interviews.

The questionnaire was applied among those who agreed to participate, and the children were referred to for dental treatment by the researcher. The questionnaire included questions about the sociodemographic characteristics of the children and their parents/guardians, as well as the Scale of Oral Health Outcomes for 5-year-old children (SOHO-5), which was translated according to transcultural use in Brazil. SOHO-5 consists of the child's self-report (SOHO-5c) and the secondary parent's report (SOHO-5p) on the child's OHRQL, each of which is structurally composed of seven items, six of which have similar content in the child and parent versions [5,22].

The seven items in the SOHO-5c version address difficulty eating; drinking, speaking; playing, and sleeping, as well as avoiding smiling due to pain and appearance. Each item has three response options: no = 0; a little = 1; and a lot = 2 [22]. The SOHO-5p version addresses the parent/guardian's perception of the child's difficulty eating, speaking, playing, sleeping, and avoiding smiling due to pain and appearance, and includes a question about whether the child's self-confidence is affected by their teeth.

Thirty days after having each mobile dental clinic, the SOHO-5 versions were reapplied by phone call, by a trained professional. To avoid interference from the participants, the children were invited to answer first, with their parents asked to wait some distance away, and in silence, and to come to the phone only when it was their turn to answer questions. When the child was not at home, the call was made on another occasion.

Figure 1 details the steps of the experimental sequence in each mobile dental clinic:

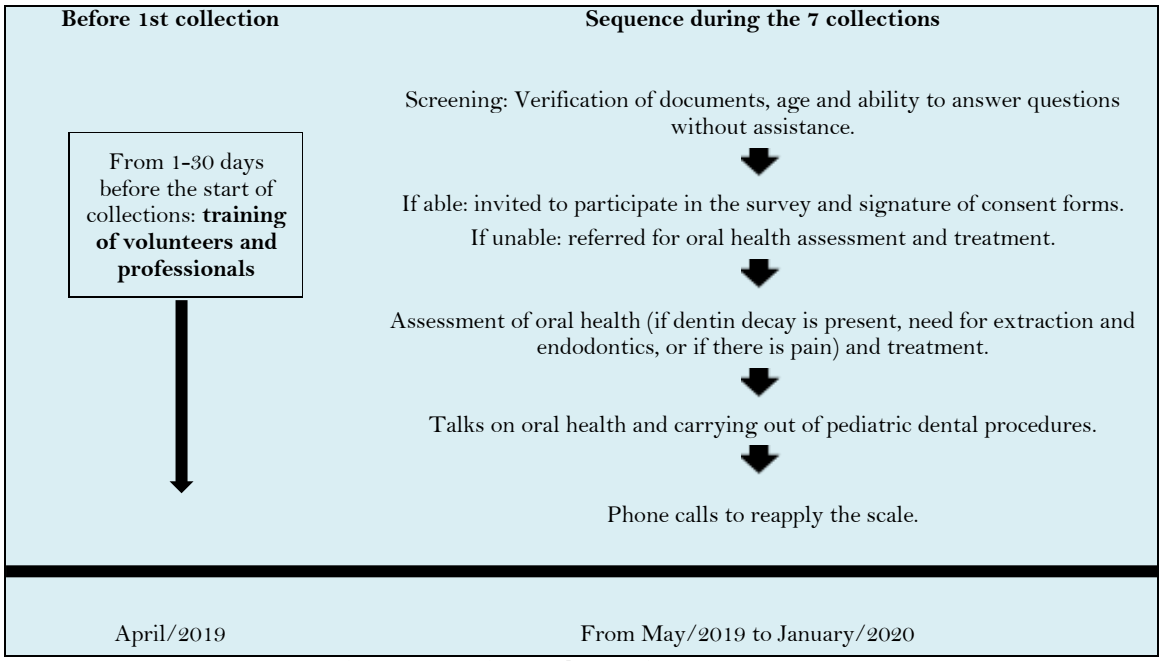

Figure 1. Design and experimental sequence.

Data Analysis

The total score for each of the SOHO-5 versions was calculated from the sum of the answers. In the parental version, the response options were grouped into three categories (no = 0; a little = 1; moderate/a lot = 2) [23,24]. In the present study, the cutoff point was the median calculated for both versions, with scores higher than the median indicative of a greater impact on the child's OHRQL.

First, a descriptive analysis of the data was performed. Absolute and relative frequencies, median, minimum and maximum values were used for this purpose. The analysis of agreement between the answers in the initial and final applications of each question of the SOHO-5 instrument was performed using the Bowker symmetry test.

Comparisons between the overall results at the beginning and end of the study were made using the nonparametric Wilcoxon test for paired samples. Next, simple logistic regression models were estimated between each sociodemographic variable and the scores of perception of parents and children about the improvement in oral health after treatment at the mobile clinic. Variables with $p<0.20$ in this crude analysis were examined in multiple models, with those with $p\leq0.05$ remaining in the final model. The odds ratios were estimated from the models with their respective 95% confidence intervals. The fit of the models was analyzed using the Akaike Information Criterion (AIC). Analyzes were performed using the R program with a significance level of 5%.

Results

A total of 325 children participated in pediatric dental care as part of the mobile clinics, of whom 143 were enrolled in the study, with a mean age of 7.8 ± 2.2 years, and met the inclusion and exclusion criteria. In addition to prophylaxis and the topical application of fluoride, the following invasive procedures were performed on these children: 43 anterior restorations, 284 posterior restorations, 99 extractions, eight endodontic procedures on the deciduous teeth, and seven expectant treatment procedures.

Table 1 shows the sociodemographic characteristics of the parents/guardians of the children. Most are female, white, aged between 25 and 35 years old, and have completed elementary school. Also, most had up to three children, were working, received one to two times the minimum wage (MW), which was R$1,045.00 (one thousand and forty-five reais) and had two or more dependents on this income.

Table 1. Descriptive analysis of the sociodemographic variables of the parents/guardians.

Variables	N (%)
Gender	
Female	124 (86.7)
Male	19 (13.3)
Skin color	
White	85 (59.4)
Black	42 (29.4)
Brown	16 (11.2)
Marital Status	
Married	55 (38.5)
Divorced	53 (37.1)
Single	22 (15.4)
Widowed	13 (9.1)
Age Group (years)	
18-25	2 (1.4)
25-35	92 (64.3)
35-45	48 (33.6)
Over 45	1 (0.7)
Schooling	
None	17 (11.9)
Incomplete elementary school	64 (44.8)
Complete elementary school	12 (8.4)
Incomplete high school	35 (24.5)

Variables	N (%)
Complete high school	15 (10.5)
Number of Children	
Up to 3	122 (85.3)
More than 3	21 (14.7)
Professional Situation	
Active	123 (86.0)
Other	20 (14.0)
Income (Brazilian Minimum Salary)	
None	2 (1.4)
Less than 1	15 (10.5)
From 1 to 2	126 (88.1)
Dependent People/ Income	
No income	1 (0.7)
1	24 (16.8)
2	78 (54.6)
3 or more	40 (28.0)

From the versions of the SOHO instrument, in the assessment before receiving treatment at the mobile clinic, the highest score reported was 9 in the child's self-report and 7 in the parental version, with the mean total score being 1.4 (±1.7) for SOHO-5c and 1.7 (±1.9) for SOHO-5p. Thirty days after treatment at the mobile clinic, the highest score for the self-report of the child and the guardian was 2 and 3, respectively, with the mean total measured scores being 0.0 (±0.2) for SOHO- 5c and 0.2 (±0.5) for SOHO-5p. Table 2 shows a significant decrease in the median of the SOHO-5 total score and a consequent improvement in the perception of oral health among parents/guardians and children ($p<0.05$).

Table 2. Median of the total scores for parents/guardians and children, from the SOHO-5 instrument, before and after treatment at the mobile dental clinic.

Time	Parents/Guardians Median (Min.-Max.)	Children Median (Min.-Max.)
Initial	1.0 (0.0-8.0)	1.0 (0.0-9.0)
Final	0.0 (0.0-3.0)	0.0 (0.0-2.0)
p-value	<0.0001	<0.0001
Perception of improvement (decrease in score)	92 (64.3%)	93 (65.0%)
Perception of no change	50 (35.0%)	50 (35.0%)
Worsening perception (increase in score)	1 (0.7%)	0 (0.0%)

Table 3 shows the results of the parents' answers regarding the perception of their child's oral health in each SOHO-5 question, before and after the child's treatment at the mobile clinic. For 43.4% and 3.5% of the parents, the child had little and reasonable difficulty eating, respectively, and no longer had any difficulties after treatment ($p<0.05$). Furthermore, the various difficulties of the children were felt more by parents/guardians before treatment at the mobile clinic care, while there was a major improvement in this perception after treatment.

Table 3. Distribution of responses from parents/guardians in the questions of the SOHO-5p instrument before and after treatment of their children at the mobile dental clinic.

Topic	Initial Time	Final Time		
		No N (%)	A little / More or less N (%)	Moderate / A lot N (%)
Difficulty Eating	No	67 (46.8)	2 (1.4)	1 (0.7)
	A little/More or less	62 (43.4)	2 (1.4)	1 (0.7)
	Moderate/A lot	5 (3.5)	2 (1.4)	1 (0.7)
	p-value		<0.0001	
Difficulty Speaking	No	127 (88.8)	0 (0.0)	0 (0.0)

	A little/More or less	14 (9.8)	2 (1.4)	0 (0.0)
	Moderate/A lot	0 (0.0)	0 (0.0)	0 (0.0)
	p-value		0.0002	
Difficulty Playing	No	127 (88.8)	1 (0.7)	0 (0.0)
	A little/More or less	14 (9.8)	0 (0.0)	0 (0.0)
	Moderate/A lot	1 (0.7)	0 (0.0)	0 (0.0)
	p-value		0.0005	
Difficulty Sleeping	No	112 (78.3)	0 (0.0)	0 (0.0)
	A little/More or less	29 (20.3)	1 (0.7)	0 (0.0)
	Moderate/A lot	1 (0.7)	0 (0.0)	0 (0.0)
	p-value		<0.0001	
Difficulty Smiling/Pain	No	112 (78.3)	0 (0.0)	0 (0.0)
	A little/More or less	30 (21.0)	1 (0.7)	0 (0.0)
	Moderate/A lot	0 (0.0)	0 (0.0)	0 (0.0)
	p-value		<0.0001	
Embarrassment Smiling/Appearance	No	113 (79.0)	0 (0.0)	0 (0.0)
	A little/More or less	28 (19.6)	2 (1.4)	0 (0.0)
	Moderate/A lot	0 (0.0)	0 (0.0)	0 (0.0)
	p-value		<0.0001	
Self-Confidence Affected	No	107 (75.4)	0 (0.0)	0 (0.0)
	A little/More or less	32 (22.5)	3 (2.1)	0 (0.0)
	Moderate/A lot	0 (0.0)	0 (0.0)	0 (0.0)
	p-value		<0.0001	

Table 4 shows the results of the children's responses before and after treatment. It was found that 71 children had difficulty eating, and 68 of them (95.8%) perceived improvement after treatment ($p<0.05$). Difficulty speaking and playing was perceived by 16 children, and all perceived improvement (100.0%). Also, 25, 27, 32, and 45 children had difficulty sleeping, smile/pain, difficulty smiling/appearance, and difficulty drinking, respectively, and all experienced improvement after treatment. Children also showed significant reductions in their felt difficulties after participating in the mobile clinics.

Table 4. Distribution of children's responses to the questions of the SOHO -5c instrument in the period before and after assistance by the mobile dental clinic.

Topic	Initial Time	Final Time		
		No N (%)	Moderate N (%)	A lot N (%)
Difficulty eating	No	71 (50.0)	0 (0.0)	0 (0.0)
	Moderate	62 (43.7)	3 (2.1)	0 (0.0)
	A lot	5 (3.5)	1 (0.7)	0 (0.0)
p-value			<0.0001	
Difficulty speaking	No	127 (88.8)	0 (0.0)	0 (0.0)
	Moderate	16 (11.2)	0 (0.0)	0 (0.0)
	A lot	0 (0.0)	0 (0.0)	0 (0.0)
p-value			-	
Difficulty playing	No	126 (88.7)	0 (0.0)	0 (0.0)
	Moderate	16 (11.3)	0 (0.0)	0 (0.0)
	A lot	0 (0.0)	0 (0.0)	0 (0.0)
p-value			-	
Difficulty sleeping	No	118 (82.5)	0 (0.0)	0 (0.0)
	Moderate	23 (16.1)	0 (0.0)	0 (0.0)
	A lot	2 (1.4)	0 (0.0)	0 (0.0)
p-value			-	
Difficulty smiling/pain	No	116 (81.1)	0 (0.0)	0 (0.0)
	Moderate	27 (18.9)	0 (0.0)	0 (0.0)
	A lot	0 (0.0)	0 (0.0)	0 (0.0)
p-value			-	
Difficulty smiling/ appearance	No	109 (76.2)	0 (0.0)	0 (0.0)
	Moderate	31 (21.7)	2 (1.4)	0 (0.0)
	A lot	1 (0.7)	0 (0.0)	0 (0.0)
p-value			<0.0001	
Difficulty drinking	No	98 (68.5)	0 (0.0)	0 (0.0)
	Moderate	44 (30.8)	0 (0.0)	0 (0.0)
	A lot	1 (0.7)	0 (0.0)	0 (0.0)
p-value			-	

Table 5 shows the results of the associations. Only the professional activity of the parents influenced the perception of improved oral health after participation in the mobile clinics. Parents who were not working were 5.96 (IC95%: 1, 32-26.84) times more likely to notice an improvement in the child's oral health after treatment than working parents (p<0.05), and children born to parents who were not working were 5.76 (IC95%: 1.28-25.95) times more likely to notice an improvement in their oral health after treatment than children of working parents (p<0.05).

Table 5. Analyzes of associations with the perception of improvement in children's oral health (decrease in the SOHO-5 score) after treatment at the mobile dental clinic.

Variables	Category	N (%)	Parent's perception of their child's oral health		Crude OR (CI95%)	p-value	OR Final Model (CI95%)	p-value
			*Improvement N (%)	No improvement N (%)				
Parents/Guardians								
Gender	Female	124 (86.7)	81 (65.3)	43 (34.7)	1.37 (0.51-3.66)	0.5302	-	-
	Male	19 (13.3)	11 (57.9)	8 (42.1)	Ref			
Skin color	White	85 (59.4)	56 (65.9)	29 (34.1)	Ref		-	-
	Black	42 (29.4)	25 (59.5)	17 (40.5)	0.76 (0.36-1.63)	0.4835		
	Brown	16 (11.2)	11 (68.8)	5 (31.2)	1.14 (0.36-3.59)	0.8239		
Marital status	Married	55 (38.5)	37 (67.3)	18 (32.7)	1.23 (0.60-2.51)	0.5624	-	-
	Single	88 (61.5)	55 (62.5)	33 (37.5)	Ref			
Age group	Under 35 years old	94 (65.7)	61 (64.9)	33 (35.1)	1.07 (0.52-2.20)	0.8470	-	-
	35 years or older	49 (34.3)	31 (63.3)	18 (36.7)	Ref			
Schooling	Up to elementary school	93 (65.0)	63 (67.7)	30 (32.3)	1.52 (0.75-3.09)	0.2474	-	-
	Above elementary school	50 (35.0)	29 (58.0)	21 (42.0)	Ref			
Number of children	Up to 3	122 (85.3)	76 (62.3)	46 (37.7)	Ref		-	-
	More than 3	21 (14.7)	16 (76.2)	5 (23.8)	1.94 (0.66-5.64)	0.2254		
Professional situation	Active	123 (86.0)	74 (60.2)	49 (39.8)	Ref		Ref	
	Others	20 (14.0)	18 (90.0)	2 (10.0)	5.96 (1.32-26.84)	0.0201	5.96 (1.32-26.84)	0.0201
Income	Less than 1 MW	17 (11.9)	14 (82.4)	3 (17.6)	2.87 (0.78-10.51)	0.1111	-	-
	From 1 to 2 MW	126 (88.1)	78 (61.9)	48 (38.1)	Ref			
Income dependents	Up to 1	25 (17.5)	16 (64.0)	9 (36.0)	Ref		-	-
	2	78 (54.6)	52 (66.7)	26 (33.3)	1.12 (0.44-2.89)	0.8065		
	3	40 (28.0)	24 (60.0)	16 (40.0)	0.84 (0.30-2.37)	0.7472		
Children								
Gender	Female	124 (86.7)	82 (66.1)	42 (33.9)	1.42 (0.53-3.80)	0.4848	-	
	Male	19 (13.3)	11 (57.9)	8 (42.1)	Ref			
Skin color	White	85 (59.4)	55 (64.7)	30 (35.3)	Ref		-	
	Black	42 (29.4)	25 (59.5)	17 (40.5)	0.80 (0.38-1.72)	0.5696		-
	Brown	16 (11.2)	13 (81.2)	3 (18.8)	2.36 (0.62-8.95)	0.2056		
Marital status	Married	55 (38.5)	35 (63.6)	20 (36.4)	0.90 (0.45-1.83)	0.7816	-	-
	Not married	88 (61.5)	58 (65.9)	30 (34.1)	Ref			
Age group	Less than 35 years	94 (65.7)	64 (68.1)	30 (31.9)	1.47 (0.72-3.01)	0.2905	-	
	35 years or more	49 (34.3)	29 (59.2)	20 (40.8)	Ref			-

Schooling	Until elementary school	93 (65.0)	64 (68.8)	29 (31.2)	1.60 (0.78-3.26)	0.1973	-	
	Above Elementary school	50 (35.0)	29 (58.0)	21 (42.0)	Ref			-
Number of children	Up to 3	122 (85.3)	77 (63.1)	45 (36.9)	Ref		-	
	More than 3	21 (14.7)	16 (76.2)	5 (23.8)	1.87 (0.64-5.45)	0.2513		-
Professional situation	Active	123 (86.0)	75 (61.0)	48 (39.0)	Ref		Ref	
	Others	20 (14.0)	18 (90.0)	2 (10.0)	5.76 (1.28-25.95)	0.0226	5.76 (1.28-25.95)	0.0226
Income (Minimum wage)	Less than 1	17 (11.9)	14 (82.4)	3 (17.6)	2.78 (0.76-10.17)	0.1231	-	
	From 1 to 2	126 (88.1)	79 (62.7)	47 (37.3)	Ref			
Dependent People/income	Up to 1	25 (17.5)	16 (64.0)	9 (36.0)	Ref		-	
	2	78 (54.6)	53 (68.0)	25 (32.0)	1.19 (0.46-3.07)	0.7150		-
	3	40 (28.0)	24 (60.0)	16 (40.0)	0.84 (0.30-2.37)	0.7472		-

*Event for the outcome variable; OR: Odds ratio; CI: Confidence Interval; Ref: Reference category for independent variables; Parents/guardians: AIC (empty model) = 188.32; AIC (final model) = 182.40; Children: AIC (empty model) = 187.11; AIC (final model) = 181.54.

Discussion

Dental treatment carried out at the mobile dental clinic significantly improved children's OHRQL in both the reports of the parents and children and this perception was more likely to be observed in families where the main caregiver did not work outside the home.

Oral health problems, especially those related to dental caries can affect children's daily lives. The assessment of the impact of measures that can mitigate the suffering of children and positively impact their OHRQL has been growing around the world [1,15,25,26]. Notwithstanding such advances, the present study is, to our knowledge, the first to demonstrate the short-term effects on OHRQL in children treated at mobile dental clinics.

The children included in the present study had lesions at the tooth level, which justifies the fact that the most performed invasive procedures were restorations, followed by tooth extractions. The presence of untreated caries can significantly affect well-being in the act of eating, causing discomfort and modifying eating patterns [27], in addition to causing difficulties with sleep, fluid intake, and the acceptance of appearance [28-30]. Although a previous study has shown that traditional and well-executed pediatric dental care has a positive effect on children's OHRQL [24], this phenomenon was also observed at the mobile clinics in the present study, where care is provided as the result of a need for treatment.

There is evidence of an association between caries and a worse OHRQL in the perception of children and their parents [16], but it has also been reported that families facing greater socioeconomic disadvantages may report a lower impact on quality of life at the same level of experience of caries [31], which may be a justification for the low pre-study SOHO-5 mean values found in the present study. In general, OHRQL improved in 65% of children and 64.3% of parents/guardians, which is consistent with previous results [32], and shows agreement between parent and child responses, as both perceived and reported an improvement in QoL after dental treatment in nontraditional contexts, in a school context, and in a mobile dental clinic.

Mobile dental clinics have emerged as an effective method of alleviating suffering and restoring the OHRQL of children such as those in the present study. In Brazil, one-fifth of Basic Health Units do not provide dental care to children [33]. More specifically, in the state of Goiás, even though an increase in population coverage of oral health has been observed, the access of the most vulnerable populations to these services has not increased proportionately [34]. Considering that a single pediatric dental rehabilitation in Brazil costs an average of R$150,00, according to the Regional Council of Dentistry/Goiás (RCD-GO) and the Brazilian Dental Association/Goiás (BDA-GO), treating the rehabilitation needs of the studied group would certainly strain the budgets of most families included in the present study, whose average income is 1 to 2 minimum wages (MW = R$ 1,045.00).

Literature has shown that black (Afro-Brazilian) and brown (mixed ethnicity) children have reported worse OHRQL when assessed by SOHO-c [34], although, in the present study, no association with skin color was found, probably due to the fact that the predominance of families self-classified as white.

A previous study has argued that parents who work outside the home, because they have less daily contact with their children, may not have the perfect overview of their children's OHRQL and, therefore, provide information that differs from that which the children themselves provide [35]. This may help to explain the finding of the present study that parents/guardians who did not work outside the home were more likely to notice an improvement in OHRQL after treatment at the mobile dental clinics; this suggests that parents/guardians who are closer to their children notice behaviors they would not notice if they worked outside the home [36]. The time that parents, especially women (who made up the majority of the sample in the present study), manage to spend with their children is important not only for getting to know the child [36] but also for the development of healthy oral health behaviors in them [37,38]. In the same way, children of parents/guardians who did not work outside the home were also more likely to perceive the impact of the treatment carried out at the mobile clinic on their OHRQL, perhaps because the adults help the children notice the differences in their daily activities.

Due to the nature of the present study, it is possible that a feeling of gratitude contributed to the responses, which indicated an improvement in the OHRQL of children 30 days aftercare. However, the training of professionals responsible for the interviews, and their non-active participation in the clinical care carried out at the mobile clinic is likely to have alleviated this bias. It is also worth noting that the final assessment was conducted by telephone, which would encourage a negative response in relation to the improvement in OHRQL, as it is easier for the respondent to deny this improvement over the phone than in person. The longitudinal design of the present study, the careful selection of the sample, and the use of SOHO -5 in its two versions give the study adequate internal validity to assess the effect of the mobile clinics on OHRQL in the two phases of the study, thus mitigating the differences between the perceptions of parents and children found in previous studies which also consider the presence of advanced lesions as an inclusion criterion [39].

The present study is limited when it comes to extrapolating the results to the general population. However, it is important to show that for the vulnerable population that receives treatment from mobile health clinics, the impact on QoL is positive, and the human and social investment needed to maintain them in this post-pandemic era is valid.

Conclusion

Pediatric dental care provided by mobile dental clinics was effective at alleviating factors that cause suffering and, therefore, affect the OHRQL of children in vulnerable conditions, both in their own perception

and in the perception of their parents/guardians. It was to be expected that the present study would efficiently reach its goals, as the assistance of trained professionals with quality material resources is an undeniable advantage to the recipients. However, other aspects are worth mentioning, such as the mobilization of a care strategy for the population, rather than the opposite; the quick response to the oral health needs of the volunteers; and the short-term relief of suffering (30 days), which efficiently meets the related demands.

Nevertheless, we recognize that no matter how efficiently the mobile dental clinic format meets these demands, several obstacles must be overcome to value and strengthen public dental care as provided for by the national oral health policy, ensuring access to health in a universal, equitable, and integral manner for all.

Authors' Contributions

ACA	https://orcid.org/0000-0003-2753-7425	Conceptualization, Investigation, Writing - Original Draft and Writing - Review and Editing.
LZ	https://orcid.org/0000-0003-0218-9313	Writing - Original Draft and Writing - Review and Editing.
FMF	https://orcid.org/0000-0001-7742-0255	Conceptualization, Writing - Original Draft, Writing - Review and Editing and Project Administration.

All authors declare that they contributed to critical review of intellectual content and approval of the final version to be published.

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Conflict of Interest

The authors declare no conflicts of interest.

Data Availability

The data used to support the findings of this study can be made available upon request to the corresponding author.

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