for the surgical treatment of clefts during this period amounted to approximately US $ 670 million; however only 18.9% of live-born infants with OFCs received surgical treatment during this period. There are several possible explanations for the delay or lack of treatment. One major contributing factor is the geographic distance between the nearest reference centre and some of the remote regions, which is associated with high travel costs, leading many families to give up on follow-up treatment[6]. This highlights the need for increased national and international efforts to provide specialized care for individuals with OFCs.

Funding

This work was financially supported by the Brazilian National Council for Scientific and Technological Development (CNPq) and the Coordination for the Improvement of Higher Education Personnel (CAPES). J. L.G.C. Monteiro and J.A.A. de Arruda are receiving a master's scholarship.

Competing interests

The authors declare no conflict of interest.

Ethical approval

Not applicable.

Patient consent

Not applicable.

J.L.G.C. Monteiro*
Department of Oral and Maxillofacial Surgery, School of Dentistry, Universidade de Pernambuco, Camaragibe, PE, Brazil

J.A.A. de Arruda
Department of Oral Surgery and Pathology, School of Dentistry, Universidade Federal de Minas Gerais, Belo Horizonte, MG, Brazil

D.F. Bueno
Institute of Teaching and Research of Sírio Libanês Hospital, São Paulo, SP, Brazil

B.C.d.E. Vasconcelos
Department of Oral and Maxillofacial Surgery, School of Dentistry, Universidade de Pernambuco, Camaragibe, PE, Brazil

*Address: Dr João Luiz G. C. Monteiro, Faculdade de Odontologia, Universidade de Pernambuco (FOP/UPE), Av. Gen. Newton Cavalcanti, 1650, Tabatinga, Camaragibe, PE, CEP: 54.753-220, Brazil. Tel.: +55 81 999961258.
E-mail address: joaoluizgcm2@gmail.com (J.L.G.C. Monteiro)

References

1. Best DL, Gauger TL, Dolan JM, Donnelly LA, Ranganathan K, Ulloa-Marin C, Sung-Hsieh HH. Orofacial cleft management by short-term surgical missions in South America: literature review. *Int J Oral Maxillofac Surg*)2018;(June). http://dx.doi.org/10.1016/j.ijom.2018.05.025. [Epub ahead of print].
2. Nagem Filho H, Moraes N, Rocha RG. Contribuição para o estudo da prevalência das más formações congênitas lábio-palatais na população escolar de Bauru. *Rev Fac Odontol Univ SÐo Paulo* 1968;**6**:111–28.
3. Spina V. A proposed modification for the classification of cleft lip and cleft palate. *Cleft Palate J* 1973;**10**:251–2.
4. Almeida AM, Chaves SC, Santos CM, Santana SF. Care for cleft lip and palate patients: modeling proposal for the assessment of specialized centers in Brazil. *Saºde em Debate* 2017;**41**:156–66. http://dx.doi.org/10.1590/0103-11042017s12.
5. Brito LA, Bassi CF, Masotti C, Malcher C, Rocha KM, Schlesinger D, Bueno DF, Cruz LA, Barbara LK, Bertola DR, Meyer D, Franco D, Alonso N, Passos-Bueno MR. IRF6 is a risk factor for nonsyndromic cleft lip in the Brazilian population. *Am J Med Genet A* 2012;**158A**:2170–5. http://dx.doi.org/10.1002/ajmg.a.35526.
6. Sousa GF, Roncalli AG. Orofacial clefts in Brazil and surgical rehabilitation under the Brazilian National Health System. *Braz Oral Res* 2017;**31**:e23. http://dx.doi.org/10.1590/1807-3107BOR-2017.vol31.0023.

https://doi.org/10.1016/j.ijom.2018.09.007

Response to comments on ''Orofacial cleft management by short-term surgical missions in South America: literature review''

We thank the authors of the letter entitled ''Five decades of orofacial cleft management and research in Brazil''[1] for their comments on our article regarding short-term surgical missions for the management of orofacial clefts (OFCs) in South America[2]. It was certainly not our intention to minimize the efforts of the Brazilian cleft team; we are truly glad for the advancements they have made since 1967. We agree that there is a need to increase national efforts in South America and international collaborative support to provide specialized care for patients with OFCs. Therefore, the aim was to review the literature describing OFC surgical missions in South America and to provide an insight into and explanation for the existence of surgical missions to assist local OFC patients.

We appreciate the information provided regarding the guarantee of OFC surgeries and management under Brazilian law. In fact, Brazilian health coverage resembles that in Chile. Both countries offer similar constitutional healthcare rights, albeit with some differences, one being that Brazilian OFC coverage, based on a decentralized regional network, results in regional disparities in public resource distribution[3]. Consequently, only 18.9% of live-born infants with OFCs in Brazil received surgical treatment under Brazilian public funds during 2009–2013[4]. On the other hand, Chile covers OFC surgeries through their Plan of Explicit Health Guarantees (GES/AUGE), a special health benefits package. This plan guarantees access, quality, opportunity (within a maximum waiting time), and financial protection to all National Health Fund and private health insurance OFC affiliates[5,6].

Funding

None.

Competing interests

None.

Ethical approval

Not required.

Patient consent

Not required.

H.H. Sung-Hsieh[12*]
[1] *Oral and Maxillofacial Surgery, University of Michigan, Ann Arbor, Michigan, USA*

[2] *Oral and Maxillofacial Surgery, Universidad de Chile, Santiago, Chile*

*Address: Hsiao Hsin Sung-Hsieh, Department of Oral and Maxillofacial Surgery, School of Dentistry, University of Michigan, 1011 N. University Ave. Rm 2010, Ann Arbor, MI 48109, USA. Tel: +1 734 764 1542; Fax: +1 734 615 1415
E-mail address: sunghsie@umich.edu (H.H. Sung-Hsieh)

References

1. Monteiro JL, de Arruda JA, Bueno DF, Vasconcelos BC. Five decades of orofacial cleft management and research in Brazil. *Int J Oral Maxillofac Surg* 2018. http://dx.doi.org/10.1016/j.ijom.2018.09.007. [Epub ahead of print].
2. Best DL, Gauger TL, Dolan JM, Donnelly LA, Ranganathan K, Ulloa-Marin C, Sung-Hsieh HH. Orofacial cleft management by short-term surgical missions in South America: literature review. *Int J Oral Maxillofac Surg*)2018;(June). http://dx.doi.org/10.1016/j.ijom.2018.05.025. [Epub ahead of print].
3. Ribeiro JM, Moreira MR, Ouverney AM, Silva CMFPD. Health policies and federative gaps in Brazil: an analysis of regional capacity of services delivery. *Cien Saude Colet* 2017;**22**:1031–44.
4. Sousa GF, Roncalli AG. Orofacials clefts in Brazil and surgical rehabilitation under the Brazilian National Health System. *Braz Oral Res* 2017;**31**:e23. http://dx.doi.org/10.1590/1807-3107BOR-2017.vol31.0023.
5. Bastias G, Pantoja T, Leisewitz T, Zarate V. Health care reform in Chile. *CMAJ* 2008;**179**:1289–92.
6. Missoni E, Solimano G. *Towards universal health coverage: the Chilean experience. World Health Report 2010, background paper, number 4*. World Health Organization; 2010: 11–5.

https://doi.org/10.1016/j.ijom.2018.09.008

Re: ''Orofacial cleft management by short-term surgical missions in South America: literature review''

In light of the article by Best et al. regarding short-term surgical missions as a means to deliver surgical expertise and alleviate the growing demand for surgical care, especially as it relates to patients with congenital orofacial clefts, we offer you this summary of Smile Train's supported programs and model in the region as a proven successful alternative to addressing such needs[1].

Since 2000, Smile Train has supported local hospitals and cleft care professionals across the Americas through funding and capacity building initiatives. The organization's footprint in the region spans more than 112,000 cleft surgeries and 224 hospitals in 25 countries since inception. More specifically in South America, Smile Train has supported the work of cleft teams to provide more than 60,000 cleft surgeries through its sustainable partnership model. Currently, Smile Train's treatment partnerships in South America include approximately 200 surgeons at more than 150 local hospitals across eight countries, and will continue to grow as the organization works with dedicated medical professionals and other supporters to expand patient access to safe, timely, high-quality cleft care within South America.

Smile Train's success has been achieved by utilizing its 'teach a man to fish' model, which at its core is committed to training and empowering local medical professionals and hospitals to provide 100% free, safe, quality, comprehensive cleft treatment. It is important to mention that some of the leading global cleft lip and palate institutions are based in Mexico and Central and South America, and Smile Train is proud to support their efforts to train the next generation of cleft care providers. Smile Train also leverages cutting-edge technology and innovative training techniques to enhance and grow its long-term, sustainable solution, not only in the Americas, but in 85+ countries around the world[2].

Smile Train does not rely on short-term surgical missions to meet the needs of the populations it serves, rather it ensures timely treatment and follow-up is available on an ongoing basis year-round, by empowering local providers with funding (to cover certain costs associated with treatment), education and training, community outreach and awareness, medical equipment and supplies, patient and family resources, or other types of essential support, depending on the specific local needs. This support is provided to ensure that patients in need can access treatment without suffering financial ruin until the professional or hospital is able to ensure the availability of treatment for these patients without Smile Train support. Using this bidirectional partnership model, Smile Train is able not only to ensure the availability of cleft care, but also to increase cleft surgical capacity. Short-term surgical missions may address the immediate cleft care needs, but by design they are not equipped to offer the same level of longitudinal effectiveness that the partnership model can provide[3]. As Smile Train's programs in the Americas continue to grow and close the gap between new cleft births and primary cleft treatments, we will use the tools at our disposal, as well as continue to develop more, to put medical professionals dedicated to cleft at the frontline of innovation and patients at the center of safe and top quality comprehensive cleft care.

Funding

None.

Competing interests

Smile Train — Chairman of the Medical Advisory Board.

Ethical approval

Not required.

Patient consent

Not applicable.

L. Hollier*
Surgeon in Chief, Texas Children's Hospital, Chief of Plastic Surgery, Baylor College of Medicine, Houston, Texas, USA

*Address: Larry Hollier, Baylor College of Medicine, Houston, Texas, USA.
E-mail address: larryh@bcm.edu (L. Hollier)

References

1. Best DL, Gauger TL, Dolan JM, Donnelly LA, Ranganathan K, Ulloa-Marin C, Sung-Hsieh HH. Orofacial cleft management by short-term surgical missions in South America: literature review. *Int J Oral Maxillofac Surg* 2018;**47**:1373–80. http://dx.doi.org/10.1016/j.ijom.2018.05.025.
2. Hollier LH. The power of a smile: elevating global standards for cleft care sustainability. *World Med J* 2018;**64**:12–3.
3. Jenny HE, Massenburg BB, Saluja S, Meara JG, Shrime MG, Alonso N. Efficacy of facilitated capacity building in providing cleft lip and palate care in low- and middle-income countries. *J Craniofac Surg* 2017;**28**:1737–41.

https://doi.org/10.1016/j.ijom.2019.03.007