Key Factors Associated with Oral Health-Related Quality of Life in Sri Lankan Adolescents: A Cross Sectional Study

Uttara Amilani (amuamilani@gmail.com)  
Family Health Bureau

Prasanna Jayasekara  
Ministry of Health, Colombo, Sri Lanka

Hannah E Carter  
Queensland University of Technology

Sameera Senanayake  
Queensland University of Technology

Sanjeewa Kularatna  
Queensland University of Technology

Research article

Keywords: Dental diseases, oral health-related quality of life, OIDP, effects, associations, youth

DOI: https://doi.org/10.21203/rs.3.rs-35938/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License
Abstract

Background

Oral Health Related Quality of Life (OHRQoL) measures have emerged as an important oral health outcome that is able to reveal the subjective burden of illness due to oral diseases. The association between socio-demographic and socio-economic factors, clinical dental conditions and OHRQoL indicators has been investigated in adolescents’ cohorts across the world. The purpose of this study was to investigate key factors associated with oral health-related quality of life of Sri Lankan adolescents.

Methods

A cross-sectional study was conducted amongst a sample of 15-19 year-old secondary school students, Gampaha district, Sri Lanka. The data was collected using two self-administered questionnaires. A modified Sinhalese version of the Oral Impact on Daily Performance (OIDP) questionnaire that has been validated for Sri Lankan adolescents was administered. A second questionnaire collected information on socioeconomic characteristics, oral health care seeking and oral health behaviours. A clinical oral examination was performed on each participant. Oral health related quality of life was measured using OIDP domains and total OIDP scores. Multiple linear regression with stepwise selection was used to investigate the key factors associated with the OIDP additive score.

Results

A total of 1,332 adolescents participated in the study. Negative quality of life impacts were more prevalent in the social and psychological domain of OIDP as compared with the functional domain. Total OIDP scores ranged from 0 to 36 with a mean of 3.16 (SD=4.71). The multivariate analysis revealed that decayed teeth, presence of anomaly, age, family income, health care seeking pattern and consumption pattern of soft drinks were all significantly associated with higher total OIDP scores, reflecting poorer oral health related quality of life. Frequency of daily tooth brushing was negatively associated with total OIDP scores.

Conclusion

Various factors were associated with OHRQoL and could have implications for the improvement of OHRQoL among Sri Lankan adolescents.

Introduction

Clinical parameters measuring oral health are usually objective, requiring a dental professional’s judgment. Although these clinical measures indicate the presence and severity of an oral condition, they have limited capacity to assess the functional and psychological aspects of oral health in an individual [1–4]. Oral Health Related Quality of Life (OHRQoL) measures have emerged as an important oral health outcome that is able to reveal the subjective burden of illness due to oral diseases. Further, OHRQoL may
serve as criteria to identify priority groups for public health interventions and to establish as outcome measures for oral health promotion activities [5].

A number of questionnaires have been developed to measure socio dental indicators in a population, including the Oral Impact on Daily Performance (OIDP) tool [6]. The OIDP is conceptually based on the international Classification of impairments, disabilities and handicaps created by WHO in 1980 [7], later validated on a cohort of Sri Lankan Adolescents [8]. The association between socio-demographic and socio-economic factors, clinical dental conditions and OHRQoL indicators has been investigated in adolescents’ cohorts across the world. It was evident that, poor OHRQoL in children and adolescents was associated with unfavourable socio-economic conditions and poor oral health [9, 10].

A recently published study on Brazilian adolescents aged 15–19 years, revealed that income inequality during childhood was associated with poor OHRQoL [11]. In addition, OHRQoL was negatively associated with poor individual socio-economic indicators, high number of untreated tooth decay and missing teeth and poor gingival status in same age cohort in Brazil [12]. Although dental caries was statistically significantly associated with children's oral health related quality of life, some studies reported equivocal findings [1, 4, 13, 14]. However, some reported significant methodological limitations on sampling, data collection and analysis in OHRQoL studies conducted among children [15–17].

The purpose of this study was to investigate key factors associated with oral health-related quality of life (OHRQoL) in a representative sample of adolescents, Gampaha district, Sri Lanka. The null hypothesis was that OHRQoL had no association with clinical oral conditions, oral health behaviours, health care utilization pattern and socio-demographic characteristics.

**Methods**

**Study setting, sample size and study design**

We report on a cross sectional study conducted in the Gampaha district, Western Province of Sri Lanka. The study population was 15–19 year old adolescents who were attending secondary government schools in the district, encompassing a total of 377 functioning schools. The sample size for the study was calculated by using the formula \( n = z^2 p (1-p)/ d^2 \) [18] and minimum sample was found to be 384. Since the study was designed to have cluster sampling technique, sample was adjusted by including the designed effect of 2.9[19]. Hence the final sample size was calculated as 1337 with the inclusion of the 20% non-response rate. As this study involved secondary school children the minimum number of children was identified as 20, thus the number of children in a cluster or cluster size was decided as 20. Due to feasibility issues even though cluster size was determined as 20, two clusters were taken from one selected school. 67 clusters were selected using the multi stage cluster sampling technique with probability proportionate to size of grade, across grades 10, 11, 12 and 13. Clusters were selected according to the school sampling frame.
This study received the approval from the Ethics Review Committee of the Faculty of Medicine, University of Colombo, Sri Lanka (Ref No EC 15–171). Administrative clearance was obtained from the Educational and Health ministerial personnel. The objectives of the study and the data collection methods were explained to participants, along with their parents, with written consent obtained prior to commencement. The field team was formed by a dental surgeon who carried out an oral examination on all participants; a retired school dental therapist for recording clinical data; and an assistant. Data were collected from the adolescents’ clinical oral examination as well as from two self-administered questionnaires: the OIDP to measure oral health related quality of life; and a second questionnaire developed for the study to collect information on socio economic characteristics and oral health care behaviours. Adolescents with dental problems were referred to the nearest government dental clinic where treatment was guaranteed.

**Oral Impact on Daily Performance scale (OIDP scale)**

The OIDP index was initially developed by Adulyanon [6] and later modified and validated in a 220 sample of 15 to 19 year-aged cohort of Sri Lankan adolescents [20]. During cross-cultural adaptation few items were modified with the consensus of the members of the expert committee. In addition, scoring system was revised to report only the severity of the impact and period was shorten to three months. This was based on the results of the pre-testing of the modified OIDP scale among a sample of 15–19 year-aged adolescents and in agreement with the expert committee members.

An assessment of factorability found that all correlation coefficients were > 0.30 with no item found to increase Cronbach’s alpha when deleted. The KMO measure of sampling adequacy was 0.87 and Bartlett’s test of Sphericity was significant (p < 0.001), indicating that the data is suitable for factor analysis. Calculated Cronbach’s alpha for the study was 0.88, indicating good internal consistency reliability of the scale. No correlation was negative indicating homogeneity among the items. Concurrent validity was assessed by testing modified OIDP scale against self-reported perceived oral treatment need and perceived oral health problems. The relationships were significant (p < 0.05) indicating that the instrument could adequately discriminate between adolescents who had not have perceived dental treatment needs and adolescents who had different perceptions of overall health problems.

It contains eight items distributed between two domains: functional; and social and psychological. The functional domain includes items assessing the impact of oral health on: chewing and enjoying foods; talking and pronouncing clearly; and cleaning teeth. The social and psychological domain includes items assessing the impact of oral health on: good sleep without disturbances; being able to smile without embarrassment; maintaining usual emotional state without being irritable; school and household activities; and enjoying time with friends. See the additional file 1 to 5 for more details.

Revised OIDP scores were recorded on a six-point likert scale to reflect how severe the impact of each event was over the past three months, ranging from 0 indicating no impact, to 5 indicating a very severe impact. The total OIDP scores for individual domains were calculated as a simple sum of the response code. The potential functional domain and social/psychological domain scores ranged from 0 to 15 and 0 to 25 respectively. Total OIDP scores could range from 0 to 40. Higher OIDP scores indicated poorer
OHRQoL. The primary outcome in this study was the total OIDP score. Domain specific scores were analysed as secondary outcomes.

**Socioeconomic characteristics, oral health care seeking and oral health behaviour questionnaire**

An additional questionnaire was developed to collect information about adolescents’ age, gender, family income (measured in Sri Lankan rupees and categorized in tertiles), oral hygiene habits (brushing frequency), consumption patterns of soft drinks, sugary items and fruits (categorized based on the frequency of consumption: occasional or regular); oral care seeking pattern (frequency of seeking care categorized according to the number of visits per year).

**Clinical examination**

The children were examined in a classroom at the school lying on ordinary desk under natural light. The clinical examination was exclusively visual, with the help of a dental mirror, CPI probe and a millimetre ruler. Biosafety measures established by the World Health Organization (WHO) were strictly followed [21]. The WHO criteria for the diagnosis of Decayed, Missing and Filled teeth (DMFT) were applied. The DMFT was categorized into caries free (DMFT = 0), low severity (DMFT = 1–4) and high severity (DMFT > 4). Oral hygiene was assessed by Oral Hygiene Index-Simplified (OHI-S). Debris and calculus indices were calculated and there by OHI-S were calculated using the standard formula. OHI-S was categorized into good oral hygiene (OHI-S = 0) and poor oral hygiene (OHI-S > 0). Periodontal status was measured by assessing the bleeding status and pocket depth. The dental trauma data were analysed according to the presence of at least one kind of trauma or the absence of trauma. Dento-facial anomaly data were classified according to the need for professional intervention.

**Quality control**

Quality control measures included a discussion of all possible classifications and criteria used in the study for the diagnosis of each oral health condition through an analysis of pictures of clinical cases for the disorders and diseases. An instruction manual for the field team was prepared and used during the training and throughout the data collection. Preceding the study, the inter examiner agreements were established. A specialist in community dentistry at Dental Institute, Colombo was considered as the gold standard and training involved 20 children of the same age and not belonging to the sample was performed to the test methodology. The inter examiner reliability was assessed using Kappa statistics. It showed a perfect agreement for both dental caries and bleeding. There was an 85.7% agreement for dental caries and 88.3% agreement for bleeding.

**Data analysis**

Statistical analyses were carried out using the Statistical Package for Social Sciences (version 23). Total OIDP scores, the overall mean OIDP score and scores for the individual domains were analysed for difference between specific oral diseases and disorders, and adjusted for socio economic characteristics and oral health behaviours. After applying statistical and graphical tests for normality, it was observed
that distribution was positively skewed; hence non-parametric tests were used predominantly. Mann Whitney tests were used to compare the OIDP scores between different levels of dental caries, oral hygiene, trauma and malocclusion, with the level of significance was set to 5% \((p < 0.05)\). Spearman correlation was used to assess the correlation between the OIDP scores with the DMFT, OHI-S, debris and calculus indices.

Univariate and multivariate regression models were used to determine factors associated with total OIDP scores. The independent variables in these regressions included socio-economic characteristics (adolescents’ age, gender, family income and mothers’ education level), oral hygiene habits (daily brushing frequency), consumption patterns of soft drinks, sugary items and fruits and oral disease conditions (presence of dental trauma, anomaly, bleeding and pocketing and as well as number of decayed, filled and missing teeth due to caries and OHI-S index). A stepwise process was used in the multiple linear regression analysis. A stepwise selection is method basically follow the forward selection, however, at each step it checks to see whether variables can be eliminated from the model using a backward elimination process. [22]. The study conformed to the STROBE guidelines.

**Results**

A total of 1,340 adolescents were approached to participate in the study. The final sample was 1,332 giving a participation rate of 99% (Table 1). All adolescents completed the questionnaire independently. No questions were excluded from the data analysis due to incompleteness of data. The mean age of the children was 16.5 years \((SD = 1.25)\) and approximately 47% were boys. Maternal education varied from elementary level of schooling to university education, with 62.7% of mothers having a highest education level of elementary or middle level schooling. Income was relatively low with approximately 50% of families in the lowest income tertile. Dental caries was present in 47.6% of the sample and the mean DMFT was 1.14 \((SD = 1.63)\).
Table 1
Socio demographic and clinical characteristics of the sample of children (n = 1332)

| Variables                                      | N (%)   |
|-----------------------------------------------|---------|
| Gender                                        |         |
| Male                                          | 623(46.8) |
| Female                                        | 709(53.2) |
| Mother’s education                            |         |
| Elementary/middle school (up to O/L)          | 835(62.7) |
| High school (up to graduate)                  | 497(37.3) |
| Family income                                 |         |
| 1st tertile (≥ Rs. 25,000.00)                 | 662(49.7) |
| 2nd tertile (< Rs. 25,000.00 to > 50,000.00)  | 494(37.1) |
| 3rd tertile (≤ < Rs. 50,000.00)               | 176(13.2) |
| Oral health care seeking pattern              |         |
| Infrequent (never)                            | 378(28.4) |
| Frequent (more than 1 visit per year)         | 954(71.6) |
| Frequency of daily tooth brushing             |         |
| Once                                          | 358(26.9) |
| Twice or more                                 | 974(73.1) |
| Consumption pattern of sugary items (candies/ sugary snacks) | |
| Occasional                                    | 394(29.6) |
| Regular                                       | 938(70.4) |
| Consumption pattern of soft drinks            |         |
| Occasional                                    | 853(64)  |
| Regular                                       | 479(36)  |
| Consumption pattern of fruits                 |         |
| Occasional                                    | 653(49)  |
| Regular                                       | 679(51)  |
| Dental caries experience (DMFT)               |         |
| Variables                                | N (%)  |
|------------------------------------------|--------|
| Caries free (DMFT = 0)                   | 697(52.3) |
| Low severity (DMFT > = 1 to < = 4)       | 568(42.6) |
| High severity (DMFT > = 5)               | 67(5)   |
| Oral hygiene (OHI-S)                     |        |
| Good (OHI-S = 0)                         | 589(44.2) |
| Poor (OHI-S > = 1)                       | 743(55.8) |
| Bleeding gums                            |        |
| Absent                                   | 1073(80.6) |
| Present                                  | 259(19.6) |
| Tooth pocketing                          |        |
| Absent                                   | 1310(98.3) |
| Present                                  | 22(1.7) |
| Dental trauma                            |        |
| Absent                                   | 1305(98) |
| Present                                  | 27(2) |
| Dento facial anomaly                     |        |
| Absent                                   | 1067(80.1) |
| Present                                  | 265(19.9) |

Table 1

Table 2 displays the distribution of the responses to the OIDP according to each question. Negative impacts were more prevalent in the social & psychological domain relative to the functional domain. Items relating to enjoying time with friends, maintaining usual emotional state without being irritable and being able to smile without embarrassment were the most frequently reported impacts on the social & psychological domain. Chewing and enjoying foods was the most frequently reported impact on the functional domain.
Table 2
Oral impact on daily performance scale responses (n = 1332)

| Impact                                      | No / very little/little impact | Average impact | Severe/very severe impact |
|---------------------------------------------|--------------------------------|----------------|---------------------------|
|                                             | N (%)                          | N (%)          | N (%)                     |
| **Social & Psychological domain**           |                                |                |                           |
| Impact on good sleep without disturbances  | 1300(97.6)                     | 20(1.5)        | 12(0.9)                   |
| Impact on being able to smile without embarrassment | 1241(93.2)                     | 53(4)          | 38(2.9)                   |
| Impacts on maintaining usual emotional state without being irritable | 1238(92.9)                     | 56(4.2)        | 38(2.9)                   |
| Impact on school and household activities   | 1306(98)                       | 16(1.2)        | 10(0.8)                   |
| Impact on enjoying with friends            | 1166(87.5)                     | 114(8.6)       | 52(3.9)                   |
| **Functional domain**                       |                                |                |                           |
| Impact on chewing and enjoying foods       | 1276(95.8)                     | 50(3.8)        | 6(0.5)                    |
| Impact on talking and pronouncing clearly  | 1299(97.5)                     | 22(1.7)        | 11(0.8)                   |
| Impact on cleaning teeth                   | 1304(97.9)                     | 185(1.4)       | 10(0.8)                   |

The OIDP scores ranged from 0 to 36 with a mean of 3.16 (SD = 4.71). When mean overall score was analysed, it was evident that health care seeking pattern, consumption pattern of sugary items and soft drinks, presence of dental trauma and presence of dento-facial anomaly had a statistically significant negative impact on OHRQoL (Table 3).
Table 3
Mean differences between selected oral clinical conditions and characteristics of oral behaviours for each domain and for overall OIDP (n = 1332)

|                              | Functional domain | Social & psychological domain | Total OIDP |
|------------------------------|-------------------|-------------------------------|------------|
|                              | Mean (SD)         | Mean (SD)                     | Mean (SD) |
| Overall                      | 0.87(1.72)        | 2.29(3.40)                    | 3.16(4.71) |
| Oral health care seeking pattern |                   |                               |            |
| Infrequent                   | 0.68 (1.42)       | 1.95(3.18)                    | 2.63(4.18) |
| Frequent (1 visit per year)  | 0.94(1.82)        | 2.43(3.48)                    | 3.37(4.90) |
| P value*                     | 0.011*            | < 0.001*                      | < 0.001*   |
| Frequency of daily tooth brushing |                 |                               |            |
| Once                         | 1.07(1.82)        | 2.55(3.89)                    | 3.62(5.23) |
| Twice or more                | 0.79(1.63)        | 2.19(3.20)                    | 2.99(4.50) |
| P value*                     | < 0.001*          | 0.229                         | 0.49       |
| Consumption pattern of sugary items (candies/ sugary snacks) | | | |
| Occasional                   | 0.73(1.48)        | 1.90(2.80)                    | 2.62(3.76) |
| Regular (daily)              | 0.93(1.81)        | 2.46(3.62)                    | 3.38(5.04) |
| P value*                     | 0.066             | 0.006*                        | 0.008*     |
| Consumption pattern of soft drinks |             |                               |            |
| Occasional                   | 0.79(1.54)        | 2.00(2.90)                    | 2.79(4.03) |
| Regular (daily)              | 1.00(1.99)        | 2.82(4.10)                    | 3.82(5.68) |
| P value*                     | 0.257             | 0.001*                        | 0.004*     |
| Consumption pattern of fruits |                   |                               |            |
| Occasional                   | 0.83(1.61)        | 2.30(3.33)                    | 3.13(4.54) |

* p< 0.05;
Mann-Whitney test was used
|                          | Functional domain Mean (SD) | Social & psychological domain Mean (SD) | Total OIDP Mean (SD) |
|--------------------------|-----------------------------|----------------------------------------|---------------------|
| **Regular (daily)**      | 0.91(1.81)                  | 2.28(3.47)                             | 3.19(4.87)          |
| **P value**              | 0.815                       | 0.961                                  | 0.932               |
| **Bleeding gums**        |                             |                                        |                     |
| Absent                   | 0.84(1.70)                  | 2.32(3.42)                             | 3.16(4.68)          |
| Present                  | 0.98(1.77)                  | 2.18(3.35)                             | 3.16(4.84)          |
| **P value**              | 0.120                       | 0.958                                  | 0.765               |
| **Tooth pocketing**      |                             |                                        |                     |
| Absent                   | 0.86(1.71)                  | 2.29(3.42)                             | 3.16(4.72)          |
| Present                  | 1.14(1.98)                  | 2.23(2.67)                             | 3.36(4.42)          |
| **P value**              | 0.448                       | 0.564                                  | 0.423               |
| **Dental trauma**        |                             |                                        |                     |
| Absent                   | 0.86(1.72)                  | 2.27(3.40)                             | 3.14(4.71)          |
| Present                  | 1.07(1.77)                  | 3.22(3.66)                             | 4.30(4.92)          |
| **P value**              | 0.386                       | 0.052                                  | 0.037*              |
| **Dento facial anomaly** |                             |                                        |                     |
| Absent                   | 0.77(1.62)                  | 2.17(3.27)                             | 2.95(4.51)          |
| Present                  | 1.26(2.01)                  | 2.76(3.88)                             | 4.02(5.39)          |
| **P value**              | < 0.001*                    | 0.006*                                 | < 0.001*            |

* p < 0.05;

Mann-Whitney test was used

**Table 3**

Table 4 displays the correlations between selected oral health conditions between domain specific scores and with the total OIDP score. However, the DMFT index and number of decayed teeth had significant positive correlations with both domains as well as with the total OIDP score the strength of association is small (Table 4).
Table 4
Correlation between selected oral clinical conditions for each domain and for overall OIDP (n = 1332)

|                          | Functional domain Spearman r | Social & psychological domain Spearman r | Total OIDP Spearman r |
|--------------------------|-------------------------------|----------------------------------------|-----------------------|
| **DMFT index**           | 0.108*                        | 0.133*                                 | 0.14*                 |
| **Number of decayed teeth** | 0.121*                        | 0.121*                                 | 0.13*                 |
| **Number of filled teeth due to caries** | 0.041                         | 0.066*                                 | 0.068*                |
| **Number of missing teeth due to caries** | 0.017                         | 0.037                                 | 0.035                 |
| **OHI-S index**          | 0.001                         | 0.019                                 | 0.012                 |
| **Debris index (DI)**    | 0.001                         | 0.036                                 | 0.029                 |
| **Calculus index (CI)**  | 0.030                         | -0.003                                | 0.000                 |

*correlations significant at the 0.05 level

Spearman correlation test were used

Table 5. outlines the results of the univariate and the multivariate analyses of the association between total OIDP scores and exploratory variables. The residuals in the multivariate analysis were normally distributed and there was no evidence of heteroscedasticity. Evidence of outliers was assessed by Cook’s distance score and a score less than one was considered appropriate. Multicollinearity was assessed using Variance Inflation Factor (VIF), which should be less than four. The maximum value of the Cook’s distance was 0.117 and the VIF score was around one. The multivariate analysis revealed that higher OIDP scores were positively associated with two oral conditions, namely number of decayed teeth and presence of anomaly, as well as age, family income, health care seeking pattern and consumption pattern of soft drinks. Conversely, the frequency of daily tooth brushing showed a significant negative association with total OIDP scores.
Table 5
Unadjusted and adjusted $\beta$ coefficients of the association between total OIDP scores and exploratory variables; linear regression analysis (n = 1332)

| Variable                              | Unadjusted                      | Adjusted                       |
|---------------------------------------|---------------------------------|--------------------------------|
|                                       | $\beta$ coefficient  | 95% CI     | p     | $\beta$ coefficient | 95% CI | p     |
| Gender                                |                                 |                                |       |
| Female                                | 1                               |                                |       |
| Male                                  | 0.358                           | -0.149 to 0.866               | 0.166 |
| Age                                   | 0.409                           | 0.207 to 0.610                | <0.001* |
| Mother's education                    |                                 |                                |       |
| Elementary /middle school (up to O/L) | 1                               |                                |       |
| High school (up to graduate)          | -0.392                          | -0.915 to 0.132              | 0.142 |
| Family income                         |                                 |                                |       |
| 1st tertile (=> Rs. 25,000.00)        | 0.714                           | 0.208 to 1.219               | 0.006* |
| 2nd tertile (< Rs. 25,000.00 to > 50,000.00) | -0.539                         | -1.063 to -0.016            | 0.044* |
| 3rd tertile (<= Rs. 50,000.00)        | -0.458                          | -1.206 to 0.290             | 0.230 |
| Oral health care seeking pattern      |                                 |                                |       |
| Infrequent                            | 1                               |                                | 1     |

*p < 0.05
| Variable                                           | Unadjusted |            |          | Adjusted       |            |          |
|---------------------------------------------------|------------|------------|----------|----------------|------------|----------|
|                                                   | β coefficient | 95% CI     | p        | β coefficient | 95% CI     | p        |
| Frequent                                          | 0.736      | 0.175 to 1.296 | 0.010*  | 0.745         | 0.190 to 1.300 | 0.009*  |
| Frequency of daily tooth brushing                 |            |            |          |                |            |          |
| Once                                              | 1          |            |          | 1              |            |          |
| Twice or more                                     | -0.634     | -1.205 to -0.064 | 0.029*  | -0.599        | -1.16 to -0.037 | 0.037*  |
| Consumption pattern of sugary items (candies/sugary snacks) |            |            |          |                |            |          |
| Occasional                                        | 1          |            |          |                |            |          |
| Regular                                           | 0.763      | 0.209 to 1.317 | 0.007*  |                |            |          |
| Consumption pattern of soft drinks                |            |            |          |                |            |          |
| Occasional                                        | 1          |            |          | 1              |            |          |
| Regular                                           | 1.026      | 0.501 to 1.551 | <0.001* | 0.902         | 0.382 to 1.423 | 0.001*  |
| Consumption pattern of fruits                     |            |            |          |                |            |          |
| Occasional                                        | 1          |            |          |                |            |          |
| Regular                                           | 0.060      | -0.447 to 0.567 | 0.817   |                |            |          |
| Bleeding gums                                     |            |            |          |                |            |          |
| Absent                                            | 1          |            |          |                |            |          |

*p < 0.05
| Variable                          | Unadjusted          | Adjusted          |
|----------------------------------|---------------------|-------------------|
|                                  | $\beta$ coefficient | 95% CI            | p      | $\beta$ coefficient | 95% CI            | P     |
| Present                          | 0.004               | -0.637 to 0.644   | 0.991  |                    |                    |       |
| Tooth pocketing                  |                     |                   |        |                    |                    |       |
| Absent                           | 1                   |                   |        |                    |                    |       |
| Present                          | 0.208               | -1.780 to 2.196   | 0.838  |                    |                    |       |
| Dental trauma                    |                     |                   |        |                    |                    |       |
| Absent                           | 1                   |                   |        |                    |                    |       |
| Present                          | 1.161               | -0.637 to 2.958   | 0.205  |                    |                    |       |
| Dento facial anomaly             |                     |                   |        |                    |                    |       |
| Absent                           | 1                   |                   |        |                    |                    |       |
| Present                          | 1.073               | 0.441 to 1.705    | < 0.001* | 0.995               | 0.374 to 1.616    | 0.002* |
| Number of decayed teeth          | 0.465               | 0.248 to 0.681    | < 0.001* | 0.327               | 0.109 to 0.546    | 0.003* |
| Number of filled teeth due to caries | 0.294          | 0.005 to 0.584    | 0.046  |                    |                    |       |
| Number of missing teeth due to caries | 0.657            | -0.003 to 1.317   | 0.051  |                    |                    |       |
| OHI-S index                      | 0.091               | -0.264 to 0.447   | 0.615  |                    |                    |       |

Discussion

This study identified seven key factors that were associated with OHRQoL in a sample of Sri Lankan adolescents. To our knowledge, this is the first study to report on domain specific OIDP scores in Sri
Lankan adolescents after the recent validation of the tool in this cohort.

The importance of OHRQoL is particularly relevant for adolescents. There is evidence that juveniles are more sensitive to a variety of impacts, such as appearance, relative to older age groups. These impacts will affect their quality of life and may influence their social skills and education [23, 24]. This is supported by our findings that social and psychological impacts; such as enjoying time with friends and smiling without embarrassment, were more prevalent than those observed in studies reporting on adults and elderly [25].

Our data were strongly skewed towards the “no impact” or “very little/little impact” end of the scale, with more than 85% of the study population reporting never experienced an oral impact during past three months giving a strong floor effect. This is similar to findings in previous studies among children in Brazil [15, 26]. This OIDP distribution of scores is characteristic of a population based study and indicative of adolescents having genuinely low levels of impacts, but may be due the instrument not being sensitive to identify the impacts that are experienced in the particular cultural context. Direct comparisons with the published literature across different countries must be interpreted with caution as the nature and the magnitude of impacts may vary among the populations with different cultural backgrounds [27–29]. The prevalence of oral impacts experienced during the previous three months by the study population was less than those reported in some previous studies [30, 31], with values slightly lower than those reported in other young Asian populations [29, 32, 33].

Frequency of daily tooth brushing appeared to have a significant association with the functional domain, whereas number of filled teeth, consumption of sugary items and soft drinks showed a significant association with the social and psychological domain. Oral health care seeking pattern, number of decayed teeth and presence of dento facial anomaly were significantly associated with both domains. These finding were similar to that found in published literature on Brazilian children [15, 26].

Locker suggested that the relationship between oral disease and quality of life outcome in Canadian children is mediated by personal and environmental variables [34]. He reported that children from low income families had higher impacts on quality of life than children from high income families, signifying poorer OHRQoL. Further, family income remained a predictor of OHRQoL scores after adjusting for the effects of other explanatory variables. This is supported by our findings which revealed, even after adjustment in the multivariate analysis, a highly significant association found between the lowest family income tertile and OHRQoL. Similar findings have been reported in other studies among children in Brazil and India [26, 35, 36]. It is therefore important to assess socio economic conditions in general when dealing with OHRQoL, even among school children who are eligible for free hospital dental services in Sri Lanka.

Our findings revealed a positive significant association between oral health care seeking pattern and OHRQoL after adjustment for confounding. This may be due to the care seeking homogeneity of the population studied which outweigh the influence of the other explanatory factors. However, it could be reflecting a factor such as dental care personnel's influence on improving oral health or motivation to use
care is as routine care rather than for treatment. Further, our findings suggested a significant negative association between frequency of daily tooth brushing and total OIDP score after the adjustment revealing that adolescents’ brushing behaviour had a significant predictive power whereby those who brush their teeth less frequently are more likely to experience negative impacts. Similar observations have been reported in school children in Italy and New Zealand [25, 29]. The only demographic determinant that increased the overall impact score in our study was age. This may be explained in part by the fact that intensity of the oral disease progress with the children’s age. However, the relationship between other sociodemographic characteristics and OHRQoL is unclear [37].

Our results indicated that regular intake of soft drinks has a strong significant positive correlation with OIDP score after adjusting for other factors. The most significant risk factor developing dental caries and enamel erosion is the local action of the diet on teeth. Previous studies have recommended to reduce the frequency of consumption of foods containing free sugars to four times a day and to limit the total amount of free sugars consumed [38].

Recent studies have revealed that malocclusion plays an important role in social interactions and psychological well-being in adolescents [15, 35, 39] and it has been suggested that there is a significant impact of malocclusion on the OHRQoL of young children. Our findings confirm this and show a strong significant positive association between anomaly and the OIDP score after adjustment for other factors. Our results were also consistent with previous studies that have found the presence of decayed teeth has a measurable effect on OHRQoL among adolescents [26, 35]. Decayed teeth, whether treated or untreated, may make the children feel a lower level of oral well-being [38].

A key strength of this study was the use of an OHRQoL tool that has been validated in this population cohort. Further, our data was from a relatively large sample that can be considered representative of adolescents in Gampaha district, Sri Lanka.

A limitation of our study is it’s cross sectional nature. It is known that cross sectional studies may be constrained in relation to hypothesis testing since the data on risk factors and outcomes are assessed at the same time [40]. Nonetheless, our findings are broadly consistent with the published literature. The use of self-report data on socio-economic characteristics and oral health care behaviours may have introduced response bias that we were not able to account for. The results may not be generalizable to the broader Sri Lankan population, as population characteristics and service availability varies across the country. Future studies could be used to assess the impacts of oral diseases and socio-economic factors on oral health-related quality of life in other districts, and ideally with longitudinal studies.

**Conclusions**

This study suggests that socio demographic factors including age and family income have a strong influence when determining OHRQoL in Sri Lankan adolescents. However, other factors including number of decayed teeth and presence of anomaly, and as well as health care seeking pattern, frequency of daily...
tooth brushing and consumption pattern of soft drinks, remained significantly associated with OHRQoL even after socio-economic characteristics were adjusted for.

**Abbreviations**

OHRQoL
Oral health Related Quality of Life; OIDP:Oral Impact on Daily Performance; HRQoL:Health Related Quality of Life

**Declarations**

**Ethics approval and consent to participate**

The study is accordance with Helsinki Declaration. The study protocol has been approved by Ethics Committee of Medical Faculty, Colombo, Sri Lanka (Ref No EC 15-171). Written informed consent for the participation for the study were obtained by the parent or guardian (children under 16 years old) and students above the 16 years old, given their written informed consent to participate for the study.

**Consent for publication**

Not applicable

**Availability of data and materials**

The datasets used and/or analyses during the current study are available from the corresponding author on reasonable request.

**Competing interests**

The authors declare that they have no competing interests.

**Funding**

There is no funding to the report.

**Author’s contributions**

UA: Research idea, study design, statistical analysis & drafting the manuscript, PJ & IR: Study design, data analysis/interpretation, supervision & mentorship, HC, SS, & SK: Data interpretation, technical supervision, all authors read and approved the final manuscript.

**References**
1. Do LG, Spencer A. Oral Health-Related Quality of Life of Children by Dental Caries and Fluorosis Experience. 2007, 67(3):132–139.

2. Pentapati KC, Acharya S, Bhat M, Krishna Rao SV, Singh S. Oral health impact, dental caries, and oral health behaviors among the National Cadets Corps in South India. J Invest Clin Dent. 2013;4(1):39–43.

3. Locker D. Measuring oral health: a conceptual framework. Community Dent Health. 1988;5:3–18.

4. Krisdapong S, Prasertsom P, Rattanarangsima K, Sheiham A. Relationships between oral diseases and impacts on Thai schoolchildren's quality of life: Evidence from a Thai national oral health survey of 12-and 15-year-olds. Community dentistry oral epidemiology. 2012;40(6):550–9.

5. Gift HC, Atchison KA. Oral health, health, and health-related quality of life. Medical care 1995:NS57-NS77.

6. Adulyanon S, Vourapukjaru J, Sheiham A. Oral impacts affecting daily performance in a low dental disease Thai population. Commun Dent Oral Epidemiol. 1996;24(6):385–9.

7. WHO: International classification of impairments, disabilities, and handicaps: a manual of classification relating to the consequences of disease, published in accordance with resolution WHA29. 35 of the Twenty-ninth World Health Assembly, May. 1976. 1980.

8. Amilani U, Jayasekara P, Perera IR, Carter HE, Senanayake S, Kularatna S. Oral impact on daily performance (OIDP) scale for use in Sri Lankan adolescents: a cross sectional modification and validation study. BMC oral health. 2020;20(1):16.

9. Foster Page LA, Thomson WM, Ukra A, Farella M. Factors influencing adolescents' oral health-related quality of life (OHRQoL). International journal of paediatric dentistry. 2013;23(6):415–23.

10. Peres KG, Cascaes AM, Leão ATT, Côrtes MldS, Vettore MV. Sociodemographic and clinical aspects of quality of life related to oral health in adolescents. Revista de saude publica. 2013;47:19–28.

11. Alwadi MAM, Vettore MV. Contextual income inequality and adolescents’ oral-health-related quality of life: A multi-level analysis. International dental journal 2019.

12. Alwadi MAM, Vettore MV. Are school and home environmental characteristics associated with oral health-related quality of life in Brazilian adolescents and young adults? Community Dent Oral Epidemiol. 2017;45(4):356–64.

13. Mbawalla HS, Mtaya M, Masalu JR, Brudvik P, Astrom AN. Discriminative ability of the generic and condition-specific Child-Oral Impacts on Daily Performances (Child-OIDP) by the Limpopo-Arusha School Health (LASH) Project: A cross-sectional study. BMC Pediatrics. 2011;11(1):45.

14. Brown A, AL-Khayal Z. Validity and reliability of the Arabic translation of the child oral-health-related quality of life questionnaire (CPQ11 – 14) in Saudi Arabia. 2006, 16(6):405–411.

15. Kramer PF, Feldens CA, Helena Ferreira S, Bervian J, Rodrigues PH, Peres MA. Exploring the impact of oral diseases and disorders on quality of life of preschool children. Community Dentistry Oral Epidemiology. 2013;41(4):327–35.
16. Barbosa T, Gavião M. Oral health-related quality of life in children: part II. Effects of clinical oral health status. A systematic review. Int J Dental Hygiene. 2008;6(2):100–7.

17. Tesch FC, Oliveira BHD, Leão A. Measuring the impact of oral health problems on children's quality of life: conceptual and methodological issues. Cadernos de saúde publica. 2007;23(11):2555–64.

18. Lwanga S, Lemeshow S: Sample size determination in health studies: a practical manual. In., edn. Geneva: World Health Organization; 1991.

19. Bennett S, Woods T, Liyanage WM, Smith DL. A simplified general method for cluster-sample surveys of health in developing countries. World Health Stat Q. 1991;44(3):98–106.

20. Amilani U, Jayasekara P, Perera IR, Hannah EC, Senanayake S, Kularatna S. Oral Impact on Daily Performance (OIDP) scale for use in Sri Lankan Adolescents: Modification and validation of a Sinhalese version Under final review 2019.

21. Oral Health Surveys: Basic Methods, 5th edn: World Health Organization; 2013.

22. Derksen S, Keselman HJ. Backward, forward and stepwise automated subset selection algorithms: Frequency of obtaining authentic and noise variables. British Journal of Mathematical Statistical Psychology. 1992;45(2):265–82.

23. Reisine ST. Dental health and public policy: the social impact of dental disease. Am J Public Health. 1985;75(1):27–30.

24. Locker D, Jokovic A, Stephens M, Kenny D, Tompson B, Guyatt GJCD, Epidemiology O. Family impact of child oral and oro-facial conditions. 2002, 30(6):438–448.

25. Chen M-S, Hunter P. Oral health and quality of life in New Zealand: a social perspective. J Social science medicine. 1996;43(8):1213–22.

26. Abanto J, Carvalho TS, Mendes FM, Wanderley MT, Bönecker M, Raggio DP. Impact of oral diseases and disorders on oral health-related quality of life of preschool children. Community dentistry oral epidemiology. 2011;39(2):105–14.

27. Reisine ST. The impact of dental conditions on social functioning and the quality of life. J Annual review of public health. 1988;9(1):1–19.

28. Allison P, Locker D, Jokovic A, Slade G. A cross-cultural study of oral health values. Journal of Dental research. 1999;78(2):643–9.

29. Bianco A, Fortunato L, Nobile CGA, Pavia M. Prevalence and determinants of oral impacts on daily performance: results from a survey among school children in Italy. The European Journal of Public Health. 2010;20(5):595–600.

30. Gherunpong S, Tsakos G, Sheiham A. The prevalence and severity of oral impacts on daily performances in Thai primary school children. Health Quality of Life Outcomes. 2004;2(1):57.

31. Bernabé E, Tsakos G, Sheiham A. Intensity and extent of Oral Impacts on Daily Performances by type of self-perceived oral problems. Eur J Oral Sci 2007, 115.

32. Ilma de Souza Cortes M, Marcenes W, Sheiham A. Impact of traumatic injuries to the permanent teeth on the oral health-related quality of life in 12–14-year-old children. Community Dentistry Oral
33. Soe K, Gelbier S, Robinson P. Reliability and validity of two oral health related quality of life measures in Myanmar adolescents. Community Dent Health. 2004;21(4):306–11.

34. Locker D. Disparities in oral health-related quality of life in a population of Canadian children. Community dentistry oral epidemiology. 2007;35(5):348–56.

35. Souza JGS, Martins AMEDBL, Silveira MF, Jones KM, Meirelles MPMR. Impact of oral clinical problems on oral health-related quality of life in brazilian children: a hierarchical approach. International journal of paediatric dentistry. 2017;27(1):66–78.

36. Kumar S, Kumar A, Badiyani B, Kumar A, Basak D, Ismail MB. Oral health impact, dental caries experience, and associated factors in 12–15-year-old school children in India. International journal of adolescent medical health 2017, 29(2).

37. Sischo L, Broder H. Oral health-related quality of life: what, why, how, and future implications. J Journal of dental research. 2011;90(11):1264–70.

38. Moynihan P, Petersen PE. Diet, nutrition and the prevention of dental diseases. J Public health nutrition. 2004;7(1a):201–26.

39. Liu Z, McGrath C, Hägg U. The impact of malocclusion/orthodontic treatment need on the quality of life: a systematic review. J The Angle orthodontist. 2009;79(3):585–91.

40. Levin KA. Study design III: Cross-sectional studies. Evidence-Based Dentistry. 2006;7(1):24–5.