Faculty of Medicine

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Expectations of lower limb amputee patients from community: A qualitative study

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Decleration

I declare that the work presented here is my own. All sources used have been cited appropriately. Any mistakes or inaccuracies are my own. I also declare that for any publication, presentation, or dissemination of information of the study, I would be bound to take written consent from the Supervisor & Department of Physiotherapy of Bangladesh Health Professions Institute (BHPI).

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Acronym

BHPI: Bangladesh Health Professions Institute

BMRC: Bangladesh Medical Research Council

CRP: Centre for the Rehabilitation of the Paralysed

IRB: Institutional Review Board

NGO: Non-Government Organization

PWD: Person with Disability

QCA: Qualitative Content Analysis

UK: United Kingdom

USA: United States of America

WHO: World Health Organization

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Abstract

Background: Losing a lower limb changes a person's daily life physically, emotionally, and socially. In Bangladesh, many amputees struggle with moving around and getting proper rehabilitation services. Even though prosthetic technology is improving, support from the community is still not enough. **Objectives**: To explore and analyze the expectations of lower limb amputee patients from community. **Methodology**: The present study is qualitative research method to explore the expectations of lower limb amputees from their community. The researcher was collected data face-to-face interviews with 15 participants at the Prosthetics & Orthotics Department of CRP, Savar. **Result**: After analyzing the data, three main themes came to light. These are most amputees expect better access to public transport, local rehabilitation centers, and social inclusion . Many participants shared that high vehicle steps and lack of wheelchair access make travel very difficult. They also mentioned the absence of nearby prosthetic and therapy services, which forces them to travel long distances. Most of them wanted to be included in social events and valued peer support and sports. These findings show a strong need for inclusive and community-based support systems. **Conclusion**: This study help to find out and understand what lower limb amputees truly expect from their community. They want accessible transport, local rehab services, and emotional and social support to live independently. The researcher realized that physical recovery alone is not enough social inclusion and dignity matter just as much. These voices show the urgent need for better planning and community action. Listening to amputees can help us build a more inclusive and supportive society.

Keywords: *lower limb amputation, community support, rehabilitation, accessibility, social inclusion.*

Chapter- i Introduction

1.1Background

An amputation is the elimination of an organ or other limbs in the body. Amputation is defined as synthesis or spontaneous partial or completely removable portable or part of the processing body, which is covered by skin and is one of the most disabilities (Pooja and Sangeeta 2013). Limb amputation is one of the oldest surgical methods, first noted by Hippocrates between 460 and 377 BC. Over the centuries, it has been used in different countries both as a medical solution and, in some cases, as punishment (Chalya et al., 2012). Even today, amputation remains a necessary treatment option for certain medical conditions.

However, losing a limb doesn’t just affect the body it deeply impacts the mind too. How a person responds emotionally after an amputation can depend on many things, such as their age, the reason and level of the amputation, how much time has passed since the surgery, and the kind of support they receive from family or society. It also matters how well they can mentally cope with the change. As Bosker et al. (2008) stated, losing a limb is one of the most distressing and life-altering experiences anyone can go through both physically and emotionally. Amputations are usually classified into two types: major and minor. Major amputations involve the removal of larger parts of the limb, such as above or below the elbow, or above or below the knee, including the foot.

On the other hand, minor amputations refer to the loss of smaller parts like fingers or a part of the hand. Among these, lower limb amputations are far more common than upper limb ones. In most cases, they occur due to medical conditions like diabetes or poor circulation, while accidents and injuries come next as leading causes (Van Houtum et al., 2012). One of the biggest challenges that people face after an amputation is the risk of losing their independence, which can affect their daily living and overall quality of life (Gitter et al., 2005). Among all medical reasons, diabetes-related complications especially diabetic foot—are the most common causes of surgical amputation. These often happen due to serious vascular problems like ischemia (lack of blood supply) and peripheral artery disease (Feinglass et al., 2012).

Lower limb amputations can vary in type and severity. It might involve something small, like removing one or more toes, or more extensive procedures such as: Partial foot removal, Ankle disarticulation (removing the foot through the ankle joint), trans-tibial amputation (below the knee), Knee disarticulation Trans-femoral amputation (above the knee), Hip disarticulation, Or even hemi-pelvectomy, which involves removing part of pelvis.

Each level of amputation brings different physical and emotional challenges, and recovery often depends on the type of surgery, patient health, and support systems. Limb amputation causes major disfingurement, it renders people less mobile and at risk for loss of independence (Gitter et al., 2005). Although amputation has a major impact on a person's life, it often receives very little attention or resources, especially in low-income countries where survival rates are already poor (Aleccia et al., 2010). Globally, it's difficult to get accurate estimates of how many people live with amputations, as proper data is not always available.

In the United States alone, around 185,000 amputations take place every year (Ziegler-Graham & Mackenzie, 2015). In the United Kingdom, the number is approximately 7,000 people per year undergoing limb amputation (Robinson et al., 2010). To better understand the global picture, the Global Extremity Amputation Study analyzed lower limb amputation rates in ten different countries. For example, in Madrid, Spain, there were only 2.8 major amputations per 100,000 people annually, while in the Navajo community in the U.S., it was as high as 43.9 per 100,000 people. These differences are largely due to how common diabetes and peripheral vascular disease (PVD) are in different regions. Since both conditions can severely damage the limbs, they are major causes of amputation. In the U.S., lower limb amputations now account for about 65% of all amputations, making them significantly more common than upper limb amputations (Ziegler-Graham et al., 2008). Unfortunately, this trend is not slowing down. In developing countries, the number of lower limb amputations is expected to rise dramatically possibly reaching 58,000 cases per year by 2030, with about 75% of those in people aged 45 and older (Clark et al., 2008). Beyond the physical challenges, most people who undergo an amputation also experience a wide range of emotional and psychological difficulties. These may include fear, grief, anxiety, and depression as they adjust to life with a missing limb (McKechnie & John, 2014).

Rehabilitation after amputation is not always a smooth or positive journey. Many patients go through expensive treatments that don't bring the expected results (Luker et al., 2015). Losing a lower limb affects not just the body but also a person's mental health, social life, and financial stability and the burden often extends to the entire family (Schoppen et al., 2001). In countries like Bangladesh, the situation is even harder due to the lack of proper financial aid or social welfare. Families, especially those dependent on a single male earner, often face debt and economic crisis after an amputation (Hamid et al., 2014).

The loss of a limb leads to permanent physical disability, making it difficult to perform daily tasks or return to work. In fact, unemployment rates among amputees after injury can range from 31% to 87% (Chin & Toda, 2016). Yet, employment is a key part of successful rehabilitation, not just for income but also for improving life satisfaction and overall health (Krause, 2003). Women with disabilities face even more hardship, especially in a society where their unpaid domestic work is often undervalued (Fanchignoni et al., 2007). Social support plays a major role in recovery. Patients with stronger family or community support systems tend to adjust better after amputation (Webster et al., 2012). In the long term, quality of life and the ability to return to personal care, household roles, and social activities are seen as important outcomes of rehabilitation (Gallagher & MacLachlan, 2004).

How a person views themselves both physically and emotionally after amputation is deeply shaped by their experiences, needs, and social surroundings (Lupton, 2012). The main aim of this study is to explore how lower limb amputee patients view their community and what they expect from it. This includes understanding their needs for support, acceptance, and inclusion from people around them and from local resources. By collecting in-depth, personal experiences through qualitative methods, the study hopes to identify what kind of help these patients really want whether it's emotional support, accessible facilities, or opportunities to reconnect with daily life. The ultimate goal is to use these insights to help healthcare providers, policymakers, and community organizations design better support systems. This research aims to improve rehabilitation services and encourage a more inclusive, empathetic environment where amputees can live with dignity and independent.

1.2 Justification

An amputation significantly alters a patient life, making it more difficult for them to move around and take care of themselves. Amputation brings major change in an individual life, whose image on their whole body changed; movement activities and self-care are more difficult; the psycho- social status of the patients life is changed as well, and the performance of professional and other activities are significantly affected. Understanding the amputees can help their quality of life and overall well-being. Insight to patients expectations can guide policymakers and community organizations in developing more effective program and policies the need of amputees, fostering grater inclusivity and accessibility. Addressing the specific expectation of amputee can promote better social integration and reduce stigma, enabling a more supportive and empathetic community environment. By aligning community resource provider can offer more relevant and effective support, leading to better health outcomes and patients satisfaction. This study is crucial for bridging the gap between amputee needs and community support ensuring that amputee receive necessary resources and social integration for fulfilling lives. In this study the investigator is interested to find out the expectations of lower limb amputee patients from community. To further support the physiotherapy profession, an evidence based project study should be developed. Ischemic limb injury can occur in people with chronic vascular disease due to lack of access to proper care or socioeconomic constraints. Thus, this research rise awareness. In Bangladesh , no such patients research has yet been done this area. That’s why I interested to do it.

1.3 Research Question

What are the expectations of lower limb amputee patients from community?

1.4 Study objectives

1.4.1 General objective

To explore and analyze the expectations of lower limb amputee patients from community.

1.4.2 Specific objective

i. To determine the socio-demographic information of participants.

ii. To explore what lower-limb amputee patients expect regarding inclusive and accessible public transportation in their communities.

iii. To explore and know patients expectations about the availability of specialized healthcare services in the community after rehabilitation.

iv. To know and understand patients expectations related to social inclusion and participation in community.

1.5 Operational definition

1.5.1 Amputation

Amputation is a medical procedure involving the surgical removal or loss of a limb or bodypart, typically due to injury, disease, or infection.

1.5.2 Prosthesis

A prosthesis is a device designed to replace a missing part of the body or to make a part of the body work better. Diseased or missing arms, hands, legs, or joints are commonly replaced by prosthetic devices .

1.5.3 Prosthetics

Prosthetics refers to the branch of healthcare and technology concerned with the design, fabrication, and fitting of artificial devices (prostheses) that replace a missing or damaged body part, such as a artificial limb.

1.5.4 Community

community refers to the immediate social and environmental network surrounding a lower limb amputee patient. This includes family members, friends, neighbors, local residents, healthcare workers, support groups, and relevant local institutions (e.g., religious organizations, rehabilitation centers, local government, and NGOs) that the individual interacts with regularly.

Chapter- ii Literature review

Lower limb amputation (LLA) is a high cost, chronic health condition that is complicated by poor health-related outcomes (Mckechnie and Jhon, 2004). When compared to the norms of the general population, people with LLA have worse physical function, such as walking ability, physical capacity, and psychological health (Durmas et al., 2016). Amputation is a medical process in which a limb is removed whole or in part. Lowerlimb amputation refers to the removal of one or more lower limb components (Knezevic et al., 2015). Lower limb (LLA) amputation is frequently carried out for a number of reasons, suchas removing necrotic, ischemic, or locally incurable tum or tissue (Razak et al., 2016). It significantly affects amputees and their families on a social, psychological, and financial level. As a result, it lowers the quality of life for amputees, and some of them learn to live as beggars (Knezevic et al., 2015).

Amputation is the preferred course of therapy for a number of illnesses. Age, the kind and extent of the amputation, the amount of time since the amputation, social support, and active coping strategies are some of the many variables that influence a patient's psychological response to amputation. Significant morbidity, disability, and deathare the causes. Amputation is more than just loss in a limb; it can also result in disability, unemployment, and increased insurance costs (Bragaru et al., 2013). The majority of patients who undergo limb amputation report a range of complex psychological reactions. An amputee's ability to cope socially and mentally with their physical circumstances may be adversely affected by depression, a frequent psychological reaction that can persist for 10 to 20 years following amputation (Durmas et al, 2015).

Studies from East, South, and Southeast Asian developing countries have identified that LLA usually impacts those in lower socio-economic groups, the young, and primary family earners, who experience difficulty returning to occupation (RTO), resulting in socio- economic stress for whole families (Sayed et al.,2021). The amputees' ages ranged from less than 20 to more than 70. 32.0% of all amputees were in the age range of 21 to 30 years old, which was the most prevalent age group for amputations (Pooja & Sangeeta et al., 2013).Third place went tothoseaged20andunder (14.2%), followed by those aged 31 to 40 (23.2%), who made up 23.2% of all amputees (Pooja & Sangee, 2013).

More than 90% of all amputations are lower limb amputations (LLA) (Pooja and Sangita, 2013). Significant morbidity, death, and disability are link liked to it (Fortington et al., 2013). According to reports, the first known instance was carried out 31,000 years ago in Borneo (Maloney et al., 2022). Any total loss of any lower extremity portion in the transverse anatomical plane for whatever reason is referred to as lower limb amputation (Ang et al., 2018). The prevalence of lower limb amputation varies between 3.6 and 68.4 per 100,000 people worldwide, making it one of the most acquired impairments (Moxeyet al.,2011).

Around 30,000 and 40,000 amputations are carried out in the US each year, and by 2050, there will be 3.6 million amputees globally, up for man estimated 1.6 million in 2005 (Ziegler-Graham et al., 2007). The prevalence of limb impairment rises with age, ranging from.5% in toddlers to7.5% in teens to 16.5% in adults, with 5% of those individuals having trouble walking, according to the 2014 Ugandan national population census. Many different illnesses and traumas can cause LLA. Significant morbidity, disability, and death are the causes. An amputation is not merely limb loss as it can mean disability, joblessness, high insurance payments, depression and poor quality of life (Francis et al ., 2005).

The three D share commonly regarded as the indications for LLA: dead limb, deadly limb, and damn nuisance of a limb. Peripheral vascular disease is the leading cause of amputation in high income countries, whereas in low-to-middle-income countries—including Uganda—the indications for amputation are trauma, infection, complications from diabetes mellitus, and malignancy (Dunbar et al., 2009). As the population ages and the prevalence of vascular disorders and diabetes rises, amputation is becoming a more prevalent surgical procedure. In the United Kingdom, the National Health Service (NHS) performed 10,022 major amputations between January 2017 and December 2019, along with 3335 minor amputations and 137 trauma-related amputations (Waton et al., 2020). From 1991 to 2002, prevalence rates for all disability types a side from locomotor disability showed downward trends. The rising rates of amputation in India may be one of the main causes of this. Permanent Physical Impairment (PPI) for different levels of amputation is as follows, per the guidelines and gazette notification issued by the Ministry of Social Justice and Empowerment on June 13, 2001: 70% for below-knee amputation, 75% for through-knee amputation, 85% for above-knee amputation, 70% for below-elbow amputation, 85% for above-elbow amputation, 90% for through-hip amputation, 90%

through-shoulder amputation, and 55% for through-ankle amputation (Pooja & sangeeta, 2013). Disability remains a neglected issue in Bangladesh. There haven't been many studies done at the policy level in this area yet. However, in this political work cycle, the strategy' implementation is a significant issue. Despite having a legal obligation the ensure equal access and opportunities for those with disabilities, little has changed in the way that these individuals actually work or receive their education (Jalil 2012). Inadequacies in empirical research may be explained by the conceptual complexity of activity and involvement, which are significant constructs. Environmental factors interact with impairment and there are methodological and conceptual problems with the definition of participation (Whiteneck 2009).

Incorporate a wheelchair with adjustable components that facilitate easy access to vehicles. The design includes a transition platform that moves horizontally, allowing users to board with minimal effort (Xiaolin et al., 2019). Boarding vehicle equipped with a scissor fork lifting mechanism that stabilized boarding process, ensuring that users can safely enter and exit the vehicle (Biao et al., 2019). Innovative Transport Solutions propose a mechanism mounted on rails that allows for controlled movement into public buses. This system utilizes hydraulic power for smooth operation, enhancing the boarding experience for wheelchair users (Pourhassana et al., 2011). Gentzsch and Schultz describe buses with a servo-controlled floor that lowers to ground level, simplifying the transfer for wheelchair users and amputees (Kurt & O, 1980).
Participants cited physical obstacles to prosthesis mobility and the built environment's lack of accessibility as barriers to participation. Some of them experienced physical aan emotional distress as a result of their injuries, which further restricted their social aand community engagement. They also had chronic and severe health issues. PParticipants emphasized the usefulness of supportive community groups and peer-support nnetwork in easing the transition to their pre-amputation family, professional, and social roles. II addition, participants believed that having a strong, upbeat attitude and having sself motivation were crucial to helping them resume social and community activity (Keeves et al. 2022). Priority seating is essential for amputees, ensuring they have access to comfortable and accessible spaces on public transport. Designated areas should be clearly marked and enforced to prevent misuse by non-disabled (Wahyuni,Murti and Joebagi 2016). Staff training is crucial for enhancing the travel experience of amputees.

Training should focus on empathy, communication, and assistance techniques tailored to the needs of disabled passengers. Inclusive planning involves designing transport systems that consider the diverse needs of amputees, including accessible infrastructure and services (Saif et al., 2018). Collaboration between policymakers and transport providers is necessary to ensure that accessibility is prioritized in transport planning ("Public Transport Accessibility: Protocol of a Scoping Review (Preprint)", 2022). A supportive environment includes emotional support mechanisms, such as providing information and assistance during travel . Public transport systems should foster a culture of respect and dignity, ensuring that amputees feel valued and safe while traveling. While these measures are vital for improving accessibility, challenges remain, such as budget constraints and the need for ongoing coordination among transport providers to enhance services for amputees (Wahyuni et al., 2016). Addressing these issues is essential for creating a truly inclusive public transport system. Many countries have established laws aimed at improving accessibility in public transport, yet implementation often lags behind. For instance, despite legislative advances in Spain, significant barriers remain in urban transport systems (González et al., 2024).

Studies suggest that policymakers should collaborate with transport providers to enhance accessibility features, such as ramps and audio-visual aids, which are essential for users of mobility devices (Unsworth et al., 2019). Inclusive policies are essential for ensuring that public transport systems accommodate the needs of amputees. These policies should cover aspects such as facility and vehicle accessibility, rider accommodations, and paratransit sservices The development of scoring systems, like the TRansit ACessibility Tool (TRACT), helps evaluate and improve the accessibility of public transport systems, ensuring that policies are effectively implemented (Twardzik et al., 2024). Accessible public transport can significantly enhance social participation for amputees, reducing feelings of isolation and promoting community engagement ("Public Transport Accessibility for Disabled People: Protocol of a Scoping Review (Preprint)", 2022). Qualitative research indicates that positive interactions with transport staff and inclusive information can bolster users' confidence and emotional well-being during travel (Chapman et al., 2020).

The experience of dignity in public transport is influenced by personal preferences, impairment-specific needs, and the quality of infrastructure. Inaccessible elements can lead to feelings of indignity and exclusion (Chapman et al., 2023). Research highlights that when systems fail to accommodate the needs of amputees, it can result in vulnerability and a diminished sense of dignity (Chapman et al., 2023). Emotional support is vital for amputees using public transport, as it can influence their self-efficacy and satisfaction. Positive interactions with staff and clear communication can enhance the travel experience (Chapman et al., 2023). The absence of accessibility information on public transport websites can create barriers, restricting amputees' ability to plan and use public transport effectively, thus impacting their dignity (Twardzik et al., 2024). One of the primary expectations among lower limb amputees is access to consistent and comprehensive follow-up care. Research suggests that individuals often feel a gap in the transition between inpatient rehabilitation and community-based services.

According to Neumann and Legro (2020), many amputees expect coordinated care plans that include regular physiotherapy, prosthetic fitting, psychological support, and accessible transportation. When these services are fragmented or absent, patients report feeling abandoned by the healthcare system, which can negatively impact their recovery. A recurring theme across studies is the expectation for timely and quality prosthetic services. Patients often rely heavily on prosthetic limbs for mobility and independence, but delays in prosthesis delivery and maintenance remain common. Highsmith et al. (2016) found that lower limb amputees frequently express frustration over the time it takes to receive a properly fitted prosthesis, especially in rural or under-resourced areas. This delay not only affects mobility but also limits their participation in community activities, employment, and social relationships. Cultural sensitivity in healthcare provision is also emphasized by many patients. In diverse communities, amputees often expect healthcare workers to be respectful of cultural norms and religious beliefs, especially regarding gender, modesty, and traditional medicine (Murphy et al., 2021). Misunderstandings or insensitivities can create distrust and discourage individuals from seeking help. Patients expect healthcare providers to receive training in cultural competence to build stronger patient-provider relationships.

Patients express a need for continuous support from healthcare professionals throughout their rehabilitation journey (Gaidys & Michaelis, 2013). Patients often seek information from established amputees, indicating the importance of mentorship and shared experiences. Early referrals to rehabilitation services are crucial for setting realistic expectations and providing necessary resources (Ostler et al., 2014). Effective rehabilitation is linked to government initiatives that ensure accessible environments and resources for amputees. Policies that promote vocational rehabilitation and employment opportunities are essential for the social integration of amputees (D.V. et al., 2023). Effective government policies are vital for ensuring access to rehabilitation services, particularly in developing regions where resources may be limited (Sayeed et al., 2023).

Policies should focus on enhancing service availability and quality, as well as addressing barriers such as economic constraints and cultural attitudes (Smith, 2023). Establishing standardized rehabilitation centers within communities can provide a structured environment for amputees to receive comprehensive care. These centers should adopt a multidisciplinary approach to address the diverse needs of amputees, including physical, psychological, and social aspects (Kovač et al., 2015). A structured rehabilitation process is vital, with a focus on empowering self-care and daily living skills (Gaidys & Michaelis, 2013). Community support systems significantly influence the psychological adjustment of amputees, highlighting the need for comprehensive care. Psychological counseling is crucial to address issues such as hopelessness and body image distress, which are common among amputees (Abouammoh et al., 2021). Support groups and counseling services can help mitigate feelings of loneliness and enhance emotional well-being. Counseling services are essential for addressing the emotional challenges faced by amputees, helping them cope with their new reality (Gaidys & Michaelis, 2013).

Peer support from established amputees can provide valuable insights and encouragement, fostering a sense of community and belonging (Ostler et al., 2014). Adjusting to an acquired amputation or other obvious changes along with functional limitations and physical function deficits, the patients face includes not only impairments in body function and activity limitations but also participation restrictions. Participation is the term used by the International Classification of Functioning, Disability, and Health to describe a person's involvement in everyday activities. Social involvement is a component of participation, although the term's meaning is unclear, particularly when it comes to defining the difference between activity and participation. It has been argued that the extra idea "social participation" would be a better term to highlight both the societal involvement and the individual participant's subjective experience

(Kristjansdottir et al. 2020). Re-engagement and participation in a variety of personal, familial, and social responsibilities are also necessary for successful rehabilitation. Participation has been identified as a crucial element of successful recovery from severe physical or mental illnesses. Therefore, a better comprehension of Veterans' engagement in chosen life roles and activities may be beneficial for the creation and study of therapeutic options for Veterans living with amputation (Erbes et al. 2022). Community inclusion plays a vital role in the long-term well-being of individuals with lower limb amputation. Beyond the immediate concerns of medical rehabilitation and mobility, amputees often express a desire to reintegrate socially and be part of communal events and everyday public life. Several qualitative studies highlight that social participation is deeply tied to a person's identity, dignity, and perceived quality of life (Atkins et al., 2011).

CRP provides medical treatment, rehabilitation and support services focusing on physical, emotional, social, psychological and economic aspects. It promotes the development of skilled personnel in health care and rehabilitation in the country. The priority of P&O department of CRP is its clients' care and wellbeing throughout the process of delivering world class prosthetic devices, rehabilitation programs and orthotic solutions. The P&O team renowned for outstanding customer service, providing personalized care that best suits each client's needs and lifestyle goals (CRP, 2019).

Social connections significantly impact the mental well-being of individuals with disabilities, fostering a sense of belonging and reducing isolation (Josefsberg & Bertram, 2012). Engaging with peers who share similar experiences can provide emotional support and practical advice, enhancing participation in community activities. Rehabilitation programs should focus on individual needs, promoting autonomy and self-determination in activity choices (Czencz et al., 2024). Ensuring that rehabilitation services are accessible and inclusive is crucial for facilitating participation in community life (Barclay et al., 2015). Campaigns aimed at educating the public about the capabilities of individuals with disabilities can help reduce stigma and promote inclusion (Lloyd et al., 2006).

Community initiatives that encourage participation in sports and recreational activities can enhance social inclusion and improve quality of life (Smith et al., 2016). While these factors are vital for promoting social inclusion, it is also essential to recognize that barriers such as transportation issues and environmental inaccessibility can hinder participation. Addressing these challenges is crucial for creating a truly inclusive community environment. Amputees perceive physical activity as vital for maintaining independence and social engagement, despite challenges in mobility (MacKay et al., 2024). Participation in wheelchair sports is seen as a means to enhance physical fitness and social interaction, fostering a sense of belonging (MacKay et al., 2024). These initiatives are crucial for educating the public about the capabilities of amputees, reducing stigma, and promoting inclusivity (Keeves et al., 2022). Programs aimed at reintegrating amputees into the workforce are essential for enhancing self-esteem and financial independence (Abouammoh et al., 2021).

Support from family and care givers is critical for emotional well-being, helping amputees navigate their new realities (Abouammoh et al., 2021). Psychological support, including motivational counseling, is necessary to foster resilience and a positive mindset, which are key to successful community participation (Keeves et al., 2022). Conversely, some studies indicate that barriers such as physical inaccessibility and psychological distress can hinder participation, suggesting that while expectations are high, significant challenges remain in achieving them(Keeves et al., 2023).

Lower limb amputees face physical, emotional, and social challenges that affect their daily lives and rehabilitation. They expect empathetic healthcare, accessible facilities, affordable services, and timely prosthetic support. Beyond medical care, they seek inclusion in community life through sports, festivals, education, and peer support. Social participation helps restore confidence, dignity, and identity. Cultural sensitivity and awareness in healthcare and society are also essential. Amputees want to be active contributors, not passive recipients. True inclusion means more than access it’s about respect, empowerment, and belonging. Meeting these expectations can significantly improve their quality of life and support successful reintegration.

Chapter-iii Methodology

3.1 Study design

I choose to conduct my study using a qualitative approach since it is useful to learn about the expectations of amputees in the community. It was chosen because the participants freely express their opinions and thoughts, which aids me in achieving my objective.

3.2 Study area

The Prosthetics & Orthotics Department at the Centre for the Rehabilitation of the Paralysed (CRP) in Bangladesh ,Which situated about Savar, Dhaka.

3.3 Study duration

Data were collected from 1st June 2024 to 31st May 2025. Each participant was provided equal time to collect data.

3.4 Study population

Data collected from amputee patients who are currently present in Prosthetics & Orthotics Department, CRP, Savar, Dhaka.

3.5 Inclusion criteria

- Patients with amputation.
-
- Both Male and Female included.
- Age range from above18 years.
- Voluntary participation.
- Willingness to participate.

3.6 Exclusion criteria

- Patient with severe complication.
- Patient with mental illness.
- Non-co-operative patients and lack of interest to participate in research activities.

3.7 Sample size

15 participants were taken as sample from Prosthetics & Orthotics Department, CRP, Savar, Dhaka.

3.8 Sampling technique

For this study, the researchers employed the purposive sampling strategy, selecting participants based on predetermined criteria.

3.9 Method of data collection

A written consent was taken from the participants before collecting data. A relevant questionnaire was used for the assessment of the patients and to accumulated data through face-to-face interview with open-ended question.

3.10 Data collection tools

Informed consent was obtained before data collection, and participants were assured of confidentiality and voluntary participation. A standard questionnaire form as data collection tools, an open-ended questionnaire was used to collect qualitative data from the participants. In this study 6 open-ended questions are used which is related to participants, lived experience and expectations from a community. The questions also represent the actually need from community. Interviews and discussions were audio-recorded (with consent) and supplemented by field notes to ensure accuracy in transcription and analysis. During the data collection process, tools like pens, pencils, and notebooks were used for taking brief notes, while a laptop was used later for organizing and transcribing the recorded interviews.

Questionnaire

Following the supervisor's approval and guidance, the researcher designed the questionnaire while adhering to specific guidelines. The primary goal of this questionnaire was to gather data on the expectations of lower limb amputee patients within the community. The questionnaire was divided into two sections: Section 1 focused on socio-demographic information, while Section 2 aimed to explore the specific needs of amputees within the community. Section 1 covered essential socio-demographic details, including the age, gender, type and site of amputation, and the duration of the amputation. These factors were crucial for understanding the participant's background. Section 2 consisted of questions designed to explore the needs of amputee patients. The first two questions were centered around accessibility and iInfrastructure 1. How would you rate the accessibility of public transportation in your area? 2. What additional accessibility features do you believe are necessary in your area. These questions aimed to assess the level of accessibility for amputee patients and their independence in moving around. The feedback provided valuable insight into the transportation needs of lower limb amputees and how these could be improved for better mobility. The next set of questions focused on healthcare and rehabilitation, sspecifically 3. How would you rate the availability of specialized healthcare services for lower limb amputees in your area? 4. What aspects of healthcare services do you consider most important to you or your ccommunity These questions were designed to understand the adequacy of healthcare services for amputees and which aspects of these services were perceived as most crucial by patients. The final two questions explored social support and inclusion: 5. In your opinion, what is the level of inclusion of people with disabilities in social activities within your community? 6. What type of community activities and events would be most beneficial for you? The aim of these questions was to gauge the amputees’ sense of inclusion in social activities and identify what types of community support or events would enhance their quality of lifestyle.

3.11 Data analysis

1) First, the researcher repeatedly listened to the interviews on the phone recorder.
2) The information was then converted from Bengali to English and transcribed.
3) Verify the carefully organization of the transcribed data.
4) After that, data analysis was initiated by coding, categorization, and creating themes.

3.12 Ethical consideration

To prevent ethical issues, ethical considerations are used. The chairman of the physiotherapy department of Bangladesh Health Professions Institute (BHPI), an academic institution affiliated with CRP, and the researcher's research supervisor gave the researcher permission to carry out the study. Additionally, the Prosthetics & Orthotics department granted the researcher authority to gather research subjects in order to collect data. Each participant received an information leaflet and their consent. The inform sheet and consent form clearly state the goal and objective. Participants were orally told by the researcher about the study's topic and goal. They are reassured by the researcher that personal data will be kept totally private going forward. The patient will not be prevented from taking part in this trial, the researcher promised. The participant was free to discontinue participation at any time. Their safety and confidentiality were also ensured. Regular monitoring and oversight were maintained throughout the study by the researcher to address any ethical concerns that might arise.

3.13 Informed consent

The informed consent process ensured that all the participants were fully aware of their involvement based on their voluntary decision. Each participant was provided with a comprehensive information sheet outlining the study’s purpose, procedure, duration, potential risks, benefits and their right to withdraw at any time if they feel discomfort and discuss about their problem with senior authorities. Participants were assured that their information would be anonym to prevent identification in any reports or publications and would be handled with the highest level of confidentiality. Before written consent, a detailed verbal explanation of the study was given. After receiving and understanding the information, participants were asked to sign a consent form. This form confirmed their willingness to participate in the study.

Chapter-iv Results

A qualitative study results were analyzed by content analysis. By using this analysis process, the researcher organized collected data according to categories, coding and themes. To explore and understand the expectations of lower limb amputee patients from their community. Participants respond according to their perception. In this section coding was used to understand the participants statement and to generate the themes. In this research the results of the study are discussed in relation to the research questions and objectives of the study. The descriptions of the themes are according to the answer of the participants. Discussion according to the themes are also provided below-

4.1 Socio-demographic information of the participants

4.1.1 Age of the participant

In the study the number of subjects was 15 with lower limb amputation . Among the participants majority were in age group 19-40 years. Participants in between 19-30 years were 40% (n=6), participants in between 31-40 years were 33.33% (n=5), participants in between 41-50 years were 13.33% (n=2) and also 13.33% (n=2) participants in between 51-60 years.

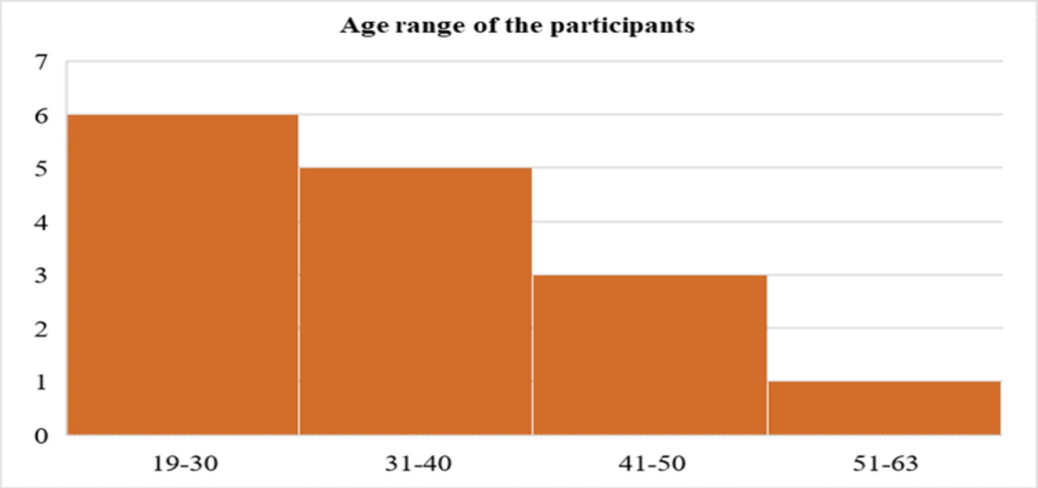

Figure-4.1.1: Age of the participants

4.1.2 Gender of the participation

In the study among the 15 participants, 67% (n=10) patients were male and 33% (n=5) were female.

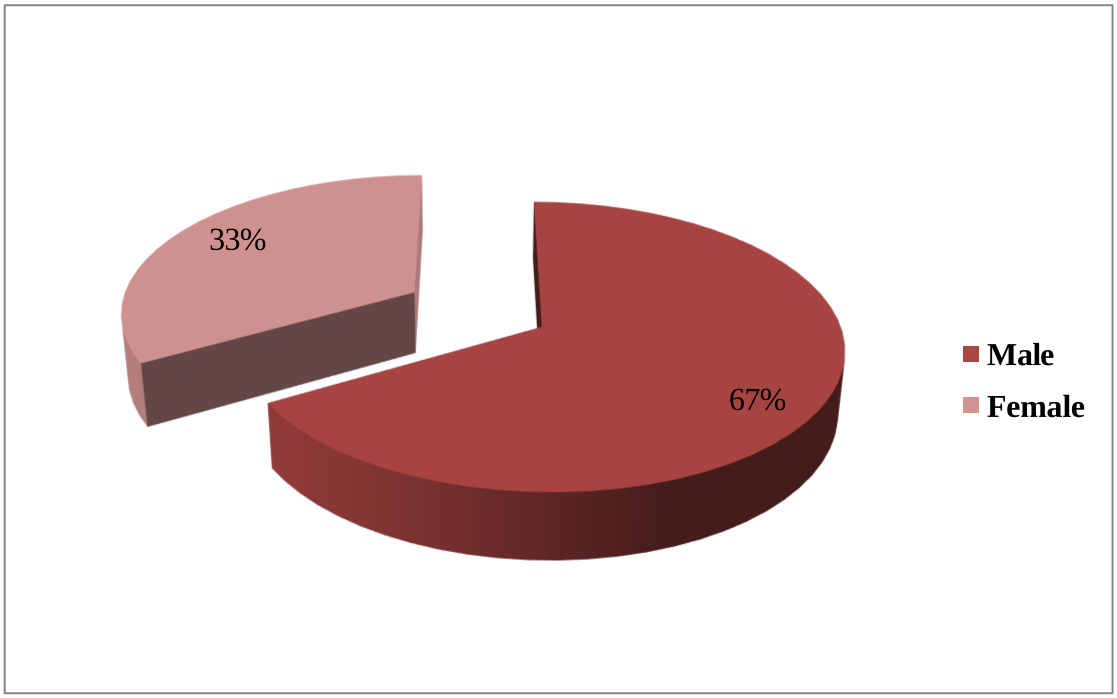

Figure-4.1.2: Gender of the participant

4.1.3 Base line data of the participants

Variables	Number of the participants (n)
Type of amputation	
Trans-femoral	10
Trans-tibial	5
Site of amputation	
Right	8
Left	7
Educational qualification	
Illiterate	1
Up to class 5	5
SSC	3
HSC	2
Graduate	
Living area	
Rural	10
Sub-urban	4
Urban	1
Duration of amputation	
1-3 years	9
4-6 years and 7-10 years	3, 3

Among 15 participants, majority participants lived in rural area that were about 10 participants, 4 were living in sub-urban area and 1 were living in urban area. The educational level among 15 participants 1 was illiterate , 5 were studied up to class 5, 3 were S.S.C completed, 4 were H.S.C completed and 2 were graduate.

This pattern clearly shows that most amputees come from rural backgrounds. One reason could be the lack of quick medical care, limited health knowledge, and delays in treatment in those areas. When we look at their education levels, the results show that most participants have low formal education. One person is illiterate, meaning they never got a chance to go to school. Five people studied only up to class five, which suggests they had to leave school early. These individuals might not know about basic health care or how to get help when they need it. Three participants passed their S.S.C (Secondary School Certificate), and four passed their H.S.C (Higher Secondary Certificate). This shows that some have a mid-level education.

However, only two participants finished graduation, which means very few had higher education. The combination of low education and rural living makes this group socially vulnerable. Without proper education, they may not know how to take care of their health, find jobs, or get the artificial limbs (prosthetics) they need to live better lives. In short, these findings show that we urgently need to bring educational and health services to rural areas. If we raise awareness, offer early medical support, and make education available to all, we can really improve the lives of people who are at risk of or already living with amputations. The combination of low education and rural living makes this group socially vulnerable. Without proper education, they may not know how to take care of their health, find jobs, or get the artificial limbs (prosthetics) they need to live better lives. In short, these findings show that we urgently need to bring educational and health services to rural areas. If we raise awareness, offer early medical support, and make education available to all, we can really improve the lives of people who are at risk of or already living with amputations. Among the participants majority were in duration of amputation 1-10 years. Participants in between 1-3 years of amputation were 60% (n=9) participants, participants in between 4-6 years duration were 20% (n= 3), participant in between 7-10 years duration were 20% (n=3). This data suggests that most participants are still in the post-amputation adjustment phase. Participants who lost a limb 1-3 years ago may still experience physical distress, such as phantom pain, or emotional distress, such as feelings of inferiority or depression. On the other hand, those who lost their limbs a long time ago have overcome these challenges and have become accustomed to a largely stable life. Such time-based differences help us understand that everyone's experience is different. Therefore, knowing the duration of someone's amputation can help us create appropriate support or rehabilitation plans for them. This aspect of research is very important, as it allows for a better understanding of the participants' real experiences.

4.1 Summary of data analysis

Table 2: Summary of data analysis

Aim of the study	Objective of the study	Categories	Theme
To identify the expectation of lower limb amputee patients from community	I. To explore what lower-limb amputee patients expect regarding inclusive and accessible public transportation in their communities.	i. Lack of accessible transportation feature.	**1.** Facilities of accessibility and inclusivity in public transportation for individuals with lower limb amputees area.
	II. To explore and know patients expectations about the availability of specialized healthcare services in the community after rehabilitation.	ii. Need to comprehensive rehabilitation facilities.	**2.** Critical gap i localized rehabilitatio and prosthetics fo lower limb amputee.

	III. To know and understand patients expectations related to social inclusion and participation in community.	iii. Community support and engagement.	**3.** Activities and event that are beneficial for lower limb amputee patients and empowered social inclusivity.

4.4 Theme that emerged from data analysis are given below:

Each table describes the interview findings, under the different categories. The tick mark was given only the columns where the participant spoke about those issue. Here p was used for participant.

Theme 1: Facilities of accessibility and inclusivity in public transportation for individuals with lower limb amputees area.

Categories 1: Lack of accessible transportation feature.

Table-3: Lack of accessible transportation feature.

Participant	Boarding Support Mechani	Priority seating	Trained support staff	Inclusive planing	Supportive environment	Policy support	Emotional support
P1	✔	✔					
P2	✔			✔	✔	✔	
P3	✔	✔	✔	✔			
P4	✔			✔		✔	
P5	✔	✔	✔		✔		✔
P6	✔	✔	✔	✔			
P7	✔				✔		✔
P8	✔						
P9	✔	✔	✔				
P10	✔	✔	✔		✔		✔
P11	✔					✔	
P12	✔						
P13	✔	✔	✔		✔		
P14	✔						

P15	✔	✔	✔				
Total:15	**15**	**7**	**7**	**4**	**5**	**3**	**3**

Disabled individuals face numerous challenges with public transportation, among 15 participants, about 15 participants mentioned that need to boarding support mechanism, also 7 participants mentioned that need to priority seating these are essential for them. Another 7 participants said that need training support staff and 4 participants said that need to Inclusive planing , 5 participants mentioned that supportive environment , 3 participants state that need trained police support, 3 participants state that emotional support. Last 4 participants said that dignity in travel.

Among 15 participants said that need boarding support mechanisms, these are majority of patients (P1, P3, P4, P5, P6, P10, P13, P15) expressed that the high doors of buses and cars create significant obstacles for lower limb amputees. These elevated entry points often make it extremely difficult for them to board public transportation independently. One participant (P1) specifically mentioned, "It would be convenient if the height of the bus or rickshaw from the road was less," emphasizing how such physical design flaws directly limit their mobility and access to community life. Another participant (P9) mentioned that danger of current conditions, stating, "I have no legs, I have to jump into the car. There is no provision for help," underlining the lack of support systems for disabled passengers.

In addition to height-related issues, inadequate seat availability on public transport was also a recurring concern among respondents (P5, P14, P15). Many shared that even when they managed to board a bus, they often found no designated seating, increasing their discomfort and risk of injury during travel. A participant (P15) reflected on the emotional and psychological toll of such exclusion by stating, "Half of the happiness and peace of a person without legs is gone," portraying the deeper impact that lack of accessible transportation has on their quality of life.

Another prominent point that emerged was the lack of wheelchair accessibility in public transport systems (e.g., P2, P6, P7, P8, P11, P12, P14). Participants shared how difficult it is to travel independently when public vehicles are not designed to accommodate wheelchairs. One participant (P2) mentioned, “When I go out, I have to go out with a wheelchair. So it would be good if there was a system so that I can get on and off the bus with a wheelchair.” Others echoed similar concerns, with P7 stating, “I have to move around in a wheelchair. Thinking of those of us who use wheelchairs, an arrangement should be made so that we can move around in vehicles with wheelchairs.” These quotes reflect the urgent need for structural adaptations, such as ramps, wider doors, or dedicated wheelchair zones within public vehicles.

Additionally, the absence of assistance and trained personnel was another major barrier highlighted by the participants (e.g., P3, P5, P6, P9, P10, P13). Several respondents noted that there is little to no support from transport staff when getting on or off vehicles, making the experience unsafe and undignified. As P9 shared, “There is no provision for anyone to get in with any help… these measures are necessary.” This indicates not just a lack of infrastructure but also a gap in awareness and service delivery. Some participants suggested that drivers and bus helpers should be trained to understand the needs of disabled passengers and provide proper assistance during boarding and travel.

A total of 4 participants (P2, P3, P4, P6) expressed the need for inclusive planning in transportation. They highlighted that the current transport system is designed without considering the challenges faced by disabled individuals. “Public vehicles are not designed for people like us. Nobody asks what we need” (P6). “There is no accessible rickshaw in my area. I feel stuck” (P3).

5 participants (P2, P5, P7, P10, P13) emphasized the importance of a supportive social environment during travel. They felt hurt or ignored by others’ behavior, which made commuting stressful. “People stare at me or move away like I don’t belong” (P7). “Sometimes I want to travel, but I avoid it because no one helps when I need support” (P13). 3 participants (P5, P7, P10) shared experiences of emotional stress while using public transportation. Their concerns included fear, anxiety, and feeling like a burden. “The night before I need to travel, I feel nervous the whole time” (P7). “I constantly worry whether I will find a seat or be pushed” (P5). 4 participants (P6, P8, P12, P14) strongly emphasized that their dignity is often compromised in public spaces. “Being dragged or lifted makes me feel like an object, not a person” (P8). “I don’t want special treatment. I just want to board like everyone else” (P6).

Together, these insights reflect a shared expectation among amputee patients a transportation system that is not only physically accessible but also socially inclusive. Their experiences suggest that meaningful improvements in vehicle design, staff training, and policy-level changes are necessary to promote equal participation and mobility in society.

Theme-2: Critical gap in localized rehabilitation and prosthetics for lower limb amputee.

Categories-2: Need to comprehensive rehabilitation facilities.

Table-4: Need to comprehensive rehabilitation facilities.

Participants	Early professional guidance	Government policy for rehab support	Standard rehabilitation center in community	Counseling
P1			✔	
P2	✔			
P3			✔	
P4		✔		
P5	✔		✔	
P6			✔	
P7		✔		
P8				✔
P9				✔
P10	✔	✔	✔	
P11			✔	
P12			✔	✔
P13			✔	
P14	✔	✔	✔	✔
P15				
Total:15	**4**	**4**	**9**	**4**

Among 15 participants, about 4 participants mentioned that early professional guidance, 4 participants said that need government policy support, and 9 participants mentioned that rehabilitation center is important in our area, 4 participants said need counseling. This theme highlights the lack of accessible, timely referral , and well-resourced rehabilitation services in local areas for lower limb amputees. Most participants shared that they struggled to access essential services like physiotherapy, prosthetics, and emotional support, mainly due to distance, poor referral systems, and lack of government-backed centers.

Several participants emphasized the importance of receiving early professional guidance after amputation. Without proper direction, many felt confused and unsure about what steps to take. For example, P2 mentioned, “If foot therapy was available in the area, it wouldn’t have been so bad. I have to stay at CRP for a week, wasting time and money.” This statement clearly shows how the lack of early intervention can lead to unnecessary financial and emotional pressure. Similarly, P10 and P14 also reflected the need for timely guidance from trained professionals.

Participants repeatedly pointed out the absence of proper government support for rehabilitation services. They said that most public hospitals don’t have dedicated departments for amputee care. P3 said, “There is a government hospital in our city, but there is no separate department for foot surgery or therapy.” P6 also mentioned the absence of any specialized services in local hospitals. These responses suggest a clear policy-level gap in planning and allocating rehabilitation resources for amputees.

The most common issue raised was the lack of standard rehabilitation centers in their communities. A majority of participants, including P1, P2, P4, P5, P6, P10, P11, P12, P13, and P14, shared that they had to travel to CRP in Savar for therapy and prosthetic devices. P5 explained, “I got my prosthetic from CRP and now I must return every three months for follow-ups.” P4 added, “If there was a hospital like CRP in our area, we wouldn’t have to come all the way to Savar.”

This long-distance travel not only caused stress but also disrupted their daily lives. For instance, P1 said, “I don’t have any income, and then I have to pay rent again.” P8 mentioned, “My mother has to leave my younger siblings alone to come take care of me.” These personal stories show how the centralization of rehab services increases emotional stress and dependency on family members.

Some participants reported emotional breakdowns after their amputation. They didn’t just face physical limitations, but also mental distress. P9 shared, “After losing my leg, I thought my life was over. I didn’t even know what rehabilitation was until I came to CRP.” This lack of emotional support and awareness often delayed their recovery process. P14 shared that she couldn’t use her prosthetic properly because she lacked muscle strength and emotional support, saying, “I need therapy just to use the prosthetic and emotional support to continue.”

Participants felt that the general public lacked awareness about rehabilitation and assistive devices. This made things harder for both patients and their families. P12 highlighted the importance of community education so that people can take the right decisions at the right time. The lack of outreach programs made many participants feel isolated and helpless, especially during the early phase after limb loss.

Some participants, like P15 from Chapainawabganj, admitted that they had relatively better access to services in their district. However, even they stressed that proper rehabilitation support is still limited. P15 said, “The rehabilitation aspect of healthcare is very important for us who cannot walk.” This shows that even in better-served regions, the overall quality and consistency of care remain questionable.

Almost every participant agreed that having CRP-like centers in their local area would reduce the burden of travel and make rehab services more accessible. They recommended that such centers offer physiotherapy, prosthetic fitting, follow-up care, and counseling. These suggestions make it clear that patients are not just asking for treatment they want a support system close to home.

Theme-3: Activities and event that are beneficial for lower limb amputee patients and empowered social inclusivity.

Categorie 3s: Community support and engagement.

Table-5: Community support and engagement.

Participant	**Social support**	**Peer support**	**Rehabilitation program**	**Wheel chair sports**	**Community awareness campaign**	**Vocational rehabilitation training**	**Family and caregiver support session**	**Motivational Counseling Sessions**
P1	✔		✔		✔		✔	
P2	✔	✔	✔				✔	
P3	✔	✔	✔	✔		✔		
P4		✔	✔	✔		✔		
P5	✔		✔	✔	✔			
P6	✔		✔	✔		✔		✔
P7		✔	✔		✔		✔	
P8	✔	✔	✔	✔		✔		
P9			✔		✔	✔		
P10			✔				✔	
P11		✔	✔		✔			
P`12	✔		✔					
P13			✔	✔				
P14			✔	✔		✔		
P15	✔	✔	✔		✔			
Total:15	**8**	**7**	**15**	**6**	**7**	**6**	**5**	**1**

Among 15 participants, about 8 participants said that Social support is beneficial for participating in community activities or event, 7 participants said that also peer support is beneficial, 15 participants said that rehabilitation program is more beneficial, 6 participants said that wheelchair basketball event, 7 participants said community awareness campaign, 6 participants said vocational rehabilitation program and 5 participants said family and care giver support session is most beneficial for participating in community activities or event. 0ne participants mentioned motivational counseling session.

A big thing that stood out was how much they value social and peer support. P1 said, "I believe events should be organized specifically for people like us who have lost a limb. When I'm alone, it feels unbearable." This shows how much loneliness affects their mental health. P10 also said, "Peer support from others like me would allow us to share our issues." When they get to be around people who truly understand their struggles, they feel less alone and more hopeful. Another major point was the need for rehabilitation programs. Many participants like P6 said, "I attended a rehab program once, where they taught how to stay emotionally strong." These programs aren't just about physical healing they help patients build inner strength and learn how to cope mentally. P15 added, "Rehabilitation services should be arranged so that even if not weekly, at least monthly we can get medical care." So, it's not just about one-time help; they want regular and reliable services. Wheelchair sports were also mentioned by several people. P3 said, "Organizing events like wheelchair basketball would lift our spirits," and P5 shared, "When I played wheelchair basketball, I felt excited again." These kinds of games are more than just fun they help them feel confident and part of something. P8 explained, "If we had wheelchair sports, we could participate equally." This shows how important it is for them to feel included like everyone eels.

Some participants talked about vocational support and jobs. P3 mentioned, "I never thought I could return to work after losing my leg, but when I learned about vocational training opportunities, I began to dream again." Similarly, P7 said, "If I had access to work suited to my capacity, that would be very helpful." These thoughts make it clear that they want to be independent and useful again they don't want to rely on others forever. A few participants also talked about the importance of community awareness. P4 said, "Once I attended an awareness campaign where people actually listened to our stories," and P9 shared, "Events that show how it feels to live without a leg would help others understand our challenges." They want society to really understand what they go through so that people treat them with more empathy and respect.

Caregiver support and training was another emerging topic from the data, identified by five participants. Patients believed their families, especially parents or spouses, needed better training and emotional support. P12 shared, "If there were training programs for caregivers, my mother could support me even better." P14 reinforced this by stating, "Caregiver support would help us live meaningfully." These reflections show that community rehabilitation should include not just the patients, but also those who support them daily.

One participant specifically emphasized the importance of motivational counseling sessions as part of their rehabilitation journey. They shared that while physical therapy helped improve mobility, what they truly lacked was emotional guidance and structured motivation. This participant expressed (P6), “If there were sessions where someone could talk to us, guide us emotionally, and show how others overcame similar challenges, it would really help.”

Their statement reflects a desire not just for general support but for formal, structured motivational programs, where patients can receive inspiration, emotional tools, and coping strategies. Although this view was not echoed widely across the group, it brings forward a valuable insight into how counseling-based interventions could enhance self-confidence and mental preparedness for social reintegration.

Chapter- v Discussion

In this chapter the results of the study are discussed in relation to the research questions and objectives of the study. The discussion focuses on expectations of lower limb amputee patients from community. By the content analysis different categories are found under which different options are expressed by different codes. Five major categories found under which five themes were emerged. This part is carried out on the basis of analysis of acquired data and its relevance with other published literature related to the study.

Summary of theme that emerged from data analysis:

Theme 1: Facilities of accessibility and inclusivity in public transportation for individuals with lower limb amputees area.

The collected data indicate that lower limb amputee patients experience significant difficulty using public transportation, primarily due to the height of vehicle doors. Respondents implied that buses and rickshaws in Bangladesh are not designed with disability access in mind. Many expressed that a reduction in the height of steps or the introduction of low-floor vehicles would improve their ability to travel independently. This issue is not unique to Bangladesh. For example, The United Kingdom continues to face accessibility issues despite existing laws, as reported by The Guardian (2025).

Another repeated concern was the lack of wheelchair-compatible facilities in public transport. Participants' views reflect a demand for onboard space and boarding ramps to accommodate wheelchairs. Comparable issues were observed in France before the 2024 Paralympics, where many Paris Métro stations remained inaccessible (Le Monde, 2024). In contrast, Japan and the United States have invested heavily in inclusive transport systems with automated ramps, wider doors, and dedicated spaces for wheelchair users.

The absence of priority seating was also interpreted as a major source of discomfort and emotional strain for amputees. Unlike in many developed nations such as the UK and the USA where such seating is legally mandated, Bangladeshi transport lacks consistent enforcement or provision. Literature confirms that such physical exclusions contribute to psychosocial stress and social isolation . Several participants also hinted at the lack of trained staff and support systems during boarding or disembarking. Globally, some countries have responded with disability awareness programs for transport staff, while others have introduced private services. For example, Kenya has launched services like Ace Mobility, which provides trained caregivers and accessible vehicles, though still limited by affordability and availability . In Bangladesh, however, there appears to be a complete absence of such services, creating additional barriers to travel. The policy gap in Bangladesh is another critical issue. While countries like the United States and United Kingdom have enforceable laws such as the Americans with Disabilities Act (ADA) and the Equality Act Bangladesh has no comparable legal framework that mandates accessible public transportation. This lack of accountability mechanisms was evident in participants' descriptions, reflecting not just dissatisfaction but also a sense of helplessness.

Finally, while high-income countries increasingly incorporate universal design principles such as tactile paths, elevators, and platform lifts into transit infrastructure, Bangladesh remains far behind. The contrast between patients' modest expectations (like lowered steps or basic seating) and the advanced measures implemented globally highlights a stark infrastructure and policy deficit. Despite all challenges, patients expressed resilience and hope, suggesting that even small-scale changes like ramps or designated seats could transform their daily lives. This is in line with global research that supports low-cost, inclusive solutions as effective pathways to improved mobility and dignity (Crist, Borrelli and Harvey, 2020).

Australia offers a more structured framework for accessible transport. The Disability Standards for Accessible Public Transport 2002 mandates that all public transport must be progressively accessible to people with disabilities, including those using wheelchairs or mobility aids. Features such as tactile flooring, low-floor buses, and wheelchair boarding ramps are now common across major Australian cities. Additionally, public feedback mechanisms and government audits are regularly conducted to ensure compliance. These standards reflect a national commitment to universal access, in stark contrast to the unregulated and inconsistent transport infrastructure observed in Bangladesh. India despite sharing many socioeconomic similarities with Bangladesh has taken initial steps to enhance transport accessibility under its Accessible India Campaign. Major urban centers like Delhi and Mumbai have begun deploying low floor buses, wheelchair lifts at metro stations, and designated seating. Although enforcement and rural coverage remain limited, India's formal acknowledgment of transport as a right for people with disabilities marks a notable policy advancement.

In Bangladesh, by contrast, the absence of such nationwide campaigns or legal mandates continues to widen the gap between expectation and reality. These comparisons show that policy intent and enforcement, even in lower-middle-income countries, can create meaningful shifts in inclusive mobility. While both Australia and India face challenges, their institutional acknowledgment and partial implementations highlight how far Bangladesh still needs to go to ensure dignity, access, and equal opportunity for people with disabilities.

Theme-2: Critical gap in localized rehabilitation and prosthetics services for lower limb amputee.

The absence of rehabilitation units, therapy centers, and prosthetic support facilities in participants' home regions directly hinders recovery. Globally, access to local rehabilitation services has been shown to significantly impact outcomes for amputees (WHO, 2011). This contrasts with health systems in countries like Norway and Germany, where rehabilitation is a decentralized service embedded in municipal healthcare. In Norway, municipal rehabilitation centers exist even in rural areas, ensuring timely therapy and reintegration support. Similarly, Germany's model emphasizes early community-level intervention to reduce dropout rates and maintain care continuity. In contrast, participants in Bangladesh reported traveling to a single major center CRP which often results in delays and increased dropout risk.

Long-distance travel for therapy and follow-up introduces both economic stress and emotional distress. Studies have shown that travel distance to rehabilitation services directly influences health outcomes, mental burden, and social reintegration potential (Fortington et al., 2017). Participants mentioned the cost of accommodation, job loss during treatment, and the hardship of being separated from family support systems. By comparison, countries like Australia and Canada offer closer or even home based rehabilitation services, which ease mental health burdens and reduce financial strain. The absence of such mechanisms in Bangladesh leaves rural and low-income amputees at a serious disadvantage.

Another key issue raised by participants is the lack of local prosthetic fitting and maintenance services. Adjustments or repairs require travel to Dhaka, leading to physical strain and interrupted use of devices. Meanwhile, countries like the United Kingdom have numerous regional prosthetic centers, and in the United States, mobile clinics provide follow-up care even in remote areas. Such models ensure consistent access something Bangladesh currently lacks A knowledge gap around rehabilitation and assistive technologies was also apparent. Several participants only learned about these options after reaching CRP, indicating poor community-level awareness. This situation mirrors challenges seen in countries like Nepal and Tanzania, where awareness and referral systems are still developing. On the other hand, in Sweden, community health workers actively guide patients through rehabilitation, ensuring better-informed decision-making and faster recovery.

Overall, the interviews reveal a lack of structured, accessible post-amputation care in Bangladesh. From prosthetics to counseling, patients often must navigate these services alone, leading to delays and a sense of exclusion. Bridging these gaps requires not only improved infrastructure but also better public awareness and outreach. The absence of rehabilitation units, therapy centers, and prosthetic support facilities in participants' home regions directly hinders recovery. This contrasts with health systems in countries like Norway and Germany, where rehabilitation is a decentralized service embedded in municipal healthcare. In Norway, for example, municipal rehabilitation centers are available even in rural regions, ensuring timely therapy and reintegration support . Similarly, Germany's rehabilitation model emphasizes "early intervention at the community level," which reduces dropout rates and enhances continuity of care. In contrast, Bangladeshi participants expressed that they had to travel to a single center CRP which acts as the country's main facility, leading to delays and dropouts.

Long-distance travel for therapy and follow-up introduces economic stress and emotional distress. Participants mentioned high living costs during treatment, job loss, and separation from family support systems. In contrast, a study from Australia noted that proximity to rehab centers not only improved functional recovery but also reduced mental health burdens among amputees . In Canada, government-assisted rehabilitation includes home-based follow-ups, which greatly reduces the financial toll and improves quality of life (Wong et al., 2019). The lack of such mechanisms in Bangladesh disproportionately affects rural, low-income amputees who cannot afford prolonged stays at distant centers.

Another key issue raised by participants is the lack of local prosthetic fitting and maintenance services. Adjustments or repairs require travel to Dhaka, leading to physical strain and interrupted use of devices. Meanwhile, countries like the United Kingdom have numerous regional prosthetic centers, and in the United States, mobile clinics provide follow-up care even in remote areas. Such models ensure consistent access something Bangladesh currently lacks. A knowledge gap around rehabilitation and assistive technologies was also apparent. Several participants only learned about these options after reaching CRP, indicating poor community-level awareness. This situation mirrors challenges seen in countries like Nepal and Tanzania, where awareness and referral systems are still developing. On the other hand, in Sweden, community health workers actively guide patients through rehabilitation, ensuring better-informed decision-making and faster recovery. Overall, the interviews reveal a lack of structured, accessible post-amputation care in Bangladesh.

Theme-3: Activities and event that are beneficial for lower limb amputee patients and empowered social inclusivity.

One of the key expectations identified among lower-limb amputees is the need for strong social and peer support systems to foster meaningful participation in community life. Although this was reflected in the findings of this study, the same theme is echoed globally. In Australia, studies have highlighted the importance of peer mentoring and group-based activities that allow individuals with disabilities to regain confidence and reduce isolation. This mirrors the current data, where a significant number of participants emphasized that community events and group interactions greatly ease emotional distress and loneliness. It suggests that the presence of peer support networks has a universal impact on promoting psychological resilience and social reintegration (WHO,2011).

Similarly, Canada has prioritized community inclusion through organized social gatherings, accessible events, and awareness campaigns aimed at reducing stigma. This aligns closely with participant expectations for social inclusion events where their challenges can be shared and understood by the wider community. These forms of interaction not only reduce feelings of alienation but also educate the public about living with limb loss, which is vital for building an empathetic society.

Another dominant theme was the overwhelming support for ongoing rehabilitation services. Every participant acknowledged that rehabilitation programs were crucial not only for physical recovery but for emotional well-being and social independence.

This expectation is supported by literature from Germany, where rehabilitation services are integrated into long-term care strategies, ensuring that patients receive continuous psychological counseling and physical therapy. Such a model contrasts with the local context where access to rehabilitation is often irregular and limited. The expectation here is not only for initial support post-amputation but for a sustained, accessible, and structured rehabilitation system that can address evolving patient needs over ttime Participation in inclusive recreational activities, particularly wheelchair sports, was also frequently mentioned. This aligns with initiatives observed in Japan, where wheelchair basketball and similar sports are part of government-endorsed programs to enhance inclusion and public visibility for people with disabilities. Participants in this study similarly expressed that sports are a key motivator, helping them feel equal and energized, and providing a platform for confidence building. These shared insights underline the value of adaptive sports in encouraging physical activity, social interaction, and psychological healing.

Vocational rehabilitation emerged as a significant expectation in this study, with several participants pointing to the need for employment opportunities suited to their physical capacities. In Sweden, vocational training is deeply embedded within the rehabilitation process, and policies ensure that individuals with disabilities are equipped with skills and placed in accessible work environments. This holistic model sharply contrasts with the realities expressed by participants here, where a lack of vocational guidance and workplace inclusion presents ongoing challenges. The desire for economic independence and productivity is consistent across countries; however, the infrastructure and institutional support available vary widely.

In addition to vocational access, community awareness was another point of focus. Several participants expected that the public should be better informed about the daily challenges faced by amputees. The United Kingdom has made considerable strides in promoting disability awareness through school-based education, inclusive media representation, and awareness days. These efforts aim to normalize disability and foster empathy from an early age. Locally, this kind of systemic awareness-building is still at a developmental stage, which reinforces participant expectations for more frequent campaigns, storytelling platforms, and public engagement to sensitize the broader population.

The importance of caregiver support also featured in participant responses. In countries like Norway, caregiver support programs are government-funded, providing both formal training and financial relief to those who care for persons with disabilities. This model contrasts with the challenges faced in the current context, where caregivers often family members lack training, recognition, and support. The expectations for caregiver empowerment show a broader understanding that patient recovery and community participation are closely linked to the well-being of those who assist them. Themes such as social inclusion, structured rehabilitation, accessible sports, vocational support, public awareness, and caregiver empowerment are not limited to any one region. However, the contrast between the expectations of local participants and existing practices in countries such as Germany, Japan, Canada, and Sweden reveal a gap in implementation. Addressing this gap requires a coordinated effort from healthcare providers, policymakers, and community organizations to develop inclusive, sustainable, and culturally appropriate support systems that enable individuals with lower-limb amputations to thrive in their community.

5.1 Limitations

This study followed a qualitative approach and used purposive sampling to select participants. The researcher designed a semi-structured questionnaire, but it was not tested for validity or reliability. In-depth interviews were conducted to gather rich information, yet limited interviewing experience affected the depth and clarity of the responses. Some participants gave off-topic answers when audio recordings were used. Due to time limitations, the study focused on a small area. The responses reflect personal views that may be influenced by emotions or social expectations. With only 15 participants, the findings remain limited. As this was the researcher's first study, expert guidance was highly valued.

Chapter- vi Conclusion and recommendations

6.1 Conclusion

This study explored the expectations of lower limb amputee patients from their communities through a qualitative approach grounded in real-life narratives. The findings clearly show that amputees face a range of physical, emotional, and social challenges that go beyond the surgical procedure itself. Participants consistently voiced the need for better accessibility in public transport, localized rehabilitation services, affordable prosthetic care, and strong social inclusion. Many highlighted the lack of awareness, infrastructure, and emotional support in their communities, which hinders their independence and reintegration into society. Despite the limitations of sample size and localized scope, this research contributes valuable insights into the lived realities of amputees in Bangladesh. It emphasizes the urgency for community-based rehabilitation, inclusive infrastructure, and culturally sensitive healthcare delivery. The study also highlights the importance of ongoing peer support, vocational opportunities, and caregiver empowerment. To bridge the gap between patient needs and existing resources, policy makers and health professionals must work collaboratively to develop sustainable, inclusive, and responsive systems. Ultimately, true rehabilitation is not just physical it involves restoring dignity, purpose, and belonging. By listening to amputees' voices and acting on their expectations, communities can foster equity, respect, and well-being for all.

6.2 Recommendations

This study suggests conducting further qualitative research involving a larger group of participants and extended observation over time to gain deeper insights. But there is only few study in this area in Bangladesh. In researcher opinion, future research should focus on the accessibility and social inclusion of amputee individuals to better support their integration into community life. There is also a need for future research on comprehensive rehabilitation facilities to ensure holistic and continuous care for amputees.

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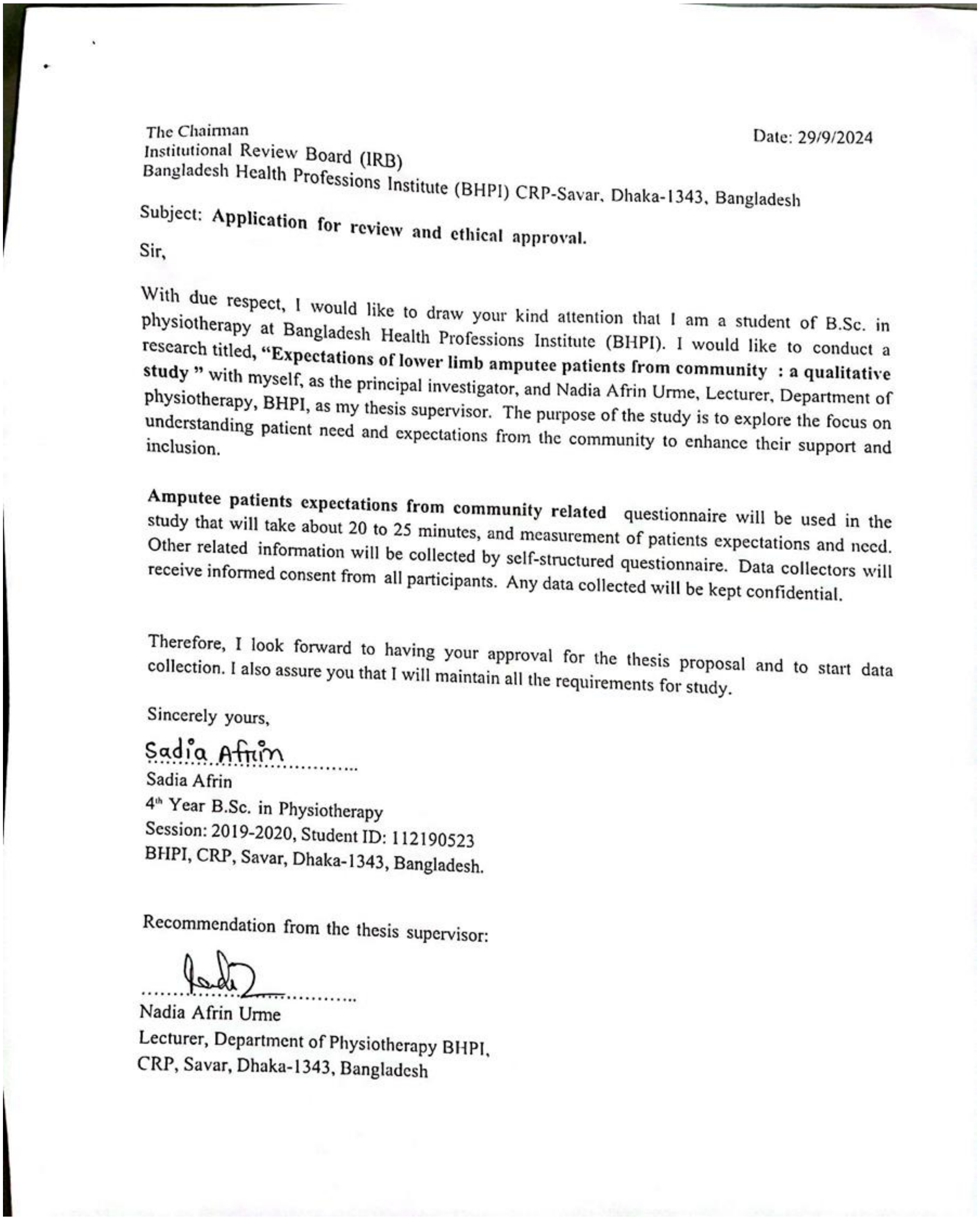
Appendix

Application for review and ethical approval



The Chairman
Institutional Review Board (IRB)
Bangladesh Health Professions Institute (BHPI) CRP-Savar, Dhaka-1343, Bangladesh

Date: 29/9/2024

Subject: **Application for review and ethical approval.**

Sir,

With due respect, I would like to draw your kind attention that I am a student of B.Sc. in physiotherapy at Bangladesh Health Professions Institute (BHPI). I would like to conduct a research titled, **"Expectations of lower limb amputee patients from community : a qualitative study "** with myself, as the principal investigator, and Nadia Afrin Urme, Lecturer, Department of physiotherapy, BHPI, as my thesis supervisor. The purpose of the study is to explore the focus on understanding patient need and expectations from the community to enhance their support and inclusion.

Amputee patients expectations from community related questionnaire will be used in the study that will take about 20 to 25 minutes, and measurement of patients expectations and need. Other related information will be collected by self-structured questionnaire. Data collectors will receive informed consent from all participants. Any data collected will be kept confidential.

Therefore, I look forward to having your approval for the thesis proposal and to start data collection. I also assure you that I will maintain all the requirements for study.

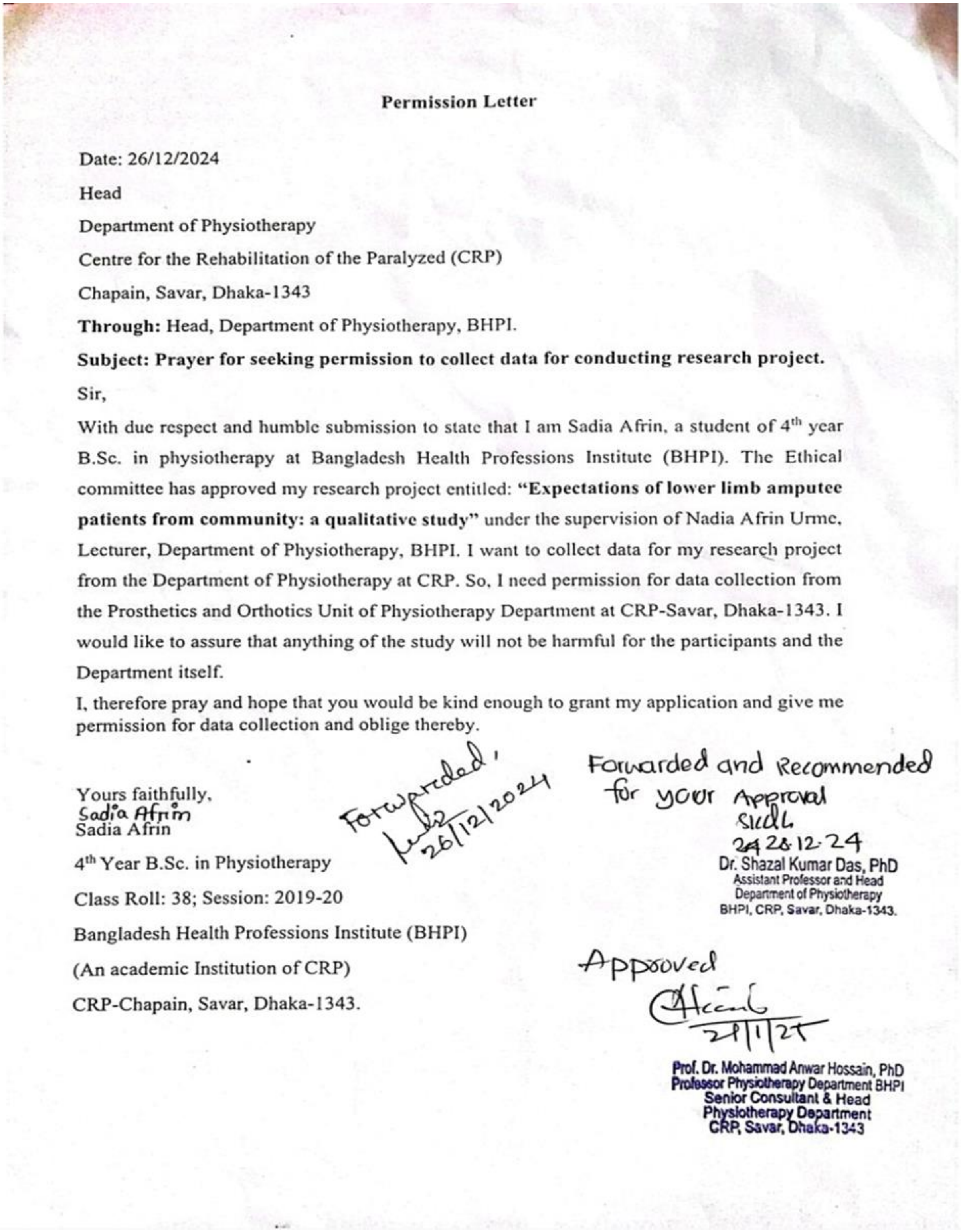
Sincerely yours,

Sadia Afrin
....
Sadia Afrin
4th Year B.Sc. in Physiotherapy
Session: 2019-2020, Student ID: 112190523
BHPI, CRP, Savar, Dhaka-1343, Bangladesh.

Recommendation from the thesis supervisor:

....
Nadia Afrin Urme
Lecturer, Department of Physiotherapy BHPI,
CRP, Savar, Dhaka-1343, Bangladesh

Permission Letter



Permission Letter

Date: 26/12/2024

Head
Department of Physiotherapy
Centre for the Rehabilitation of the Paralyzed (CRP)
Chapain, Savar, Dhaka-1343

Through: Head, Department of Physiotherapy, BHPI.

Subject: Prayer for seeking permission to collect data for conducting research project.

Sir,

With due respect and humble submission to state that I am Sadia Afrin, a student of 4th year B.Sc. in physiotherapy at Bangladesh Health Professions Institute (BHPI). The Ethical committee has approved my research project entitled: **"Expectations of lower limb amputee patients from community: a qualitative study"** under the supervision of Nadia Afrin Urme, Lecturer, Department of Physiotherapy, BHPI. I want to collect data for my research project from the Department of Physiotherapy at CRP. So, I need permission for data collection from the Prosthetics and Orthotics Unit of Physiotherapy Department at CRP-Savar, Dhaka-1343. I would like to assure that anything of the study will not be harmful for the participants and the Department itself.

I, therefore pray and hope that you would be kind enough to grant my application and give me permission for data collection and oblige thereby.

Yours faithfully,
Sadia Afrin
Sadia Afrin
4th Year B.Sc. in Physiotherapy
Class Roll: 38; Session: 2019-20
Bangladesh Health Professions Institute (BHPI)
(An academic Institution of CRP)
CRP-Chapain, Savar, Dhaka-1343.

Forwarded,
26/12/2024

Forwarded and Recommended
for your Approval
28.12.24
Dr. Shazal Kumar Das, PhD
Assistant Professor and Head
Department of Physiotherapy
BHPI, CRP, Savar, Dhaka-1343.

Approved
21/1/25
Prof. Dr. Mohammad Anwar Hossain, PhD
Professor Physiotherapy Department BHPI
Senior Consultant & Head
Physiotherapy Department
CRP, Savar, Dhaka-1343

Information sheet (English)

Research study tittle: Expectations of lower limb amputee patients from community: A qualitative study.

Objective of the study: This study is being conducted

i. To identify the socio-demographic information of the participants.

ii. To explore what lower-limb amputee patients expect regarding inclusive and accessible public transportation in their communities.

iii. To explore and know patients expectations about the availability and quality of specialized

healthcare services in the community after rehabilitation.

iv. To know and understand patients' expectations related to social inclusion and participation in

community activities.

Participants of the study: patients with amputation problems who have lower limb amputees are invite to participate in this research study.

Data collection procedure: If you participate in this study, you will asked to some personal and other related information regarding amputation by using a questionnaire. This will take approximately 10-15 minutes of your time.

Benefits of participations: Participants will have the opportunity to reflect on, share and more aware of their thoughts and feelings expectation from community after amputation. Additionally, your participation and better statements are likely to help us find the answer to the research questions and future study it may benefited to the researcher.

Risks of participations: We do not forces any risk or discomfort from your participation in the study.

Economic benefits: You will not be given any money or gifts to take part in this research.

Confidentiality: All information provided by you will be treated as confidential it will ensure that the source of information remains secret. Also, your name will not appear anywhere and no one except me will know about your specific answer.

Voluntary participation: Yours participation in this study is voluntary, so you may choose to participate or not. Your decision will not to volunteer will not influence the treatment you may be receiving either in the future. If you do not wish to continue, you have the right to withdraw from the study, without penalty, at any time.

Who to contact: If you have any query, you may ask me now or later, even after the study has started. If you wish to ask questions later, you may contact any of the following:

Researcher:

Sadia Afrin

4thprofessional B.Sc. in Physiotherapy

Bangladesh Health Professions Institute

(BHPI) Contact no: 01883140508,

E-mail:

sadiaafrrindlb@gmail.com

Or,

My research supervisor

Nadia Afrin Urme

Lecturer, Department of Physiotherapy

Bangladesh Health Professions Institute (BHPI),

CRP, Savar, Dhaka-1343

E-mail: afrinnadia4127@yahoo.com

Consent certificate

A) Participant or witness:

1. Did you understand

   the information sheet

   yes/no

2. Do you have anything else to know?

   yes/no (If yes, ...)

3. Do you understand that you will not be benefited

   financial from this research ?

   yes/no

4. Do you consent to your information being recorded?

   Yes/no

5. Have you got enough time to decide?

   Yes/no

6. Are you consenting to participate in this study?

   Yes/No

Name of Participant ______________________________

Signature of Participant ________________Date ______________

If participants Illiterate

Name of literate witness ____________________

Thumb print of participant

Signature of literate witness____________________Date___________________

B) Researcher:

Explained the above study precisely to the participant and she indicated his willingness to participate in the study.

Signature of Researcher _________________Date __________________

Questionnaire (English version)

Date:

Patient's name:

Mobile No:

Address:

Section 1: Socio-demographic Information

1. Age

- 19-30
- 31-40
- 41-50
- 51-60

2. Gender

- Male
- Female

3. Types of amputation

- Trans-femoral
- Trans-tibial

4. Site of amputation

- Right
- Left
- Bilateral

5. Living area

- Urban
- Sub-urban
- Rural

6. Educational level

- Illiterate
- Up to class 5
- S.S.C
- H.S.C
- Graduate

7. Duration of amputation

- Less than 1years
- 1 years
- 4-6years
- 7-10years

Section 2: Interview Questions

1**.** How would you rate the accessibility of public transportation in your area?

2. What additional public transportation accessibility features do you believe are needed in your area?

3. How would you rate the availability of specialized healthcare services for lower limb amputees in your area?

4. What aspect of health care services do you think is important to you or your area?

5. In your opinion, what is the rate of inclusion of people with disabilities in social activities in your community?

6. What type of community activities and event would be most beneficial for you?

সম্মতিপএ

গবেষণা অধ্যয়নের শিরোনাম: সম্প্রদায় থেকে নিম্ন অঙ্গবিচ্ছিন্ন রোগীদের প্রত্যাশা: একটি গুণগত অধ্যয়ন।

অধ্যয়নের উদ্দেশ্য: এই গবেষনাটি পরিচালিত হচ্ছে

১. অংশগ্রহণকারীদের সামাজিক জনসংখ্যা সংক্রান্ত তথ্য সনাক্ত করা।

২. কমিউনিটিতে অন্তর্ভুক্তিমূলক ও সহজপ্রাপ্য গণপরিবহন ব্যবস্থার বিষয়ে নিম্ন অঙ্গ বিচ্ছিন্ন রোগীদের প্রত্যাশা অন্বেষণ করা।

৩. পুনর্বাসন পরবর্তী সময়ে কমিউনিটিতে বিশেষায়িত স্বাস্থ্যসেবা পাওয়ার সুযোগ ও মান নিয়ে রোগীদের প্রত্যাশা অন্বেষণ করা।

৪. সমাজে অন্তর্ভুক্তি ও কমিউনিটির বিভিন্ন কার্যক্রমে অংশগ্রহণের ক্ষেত্রে রোগীদের প্রত্যাশা ও অভিজ্ঞতা জানার চেষ্টা করা।

অধ্যয়নের অংশগ্রহণকারীরা: অঙ্গচ্ছেদের সমস্যায় আক্রান্ত রোগীদের যাদের নিম্ন অঙ্গপ্রত্যঙ্গ কেটেছে তাদের এই গবেষণা গবেষণায় অংশগ্রহণের জন্য আমন্ত্রণ জানানো হচ্ছে।

ডেটা সংগ্রহের পদ্ধতি: আপনি যদি এই গবেষণায় অংশগ্রহণ করেন, তাহলে আপনাকে একটি প্রশ্নাবলী ব্যবহার করে অঙ্গচ্ছেদ সংক্রান্ত কিছু ব্যক্তিগত এবং অন্যান্য সম্পর্কিত তথ্য জিজ্ঞাসা করা হবে। এতে আপনার সময় প্রায় ১০-১৫ মিনিট লাগবে।

অংশগ্রহণের সুবিধা: অংশগ্রহণকারীরা অঙ্গচ্ছেদ করার পরে সম্প্রদায়ের কাছ থেকে তাদের প্রচেষ্টা এবং প্রত্যাশা সম্পর্কে প্রতিফলিত করার, শেয়ার করার এবং আরও সচেতন হওয়ার সুযোগ পাবে। উপরন্তু, আপনার অংশগ্রহণ এবং আরও ভালো বিবৃতি আমাদের গবেষণা প্রশ্নগুলির উত্তর খুঁজে পেতে সাহায্য করবে এবং ভবিষ্যতের অধ্যয়ন এটি গবেষকের জন্য উপকৃত হতে পারে।

অংশগ্রহণের ঝুঁকি: অধ্যয়নে আপনার অংশগ্রহণ থেকে আমরা কোনো ঝুঁকি বা অস্বস্তির পূর্বাভাস দিই না।

অর্থনৈতিক সুবিধা: এই গবেষণায় অংশ নেওয়ার জন্য আপনাকে কোনো অর্থ বা উপহার দেওয়া হবে না।

গোপনীয়তা: আপনার দ্বারা প্রদত্ত সমস্ত তথ্য গোপনীয় হিসাবে বিবেচিত হবে এটি নিশ্চিত করবে যে তথ্যের উৎস গোপন থাকবে। এছাড়াও, আপনার নাম কোথাও প্রদর্শিত হবে না এবং আমি ছাড়া কেউ আপনার নির্দিষ্ট উত্তর সম্পর্কে জানবে না।

স্বেচ্ছায় অংশগ্রহণ: এই গবেষণায় আপনার অংশগ্রহণ স্বেচ্ছাসেবী, তাই আপনি অংশগ্রহণ বা না করা বেছে নিতে পারেন। আপনার স্বেচ্ছাসেবক না করার সিদ্ধান্ত আপনি এখন বা ভবিষ্যতে যে চিকিৎসা গ্রহণ করছেন তা প্রভাবিত করবে না। আপনি যদি চালিয়ে যেতে না চান, তাহলে যেকোন সময় জরিমানা ছাড়াই আপনার অধ্যয়ন থেকে প্রত্যাহার করার অধিকার রয়েছে।

যোগাযোগ করবেন: আপনার যদি কোন প্রশ্ন থাকে, আপনি আমাকে এখন বা পরে জিজ্ঞাসা করতে পারেন, এমনকি অধ্যয়ন শুরু হওয়ার পরেও। আপনি যদি পরে প্রশ্ন জিজ্ঞাসা করতে চান, তাহলে আপনি নিম্নলিখিত যেকোনও সাথে যোগাযোগ করতে পারেন:

গবেষক:

সাদিয়া আফরিন

৪র্থ বর্ষ বি এস সি ইন ফিজিওথেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই)

যোগাযোগের নম্বর: 0১৭২০১২০৩৮৩

ই-মেইল: sadiaafrindlb@gmai.com

অথবা,

আমার গবেষণা সুপারভাইজার

নাদিয়া আফরিন ঊর্মি

প্রভাষক, ফিজিওথেরাপি বিভাগ

বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই), সিআরপি, সাভার, ঢাকা-১৩৪৩

ই-মেইল: afrinnadia4127@yahoo.com

সম্মতি প্রশংসাপত্র:

ক) অংশগ্রহনকারী বা সাক্ষী :

১. আপনি কি তথ্যশীট বুঝতে পেরেছেন?

হ্যাঁ/না

২. আপনার কি আর কিছু জানার আছে?

হ্যাঁ/না

(যদি হ্যা হয় ____)

৩. আপনি কি বুঝেন যে এই গবেষণা থেকে আর্থিক লাভবান হবেন না?

হ্যাঁ/না

৪. আপনাকে প্রশ্ন করার অনুমতি দিবেন?

হ্যাঁ/না

৫. আপনি কি আপনার তথ্য রেকর্ড করতে সম্মতি দিবেন?

হ্যাঁ/না

৬. আপনার কি সিদ্ধান্ত নেওয়ার জন্য যথেষ্ট সময় আছে?

হ্যাঁ/না

৭. আপনি কি এই গবেষনায় অংশ নিতে সম্মতি দিচ্ছেন?

হ্যাঁ/না

অংশগ্রহণকারীর নাম _______________________

অংশগ্রহণকারীর স্বাক্ষর__________________________তারিখ_____________

খ) গবেষকের স্বাক্ষর:

আমি অংশগ্রহণকারীকে উপরোক্ত অধ্যয়নটি সুনির্দিষ্টভাবে ব্যাখ্যা করেছি এবং তিনি অধ্যয়নে অংশগ্রহণের জন্য তার ইচ্ছুকতার ইঙ্গিত দিয়েছেন।

গবেষকের নাম _________________________

গবেষক তারিখের স্বাক্ষর_______________________

প্রশ্নপত্র (বাংলা)

তারিখ:

রোগীর নাম:

মোবাইল নম্বর:

ঠিকানা:

বিভাগ ১: জনসংখ্যা সংক্রান্ত তথ্য

১. বয়স:

- ১৯-৩০
- □□–□□
- ৪১-৫০
- □□–□□

২. লিঙ্গ:

- পুরুষ
- মহিলা

৩. অবস্থান:

- শহুরে
- শহরতলী
- গ্রামীন

৪. অঙ্গচ্ছেদের প্রকার:

- হাটুর উপরে
- হাটুর নিচে

৫. অঙ্গচ্ছেদের স্থান

- ডান
- বাম
- দ্বিপাক্ষিক

৬. অঙ্গচ্ছেদের সময়কাল:

- ১ বছরের কম
- ১-৩বছর
- ৪-৬ বছর
- ৭-১০ বছর

বিভাগ ২: উন্মুক্ত প্রশ্নপত্রের মাধ্যমে নিম্নঅঙ্গচ্ছেদের রোগীরা সমাজ থেকে কি চাহিদা রাখেন তা অনুসন্ধান।

(সরাসরি রোগীর নিকট থেকে সংগৃহীত)

১. আপনি কীভাবে আপনার এলাকায় পাবলিক ট্রান্সপোর্টের অভিগম্যতা মূল্যায়ন করবেন ?

২. আপনার এলাকায় পাবলিক ট্রান্সপোর্টের কোন অতিরিক্ত অভিগম্যতা বৈশিষ্ট্য প্রয়োজন বলে আপনি মনে করেন?

৩. আপনি আপনার এলাকায় নিম্নাঙ্গের জন্য বিশেষ স্বাস্থ্যসেবা পরিসেবার প্রাপ্যতাকে কীভাবে মূল্যায়ন করবেন?

৪. স্বাস্থ্যসেবা পরিসেবার কোন দিকটি আপনার জন্য বা আপনার এলাকার জন্য গুরুত্বপূর্ণ বলে মনে করেন?

৫. আপনার মত অনুযায়ী, আপনার কমিউনিটিতে প্রতিবন্ধী ব্যক্তিদের সামাজিক কর্মকাণ্ডে অংশগ্রহণের হার কতটা?

৬. কোন ধরণের সামাজিক কার্যকলাপ বা ইভেন্ট আপনার জন্য সবচেয়ে উপকারী হবে?