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Level of Satisfaction and Quality of Life of Caregivers of School Going Children with Disability

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We the undersigned certify that we have carefully read and recommended to the Faculty of Medicine, University of Dhaka, for the acceptance of this dissertation entitled

Level of Satisfaction and Quality of Life of Caregivers of School Going Children with Disability

Submitted by **G M Mainuddin Chisty**, for the partial fulfillment of the requirement for the degree of Bachelor of Science in Physiotherapy (B.Sc. PT).

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Declaration

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 same any publication, presentation or dissemination of information of the study. I would bind to take consent from the department of Physiotherapy of Bangladesh Health Profession Institute (BHPI).

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Acronyms

AHA	American Health Association
BHPI	Bangladesh Health Profession Institute
BMRC	Bangladesh Medical Research Council
CRP	Centre for the Rehabilitation of the Paralysed
IRB	Institutional Review Board
Qol	Quality of life
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

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Abstract

Purpose: The purpose of the study was to evaluate the Level of Satisfaction and Quality of life among Caregivers of School going Children with disability. **Objectives:** To evaluate the Level of Satisfaction and Quality of life of Caregivers of School going Children with Disability. **Methodology:** This study aimed to find out the Quality of life and level of satisfaction of caregivers of school going children with disability. For this reason, a quantitative research model in the form of a cross sectional type survey design was used. Cross sectional studies (also called a prevalence survey) aim at describing and quantifying the distribution of certain variables in a study population at point of time. It provided a snapshot of the health experience of a population at a given time (Hannan et al .2007). Researcher used this method so that the aim and objectives of the study can be fulfilled. Ethical permission was obtained from Institutional Review Board (IRB) and written informed consent was obtained from all participants. The study was conducted by using quantitative descriptive analysis through using SPSS software 22.0 version. **Results:** In the studied the caregivers of children with disability showed, 47.60% (n=20) described they had neither good nor poor QoL; 9.5%(n=4) described very poor,11,9%(n=5) showed poor,23.8%(n=10) described good and 7.1%(n=3) had very good quality of life. **Conclusion:** Among 42 participant's caregivers of children with disability experienced moderate level of quality life and life satisfaction**.**

Key words: *Quality of life, satisfaction level, caregivers, Disable children.*

CHAPTER 1 INTRODUCTION

Background:

According to World Health Organization [WHO] (2001**)** A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions).

The most common developmental disabilities are:

Autism and Asperger syndrome, Down syndrome, Fragile X syndrome, Evasive developmental disorders, Fetal alcohol spectrum disorders, Cerebral palsy, Intellectual disability, Attention deficit hyperactivity disorder [WHO] (2001).

The World Health Organization [WHO] (1980) has defined health as "a complete physical, mental and social well-being and not merely an absence of disease or infirmity." The concept has more recently been extended to include health related quality of life.

According to the international the classification of impairments, disabilities, and handicap concerned with physical aspects of health, disability has to do with the loss of functional capacity resulting from impaired organ, and handicap is a measure of the social and cultural consequences of an impairment or disability [WHO] (1980). Disability affects various aspects of life, including physical health, social interactions, family dynamics, psychological well-being, the surrounding environment, and personal independence. These effects ripple through personal, social, and family levels, impacting relationships and overall quality of life. Society's inclusivity and support play a crucial role in determining the extent of these impacts. (Barbotte, Guillemin and Chau 2001).

The United Nations Children's Fund [UNICEF] (2021) argued that, an estimated 1.3 billion people experience significant disability. About 16% of the global population, or 1 in 6 people, have disabilities. Some individuals with disabilities have a lifespan up to 20 years shorter than those without disabilities. People with disabilities are at a higher risk of experiencing health issues like depression, asthma, diabetes, stroke, obesity, and poor oral health—often double the risk compared to those without disabilities.

Petermans and Cleempoel (2009) have argued that I un 2004, approximately 92 million adults, or 2.2% of the population, had significant difficulties due to disabilities. Extrapolating this data to include adults aged 15 and above, around 720 million people face functional difficulties, with about 100 million experiencing severe challenges. Vulnerable groups, including women, those in the poorest wealth bracket, and older individuals, had higher disability rates. Developing countries showed higher rates compared to developed ones, such as a 43.4% disability prevalence among people aged 60 and above in lower-income nations, in contrast to 29.5% in higher-income countries.

According to the Global Burden of Disease 2004 analysis, around 15.3% of the world population, or about 978 million individuals out of an estimated 6.4 billion in 2004, experienced "moderate or severe disability." Of these, roughly 2.9% (about 185 million people) faced "severe disability." Among those aged 0-14 years, the percentages were 5.1% (approximately 93 million children) for moderate or severe disability and 0.7% (about 13 million children) for severe disability. For those aged 15 and older, the rates were 19.4% (approximately 892 million individuals) for moderate or severe disability and 3.8% (about 175 million individuals) for severe disability (Petermans and Cleempoel 2009).

According to World Health Organization [WHO] (2008) The disparity in disability prevalence between genders varies between the World Health Survey and the Global Burden of Disease data. Globally, the Global Burden of Disease indicates that moderate and severe disability prevalence is around 11% higher in females than males. This difference can be attributed to higher age-specific disability rates among females and the larger number of older women in the population. However, the World Health Survey estimates show a significantly higher female disability prevalence of almost 60% compared to males. This difference may partially arise from variations in how response categories were used in the two studies [WHO] (2009).

The United Nations Children's Fund [UNICEF] (2021) stated that, Globally, there are nearly 240 million children with disabilities, meaning that one in every ten children worldwide lives with a disability.

Pediatric chronic illness affects not only the child but the entire family (Law et al. 2019). According to Canadian Council on Social Development [2006] In Canada, the setting for this study, 3.7% of children 15 years or younger were reported to have a disability and 500,000 children were estimated to have a long-term chronic illness or mental illness (Statistics ,2008). Among children with chronic illness, nearly half experience severe disease and 8% experience ongoing activity limitations. The number of children with diagnosed disability is likely to increase over time as children with chronic illness are living longer and healthier lives (Martinez and Ercikan 2009).

According to World Health Organization (WHO) 10% of total population in Bangladesh are disable. Bangladesh is one of least developed countries in the world situated in the South Asia as measured in terms of average income, calories consumed per person, high infant mortality. The rising numbers of poor and the population boom have been two major challenges facing Bangladesh. The continued stress on national resource potentials caused by increasing population will retard the poverty alleviation efforts. Over population is the major problem in Bangladesh. The literacy rate is increasing but most of the people are less aware about health (Hosain et al. 2002).

According to the findings come from the recently-published conducted by the Bangladesh Bureau of Statistics (BBS) with technical support from UNICEF National Survey on Persons with Disabilities [NSPD] (2021) stated that more than half of children with disabilities in Bangladesh are not enrolled in any formal education according to new national-level data. The survey reveals that among children with disabilities (aged 5-17 years), only 65% were enrolled in primary school and only 35% were enrolled in secondary school. In total, 60 per cent of children with disabilities aged 5-17 years are not in education. The survey also found that children with disabilities who do attend formal education lag behind academically by over two years for their age on average. According to the survey, 1.7 per cent of children in Bangladesh live with one of the twelve types of disability defined in the Persons with Disability Rights and Protection Act 2013, while 3.6 per cent of children face functional difficulty in at least one of the domains of seeing, hearing, walking, fine motor skills, communication, learning, playing or controlling behavior.

Data from the survey also shed light on the difficulties that children with disabilities face as adults. Only one third of persons with disabilities of working age are employed, with women with disabilities far more likely to be unemployed compared to men. And

while 90 per cent of persons with disabilities who are registered with the Government receive disability allowances, the vast majority of them about 65% remain unregistered.

Living with a disabled child can have profound effects on the entire family—parents, siblings, and extended family members. It is a unique shared experience for families and can affect all aspects of family functioning (Reichman et al. 2008).

Quality of Life (QOL) has been defined by the World Health Organization as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad concept incorporating the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of the environment (Browen et al. 2006, p. 238).

As the concept of life satisfaction reflects cognitive aspects of individuals. It is important to understand how caregivers of children with disability perceive their life and assess their life satisfaction as it reflects their cognitive appraisal of burden that may be part of caring for their children with disability (Gebeyehu, Sahile and Ayalew 2019, p. 147).

Dale et al. (2006**)** find out when a child has a disability, most families experience some distress. Parents may experience, emotional stress, anxiety, fear, and guilt. They may have to rearrange their way of life to accommodate their child, and the child’s problems such as generalized motor disabilities absence of language and behavioral difficulties are likely to exacerbate stress levels. The significant difficulties associated with disability often necessitate that parents or primary caregivers gain additional skills and knowledge. They may also incur additional expenses that go beyond what is usual in 3 raising a child.

Bourke-Taylor et al. (2012) Said that many caregivers of children with developmental disabilities are known to experience high levels of stress, and compromised mental health and ultimately better service families raising and supporting a child with a disability. Quality of life of caregivers in school going children with disability is a complex construct that is influenced by many factors.

Chronic disorders of movement and posture in children with disability will cause a decrease in functioning and inability to perform activities of daily living (Sauve et al. 2010).

1.2 Rational:

Quality of life may be compromised due to the frequent care required by the disabled individual. The role of the primary caregiver is essential in helping disabled individuals in maintaining their life and connection to the community in order to avoid exclusion situations. However, the tasks assigned to the caregiver, with changes in routine and time spent in care and often without adequate guidance and support from health institutions and social networks, may directly affect aspects of their family and social life and consequently hamper in their Quality of life and decrease the level satisfaction in life.

Quality of life is an important parameter in the assessment of both individuals affected by disabilities and their relatives and caregivers.

Thus, there is a clear need to evaluate the level of satisfaction and the quality of life of caregivers of school going children with disability. Since most of these disable individuals are dependent on their caregivers, which can generate significant changes in their life dyna

1.3 Research question:

What is the level of satisfaction and quality of life among caregivers of school-aged disabled children?

1.4 Aims:

The aim of the study was to evaluate the Level of Satisfaction and Quality of life among Caregivers of School going Children with disability.

1.5 Objectives

1.5.1 General Objective

To evaluate the Level of Satisfaction and Quality of life among Caregiver of School going Children with Disability.

1.5.2 Specific Objectives

1. To find out the socio-demographic status of the caregiver’s pf children with disability

2. To determine what are the perceptions of family members about family life in general.

3. To explore how various domains of life of caregivers are impacted when they had to deal with a child with disability. such as- Physical domain, Psychological domain, Social domain, Environmental domain.

4. To determine the financial factors affecting parents or caregivers of children with disability.

5. To find out the association between stress and QoL of caregivers of children with disability.

6. To evaluate the level of burden that caregivers are facing. Such as: gender, age, marital status, income, and education. Psychosocial factors include health and illness, functional ability, activity level, and social relationships.

7. To find out the association between various components of WHOQOL-BREF questionnaires and LISAT-11 questionnaire.
8. To identify physical, psychological, social and environmental health of the participants

1.6 Operational Definition

Disability

A disability is any restriction or lack of ability in activity in the manner or within the range considered normal for a human being. A handicap is disadvantage for a given individual, resulting from impairment or a disability that limits or prevents the fulfillment of a role that is normal. A physical disability is any condition that permanently prevents normal body movement and/or control.

School –age child

The age at which a child may or must begin to attend school. According to the Bangladeshi law children from the age of six years should go to school.

Quality of Life

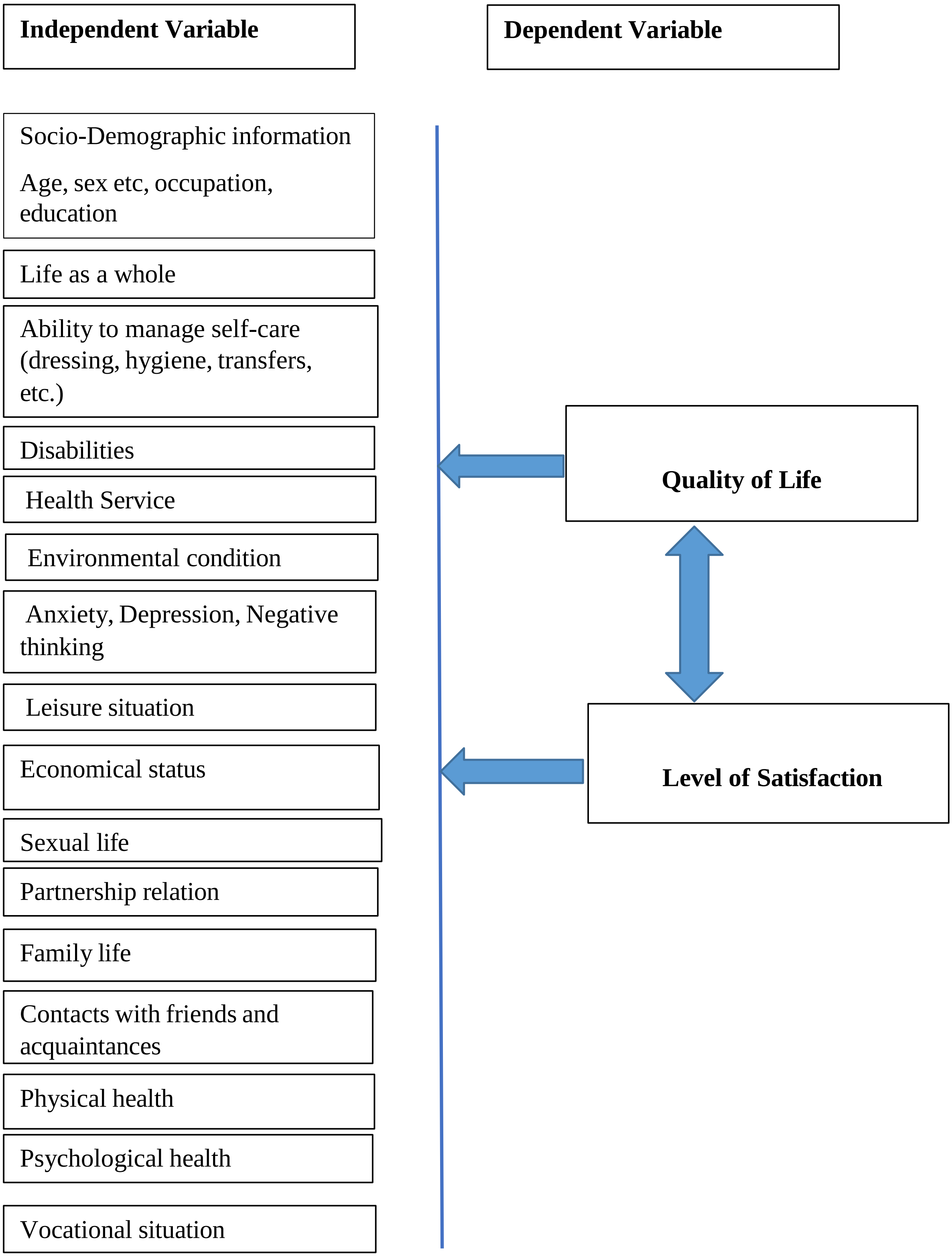
Family Quality of Life can be defined as “a dynamic sense of well-being of the family, collectively and subjectively defined and informed by its members, in which individual- and family-level needs interact”.

Satisfaction of life

Life satisfaction is a measure of a person's well-being, assessed in terms of mood, relationship satisfaction, achieved goals, self -concepts and self-perceived ability to cope with life. Life satisfaction involves a favorable attitude towards one's life rather than an assessment of current feelings. Life satisfaction has been measured in relation to economic standing, degree of education, experiences, residence, and other factors.

Life satisfaction is a key part of subjective well-being. Many factors influence subjective well-being and life satisfaction. Socio-demographic factors include gender, age, marital status, income, and education. Psychosocial factors include health and illness, functional ability, activity level, and social relationships.

1.7 Conceptual framework



CHAPTER-II LITERATURE REVIEW

The International Classification of Functioning, Disability and Health (ICF) defines that disability is an umbrella term for impairments, activity limitations and participation restrictions and a interaction between individuals with a health condition such as cerebral palsy, down syndrome and spina bifida etc. It is also associated with individual and environmental elements such as unfavorable attitudes, lack of accessible transportation and public infrastructure, and limited social assistance [WHO] (2011).

The World Health Organization has defined health as "a complete physical, mental and social well-being and not merely the absence of disease or infirmity." The concept has more recently been extended to include health related quality of life [WHO] (2011). As per the international classification addressing impairments, disabilities, and handicaps, impairment pertains to the physical aspects of well-being. Disability relates to the decline in functional ability due to impaired organs, while handicap gauges the societal and cultural aftermath of an impairment or disability. Disability influences physical well-being, social interactions within one's circle of family, friends, and acquaintances, mental well-being, and the degree of self-reliance. The ramifications of disability can influence individuals personally, interpersonally, within their families, and across society [WHO] (2006).

Physical disabilities stem from a variety of factors, encompassing inherited or genetic conditions like muscular dystrophy, congenital issues like spina bifida, severe illnesses impacting the brain, nerves, or muscles such as meningitis, as well as accidents resulting in spinal cord or brain injuries (Davis, 2014). Only a small fraction of children have untroubled early years devoid of the necessity for specialized healthcare. The majority of children encounter challenges during their early years and necessitate substantial healthcare support over time. While compromised physical movement is a defining characteristic of disability, numerous children with developmental disorders also contend with issues in senses, communication, and intellect, often grappling with intricate restrictions in self-care abilities. Many children facing disabilities encounter a range of difficulties such as mobility, behavioral, auditory, cognitive, sensory, and visual concerns, among others (Raina et al. 2005).

As discussed in the Bangladesh Act (2013) disability refers to the enduring or lasting impairment of an individual, resulting from various factors including physical, mental, intellectual, developmental, or sensory issues. It can also encompass the negative impact of societal attitudes and environmental obstacles, which impede the person's equitable and complete involvement in society. As outlined by this legislation, disability can be categorized into twelve domains: autism or conditions within the autism spectrum, physical disabilities, mental health-related disabilities, visual impairments, speech impairments, intellectual disabilities, hearing impairments, cerebral palsy, Down syndrome, combined hearing and speech impairments, multidimensional disabilities, and other forms of disability [WHO] (2017).

Approximately 10-15% of the world’s population lives with disability [WHO] (2010). This notion holds validity in the context of Bangladesh as well, with certain references indicating an elevated prevalence of disabilities in rural areas of the country (Brown et al. 2006).

Around 2004, the occurrence of disabilities was approximately 6% for individuals under 18 years old and around 14% for those older [World Bank] (2016). Particularly in rural regions, disabilities are frequently regarded as a result of parental wrongdoings and are sometimes thought to be transmissible [WHO] (2010).

According to the National Survey on Persons with Disabilities [NSPD] (2021), In Bangladesh, physical disability surpasses all other forms, affecting approximately 1.19% of the population. Following this, visual disability (0.39%), multiple disabilities (0.26%), and hearing disability (0.19%) are the subsequent prevalent types. Across all disability categories, males exhibit higher prevalence rates compared to females. To illustrate, 1.49% of males experience physical disability, whereas the figure stands at 0.90% for females. The Global Burden of Disease assessment indicates that around 93 million children aged 0–14, which is about 5.1%, face either "moderate or severe disability." Among them, 13 million children (0.7%) deal with severe challenges [WHO] (2014). United Nations Children’s Fund [UNICEF] (2005) has estimated that roughly 150 million children below the age of 18 have disabilities (102). A recent examination of available literature from low- and middle-income nations reveals a range of child disability prevalence, spanning from 0.4% to 12.7%, contingent on the particular study and evaluation method (Maulik and Darmstadt 2007).

In Bangladesh, the prevalence of disability among children under the age of 5 was 2.8%, where 2.0% exhibited at least one disability, and 0.8% experienced more than one disability. The occurrence of disabilities also showed variation across different districts. This particular disability rate for this age group aligns with findings from another study. As defined by the Persons with Disability Rights and Protection Act (`2013) of Bangladesh, 2.8% of the overall population and 1.7% of children have at least one disability.

The presence of disability in a child, a fundamental member of a family, along with the associated challenges, significantly impacts other family members and can generate considerable anxiety. The care and support required, particularly for children with special and enduring needs, place substantial physical and psychological stress on caregivers (Kaya et al. 2010).

Numerous studies indicate that mothers who care for disabled children experience more pronounced physical and psychological challenges compared to mothers with non-disabled children (Laurvick et al., 2006). Rostami et al. (2013) discovered that factors like socioeconomic status, marital contentment, and specific types of pervasive developmental disorders exert a noteworthy impact on the quality of life among caregivers of children with pervasive developmental disorders in Iran.

Consequently, the responsibility of tending to a disabled child inevitably exerts a profound influence on both the quality of life and overall health of the mothers who assume the caregiving role. Nevertheless, a comprehensive assessment of its diverse aspects and magnitudes should be conducted within each region or nation, considering the distinct lifestyles prevalent in those areas (Davis et al. 2010).

Life satisfaction pertains to an individual's subjective evaluation of contentment with their current circumstances, measured through a self-established comparison criterion (Diener et al. 1985). As life satisfaction encapsulates cognitive dimensions of individuals, comprehending how caregivers of children with disabilities perceive their lives and evaluate their own satisfaction becomes crucial. This evaluation reflects their cognitive assessment of the challenges inherent in caring for their disabled children (Llewellyn, 1995). Investigations into caregivers' life satisfaction have acknowledged gender, age, and household monthly income as significant sociodemographic variables. However, these characteristics were treated as controlling factors, with no detailed explication provided. Despite inconsistent findings and limited correlation with life satisfaction, these caregiver-related factors are pertinent due to their potential to elucidate how specific caregiver traits impact their sense of life satisfaction (Brodin and Molosiwa 2000).

Quality of life (QoL) serves as a prevalent metric in health and medical research to gauge an individual's health condition (Habashneh et al. 2012). The discernment of factors influencing QoL holds potential to enhance the efficacy of treatment, care, and rehabilitation initiatives (Soh et al. 2013). A fundamental objective across nations is the advancement of individuals' QoL and overall well-being (Prudente et al. 2010). QoL represents a subjective construct encompassing the entirety of human life's conditions and dimensions (Nesterko et al. 2013).

Acoording to the World Health Organization, Quality of life denotes an individual's subjective assessment of their standing within the framework of their cultural and value systems, as well as their aspirations, anticipations, benchmarks, and apprehensions (Susniene and Jurkauskas, 2009).

Quality of life encompasses indicators such as sound health, suitable housing, employment, personal and familial security, education and leisure, psychological and physical well-being, appropriate family and social dynamics, job stability, and personal liberty (Sadeghi et al. 2013). Within the intricate web of social relationships, quality of life holds a multifaceted position, influencing the maintenance of its standards and hinting at the augmentation of social connections (Bayatiani et al. 2011).

Cross-cultural comparative investigations have disclosed that underlying social factors, encompassing race, gender, religion, and the socioeconomic standing of families with disabled children, are pivotal elements that can give rise to challenges in the care of these children (Soh et al. 2013).

Providing care for a child with developmental disability presents caregivers with a range of complex obstacles, including added financial responsibilities for addressing the child's condition, managing the child's difficult behaviors, and confronting societal prejudices linked to disabilities (Raina et al. 2006).

Research outcomes demonstrate that caregivers responsible for a child with a disability frequently encounter a greater occurrence of physical health indications, adverse consequences, and diminished psychological welfare in comparison to parents of children without disabilities (Wang, Hu and Han 2020).

The supplementary social, psychological, physical, financial, and emotional requisites of non-functioning children with disabilities can influence the holistic contentment of caregivers (Gebeyehu, Sahile, and Ayalew, 2019, p. 147). Attending to these children, particularly those demanding distinctive and prolonged assistance, leads to both physical and mental strain for caregivers (Mugno et al. 2007).

Extensive evidence underscores that mothers responsible for the care of disabled children experience more pronounced physical and psychological challenges in comparison to mothers with non-disabled children (Sloper et al. 1991).

The Quality of life of caregivers for children with pervasive developmental disorders is notably affected by factors such as socioeconomic status, marital contentment, and the specific subtypes of pervasive developmental disorders (Gray and Holden, 1992). Undoubtedly, these circumstances have the potential to impact the Quality of life of caregivers of children with developmental disabilities (Mugno et al. 2007).

Researcher used an established questionnaire which is modified socio-demographical informative questionnaire was developed by researcher to collect data. A preformed pretested questionnaire/tool named the WHOQOL-BREF questionnaire which measures Quality of Life (QOL) across four domains and LISAT-11 questionnaire which measures satisfaction of life that includes structured questions including both open ended and close ended questions. Structured questions are always closed questions and most frequently used in survey research design

The WHOQOL-BREF (Field Trial Version) produces a quality of life profile. The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The WHOQOL-BREF is a shorter version of the original instrument that may be more convenient for use in large research studies or clinical trial. It is possible to derive four domain scores. There are also two items that are examined separately: question 1 asks about an individual's overall perception of quality of life and question 2 asks about an individual's overall perception of their health. The four domain scores denote an individual's perception of quality of life in each particular domain. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score.

The Life Satisfaction Questionnaire (LiSat-11) assesses how satisfied an individual is with different aspects of life. LiSat-11 consists of 11 items that cover different domains of life satisfaction, including: Life as a whole, Vocational situation, Financial situation, Leisure situation, Sexual life, Partner relationship, Familial life, Friendships and social contacts, Somatic and psychological health, Memory and thinking abilities, ADL (Activities of Daily Living) abilities.

Each item is rated on a scale, often ranging from 1 to 6 or 1 to 10, where higher scores indicate higher levels of satisfaction. The LISAT-11 questionnaire provides insights into how individuals perceive their quality of life and satisfaction in various areas. The LISAT-11 has been used in research and clinical settings to assess life satisfaction over time. It can be a valuable tool for healthcare professionals, researchers, and caregivers.

CHAPTER III METHODOLOGY

3.1 Study design

This study aimed to find out the Quality of life and level of satisfaction among caregivers of school going children with disability. For this reason, a quantitative cross sectional type survey design was used. Cross sectional studies (also called a prevalence survey) aim at describing and quantifying the distribution of certain variables in a study population at point of time. It provides a snapshot of the health experience of a population at a given time (Hannan et al. 2007). Researcher used this method so that the aim and objectives of the study can be fulfilled. Ethical permission was obtained from Institutional Review Board (IRB) and written informed consent was obtained from all participants. The study was conducted by using quantitative descriptive analysis through using SPSS software 22.0 version.

3.2 Study Area and site

The study was conducted at the William and Marie Taylor school at Center for the Rehabilitation of the Paralised (CRP). The choice of this area was made, and the participants existing in this area met the inclusion and exclusion criteria of the study.

3.3 Study population

The study populations were parents and caregivers of school going children with disability, who came at William and Marie Taylor school to receive education.

3.4 Study Duration

The study was conducted from 3rd May 2023 to 30th July 2023.

3.5 Sampling technique

The researchers chose CRP participants because they were readily available. Convenient sampling was a technique used to identify and contact a specific group of people. In the study convenient sampling technique was used here, considering the inclusion – exclusion criteria of the participants, who came to William and Marie Taylor school at CRP, Savar.

3.6 Criteria of sampling

One primary caregiver per household was selected for this study. The primary caregiver was defined as the person who is most responsible for the day-to-day decision making and care of the child; the family determined who was best considered the primary caregiver. Caregivers who were asked to participate in this study had to meet the following criteria:

3.6.1 Inclusion Criteria

1. Caregivers of CWD who were attended at inclusive school at CRP.
2. Identify themselves as a primary caregiver whose child lived with them,
3. Parents or caregivers who had given consent to participate in the study and able to fill the questionnaire
4. The caregivers had to be a person who was staying with the child for a period of more than three months
5. Caregivers who had better understanding of command.

3.6.2 Exclusion Criteria

1) Were unwilling to participate
2) Cognitive problem to answer the required question
3) Parents or caregivers unable to consent to partaking in the study
4) Those who didn’t fulfill the criteria will be excluded
5) Parents or caregivers of children with a developmental disability who didn’t attending their child’s education.

3.7 Sample size

Sampling procedure for cross sectional study done by following equation

$$n = \left\{\frac{z - \frac{\alpha}{2}}{d}\right\}^2 \times pq$$

Here,

n= The desired sample size (eventual sample size).

$z - \frac{\alpha}{2}$ = 1.96

P =0.0286 (Blackburn, Spencer and Read, 2010).

q = 1-p

= 1- 0.0286

= 0.97

d = 0.05

$$n = \left\{\frac{z - \frac{\alpha}{2}}{d}\right\}^2 \times pq$$

$$= \left\{\frac{1.96}{.05}\right\}^2 \times 0.0286 \times 0.97$$

=1536.64 $\times 0.0286 \times 0.97$

=42

Calculating sample was 42. However, as the research was conducted as an academic purpose so there were time limitations. So, researcher had taken 42 samples for the study.

3.8 Data Collection Tools

The tools that needed for the study were Consent form, Questionnaire form, Scale- The Quality of life scale(WHOQOL-BREF), Satisfaction With life scale (LISAT-11); Pen , Pencil , Paper ,calculator, File, Notebook, Clipboard, Laptop.

3.9 Measurement Tools

Data was collected through the face-to-face interview with participants. Researcher used an established questionnaire which is modified socio-demographical informative questionnaire was developed by researcher to collect data. A preformed pretested questionnaire/tool named the WHOQOL-BREF questionnaire which measures Quality of Life (QOL) across four domains and LISAT-11 questionnaire which measures satisfaction of life that includes structured questions including both open ended and close ended questions. Structured questions are always closed questions and most frequently used in survey research design.

WHO-BREF

The WHOQOL-BREF instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. The WHOQOL-BREF is a shorter version of the original instrument that may be more convenient for use in large research studies or clinical trial [WHO] (1996). WHOQOL-BREF is the most useful scale for measurement of quality of life or health status and wellbeing of a person. This is also translated in Bangla by linguistic for better understanding. Quality of life of caregivers detected by this Questionnaire. Most of the research that are used here also follow this Questionnaire for detect Quality of life of caregivers of school going children with disability and this study also use this Questionnaire (Okurowska-zawada et al. 2011).

The Life Satisfaction Questionnaire-11 (Lisat-11)

The Life Satisfaction Questionnaire (LiSat-11) assesses how satisfied an individual is with different aspects of life. LiSat-11 consists of the global item “Life as a whole” and the following 10 domain-specific items: vocation; economy; leisure; contacts with friends and acquaintances; sexual life; activities of daily living (ADL) (ability to manage self-care in dressing, hygiene, transfers); family life; partner relationship, somatic health; and psychological health. The items are rated according to 6 response options: 1=very dissatisfying; 2=dissatisfying; 3=rather dissatisfying; 4=rather satisfying; 5=satisfying; and 6=very satisfying. Higher scores indicate a greater level of perceived satisfaction.

3.10 Data collection

Before data collection, researcher was first took approval from IRB then collect data collection permission from Physiotherapy department head of BHPI and principal of William and Marie Taylor school of CRP; Savar. Then researcher introduced himself to the participants and took verbal consent. Then provided written consent form to the participant, and after signed the consent form, data was collected through a questionnaire from the participants by face to face conversation. In that way questionnaire was presented and data was completed. In the questionnaire, there was participant's demographic information including age, sex, area, education, type of injury and disability, along with questionnaire of WHOQOL-BREF and LISAT-11. Data was collected from caregivers present in William and Marie Taylor school of CRP; Savar and researcher collected data from 1 July 2023 to 1 August 2023.

3.11 Data analysis

After completing the initial data collection, every questionnaire was checked again to find out any mistake or unclear information. Then data was analyzed through Statistical package of social science (SPSS) version 20 and data was leveled in Microsoft Excel worksheet and arranged in results. Then data was analyzed through descriptive statistics and descriptive statistics was used to fulfill research objectives.

3.12 Ethical consideration

The proposal was submitted to the Institutional Review Board (IRB) of Bangladesh Health Professions Institute (BHPI) & approval was obtained from the board. The whole process of this research project was done by following the Bangladesh Medical Research Council (BMRC) guidelines and World Health Organization (WHO) Research guidelines. Verbal and written inform consent was taken from every participant. And ensure every participant that they can leave any time during data collection, & it was ensured that participants were not influenced by data collector. The researcher strictly maintained the confidentiality regarding participant's condition. The study was conducted in a clean and systematic way. Every subject had the opportunity to discuss their problem with the senior authority or administration of CRP and have any questioned answer to their satisfaction.

CHAPTER-IV RESULTS

The data was collected by the researcher himself. A structured question was used with close ended questions in the questionnaire. In the present study, Level of satisfaction and quality life of caregivers were assessed by using WHOQOL-BREF and LISAT-11 questionnaires among the 42 caregivers of school going children with disability.

4. Socio-demographic information

4.1 Ratio of male and female caregivers among disable children

Among the 42 participants, majority of the caregiver was female with the estimated ratio as 95.80%(n=40), In addition, 4.2%(n=2) caregivers are male only.

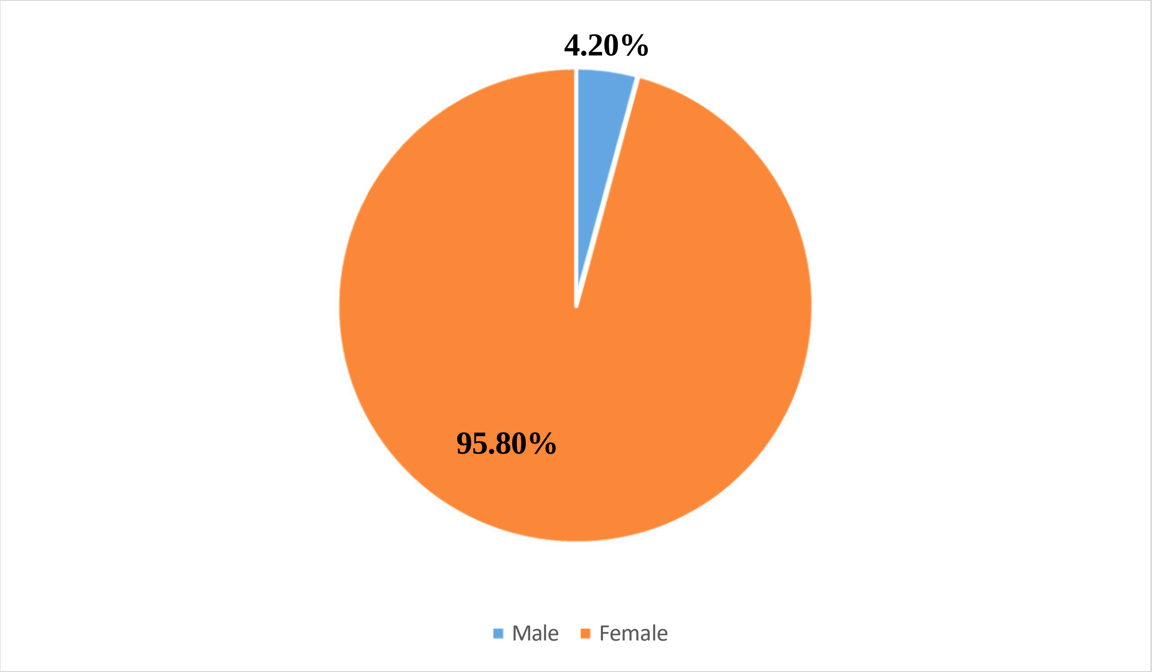


Figure –(1): Ratio of male and female caregivers among disable children

4.2 Percentage of age range of caregivers

Among the 42 participants, about 47.6% (n=20) participants were between 31-40 years of age, about 35.7%(n=15) participants were between 21-30 age, 9.5%(n=4) participants were between 41 to 50 age, 4.8%(n=2) participants were between 51 to 60 years and 2.4%(n=1) participant was above 60 years.

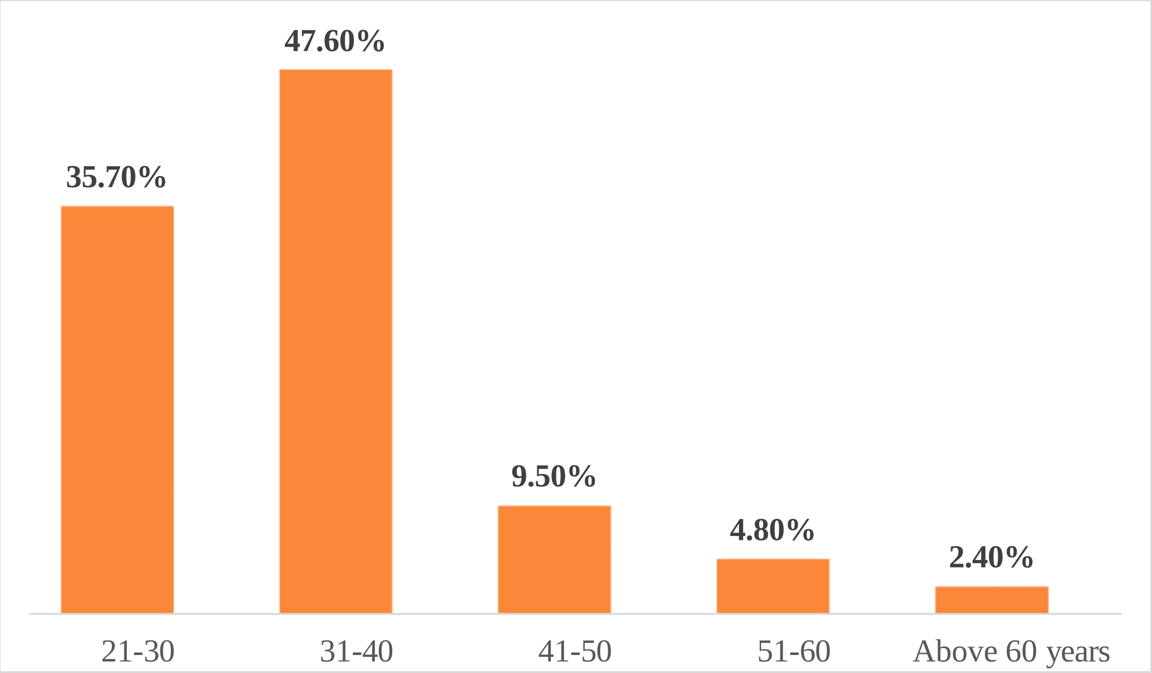


Figure –(2): Percentage of age range of caregivers

4.3 Percentage of Educational Status of caregivers

Out of the 42 participants, education status showed that 50% (n=21) completed Secondary education, 16.7% (n=7) completed primary education, 16.7%(n=7) were undergraduate, 7.1% (n=3) caregivers were illiterate, 4.8% (n=2) completed higher secondary and 4.8%(n=2) completed post -graduation education.

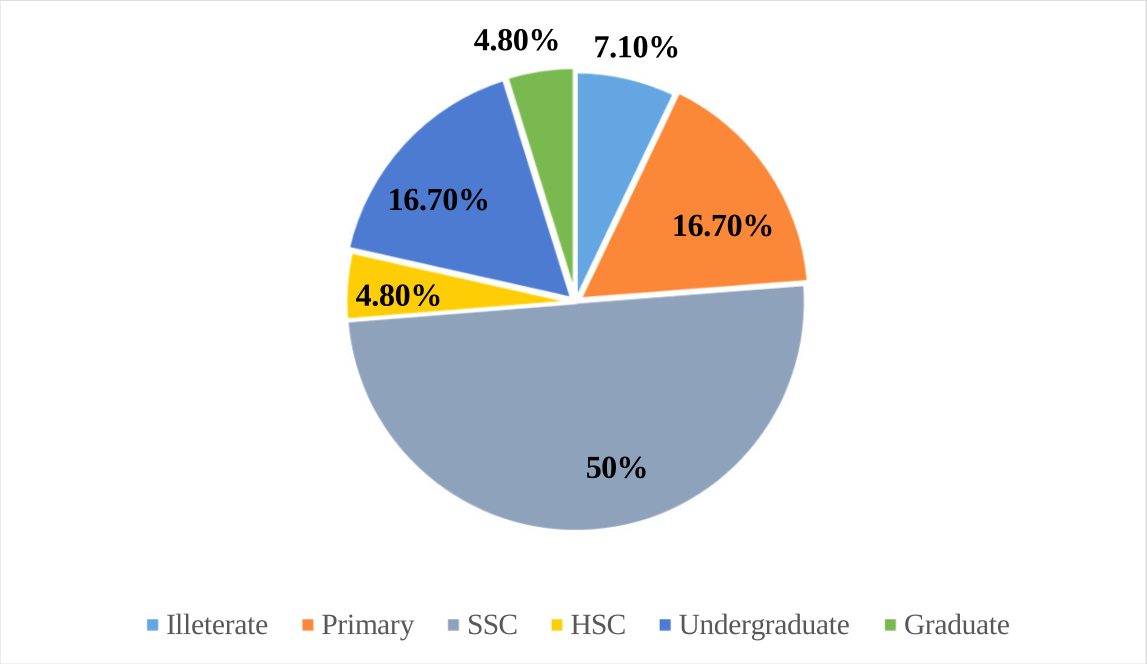


Figure-(3): Percentage of Educational Status of caregivers

4.4 Percentages of living area of caregivers

Among 42 participants 66.7%(n=28) lived in the sub-urban area, 23.8%(n=10) lived in the urban and 9.5%(n=4) lived in rural area.

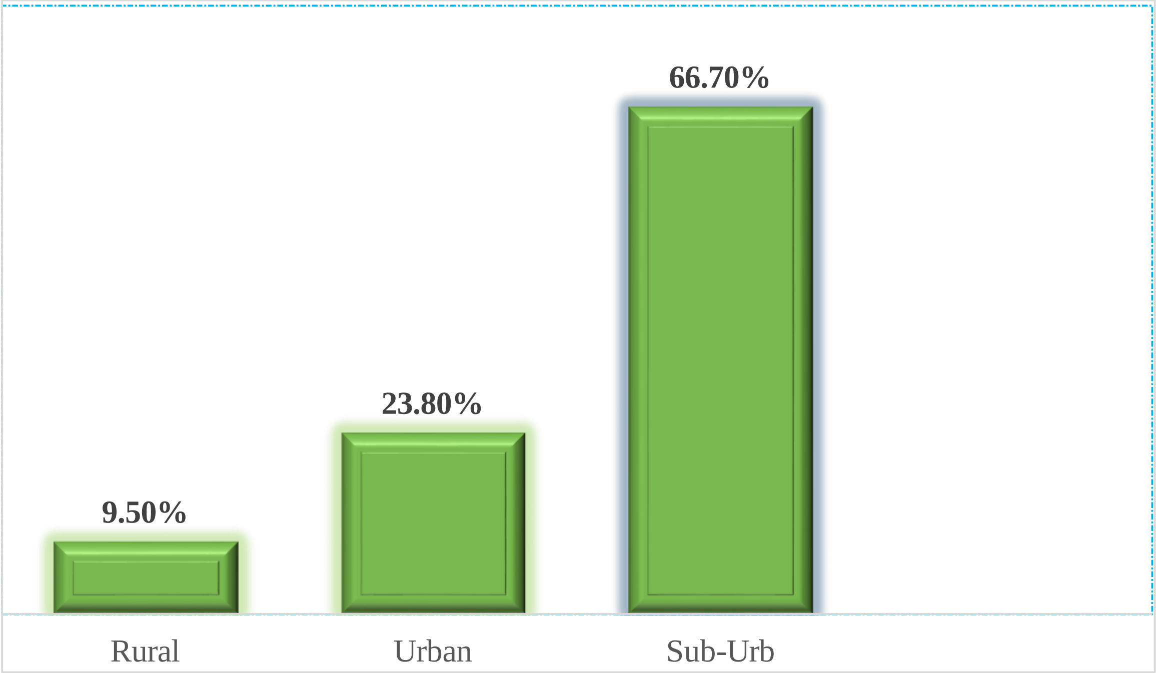


Figure-(4): Percentages of living area of caregivers

4.5 Percentages of Marital Status of caregivers

Among the 42 respondents, the almost number of participants were married, accounting for 95.2%(n=40). Meanwhile, only 2.4%(n=1) were separated and widow for each.

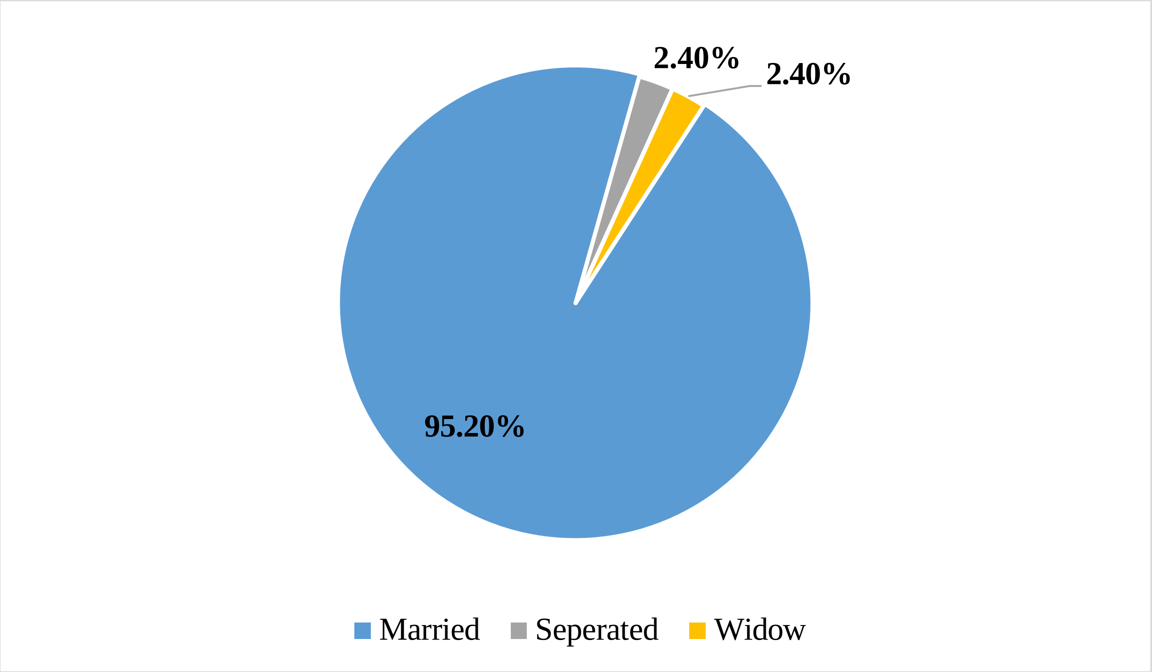


Figure-4.5: Percentages of Marital Status of caregivers

4.6 Percentages of Employment Status of caregivers

Out of 42 participants, 64.3%(n=27) were unemployed, 16.7%(n=7) were full time worker, 9.5%(n=4) were different type of worker, 7.1%(n=3) were retired and 2.4%(n=1) was student.

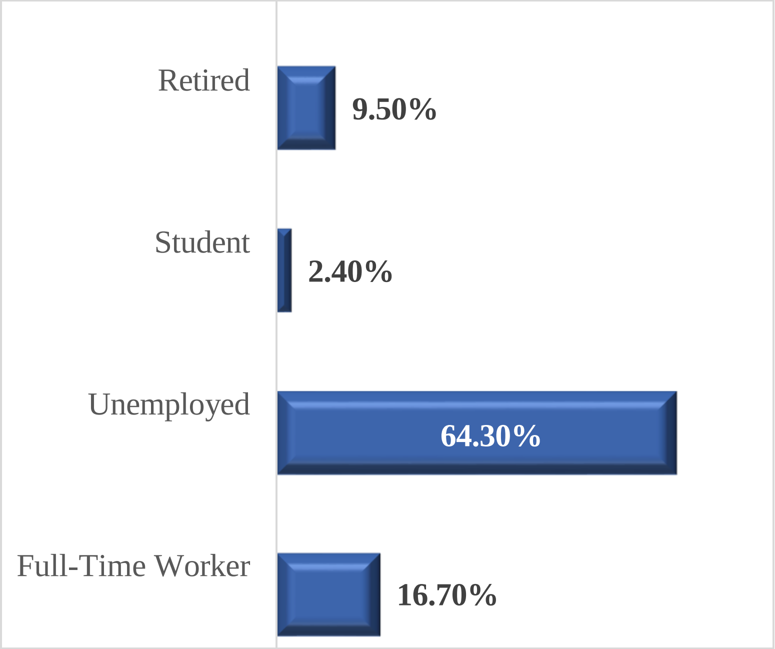


Figure-4.6: Percentages of Employment Status of caregivers

4.7 Percentages of receiving disability allowance of caregivers

Out of 42 participants, 73.8% (n=31) did not receive any disability allowance, while 26.2% (n=11) received disability allowance.

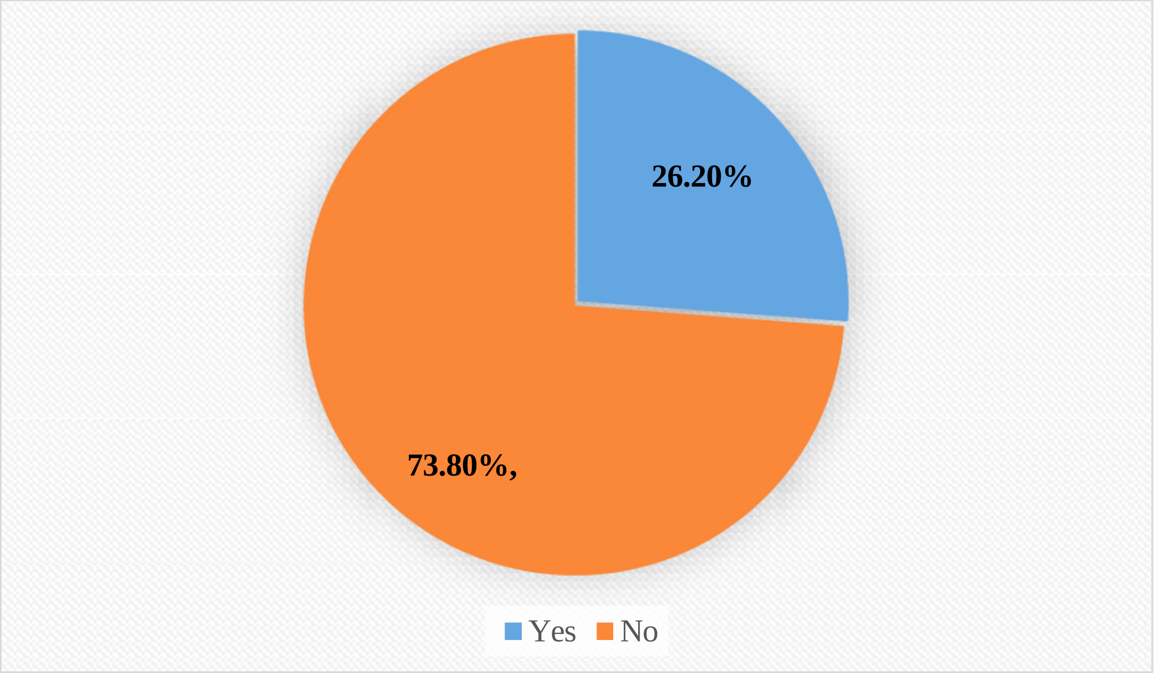


Figure-4.7: Percentages of receiving disability allowance of caregivers

LISAT-11 scoring among the participants

4.8 Percentages of life satisfaction of life as a whole

As a whole, the satisfaction percentage of caregivers among the 42 participants was as follows: 35.7% (n=15) reported being satisfied, 31.0% (n=13) reported being rather satisfied, 16.7% (n=7) of participants reported being dissatisfied, 9.5% (n=4) reported being rather dissatisfied, and 7.1% (n=3) reported being very satisfied.

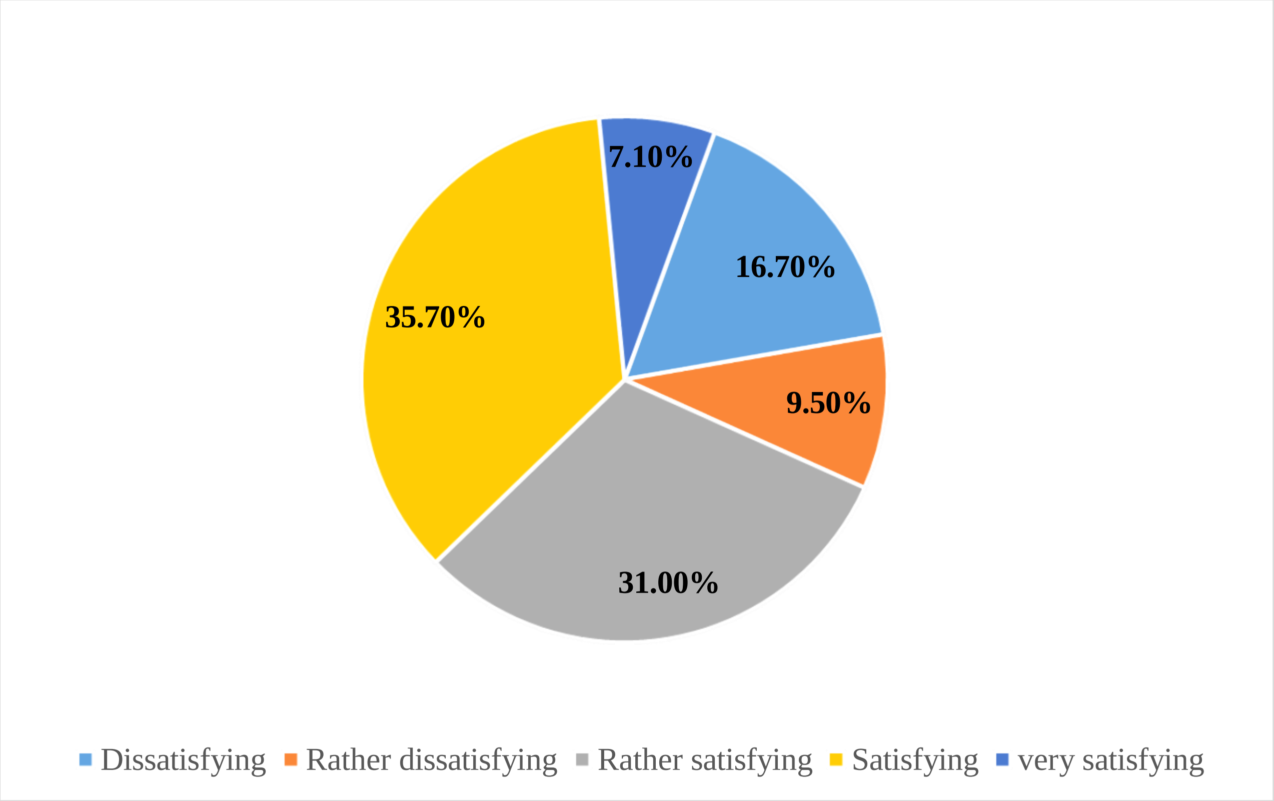


Figure-4.8: Percentages of life satisfaction of life as a whole

4.9 Level of satisfaction with vocational situation of caregivers

"Vocational situations" a term closely related to the occupational aspects of caregivers' lives, were explored in this study. The findings revealed that approximately 33.30% (n=14) of participants reported a rather satisfying vocational situation, while another 33.30% (n=14) indicated a satisfying vocational situation. Additionally, 11.90% (n=5) expressed having a dissatisfying vocational situation, while an equal percentage of 11.90% (n=5) reported a rather dissatisfying vocational situation. Furthermore, 7.10% (n=3) of participants on average characterized their vocational situation as very dissatisfying, and a minority of 2.40% (n=1) reported a very satisfying vocational situation.

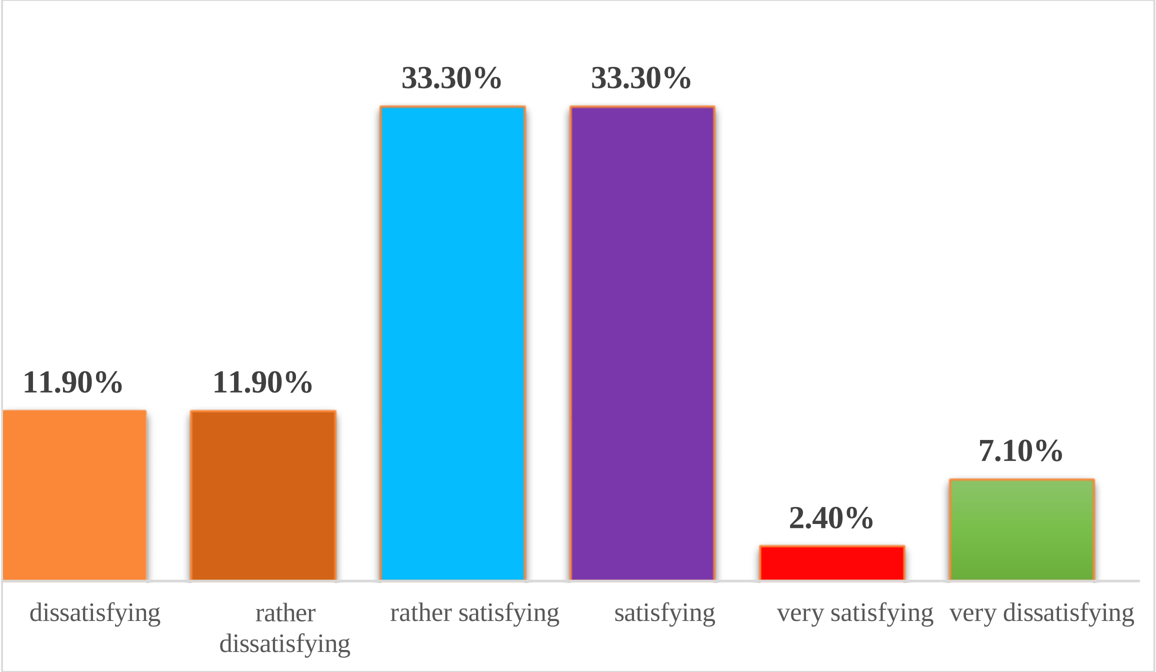


Figure 4.9- Satisfaction with Vocational Situation of caregivers

4.10 Level of satisfaction with the financial situation among the caregivers

Financial situation is a very important component and strongly associated to the satisfaction of life which varies in accordance with this study at a range where 31.0% (n=13) had satisfying, 23.8% (n=10) had rather satisfying, 19.0% (n=8) had rather dissatisfying, 14.3% (n=6) had dissatisfying, 7.1% (n=3) participants had very dissatisfying and 4.8% (n=2) had very satisfying.

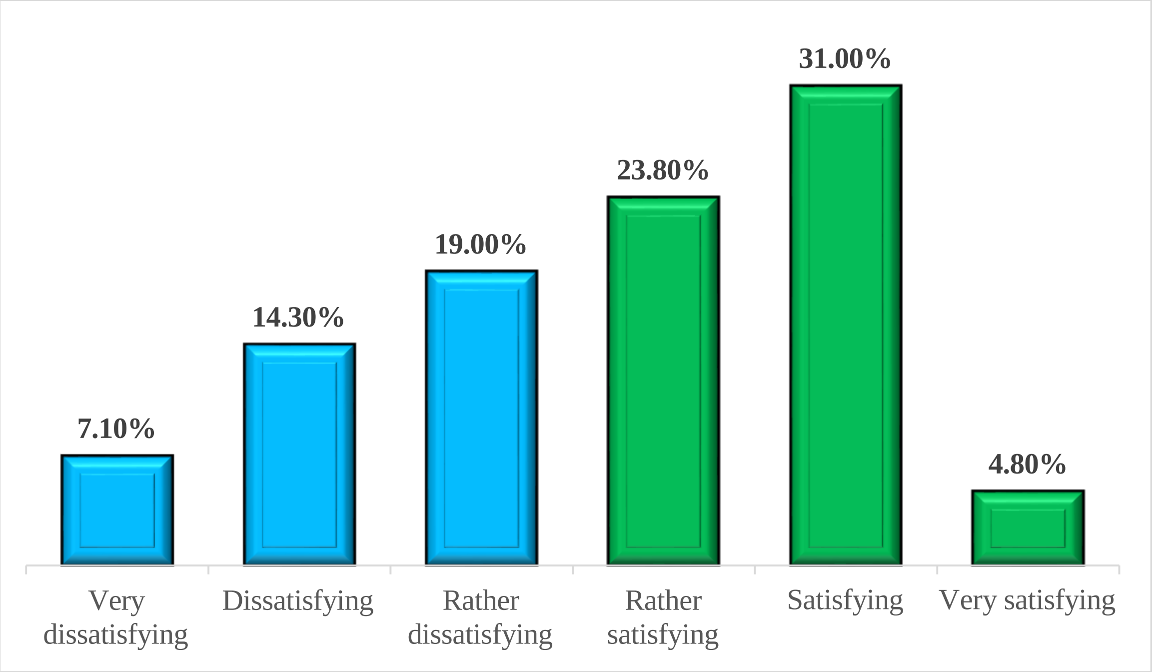


Figure-4.10: Level of satisfaction with the financial situation among the caregivers

4.11 Level of satisfaction with the leisure situation among the caregivers

Among the 42 participants about 35.7% (n=15) had rather satisfying, 31.0% (n=13) had satisfying, 19.0% (n=8) had rather dissatisfying, 14.3% (n=6) participants had dissatisfying perceptions to their leisure situation.

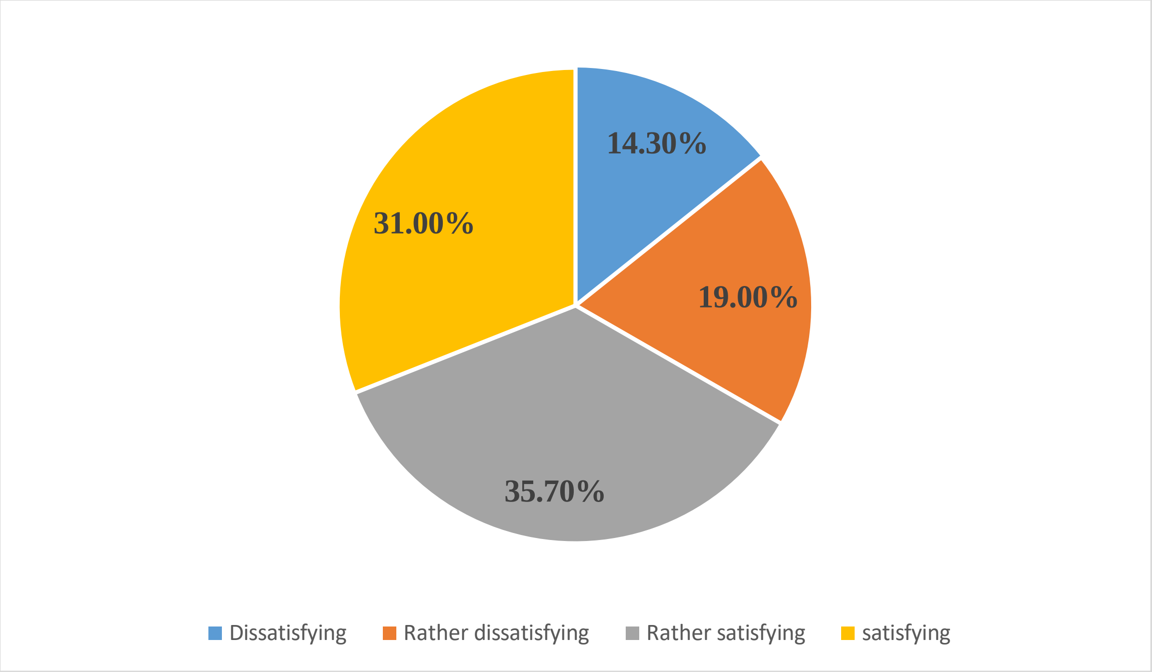


Figure-4.11: Level of satisfaction with the leisure situation among the caregivers

4.12 Level of Satisfaction with the Contact with friends among the caregivers

In this study it has been found that about 57.1% (n=24) had satisfying, 26.2% (n=11) had rather satisfying, 7.1% (n=3) had rather dissatisfying, 7.1% (n=3) had very satisfying and 2.4% (n=1) had dissatisfying perceptions in contact with friends and acquaintances.

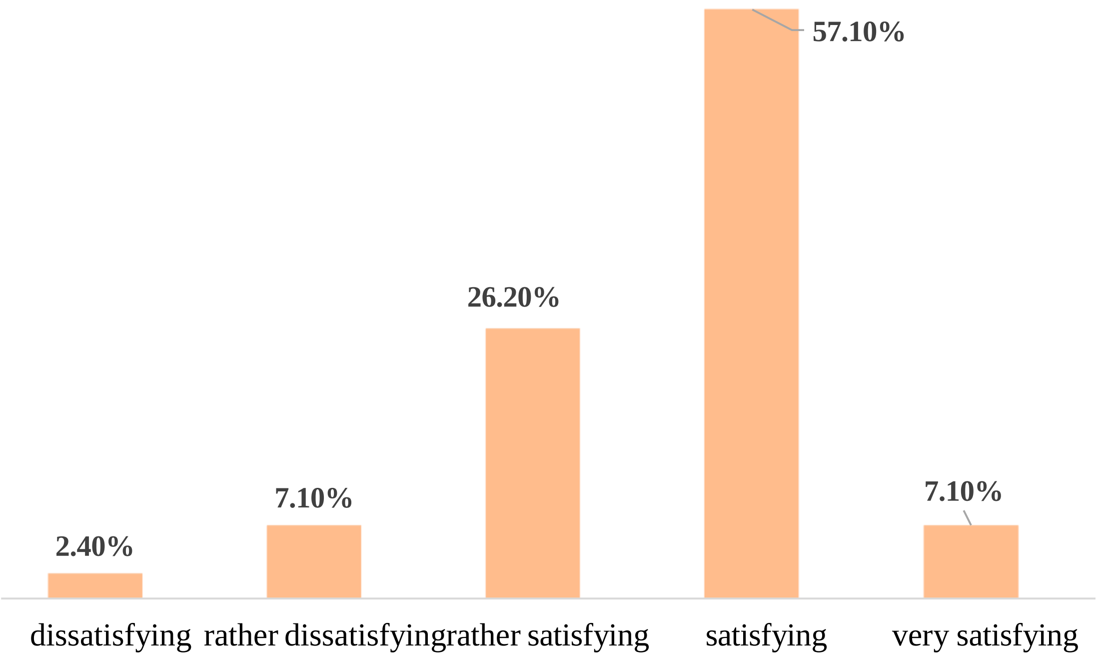


Figure-4.12: Level of Satisfaction with the Contact with friends among the caregivers

4.13 Level of Satisfaction with the Sexual life among the caregivers

Among the 42 participants with spinal cord injury about 50.0% (n=21) had satisfying, 19.0% (n=8) had rather satisfying, 11.9% (n=5) had rather dissatisfying, 9.5% (n=4) had very satisfying, 4.8% (n=2) participants had very dissatisfying and 4.8% (n=2) had dissatisfying perceptions with their sexual life.

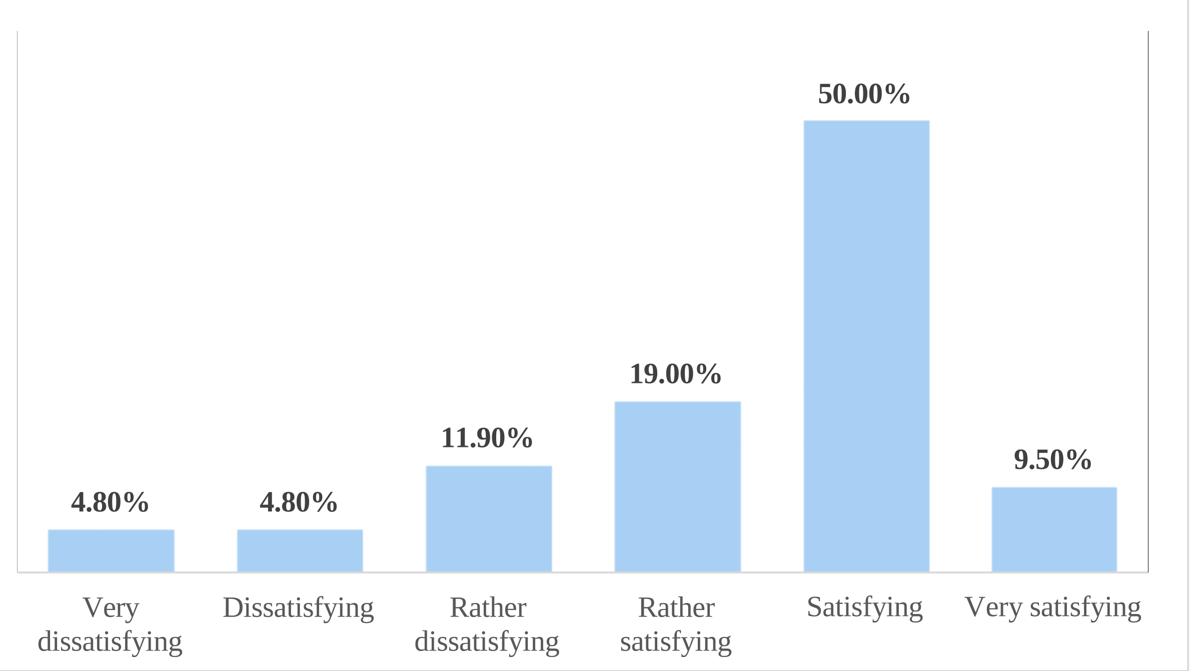


Figure-4.13: Level of Satisfaction with the Sexual life among the caregivers

4.14 Level of Satisfaction with the ability to manage self-care among the caregivers

In this study it has been found that about 50.0% (n=21) had satisfying, 19.0% (n=8) had very satisfying, 11.9% (n=5) had rather dissatisfying, 11.9% (n=5) had rather satisfying and 7.1% (n=3) participants had dissatisfying perceptions in ability to self-care.

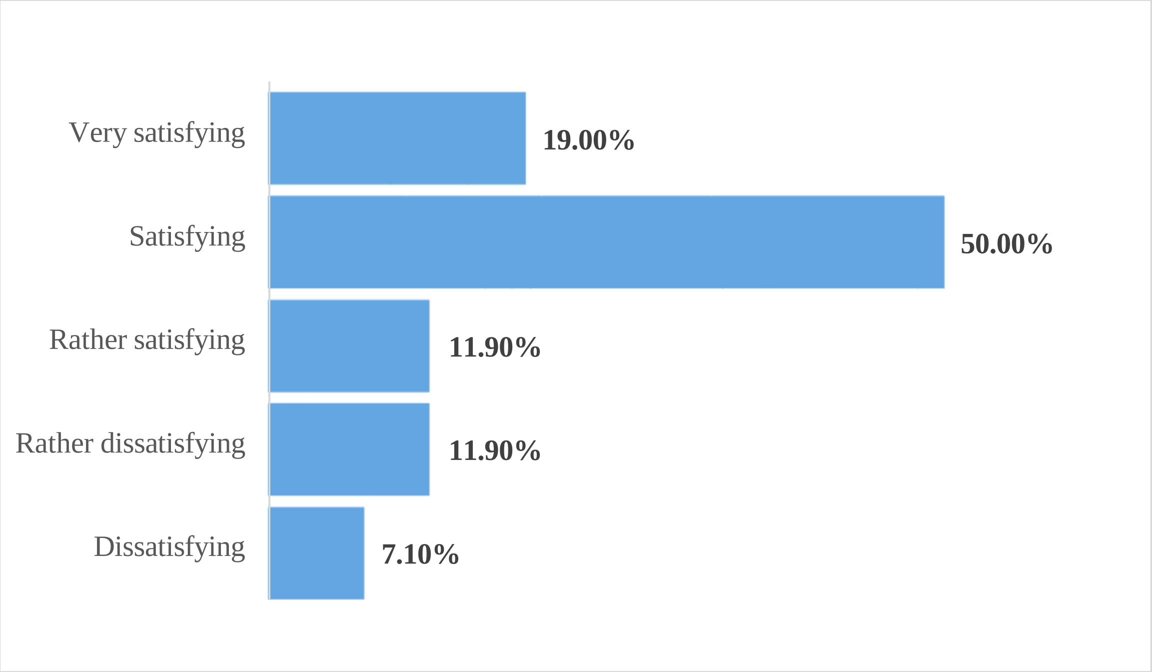


Figure-4.14: Level of Satisfaction with the ability to manage self-care among the caregivers

4.15 Level of satisfaction with the family life among the caregivers

Among the 42 participants about 52.4% (n=22) had satisfying, 35.7% (n=15) had rather satisfying, 9.5% (n=4) had rather dissatisfying and 2.4% (n=1) participants had very dissatisfying perceptions in their family life.

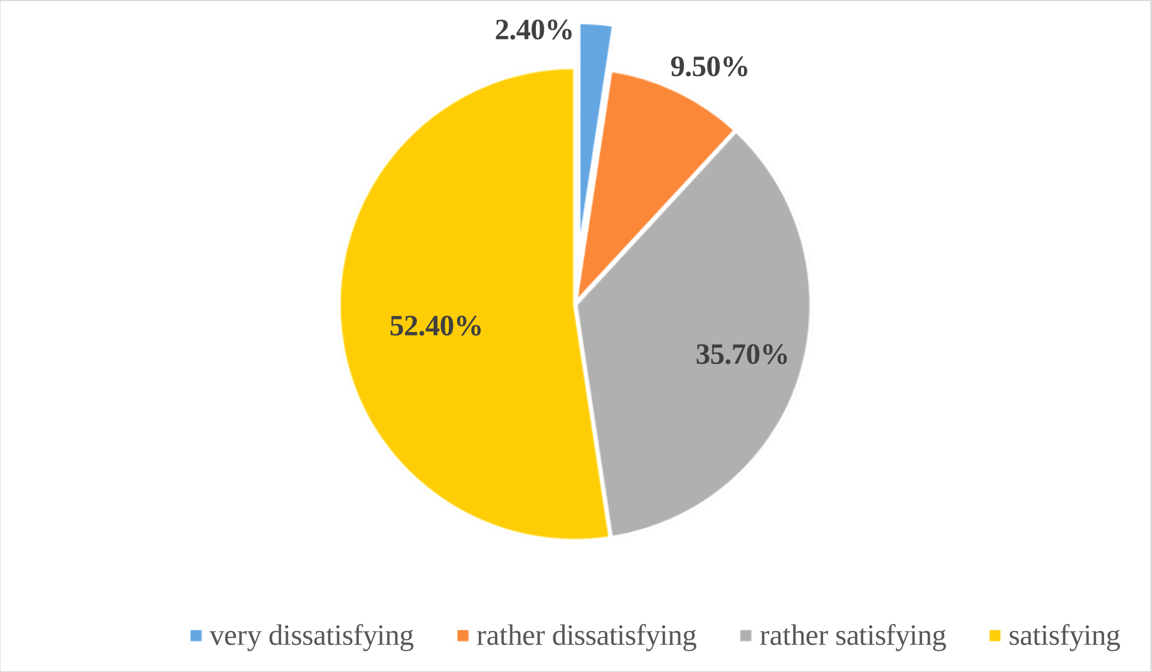


Figure-4.15: Level of satisfaction with the family life among the caregivers

4.16 Level of satisfaction with the partner relationship among the caregivers

Among the 42 participants about 64.3% (n=27) had satisfying, 16.7% (n=7) had rather satisfying, 14.3% (n=6) had rather dissatisfying, 2.4% (n=1) participants had very dissatisfying, 2.3% (n=1) had dissatisfying, and perceptions to their Partner relationship.

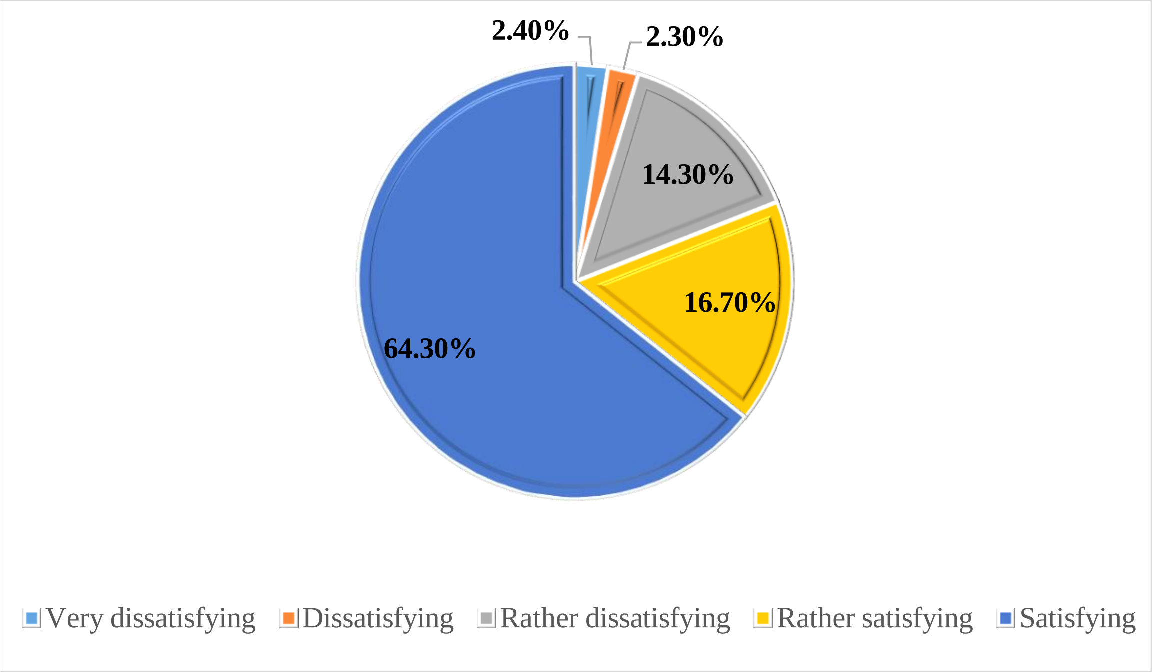


Figure-4.16: Level of satisfaction with the partner relationship among the caregivers

4.17 Level of satisfaction with the physical Health among the caregivers

Out of the 42 participants, approximately 38.1% (n=16) reported having satisfying perceptions of their physical health. Additionally, 19.0% (n=8) indicated rather dissatisfying perceptions, while 26.2% (n=11) reported rather satisfying perceptions. Furthermore, 9.5% (n=4) of participants had perceptions of their physical health as dissatisfying and 7.1% (n=3) expressed having very satisfying perceptions of their physical health.

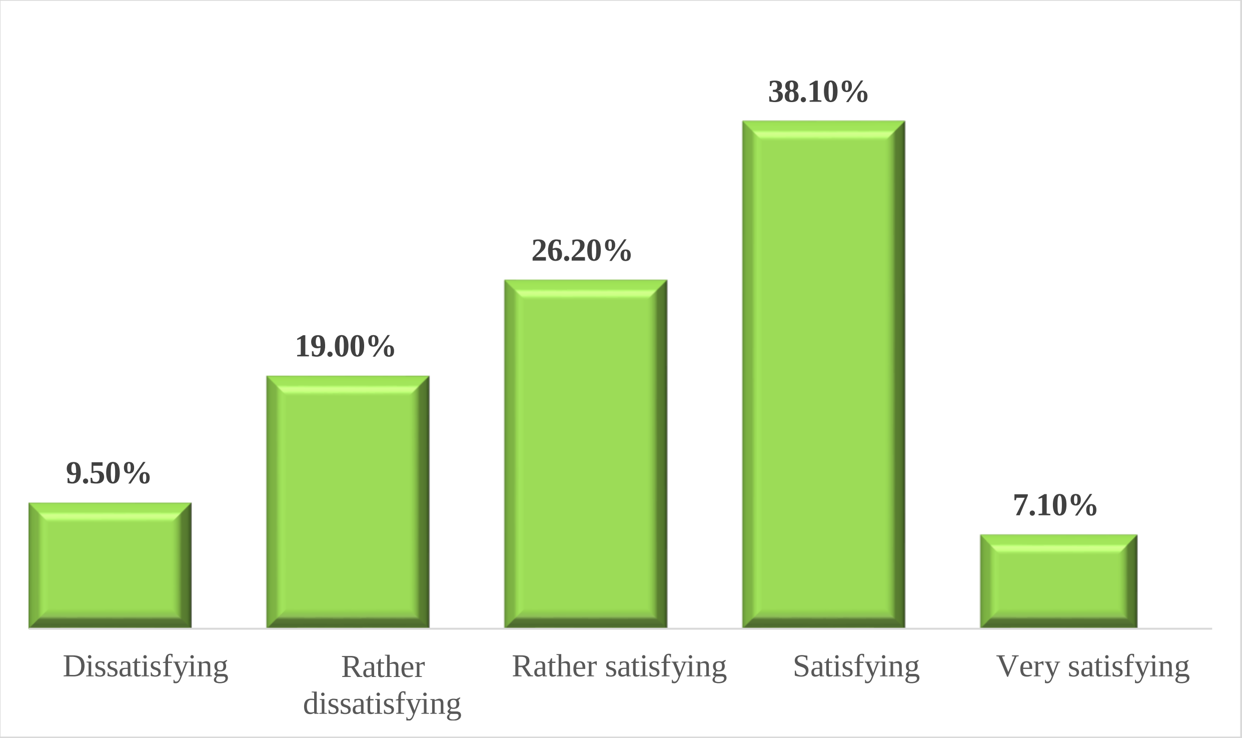


Figure-4.17: Level of satisfaction with the physical health among the caregivers

4.18 Level of satisfaction with the Psychological Health among the caregivers

Within the group of 42 participants, approximately 42.9% (n=18) expressed dissatisfying perceptions of their psychological health. Additionally, 21.4% (n=9) reported rather dissatisfying perceptions, while 16.7% (n=7) conveyed having rather satisfying perceptions. Moreover, 9.5% (n=4) of participants characterized their psychological health as very dissatisfying, whereas 7.1% (n=3) found their perceptions to be satisfying, and a minority of 2.4% (n=1) deemed their psychological health to be very satisfying.

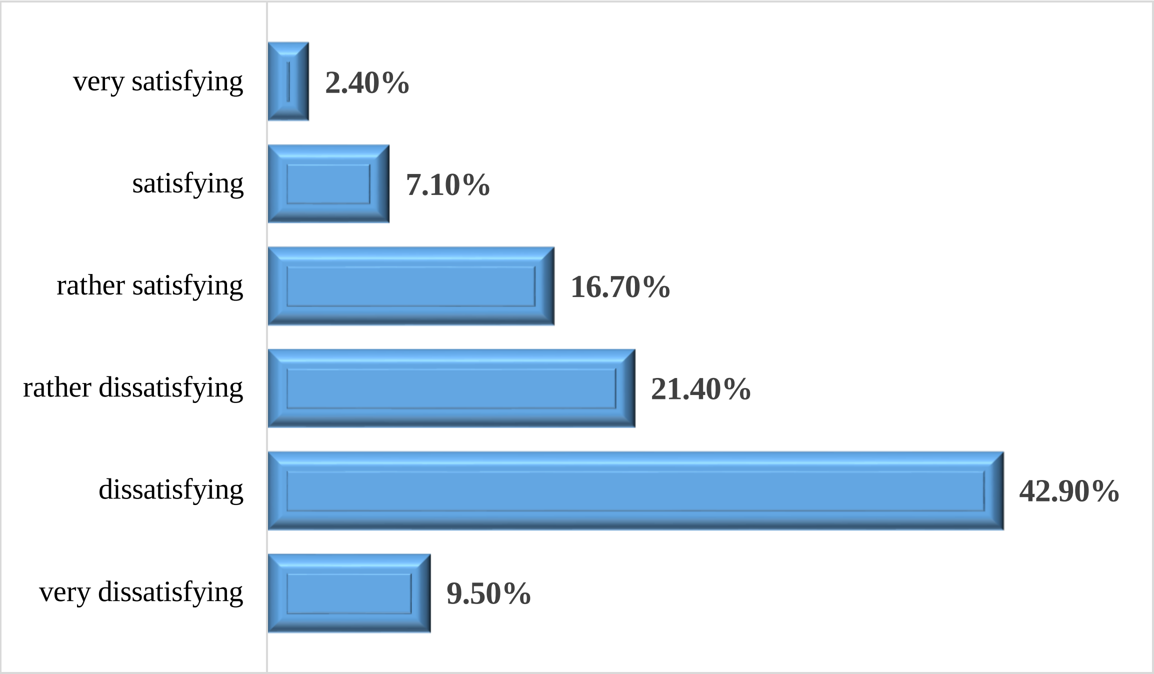


Figure-4.18: Level of satisfaction with the Psychological Health among the caregivers

WHOQOL-BREF scoring among the Caregivers

Scoring:

		Equations for computing domain scores	Mean;(SD) Score
Domain 1	Physical Health	(6-Q3) + (6-Q4) + Q10 + Q15 + Q16 + Q17 + Q18	3.29;(±4.85)
Domain 2	Psychological Health	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26)	3.08;(±3.51)
Domain 3	Social Relationship	Q20 + Q21 + Q22	3.77;(±1.73)
Domain 4	Environmental	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25	3.48;(±3.62)
		Total mean	3.41(±3.42)

Narrative Summary of Findings

Findings from the World Health Organization Quality of Life (WHO-QOL-BREF) indicate client's perception of the quality of environment as adequate (Environment = 3.48).In addition there was slightly reduced satisfaction with physical health (Physical Health = 3.29). Of most concern is the client's report of moderate psychological health (Psychological Health = 3.08) and good of quality social relationships (Social Relationships = 3.77). Client additionally reported overall satisfaction with health as moderate and overall QOL as Good. The average of all domain scores yielded a 3.41 indicating moderate QOL perception.

4.19 Overall satisfaction level of quality of life among the caregivers

Characteristics of the group of caregivers of children with disability who completed the questionnaire. The clinical data of individual overall perception of quality of life are presented in figure-18.

In the study, caregivers of children with disabilities reported their quality of life as follows: 47.60% (n=20) described it as neither good nor poor, 23.8% (n=10) described it as good, 11.9% (n=5) reported it as poor, 9.5% (n=4) described it as very poor and 7.1% (n=3) reported having a very good quality of life.

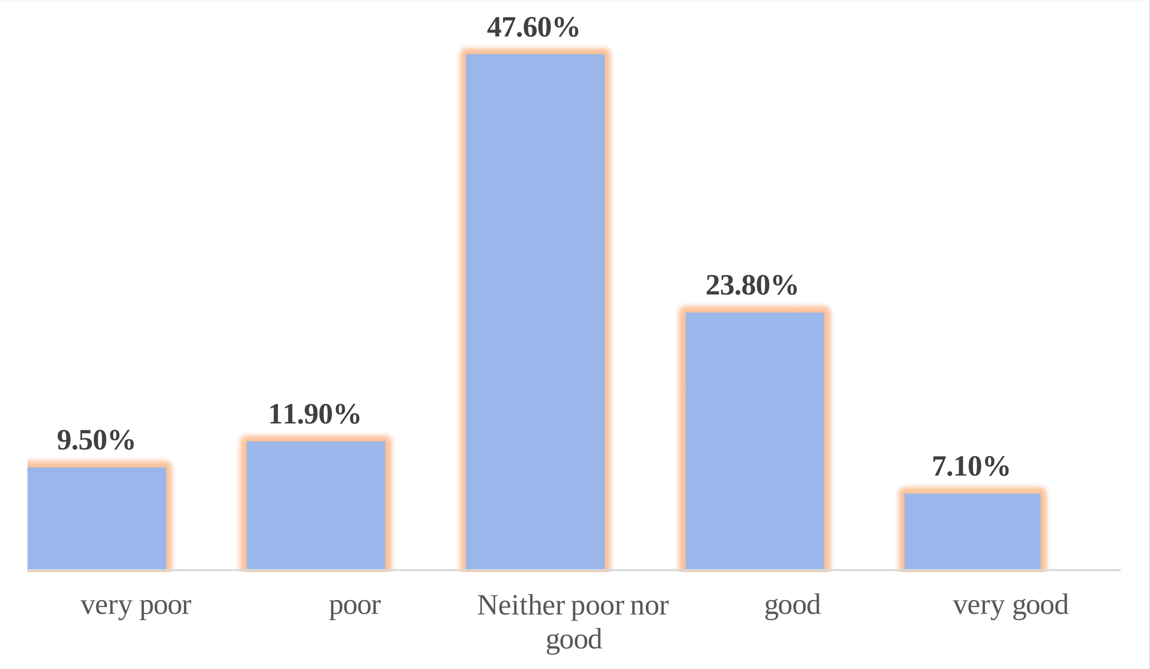


Figure-4.19: Overall satisfaction level of quality of life among the caregivers

4.20 Overall satisfaction level of caregivers with their own health

In the group of caregivers of children with disability, 45.2%(n=19) stated that they were dissatisfied, 42.9%(n=18) were satisfied with their own health, 4,8%(n=2) were very satisfied and 2.4%(n=1) were very dissatisfied with their own health.

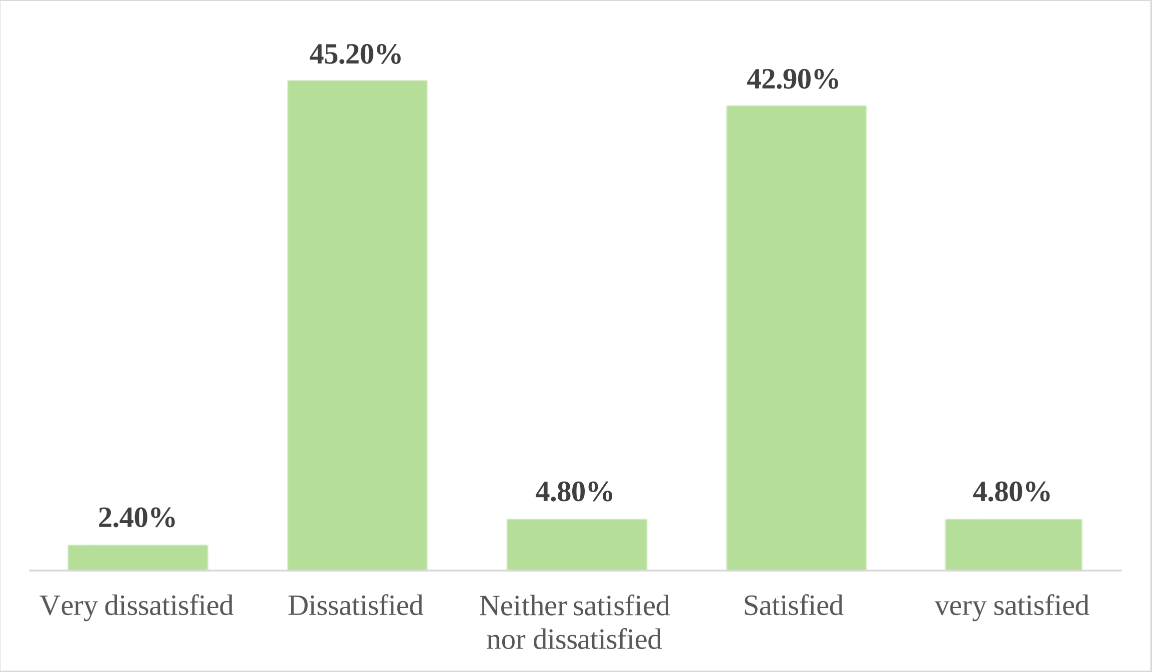


Figure-4.20: Overall satisfaction level of caregivers with their own health

4.19 Quality of life of caregivers in the Physical Health domain:

Physical Domain	Mean;(±SD) Caregivers of children with disability
To what extent do you feel that physical pain prevents you from doing what you need to do?	2.90; (±1.14)
How much do you need any medical treatment to function in your daily life?	3.19; (±1.01)
Do you have enough energy for everyday life?	3.36; (± .96)
How well are you able to get around physically?	3.40; (±1.06)
How satisfied are you with your sleep?	3.26; (±1.25)
How satisfied are you with your ability to perform your daily living activities	3.39; (±.78)
How satisfied are you with your capacity for work	3.52; (±.97)
Mean	3.29; (±4.85)

Table-2: Quality of life of caregivers in the Physical Health domain

Among the 42 participants, most caregivers experienced moderate satisfaction in various aspects of physical health, including work capacity, the ability to get around physically, the ability to perform daily living activities, energy level, satisfaction with their sleep, and the need for medical treatment for daily life functioning. The average scores for these aspects were 3.52, 3.40, 3.39, 3.36, 3.26, and 3.19, respectively. Only a few caregivers expressed dissatisfaction with their physical health in terms of the assessment of physical pain preventing them from work, with an average score of 2.90.

According to the WHO QoL-Brief Questionnaire, we can infer that the quality of life of caregivers with regard to their physical health was not classified as poor, nor was it classified as good; instead, it was more closely aligned with being good.

4.20 Quality of life of caregivers in the Psychological Health domain:

Psychological Domain	Mean;(±SD) Caregivers of children with disability
How much do you enjoy life?	2.86; (±.98)
To what extent do you feel your life to be meaningful?	3.05; (±.70)
How well are you able to concentrate?	3.10; (±.88)
Are you able to accept your bodily appearance?	2.67; (±.95)
How satisfied are you with yourself?	3.19; (±.91)
How often do you have negative feelings such as blue mood, despair, anxiety or depression?	3.66; (±1.02)
Mean	3.09; (±3.51)

Table-3**:** Quality of life of caregivers in the Psychological Health domain

In the assessment of the psychological health domain among 42 caregivers, many of them expressed dissatisfaction with their bodily appearance and their ability to enjoy leisure time, with average scores of 2.86 and 2.67, respectively. Additionally, most of the caregivers showed moderate satisfaction with aspects like having a meaningful life, concentration power, satisfaction level with themselves, and experiencing negative feelings, with average scores of 3.05, 3.10, 3.19, and 3.66, respectively.

According to the WHO QoL-Brief Questionnaire- Hence, we can conclude that the psychological health of caregivers was moderately good.

4.21 Quality of life of caregivers in the Social relationship domain:

Social Relationship	Mean; (±SD) Caregivers of children with disability
How satisfied are you with your personal relationships	3.83; (±.88)
How satisfied are you with your sex life?	3.76; (±.76)
How satisfied are you with the support you get from your friends?	3.74; (±.77)
Mean	3.78; (±1.73)

Table-4: Quality of life of caregivers in the Social relationship domain

Among the 42 participants, the caregivers experienced a moderately good quality of life in their personal relationships, sex life, and getting support from others, with average scores of 3.83, 3.76, and 3.74, respectively.

According to the WHO QoL-Brief Questionnaire, Most of them reported feeling neither satisfied nor dissatisfied, indicating results that were nearly close to being satisfying.

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4.12 Quality of life of caregivers in the Environmental domain:

Environmental Domain	Mean; (±SD) Caregivers of children with disability
How safe do you feel in your daily life?	3.43; (±.86)
How healthy is your physical environment?	4.00; (±.77)
Have you enough money to meet your needs?	2.67; (±.95)
How available to you is the information you need in your daily life?	3.62; (±.81)
To what extent do you have the opportunity for leisure activities?	3.17; (±.93)
How satisfied are you with the conditions of your living place?	3.79; (±88)
How satisfied are you with your access to health services?	3.65; (±.79)
How satisfied are you with your transport?	3.60; (±.96)
Mean	3.49; (±3.62)

Table-5: Quality of life of caregivers in the Environmental domain

In the environmental domain, the biggest difference was shown in the assessment of having enough money to meet own needs which average score was 2.67. So, caregivers leading a poor quality of life in managing their financial requirements. However, for other aspects in the environmental domain, such as living place, health service, getting information for daily life, transport, safety in daily life and opportunity for enjoying leisure activity, the average scores were 3.79, 3.65, 3.62, 3.60, 3.43 and 3.17 respectively, indicating moderately satisfying results.

Furthermore, caregivers demonstrated a good quality of life with their physical environment, with an average score of 4.

According to the WHO QoL-Brief Questionnaire-

In the assessment of the environmental domain, most of the caregivers' quality of life was neither poor nor good, showing a balance between the different aspects of their environmental well-being.

Table 6: Association between caregiver’s financial situation and component of WHOQOL-BREF (physical health, psychological health, social relationship and environmental health).

Caregiver’s Financial Situation	Component of WHOQOL BREF	Chi-Square Value	P-Value
Very dissatisfying, dissatisfying, rather dissatisfying, rather satisfying, satisfying, very satisfying	Physical Health	6.08	.01*
	Psychological Health	2.71	.09
	Social Relationship	.59	.44
	Environmental Situation	6.48	.01*

Table-6, presents significant associations between Physical health as well as the environmental situation with financial situation of caregivers with school-going children with disabilities, with both p-values measuring 0.01, which is below the significance level of 0.05. This implies that the financial situation has a substantial impact on their quality of life. However, when examining the association between Psychological health and social relationships with the financial situation, the p-values were 0.09 and 0.44, respectively, which was >.05. As a result, there was no statistically significant evidence suggesting a direct link between the financial situation and these aspects of caregivers' well-being.

So, it remains evident from the study that the financial situation plays a crucial role in influencing the overall quality of life among caregivers of school-going children with disabilities.

Table-7: Association between caregiver's partnership relationship and component of WHOQOL-BREF (physical health, psychological health, social relationship and environmental health).

Caregiver's Partnership Relationship	Component of WHOQOL BREF	Chi-Square Value	P-Value
Very dissatisfying dissatisfying rather dissatisfying rather satisfying satisfying very satisfying	Physical Health	3.35	.07
	Psychological Health	2.30	.13
	Social Relationship	14.08	.00*
	Environmental Situation	.09	.76

According to Table-7, a statistically significant association was observed between caregiver's partnership relationship and their social relationships, with a p-value of 0.00, which is less than the significance level of 0.05. However, no significant associations were found among caregiver's physical health, psychological health, and environmental situation, as indicated by p-values of 0.07, 0.13, and 0.76, respectively, all of which exceeded the significance level. Thus, the results suggest that the partnership relationship has a slight impact on the caregiver's overall quality of life.

Table-8: **Association between LISAT-11 and component of WHOQOL-BREF (physical health, psychological health, social relationship and environmental health).**

Level of satisfaction	WHOQOL BREF	Chi-Square Value	P-Value
Very dissatisfying Dissatisfying, Rather dissatisfying, Rather satisfying, Satisfying, Very satisfying	Physical Health	11.59	.00*
	Psychological Health	9.71	.00*
	Social Relationship	11.34	.00*
	Environmental Situation	4.52	.03*

According to Table-8, there was a statistically significant association between LISAT-11 and WHOQOL BREF. The p-value for environmental situations was 0.03, which also suggests a significant association, as it is less than 0.05. Additionally, the p-values for physical health, psychological health, and social relationships were 0.00, indicating a highly significant relationship, as they were less than the significance level of 0.05.

These findings indicate that individuals with better quality of life, as measured by, also tend to experience higher levels of life satisfaction. In other words, there is a positive correlation between overall life quality and life satisfaction, with better quality of life being linked to increased life satisfaction

Table-9: Association between life satisfaction and negative feeling such as: blue mood, despair, anxiety or depression.

Level of satisfaction	Negative Feelings	**Chi-Square Value**	**P-Value**
Very dissatisfying Dissatisfying, Rather dissatisfying, Rather satisfying, Satisfying, Very satisfying	Seldom Quite Often Very often Always Never	8.02	0.00*

From table-9. Association found level of significance between level of life satisfaction and negative feelings which was statistically significant where p value was 0.00.

So, it has shown that negative feelings such as despair, blue mood, anxiety, depression greatly affect caregivers level of life satisfaction with children with disability.

CHAPTER-V DISCUSSION

This discussion is based on among 42 participants' caregivers who had school going children with disability. According to the results of the present study, most of the participants age range were 31-40 (47.6%); followed by -21-30 (35.7%); 41-50 (9.5%); 51-60(4.8%) years and above 60 was 2.4%. Therefore, young age of the caregivers was more sufferer than old age and affect quality of life. In this study maximum age of the mothers was 65 years and minimum age was 23.

Among the 42 participants, 95.2%(n=40) were female and 4.8%(n=2) caregivers were male. The situation was worse for females. In my study, Females in Bangladesh generally have a lower status and are not as actively involved in income- generating activities as males, and neither do they control family resources. A study by (Palgi 1962) has shown that females were more likely to suffer from problems, such as 'cannot marry' and 'breakdown of marriage' than their male counterparts. We also observed that, in some cases, a huge dowry was paid to some bridegrooms. Spouses of eastern origin were more rejected by their husbands after a disability than spouses of western origin.

In my study, Out of the 42 caregivers' educational status showed that 50% (n=21) completed secondary education, 16.7% (n=4) caregivers' were completed primary education 16.7% (n=7) were undergraduate, 7.1%(n=3) were illiterate, 4.8% (n=2) completed Higher Secondary education,4.8%(n=2) completed post -graduation education. So, educational status is not very good. There is association between caregivers' educational qualification and extend he/she feels his/her life to be meaningful. Another study in Australia found that, 1.5% were completed primary level, 37.2% high school level, 22.1% trade certification and 29% university. From another study in U.S.A showed that 6.7% mothers were completed H.S.C (Hwang et al. 2011).

In my study among 42 participants, I found that 95.2%(n=40) were married, 2.4(n=1) were separated and 2.4%(n=1) were widow. Caring a child with disability had considerable effect on the marriage prospects of caregivers. In this sample, most caregivers were married, which result is similar to that found in other studies, representing a potential for strengthening and support when care is divided among spouses (Isa et al.2016). However, Khayatzadeh et al. (2012) showed that although most caregivers of children with disability are married, marital dissatisfaction was significantly higher than mothers of children without disabilities.

Out of 42 participants, 64.3%(n=27) were unemployed, 16.7%(n=7) were full time worker, 9.5%(n=4) were different type of worker, 7.1%(n=3) were retired and 2.4%(n=1) was student. Low schooling is observed in this study, Caregivers of child with disabilities because many of these caregivers abandon their studies to dedicate themselves to the role of caregiver, which leads to low levels of information and self-care toward their health. Low schooling of caregivers impairs them to enter the labor market; thus, they end up dedicating themselves to household tasks and caring for the dependent child. Notably, despite the working age of these caregivers, most of the sample was unemployed (Chan,Abdullah and Ling 2013) and Abbasi et al.(2016) argued that most were female housewives. Evaluating the QoL of parents of disabled individuals, it was observed that only one of the spouses was employed. This fact reflects the employment situation of caregivers in this study, suggesting a situation of underemployment demonstrating the social condition to which these families are subjected. (Gogoi, Kumar and Deuri 2016).

From my study the satisfactory percentage to the life as a whole of caregivers among the 42 participants, about 35.7% (n=15) had Satisfied, 31.0% (n=13) participants had Rather Satisfied, 16.7% (n=7) participants had dissatisfied, whereas 9.5% (n=4) had rather dissatisfied and 7.1% (n=3) had very satisfied.

Financial situation is a very important component and strongly associated to the satisfaction of life which varies in accordance with this study at a range where 31.0% (n=13) had satisfying, 23.8% (n=10) had rather satisfying, 19.0% (n=8) had rather dissatisfying, 14.3% (n=6) had dissatisfying, 7.1% (n=3) participants had very dissatisfying and 4.8% (n=2) had very satisfying.

Among the 42 participants about 35.7% (n=15) had rather satisfying, 31.0% (n=13) had satisfying, 19.0% (n=8) had rather dissatisfying, 14.3% (n=6) participants had dissatisfying perceptions to their leisure situation.

In this study it has been found that about 57.1% (n=24) had satisfying, 26.2% (n=11) had rather satisfying, 7.1% (n=3) had rather dissatisfying and 2.4% (n=1) had dissatisfying perceptions in contact with friends and acquaintances.

In this study it has been found that about 50.0% (n=21) had satisfying, 19.0% (n=8) had very satisfying, 11.9% (n=5) had rather dissatisfying, 11.9% (n=5) had rather satisfying, and 7.1% (n=3) participants had dissatisfying perceptions in ability to self-care. A study conducted by (Guillamón et al. 2013) stated that, Self-care has been acknowledged in previous studies as a predictor of life satisfaction and mental health of caregivers Parents with higher self-efficacy showed better physical health, mental health, more satisfaction with their relationship with the environment and have less anxiety. Rezendes and Scarpa (2011) indicated that increased stress was associated with a decreased self-efficacy, which in turn accounted for increases in anxiety/depression. Furthermore, self-esteem was found to be the strongest predictor of subjective well-being, as higher levels of self-esteem influenced to a positive subjective wellbeing (Werner and Shulman, 2013).

Among the 54 participants about 52.4% (n=22) had satisfying, 35.7% (n=15) had rather satisfying, 9.5% (n=4) had rather dissatisfying and 2.4% (n=1) participants had very dissatisfying perceptions in their family life.

Among the 42 participants about 64.3% (n=27) had satisfying perceptions to their Partner relationship, 16.7% (n=7) had rather satisfying, 14.3% (n=6) had rather dissatisfying, 3.7% (n=1) had dissatisfying and 2.4% (n=1) participants had very dissatisfying.

Among the 42 participants about 38.1% (n=16) had satisfying, 26.2% (n=11) had rather satisfying, 19.0% (n=8) had rather dissatisfying, 9.5% (n=4) participants had dissatisfying and 7.1% (n=3) had very satisfying perceptions to their physical health. The physical domain refers to physical pain and discomfort, energy for daily activities and fatigue, sleep and rest, ability to move, satisfaction to perform daily life, and work activities and dependence on medication (Fleck et al. 2000). Among these caregivers of disable children presented worse values in this domain. As observed in a study that included caregivers of people with disabilities, since many of these individuals are unable to perform routine activities such as dressing, performing personal hygiene, feeding and moving independently, thus burdening their caregivers by demanding greater physical effort (Braccialli et al. 2012).

Among the 42 participants about 42.9% (n=18) had dissatisfying, 21.4% (n=9) had rather dissatisfying, 16.7% (n=7) had rather satisfying, 9.5% (n=4) participants had very dissatisfying, 7.1% (n=3) had satisfying and 2.4% (n=1) had very satisfying perceptions with their psychological health. In one study performed by Diwan et al. (2011) 70% of caregivers with CP children were reported to have mild-to-moderate depression, and the depression was reported to have a negative effect on life satisfaction of caregivers.

Findings from the World Health Organization Quality of Life (WHO-QOL-BREF) indicate client's perception of the quality of environment as adequate (Environment = 3.48); with slightly reduced satisfaction with physical health (Physical Health = 3.29). Of most concern is the client's report of moderate psychological health (Psychological Health = 3.08) and good quality of social relationships (Social Relationships = 3.77). Client additionally reported overall satisfaction with health as moderate and overall QOL as Good. The average of all domain scores yielded a 3.41 indicating moderate QOL perception. A study conducted by Malhotra and Bhatia in 2012, the analysis of the WHOQOL-BREF instrument revealed that all domains showed higher scores for caregivers of children with no disabilities. As a result, these caregivers experienced significantly better Quality of Life (QoL) compared to caregivers of children with disabilities. This finding aligns with previous literature from controlled studies that utilized the same QoL evaluation instrument. Consequently, caregivers of disabled children face additional challenges and responsibilities, which can impact their overall QoL in comparison to caregivers of non-disabled children.

In the studied the caregivers of children with disability showed, 47.60% (n=20) described their quality of life as neither good nor poor,9.5%(n=4) describe very poor,11,9%(n=5) showed poor,23.8%(n=10) describe good and 7.1%(n=3) had very good quality of life.

Among the 42 participants, most caregivers experienced moderate satisfaction in various aspects of physical health, including work capacity, the ability to get around physically, the ability to perform daily living activities, energy level, satisfaction with their sleep, and the need for medical treatment for daily life functioning. The average scores for these aspects were 3.52, 3.40, 3.39, 3.36, 3.26, and 3.19, respectively. Only a few caregivers expressed dissatisfaction with their physical health in terms of the assessment of physical pain preventing them from work, with an average score of 2.90. Overall, we can infer that the quality of life of caregivers with regard to their physical health was not classified as poor nor good; it was more closely aligned with being good. The physical domain refers to physical pain and discomfort, energy for daily activities and fatigue, sleep and rest, ability to move, satisfaction to perform daily life, and work activities and dependence on medication (Fleck et al. 2000). Among these caregivers of disable children presented worse values in this domain. As observed in a study that included caregivers of people with disabilities, since many of these individuals are unable to perform routine activities such as dressing, performing personal hygiene, feeding and moving independently, thus burdening their caregivers by demanding greater physical effort (Braccialli et al. 2012).

In the assessment of the psychological health domain among 42 caregivers, many of them expressed dissatisfaction with their bodily appearance and their ability to enjoy leisure time, with average scores of 2.86 and 2.67, respectively. Additionally, most of the caregivers showed moderate satisfaction with aspects like having a meaningful life, concentration power, satisfaction level with themselves, and experiencing negative feelings, with average scores of 3.05, 3.10, 3.19, and 3.66, respectively. Hence, we can conclude that the psychological health of caregivers was moderately good. A great deal of research has shown that raising a child with disability strongly impacts the family caregivers. In comparison with caregivers of healthy children, the researchers have found that caregivers of children with disabilities had greater odds of reporting poorer general health and mental health, chronic conditions, psychological status, elevated depressive symptoms, more somatic symptoms, and higher levels of stress (Brehaut et al. 2009)

Among the 42 participants, the caregivers experienced a moderately good quality of life in their personal relationships, sex life, and getting support from others, with average scores of 3.83, 3.76, and 3.74, respectively. Most of them reported feeling neither satisfied nor dissatisfied, indicating results that were nearly close to being satisfying. As a result of cultural impacts caregivers mostly take over the responsibility for disabled children. In the assessment of the social relationship domain, the caregivers demonstrated a moderately good quality of life in relation to their psychological health and its impact on their social interactions. In another study, Kaya et al. (2010) reported that the deterioration of mental health in caregivers with disable children gives rise to experiencing further low back pain by mothers, leading to more deterioration in Quality of Life and it was reported that decrease the social activities of mothers with disable children. In several studies, it has been indicated that mothers of disabled children give up other roles in society, attend less to social activities, and have less social life due to their increased responsibilities for childcare (Ergun et al.2012).

In the environmental domain, the biggest difference was shown in the assessment of having enough money to meet one's needs, with caregivers leading a poor quality of life in managing their financial requirements. However, for other aspects in the environmental domain, such as transport, safety in daily life, living place and health service, the average scores were 3.43, 3.62, 3.17, 3.79, 3.65, and 3.60, respectively, indicating moderately satisfying results.

Furthermore, caregivers demonstrated a good quality of life with their physical environment, with an average score of 4. Overall, in the assessment of the environmental domain, most of the caregivers' quality of life was neither poor nor good, showing a balance between the different aspects of their environmental well-being. A study by (Fleck et al. 2000) argued that, The environmental domain includes aspects such as physical safety/protection, financial resources, access to information, physical environment, living conditions, opportunity to participate in leisure activities, and access to health services and transportation.8 This domain shows the daily environmental reality of individuals, and this domain received the lowest mean score for all groups studied, suggesting that the environmental context may be the least satisfactory factor for QoL.

My study found association that the financial situation of caregivers with school-going children with disabilities significantly affects their Physical health and environmental situation ($p=0.01$). However, no statistically significant evidence was found for the association between the financial situation and Psychological health or social relationships ($p>0.05$). Nonetheless, the study highlights the crucial role of the financial situation in influencing caregivers' overall quality of life.

My study also found that there is a significant association between caregiver's partnership relationship and their social relationships, indicating a strong link.

However, no significant associations were found with caregiver's physical health, psychological health, and environmental situation. Therefore, the partnership relationship has only a minor impact on the caregiver's overall quality of life.

My study found statistically significant association between LISAT-11 and WHOQOL BREF. The p-values for physical health, psychological health, and social relationships were 0.00, indicating high significance, while the p-value for environmental situations was 0.03, also significant. This indicates a positive correlation between better quality of life and higher life satisfaction.

This study also found Association between level of life satisfaction and negative feelings which was statistically significant where p value was 0.00. So, it has shown that negative feelings such as despair, blue mood, anxiety, depression greatly affect caregivers level of life satisfaction with children with disability. A qualitative study revealed stress is the most frequent theme that arises in the parents" accounts of how their child with ASD has affected their lives and their families lives (Myers et al., 2009).

5.1 Limitation

This study had certain limitations that need to be considered when interpreting the results. Firstly, the small sample size could impact the generalizability of the findings, as it might not represent the entire population adequately. Additionally, the short duration of the study, coupled with the presence of other course work and a limited three-month placement, might have restricted the scope of data collection, potentially affecting the comprehensiveness of the results.

Another limitation was that the samples were collected only from a specific area, As a result, the findings may not be applicable to the entire population in Bangladesh, limiting the generalizability of the study.

Moreover, the study focused solely on the quality of life and level of satisfaction of caregivers with school-going children with disability. This narrow focus means that the results cannot be directly compared with other children with different disabilities, limiting the overall understanding of the broader impact of disabilities on caregivers' quality of life.

Considering these limitations, it is essential to interpret the study's results cautiously and recognize the need for more extensive and diverse research to gain a comprehensive understanding of the life satisfaction and quality of life among caregivers of children with disabilities in Bangladesh.

CHAPTER-VI CONCLUSION AND RECOMMANDATION

6.1 Conclusion

This paper provided an overview on the current knowledge pertaining to the impact of caring for children with disabilities on the life satisfaction and QOL of caregivers. Comparing the profile of caregivers of child with disabilities, it was observed that for most of them the primary caregiver is female and married. Regarding age, it was observed that most caregivers age range between (31-40 years) in comparison to other caregivers. Lower education level was observed for caregiver, most of them were unemployed and have lower incomes. Regarding health condition caregivers were presenting health problems. Negative impact on QoL was observed with increase in the level of burden of primary caregivers of children/ young adults with disabilities compared to those without disabilities. This paper also discussed potent factors which were discovered in most of the past studies. Some factors that were found to be associated with QOL showed considerable overlap with those related to parental stress and the psychological well-being of the caregivers. Maximum caregivers had lower level of functional status and we general people sometime think that this poor functional level can affect the Qol of school going cerebral palsy children caregivers, but caregivers of children with disability describe their life satisfaction and quality of life as good and are moderate satisfied with their life. They have adapted to this situation and accepted it and from this study we see that social life is moderate good of caregivers of school going children with disability.

6.2 Recommendation

In future, larger sample size is recommended to assess the Quality life of caregivers with disable children in Bangladesh. In additionally conduct the study in large community and other institute.

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APPENDIX

IRB Permission Letter
Permission Letter
Inform consent (English)
Inform consent (Bangla)
Questionnaire (English)
Questionnaire (Bangla

বাংলাদেশ হেল্থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)
BANGLADESH HEALTH PROFESSIONS INSTITUTE

Ref: CRP/BHPI/IRB/03/2023/718 Date: 13/03/2023

To
G M Mainuddin Chisty
4•hYear B.Sc. in Physiotherapy
Session: 2017-2018, DU Reg.no: 8661
BHP!, CRP, Savar, Dhaka- 1343. Bangladesh

Subject: Approval of the dissertation proposal **"Level of Satisfaction and Quality of life of Caregivers of School Going Children with Disability"** by ethics committee.

Dear G M Mainuddin Chisty,
Congratulations.
The Institutional Review Board {IRB) of BHP! has reviewed and discussed your application to conduct the above-mentioned dissertation, with yourself. as the Principal Investigator and Dr. Shamima Islam Nipa, Lecturer-Rehabilitation Science, Department of Rehabilitation Science as dissertation supervisor. The following documents have been reviewed and approved:

Sr. No.	Name of the Documents
1	Dissertation Proposal
2	Questionnaire (English and Bengali version)
3	Information sheet & consent form

The purpose of the study is to evaluate the level of satisfaction and quality of life among caregivers of school going children with disability. Should there any interpretation, typo, spelling, grammatical mistakes in the title, it is the responsibilities of the investiga1or. The study involves face-to-face interview by using semi-structured questionnaire to explore the perception of caregivers of school going children with disability residing at CRP-Savar. Dhaka in Bangladesh. Since the study involves questionnaire that takes maximum 20- 30 minutes and have no likelihood of any harm to the participants. The members of the Ethics committee approved the study to be conducted in the presented form at the meeting held at 09:00 AM on January 9. 2023 at BHPI (34mIRB Meeting).

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,

Muhammad Millat Hossain
Associate Professor, Dept. of Rehabilitation Science
Member Secretary, Institutional Review Board (IRB). BHPI
CRP. Chapain. Savar, Dhaka-1343

পি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
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20t1¹ May. 2023
The Principal
William & Marie Taylor School (WMTS)
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Through: Head ofl'hysiotherapy Department, BHPI.

Subj«r: Application for seeking permission to collect data for conducting dissertation project.

Sir,

With due to respect ond humble submission to stale that r am G M Mainuddin Chisty,a student of **4th** year B.Sc. in physiotherapy at Bangladesh Health Professions lnstitute (BHPI). TI1c Ethical committee has approved my dissertation project entitled: **"Level of satisfaction** and quality of life among caregivers of school going children with disabiJity" under the supervision of Dr. Shamima Islam Nipo, Lecturer-Rehabilitation Science, Department of Physiotherapy, BHPI. I have to collect data for my dissertation project from the persons who have a child with disability. WMTS is a school where children with disabilities receive education and I want to collect data from here. Therefore, I need permission for the data collection from WMTS. I would like to assure that anything of the study will not be harmful for the participants and the Institute itself.

I therefore pray and hope that you would be kind enough to grant my application for data collection from WMTS and oblige thereby.

Sincerely,

inChisty
4th Year B.Sc. in Physiotherapy
Session: 2017-2018 Student ID: 112170380
BHPJ, CRP, Savar, Dhaka-1343, Bangladesh

Recommended & forwarded
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Approved
24/05

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Recommended
Shofiq
21.05.23

Informed consent

(Please read out to the participant)

Assalamualaikum, I am G M Mainuddin Chisty, a student of Physiotherapy Course 2017-18 session of Bangladesh Health Professions Institute (BHPI) under Faculty of Medicine, University of Dhaka. I need to complete a research to get my BSc in Physiotherapy degree. The title of my research is, “Level of Satisfaction and Quality of Life among caregivers of School Going Children with Disability”. The purpose of the study is to evaluate the level of satisfaction and quality of life among caregivers of school going children with disability. To complete this survey, I will ask you some questions about your physical and mental condition. I assure you, you will not be harmed by me and my questions. The information you provide will be kept confidential and used for research purposes only. You have the right to stop participating in research at any time. Also, if you feel unsure about answering a question, you can skip that question. It will take 30 minutes to 40 minutes to complete the questionnaire. Please answer my questionnaire correctly and assist the data collector as much as possible in evaluating your health.

Yes No

Thank you for your participation as well as your cooperation by answering the questions appropriately.

Signature of Participant.................. Date ....

Signature of Data Collector .... Date ....

Signature of the Researcher.................. Date ....

সম্মতিপত্র

(অংশগ্রহণকারীকক পড়ার জন্য অন্ুকরাধ করা হক ◌া)

আসসা ◌ামুআ ◌াইকু ম, আমম জজ এম মাঈন্উজিন্ মিশতী, ঢাকা মিশ্বমিদ্যা ◌্কের মিমকৎসা অন্ুষকদ্র অধীকন্ ি◌া◌ং ◌াকদ্শ হহ থ প্রকেশন্স ইন্সটিটিউ (মি এইি মপ আই) এর মেজজও৩কথরামপ হকাকসরে ২০১৭-১৮ হসশকন্র মশক্ষাথী। আমার মিএসমস ইন্ মেজজও৩কথরামপ মিগ্রী অজেকন্র জন্য আমাকক একটি গকিষন্◌া সম্পূন্ ◌েকরকত হকি। আমার গকিষন্◌ার মশকরান্◌াম হ , "মিদ্যা ◌়◌েগামী প্রমতিন্ধী মশশুকদ্র পমরির্◌া◌েকারীকদ্র মকধয সন্তুটির স্তর এিং জীি◌ন্র্◌াত্রার মান্"। এই গকিষণাটি অধয়েকন্র মূ ক্ষয হকে মিদ্যা ◌়◌েগামী প্রমতিন্ধী মশশুকদ্র পমরির্◌া◌েকারীকদ্র মকধয সন্তুটির স্তর এিং জীি◌ন্র্◌াত্রার মান্ মক তা মন্রুপন্ করা। এই গকিষন্◌া সম্পুন্ ◌েকরার জন্য আমম আপন্◌াকক আপন্◌ার শামররীক ও মান্মসক অিস্থা সম্পমকেত মকছু প্রশ্ন করি। আপন্◌াকক আশ্বস্ত করমছ. আমার ও আমার প্রকশ্নর দ্বারা আপন্◌ার হকান্রূপ ক্ষমত হকি ন্◌া। আপন্◌ার হদ্ও্য়া তথয হগাপন্ রাখা হকি এিং শুধুমাত্র গকিষন্◌ার উকিযকশয ি◌যা◌িহার করা হকি। হর্ হকান্ সময়ে গকিষন্◌া◌়◌ে আপন্◌ার অংশগ্রহন্ ি◌ন্ধ করার অমধকার রকেকছ। পাশাপামশ আপমন্ র্মদ্ হকান্ প্রকশ্নর উত্তর মদ্কত অস্বজস্ত হিাধ ককরন্ তকি আপমন্ হসই প্রশ্ন এমড়কে হর্কত পাকরন্। প্রশ্নাি◌ ◌ী পূরন্ করকত ৩০ মমমন্◌ি হথকক ৪০ মমমন্◌ি সময়ে ◌াগকি। অন্ুগ্রহ ককর আমার প্রশ্নাি◌ ◌ীর সটিক উত্তর মদ্ন্ এিং আপন্◌ার স্বাকস্থযর মূ য়েন্ করকত হিি◌া সংগ্রহকারীকক র্থাসাধয সহকর্◌াগীতা করুন্। আপন্◌ার হকান্ প্রশ্ন থাকক আমার সুপারভাইজাকরর সাকথ হর্◌াগাকর্◌াগ করকত পাকরন্। ি◌ঃ শামীমা ইস ◌াম মন্পা, প্রভাষক, মরহযামিম কিশন্ সাইন্স, মিপাি◌েকমন্ট অে এমএসমস ইন্ মরহযামিম কিশন্ সাইন্স (এমআরএস)। আপমন্ র্মদ্ অন্ুগ্রহ
পূিকি আপন্◌ার সম্মমত হদ্ন্, তাহক আমরা শুরু করকত পামর।

হযা ন্◌া

ধন্যিাদ্ আপন্◌ার অংশগ্রহকন্র পাশাপামশ প্রশ্নগুক ◌ার র্থার্থ উত্তর মদ্কে সহকর্◌ামগতা করার

জন্য।=

অংশগ্রহন্কারীর স্বাক্ষর .... তামরখ..............

তথয সংগ্রহকারীর স্বাক্ষর .... তামরখ..............

গকিষককর স্বাক্ষর .... তামরখ..............

Research Questionnaire

Title: Level of Satisfaction and Quality of Life among Caregivers of School going Children with Disability

We would like to ask you to answer a few general questions about yourself: Please **tick** the correct answer or fill in the space provided.

1. Caregiver Name:		
2. Are you	Male	Female
3. Age:		
4. What is your relationship with	----------------------------------	
5. Mobile Number :		
6. Adress: Village : Post Office : Thana: District :		
7. Area of living Rural Urban Suburb		
8. What is the highest level of education you have completed?	None at all Secondary school	Primary School Tertiary Other: ________
9. What is your marital status?	Single Married Living as married	Separated Divorced Widowed

10. What is your current employment status?	Full-time work Part-time work Unemployed	Student Retired Other: ________
11. Are you currently ill or do you have a medical condition?	Yes	No
If you answered **yes,** What is the diagnosis? ______________________________		
12. Monthly Income (Taka) =		
13. Disability Allowance	1) Yes 2) No	

The questionnaire –

Please read the question, assess your feelings OVER THE LAST TWO WEEKS and circle the number on the scale for each question that gives the best answer for you.

PART A- Generic Questions:

		Very poor	Poor	Neither poor nor good	Good	Ver goo
1	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfi
2	How satisfied are you with your childs health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the **last two weeks**.

		Not at all	A little	A moderate amount	Very much	An extr amou
3	What is the monthly cost of treatment?	1	2	3	4	5
4	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
5	How much do you need any medical? treatment to function in your daily life?	1	2	3	4	5
6	How much do you enjoy life?	1	2	3	4	5
7	To what extent do you feel your life to be meaningful?	1	2	3	4	5
8	How well are you able to concentrate?	1	2	3	4	5
9	How safe do you feel in your daily life?	1	2	3	4	5

10	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you have experienced **or** were able to do certain things in the **last two weeks.** Circle your best answer number.

		Not at all	A little	A moderate amount	Very much	Extrem
12	Do you have enough energy to perform your daily activity?	1	2	3	4	5
13	How much you can afford the medical treatment?	1	2	3	4	5
14	Have you enough money to meet your needs?	1	2	3	4	5
15	How available to you is the information you need in your day-to-day life?	1	2	3	4	5
16	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
17	How well you can move ?	1	2	3	4	5

The following questions ask about **how good or satisfied** you have felt about aspects of your life over the

last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
18	How satisfied are you with your sleep?	1	2	3	4	5
19	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
20	How well can you do your job?	1	2	3	4	5
21	How satisfied are you with yourself?	1	2	3	4	5
22	How satisfied are you with your personal relationships with others?	1	2	3	4	5
23	How satisfied are you with your sex life?	1	2	3	4	5
24	How satisfied are you with the support you get from your friends?	1	2	3	4	5
25	How satisfied are you with the conditions of your living place?	1	2	3	4	5
26	How satisfied are you with your other family member?	1	2	3	4	5
27	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
28	How often do you have negative feelings such as blue mood, despair, anxiety or depression?	1	2	3	4	5

PART B - National Questions

The following question asks about **how good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
29	How satisfied are you that you are able to meet the expectations placed on you?	1	2	3	4	5

The following questions ask about **how completely** you have experienced **or** were able to do certain things in the **last two weeks**.

		Not at all	A little	A moderate amount	Very much	Extremely
30	To what extent do you feel respected by others?	1	2	3	4	5
31	To what extent are you able to manage personal difficulties?	1	2	3	4	5

Life-Satisfaction Questionnaire-11 (LISAT-11) Worksheet:

Patient Name:_______________________ Date: ________________________

How satisfactory are these different aspects of your life? Indicate the number which best suits your situation for each of these statements.

1 = very dissatisfying
2 = dissatisfying
3 = rather dissatisfying
4 = rather satisfying
5 = satisfying
6 = very satisfying

Score: (1-6)

Life as a whole is ______

My vocational situation is ______

My financial situation is ______

My leisure situation is ______

My contacts with friends and acquaintances are ______

My sexual life is ______

My ability to manage my self-care (dressing, hygiene, transfers, etc.) is

____

My family life is ☐ have no family

____

My partnership relation is ☐ have no steady partner relationship

____

My physical health is ______

My psychological health is ______

Sum: ____

গবেষনার প্রস্নমালা

তিবরানামঃ মিদ্যা ়েগামী প্রমতিন্ধী মশশুকদ্র পমরির্ােকারীকদ্র মকধয সন্তুটির স্তর এিং জীিন্র্াত্রার মান্

১ পমরির্াোকারীর ন্াম :

২ ম ঙ্গ ঃঃ **পুরুষ** **মমহ া**

৩ িে়েস ____

৪ আপন্ার সাকথ সম্পকে ঃঃ

৫ হোন্ ন্াম্বার:

৬ টিকান্া

গ্রাম : িাকঘর :

থান্া: হজ া :

৭ িসিারকস স্থান্ ১=গ্রাম
২= শহর
৩=উপসহর

৮ মশক্ষযাগত হর্◌াগযতা ◌ঃ◌ঃ	শশক্ষাগত যগযতা নাই মাধ্যশমকঃ উচ্চমাধ্যশমক	অকক্ষ জ্ঞান্ সম্পূণ ৫ স্নাতক অথিা এর হথকক হিমশ অন্◌্যান্য: ________
৯ বি◌িামহক অিস্থা ? হত	অমি◌িাম মি◌িামহত	মিজেন্ন তা ◌াকপ্রাপ্ত মিধিা
১০ কমসে ◌ংস্থাকন্র অিস্থা ?	কমজী ি◌ হিকার	ছাত্র অিসর প্রাপ্ত অন্◌্যান্য: ________
১১ আপমন্ মক িম ◌াকন্ অসুস্থ ি◌া মিমকৎসাধীন্ অিস্থা◌ে আকছন্?	হযা	ন্◌া
র্মদ্ হযা হে তকি, মক হরাগ হকেকছ? ________________________________		

১২, মামসক আ◌ে (ি◌◌াকা) =

১৩, প্রমতিমন্ধ ভাতা	১) ভাতা আকছ ২) ভাতা হন্ই

প্রশ্নমালাঃ

অন্ুগ্রহ ককর প্রশ্নটি পড়ু ন্, গত দ্ুই সপ্তাকহ আপন্ার অন্ভূ মতর মূ য্যাে ন্ করুন্ এিং আপন্ার জন্য হসরা উত্তর হদ্ে এমন্ প্রমতটি প্রকশ্নর জন্য হেক ন্বরটি িৃত্ত করুন্।

ক তেভাগ – সাধারন প্রশ্নঃ

		খুি খারাপ	খারাপ	ভা ও ন্ে খারাপও ন্ে	ভাক া	খুি ভাক া
১	আপন্ার জীিন্ র্াত্রার মান্ হককমান্?	১	২	৩	৪	৫

		খুি অসন্তুি	অসন্তুি	সন্তুিও ন্ে আিার অসন্তুিও ন্ে	সন্তুি	খুি সন্তুি
২	আপন্ার সন্তাকন্র স্বাস্থ্য মন্কে আপমন্ কতিকু সন্তুি ?	১	২	৩	৪	৫

মন্কির প্রশ্নগুক া গত দ্ুই সপ্তাকহর মন্মিমতকে অমভজ্ঞযতাগুক া মক পমরমাকন্ হকেকছ হস সম্পককে।

		একদম্ ন্া	কম	হমাািামুটি	হিশী	খুি হিশী
৩	আপন্ার মিমকৎসার সাপ্তামহক খরি কত?	১	২	৩	৪	৫
৪	শারীমরক িযাথার জন্য আপমন্ মক প্রকোজমন্ে কাজ হথকক মিরত মছক ন্	১	২	৩	৪	৫
৫	আপন্ার বদ্ন্জিন্ কাকজ ম টিক রাখকত মিমকৎসা কতিকু প্রকোজন্?	১	২	৩	৪	৫
৬	আপমন্ জীিন্কক কতিুকু উকপাকভাগ ককরন্?	১	২	৩	৪	৫
৭	জীিন্কক আপন্ার কতিুকু অথপে ুন্ েমকন্ হে	১	২	৩	৪	৫
৯	আপমন্ কাকজ কতিুকু মন্সংকর্াগ করকত পাকরন্?	১	২	৩	৪	৫

১০	আপমন্ বদ্নিজন্ জীিকন্ কতিুকু মন্রাপত্তা অন্ুভি ককরন্?	১	২	৩	৪	৫
১১	আপন্ার হভৌত পমরকিশ কতিুকু স্বাস্থ্যকর?	১	২	৩	৪	৫

মন্কির প্রশ্নগুক াকত জান্কত িাওো হকেকছ-গত দ্ুই সপ্তাকহ আপমন্ কতিুকু সম্পুন্ভাকি হকান্ কাজ করকত িা অমভজ্ঞতা াভ করকত হপকরকছন্।.

		একদম্ ন্া	কম	হমািামুটি	অমধকাংশ	পমরপূ ভাকি
১২	আপন্ার মক প্রমতমদ্ন্ কাজ করার মত শজি আকছ?	১	২	৩	৪	৫
১৩	মিমকৎসার খরি িহন্ করকত আপমন্ কতিুকু সক্ষম?	১	২	৩	৪	৫
১৪	আপন্ার মক হপ্রােজন্ হমাকত র্কথি িাকা আকছ?	১	২	৩	৪	৫
১৫	আপমন্ মক বদ্নিজন্ জীিন্-র্াপকন্র জন্য হপ্রােজমন্ে তথয পান্?	১	২	৩	৪	৫
১৬	অিসর কািাকন্ার/মিন্দ্কন্র সুকর্াগ আপন্ার কতিুকু আকছ?	১	২	৩	৪	৫
১৭	আপমন্ কতিা ভাক াভাকি িাকেরা করকত পাকরন্?	১	২	৩	৪	৫

মন্কির প্রশ্নগুক াকত িাাও়ো হকেকছ- গত দ্ুসপ্তাকহ আপন্ার জীিকন্র মিমভন্ন মদ্ক মন্কে আপমন্ **কতিু কু সন্তুি?**

		খুি অসন্তু **ি**	অসন্তু **ি**	**সন্তুিুও ন্ে আার অসন্তুিও ন্ে**	সন্তু **ি**	খুি সন্তুি
১৮	আপন্ার ঘুম মন্কে আপমন্ কতখামন্ সন্তুি?	১	২	৩	৪	৫
১৯	বদ্নন্দিন্ জীিকন্র কাজ করার ক্ষমতা মন্কে আপমন্ কতিু কু সন্তুি?	১	২	৩	৪	৫
২০	আপমন্ আপন্ার কাজ কত ভাক া করকত পাকরন্?	১	২	৩	৪	৫
২১	মন্কজকক মন্কে আপমন্ কতখামন্ সন্তুি?	১	২	৩	৪	৫
২২	অন্যকদ্র সাকথ আপন্ার িযাজিগত সম্পকে মন্কে আপমন্ কতিা সন্তুি?	১	২	৩	৪	৫
২৩	আপন্ার হর্ৌন্ জীিন্ আপমন্ কতিু কুসন্তুি?	১	২	৩	৪	৫
২৪	িন্ধু কদ্র কাছ হথকক পাও়ো সাহার্য মন্কে আপমন্ কতিু কু সন্তুি?	১	২	৩	৪	৫
২৫	আপমন্ আপন্ার িসস্থাকন্র অিস্থা মন্কে কতিু কু সন্তুি?	১	২	৩	৪	৫
২৬	আপমন্ আপন্ার পমরিাকরর অন্য সদ্সযকদ্র মন্কে কতিু কু সন্তুি?	১	২	৩	৪	৫
২৭	আপমন্ আপন্ার র্াতা়োত িযািস্থা মন্কে কতিু কু সন্তুি?	১	২	৩	৪	৫

মন্কির প্রশ্নগুক াকত িাাও়ো হকেকছ- গত দ্ুসপ্তাকহ ঐ মন্মদ্ি মিষেসমূহ আপমন্ কতকিমশ/ঘন্ঘন্ অন্ুভি ককরকছন্.

		কখকন্া ন্া, , ,	কখকন্া কখকন্া	মাকে মাকে,	প্রাে সই	সিসমে

২৮	আপনার হতাশা, উকদ্বগ,অিসন্নতা এই সিং হন্মতাি িক অন্ুভু মত জত ঘন্ ঘন্ হে?	১	২	৩	৪	৫

খ মিভাগ – জাতীে প্রশ্নঃ

মন্‌নম মখত প্রশ্নটি জজজ্ঞাসা ককরকছ হর্- আপমন্ গত দ্ুই সপ্তাকহ আপন্ার জীিকনর মিমভন্ন মদ্ক সম্পককে কতিা ভা িা সন্তুি হিধ ককরকছন্।

		খুি অস্নতুি	অস্নতু ি	সন্তুিুও ন্ে আার অস্নতুিও ন্ে	স্নতু ি	খুি স্নতুি
২৯	আপমন্ আপন্ার উপর রাখা প্রতযাশা পূরণ করকত পারা মন্কে কতিুকু সন্তুি?	১	২	৩	৪	৫

মন্কির প্রশ্নগুক া জজজ্ঞাসা ককরকছ হর্ আপমন্ গত দ্ুই সপ্তাকহ কতিা সম্পূণভাকি অমভজ্ঞতা হপকেকছন্ িা করকত হপকরকছন্.

		একদ্ম ন্া	কম	হমাািামুটি	অমধকাংশ	পমরপূ ভাকি
৩০	আপমন্ অন্যকদ্র দ্বারা হককমান্ সম্মান্ পান্?	১	২	৩	৪	৫
৩১	িযার্জিগত সমসযাগুক া সমাধান্ করকত আপমন্ কতিুকু সক্ষম?	১	২	৩	৪	৫

জী◌েন সন্তুষ্টির প্রশ্না◌েতল -

হরাগীর ন্◌াম :________________________ তামরখ: ________________________

আপন্◌ার জী◌িকন্র এই মিমভন্ন মদ্ক কতি সকন্তাষজন্ক? এই মি◌ৃমতগুম র প্রমতটির জন্য আপন্◌ার পমরমস্থমতকত সিকিকে উপর্◌ু◌ি সংখযাটি মন্কদ্◌েশ করুন্.

১ = খু◌ি অসন্তু◌ি	৪= অল্প সন্তু◌ি
২= অসন্তু◌ি	৫ = সন্তু◌ি
	৬= খু◌ি

ে◌ ◌াে◌ : (১-৬)

আপন্◌ার সামমগ্রক জী◌িন্ ________

আমার হপশাগত অিস্থা ________

আমার আমথকে অিস্থা ________

আমার অিসকরর অিস্থা ________

◌িন্ধু ◌িং পমরমিতকদ্র সাকথ আমার সম্পকে আমার ________

হর্◌ৌন্ জী◌িন্ ________

আমার মন্কজর র্ত্ন করার ক্ষমতা (হপাষক,স্বাস্থয, ◌ি ◌াকেরা) ________

আমার পামরিামরক জী◌িন্ ☐ পমরিার হন্ই

আমার বি◌◌ামহক জী◌িন্ ☐ জী◌িন্সংমগ হন্ই

আমার শারীমরক স্বাস্থয ________

আমার মান্মসক স্বাস্থয ________

সিকে মা◌ি :