CAREGIVER'S PERFORMANCE FOR DISABLED CHILDREN AND IT'S RELATED FACTORS UNDER COMMUNITY BASED REHABILITATION PROGRAM IN BINH SON DISTRICT OF QUANG NGAI PROVINCE, VIETNAM

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CAREGIVER PERFORMANCE FOR DISABLED CHILDREN UNDER COMMUNITY BASED REHABILITATION IN BINH SON DISTRICT OF QUANG NGAI PROVINCE- VIETNAM

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ABSTRACT

Most disabled children live in rural and remote areas where they lack conditions to improve their living. Many of them die before they come to school age because of the circle of disability and poverty. There is no doubt about the important roles of caregivers in disabled children care.

A cross-sectional descriptive study was conducted to assess the performance of 122 caregivers who had directly participated in the Community Based Rehabilitation (CBR) program and taken care of disabled children. They were randomly collected from 11 communes in Binh Son district where the program has been in place for five years. The factors affecting their performance were also determined. The study was carried out in January 2008. Structured questionnaires were used for collecting data and Chi-square test was used to analyze the relationship between the independent and dependent variables with p-value set at 0.05.

The results of this study showed that the percentage of good performance among caregivers for disabled children under the CBR program was about 49 percent. Sociodemographic factors were not related to caregiver performance. There was a significant relationship between knowledge and attitude of caregivers toward the CBR program and the performance. The motivation factors had a relationship with the performance of respondents, whereas the study did not find a relationship between caregiver performance and the sources of information.

The findings suggest that the performance of caregivers needs to be improved as well as their knowledge and attitude toward the CBR program in order to motivate their confidence and efforts to perform better job.

In order to have an overall picture of both the quality and effectiveness of caregiver work for disabled children, similar research with a larger sample size is suggested. Further study might apply techniques such as real observation and comparison before and after joining the CBR program, and in depth interviews are also recommended

KEY WORDS: CAREGIVER/ PERFORMANCE/ COMMUNITY BASED REHABILITATION/ DISABLED CHILDREN.

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LIST OF ABBREVIATIONS

CBR	:	Community Based Rehabilitation
CPCC	:	Committee for Protection and Care for Children
CPFC	:	Committee for Population, Family and Children
CWD	:	Children With Disabilities
DC	:	Disabled Children
HVs	:	Health Volunteers
ILO	:	International Labor Organization
MoE	:	Ministry of Education
MoH	:	Ministry of Health
MoLISA	:	Ministry of Labor, Invalids and Social Affairs
PWD	:	People With Disabilities
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
WHO	:	World Health Organization

CHAPTER 1
INTRODUCTION

1.1 Rational and justification

Situations of disabled people

Around the world an estimated 600 million people live with disabilities. Eighty percent of people with disabilities live in low-income countries where they have difficulties accessing health and rehabilitation services. Seven to ten percent of them are children and 90% of children with disabilities (CWDs) live in developing countries. Most of them are living in rural or remote areas where they lack conditions to improve their living. Many of them die before they come to school age because of the circle of disability and poverty (1).

The number of people with disabilities (PWDs) is increasing. War injuries, landmines, HIV/AIDS, malnutrition, chronic diseases, substance abuse, accidents and environmental damage, population growth, and medical advances that preserve and prolong life all contribute of this increase. These trends are creating an overwhelming demand for health and rehabilitation services (2).

The fact that, PWD are also poor people subjected to the consequences of poverty such as malnutrition, unsanitary environment and ignorance of basic health practices (3).

Poverty and disability which go hand in hand create a vicious circle that exhausts the community's life. Families with disabled children (DCs) tend to be poorer than other families. Disability continues to be poorly diagnosed and often goes untreated, thereby leading to lasting disadvantage. Lacking proper support from the

State and with limited access to quality basic social services for treatment and care of their children, many parents feel that they have no choice but to give up their children. World's disabled in rural areas are 80% and only 2% of them obtain treatment (4). In addition, PWDs live in areas where medical in other services were scare, or even totally absent. In such cases, disabilities were not and could not detect in time. When they received medical attention, the impairment might have already become irreversible. Another dimension to the problem was the concentration of rehabilitation facilities and trained personnel in the major urban areas. As a result, PWDs in rural areas were deprived of rehabilitation services, or they flock to urban areas to secure these services in centers or institutions, which are consequently placed under heavy strain (3).

Those conditions can be recognized in Quang Ngai Province which has more than 13,000 CWDs, and about 85% of them are living in rural and remote areas (5).

In addition, Unfortunately, the current situation of many CWDs include: poverty-level living conditions, low literacy and education levels, very limited vocational training and employment opportunities, and limited awareness of, and access to, rehabilitative services (and rehabilitative aids and devices), and lack of adequate social integration in the community.

People with disabilities face many challenges. They often cannot do things due to their disability. The disability has many other effects on their lives. As they cannot walk it is difficult for them to get out of the house. So they cannot get into the community to meet people, shop, go to school or work or be part of any family or community activities. People with disabilities are also often "discriminated" against. Many people think they cannot do things that they can do. Many people also look down on them and will not allow them to do things.

WHO estimated that about 98% of PWDs living in developing countries are totally neglected. PWDs are often poor, dependent and vulnerable. The major problem

of PWDs in rural areas is a disadvantaged group in society. They are generally unemployed and low education. The first and the most important disadvantage is that the opportunities for them to take care of themselves to have appropriate jobs to generate income, are small. In Vietnam, most (98.35%) of PWDs live in the rural areas have no technical specialization. They have never attended any simple technical training. More than 67% of handicapped people said that they wished to be helped and assisted to improve their lives. High percent of CWDs in Vietnam are illiterate and most of the children with disabilities in Vietnam are unable to have professional occupations (6). Only 10.45% of disabled children in Vietnam can read and write (7).

Beside, social and family attitude often worsens the situation of PWD. In many communities, PWD are hidden away and considered less than whole people, so their potential for happiness and success is never realized. Members of the community and family never get any chance to see how capable a PWD can become, and many people believed that a person with disability was sent to family as punishment for sin. So their families and relatives always think that their neighbors look down their families because family has a disabled member. They always keep and hide the disabled in house. They do not let anybody know about the disabled so that the disabled in rural areas also have less opportunity to enjoy welfare in education, health and culture in their communities (6).

Furthermore, most of DC family members lack knowledge, attitude, and practical skills about disability and rehabilitation. They do not know how to take care the disabled. They think that the disabled have to suffer their situation for all their lives and CWDs live quietly depend on the family. They take care of DCs with their skills by their own themselves (6).

As a consequence, those situations made the vicious circle between poverty and disease leave its effect on economical development of lower- income countries. Two areas of community–based rehabilitation and hunger eradication and poverty alleviation for people with disabilities have a close link with each other because after being rehabilitated adequately and effectively people with disabilities will be

facilitated to strive for full equality, have chances to find employment appropriate to their capability, health conditions, to get stable income and community integration for the betterment of life (7).

Persons living in poverty are at risk of becoming disabled because of a lack of food or balanced diet; unhealthy and unsafe living environment; low paid, dangerous and insecure employment; exposure to violence; a lack of access to health facilities and treatment; high illiteracy rate, lower education level which prevents access to information (8).

In the remote areas of Vietnam, the main income of the family is depended on the number of laborers in each family. It also can be said that the families could be facing with difficulties, if they have to take care of DPs at home and transferring the disabled to have treatment in hospital.

Secondly, disabled people have effect on increasing morbidity and mortality rate. In a situation of poverty children with disabilities are more likely to become malnourished, are often weaker and have higher mortality rate (9).

Finally, for the social problem, they are burden of family and society. Studies have consistently found that disabled people as a group are poorer, and have fewer years of school, fewer occupational skills, more unemployment and higher rates of poverty. The life situation of PWD can be described by a reduced level of performance, lack of income and employment, and exclusion from participation in the community. The costs and burdens of disability are very great and are borne by many statutory and non- statutory services as well as by individual people. The burden is particularly high in terms of money, manpower and equipment. To these direct costs should be added the loss of potential income for disabled people and the contribution, they could make to community life and the generation wealth (10).

The needs for rehabilitation of disabled children can be summarized in 4 domains:

- Medical rehabilitation:
  To be received health services.
  To be received functional rehabilitation.
- Educational rehabilitation.
- Vocational rehabilitation.
- Social rehabilitation.

Rehabilitation for disabled people

In the past, rehabilitation for DPs was only in the special hospitals and rehabilitation centers. Most rehabilitation departments of hospitals and rehabilitation centers are located in the big city, and the number of rehabilitation professionals is rare. In Vietnam, there are 22 professionals with masters/ doctoral degrees, 195 specialized doctors, 360 medical doctors, 395 physical therapists and 973 physical therapist assistance (11).

In hospitals and rehabilitation centers, there are specialized therapists, good assistant equipment, and high quality of services. However, some disadvantages create obstacles for DCs to be able to afford the whole process of CBR program. These disadvantages include:

- Severe disabilities.
- Poor family.
- Living in the rural areas.

CBR is better to be operated within the local community and the families where the disabled base their lives. The local community members should place the emphasis on raising understanding and responsibility awareness of the rehabilitation. CBR should be a chance where the disabled can attain the will for self-help along with independence and the local residents can learn simple methods related to treatment and acquire chances to resolve problems by themselves (12).

The purpose of the CBR is to heighten the quality of life of the disabled staying at home by providing continuous and effective rehabilitation service through the maximum facilitation of the human power and physical resources within the community and CBR also create social integration of the residents and the disabled according to the Ministry of Health (MoH) and Welfare. The following are the proposed basic directions for the project.

- To develop community-based disability prevention and early diagnosis, rehabilitation, to improve health of the disabled, family support and continuous management system and to minimize disability and increase independence of the disabled in daily lives.

- To raise the awareness of the community members about rehabilitation and set up networking between concerned organizations while strengthening the capacity of the community to provide rehabilitation service.

- To develop, implement and assess the suitable rehabilitation strategies and programs for the local community, distribute and spread project models depending on the characteristics of the community.

-To operate a community rehabilitation consultative body for the voluntary participation and active linkage of the community and to provide comprehensive rehabilitation service by taking advantage of various resources (13).

In conclusion CBR program attempt to: (9)

- Change community attitudes and behaviors toward disability;
- Empower PWD, enabling them to function in the community;
- Transfer appropriate rehabilitation knowledge and skills to the community;
- Assist in the change from users of services to participants in health programs;
- Establish partnership in the development and implementation of programs;
- Translate appropriate clinical knowledge to self-help skills;
- Increase level of knowledge of contact people;
- Develop appropriate rehabilitation services.

Caregiver's role in CBR program and performance of caregiver

There are eight main stakeholders in any CBR program: persons with disabilities, the family and caregivers of PWD, the community, volunteers, community health workers, rehabilitation professionals, multilateral and non-government organizations, and employers (9).

In CBR, family members and caregivers are trained in providing simple rehabilitation services to PWD, and are encouraged to be creative about the use of simple aids and devices enabling PWD to function as contributing family members. Up to 90% of all personal assistance to the elderly and PWD comes from family members and caregivers and not from formal programs. Women are the major caregivers in all societies and frequently have to balance this roles with other family responsibilities and work outside the home. Although many women and families support the concept of elderly and disabled persons remaining in the home and community, they often feel inadequately supported (14).

The greatest success of CBR program is its impact on the lives of people that it has supported, and CBR program has emerged as an alternative strategy to deal with disability issues as a whole in this situation. DC's members and community people can be trained to assist DCs at home by activities of CBR program. They can improve their knowledge, attitude, and rehabilitation practical skills to help the disabled children who have worthy quality of life. The rehabilitation for handicapped child is a long process, and the roles of their family and community are very important to improve their conditions and to help them integrate community, especially caregivers who played a prominent role to help DCs integrating with their social setting. If the caregivers who were appropriately trained about CBR program improve their knowledge, skills, and attitude toward CBR program and disability, those performances will help the disabled children receive more comprehensive rehabilitation because they created conditions for DCs to receive rehabilitation services, they can know how to take care, how to practice daily for DCs.

Why did the researcher choose in Binh Son district as the research area

CBR program has been implemented in the east of Binh Son District including 11 communes with 225 disabled children. In the past, this area was suffered injury from Wartime and disaster. Poverty and disease look like a vicious circle that exhausts the community's life. The number of PWDs, therefore, is quite high.

The researcher, then, wants to assess the achievement of the CBR in providing alleviation the quality of life of DCs through the trained caregivers under CBR supporting program.

1.2 Research question

- What is the caregiver's performance for disabled children under CBR program and its related factors?
- What is the relationship between the caregiver's performance for disabled children and its related factors?

1.3 Research objectives

General objectives

To identify the caregiver's performance for disabled children under CBR program and its related factors.

Specific objectives:

- To examine the caregiver's performance in facilitating DCs in their family to receive medical, educational, social, and vocational rehabilitation services from CBR program.
- To describe Sociodemographic factors, psychosocial factors, motivational supports, sources of information.

- To describe the relationship between the caregiver's performance for disabled children under CBR program and:
  - Sociodemographic factors (age, gender, education level, occupation, relationship with DC, income, working experiences, training),
  - Psychosocial factors (knowledge and attitudes toward CBR program and disabilities),
  - Motivational supports (maintenance factors and motivation factors),
  - Sources of information.

1.4 Operational definitions of the key variables

Disabled children mean that the children, younger than 16 years old, by definition of this Ordinance, irrespective of the cause of disability, are defective of one or many parts of the body or functions which are shown in different forms of disability, and impairment which reduce the capability of activity and handicapped that cause many difficulties to work, live, and study.

Performance of caregivers for disabled children refers to the number of rehabilitation services that the caregivers assisted the disabled children received including four domains: medical, educational, vocational, and social services.

- Medical rehabilitation
  - To receive the good health service,
  - To receive the functional rehabilitation.

- Educational rehabilitation
  - To attend the school,
  - In school, they are accepted as equally as non disabled children.

- Vocational rehabilitation means that CWDs at working age who are able to participate in labor with their family are vocationally rehabilitated. There is no vocational school in Binh Son and labor age is equal to 18 years old and over.

- Social rehabilitation means that the CWDs can enjoy outdoor activities with other children.

Knowledge on CBR program and disabilities refers to the understanding of the caregivers about activities and organization of CBR program, and the disability status of his/her child, as well as the needs of his/her child.

Attitude on CBR program and disabled children refer to the feeling of the caregivers toward CBR program and disabled children.

Motivational supports refer to feelings or opinions performed to current jobs on CBR program of caregivers. In this study, the motivational factors are mentioned the factors necessary to perform designed actions of caregivers as being provided from external and internal sources. The supports can come from various sources but in this study it includes:

- **From family:** in term of encouragement for caregivers to work for CBR program, e.g helping with house chores, so that caregivers have enough time to perform their job.

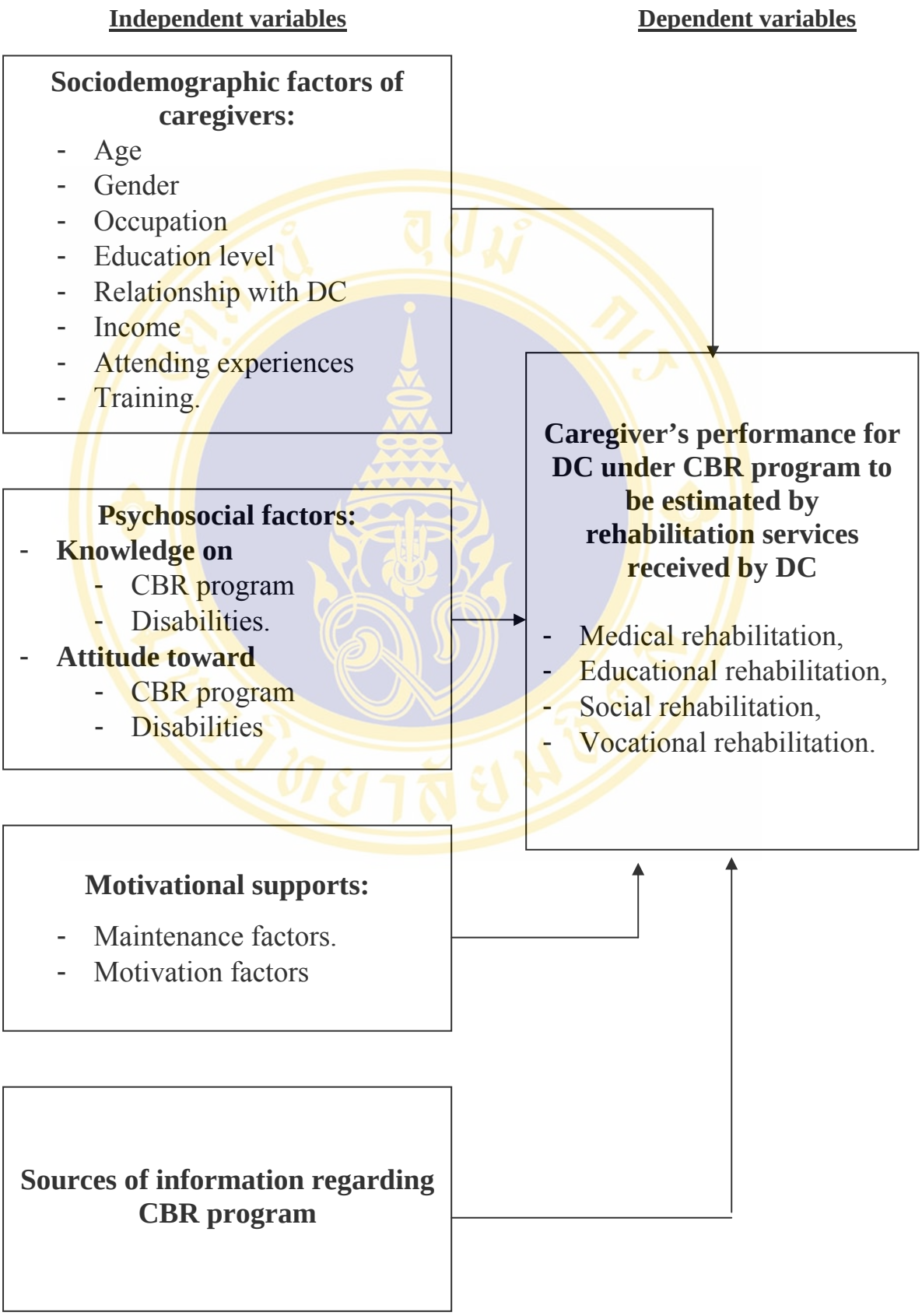
- **From health volunteers:** in term of health volunteer's help for caregiver in CBR program, e.g supervision and instruction about technical skills on CBR program.

- **From local leaders and neighbors:** in term of giving advices in CBR program; helping caregivers to solve the problems related to CBR program.

- **From their own:** means that caregiver's feelings that they were recognized by family, their achievement in helping DCs, and their feeling proud to attend CBR program to take care of disabled children.

Sources of information on CBR program: refers to sources of information regarding CBR program that the caregivers obtained and the channel caregivers receive such information.

1.5 Conceptual framework



1.6 Limitations

The results of this study would be limited by the reasons as follows:

- The study was limited to only the caregivers who have directly attended CBR program and taken care of disabled children who are under 16 years old so the sample size was too small.

- It is due to the limitation of time, moreover the data collection was carried out on the days before Lunar New Year. Therefore, both of the caregiver and health volunteer were easy to get the neglect of their interview.

CHAPTER 2
LITERATURE REVIEW

2.1 Definitions of disability and CBR program

Definitions of disability

The definitions of disability proposed by World Health Organization (WHO) have gained wide acceptance. This classification has reduced the confusion that was caused by the often interchangeable use of the terms: impairment, disability, and handicap (9).

- Impairment, in the context of health experience, is any loss or abnormality of psychological, physiological or anatomical structure or function.
- Disability, in the context of health experience, is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
- Handicap, in the context of health experience, is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, social and culture factors) for that individual (15).

They are all handicapped people of the 8 disability groups, by WHO standards, including: difficulty in moving, difficulty in hearing and speaking, difficulty in seeing, difficulty in learning, strange behavior, lost sensation, epilepsy, and disabilities of other types (16).

Only about 10% of treatment for the disabled requires the help of rehabilitation specialists, 20% of the cases can be dealt with by ordinary experts and

the remaining 70% can be solved by the patient themselves, and by their communities, according to one report (17).

Community Based Rehabilitation (CBR)Program

CBR may be defined, according to three United Nation Agencies, ILO, UNESCO, and the WHO, as a "strategy within community development for the rehabilitation, equalization of opportunities, and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services" (18).

There are 7 components in the CBR program as follows:

- Creating a positive attitude towards people with disabilities.
- Provision of functional rehabilitation services.
- Provision of education and training opportunities.
- Creation of income-generation opportunities.
- Provision of care facilities.
- Prevention of the causes of disabilities.
- Management, monitoring and evaluation

2.2 Global situation of disabled people (DPs)

In 1981, WHO stated that the number of DPs in the world was between 7% and 10% of the world's population, which means there may be more than 500 million global people need special help. The percentage of DP population could be as high as 20% and if families and relative were included, 50% of the population could be adversely affected by disability. The majorities of these groups, 80% of DPs live in isolated rural areas. The fact that, DPs were also poor people subjected to the consequences of poverty such as malnutrition, unsanitary environment and ignorance of basic health practices. DP live in areas where medical and other services were scare, or even totally absent. In such cases, disabilities were not and could not be

detected in time. When they received medical attention, the impairment might have already become irreversible. Another dimension to the problem was the concentration of rehabilitation facilities and trained personnel in the major urban areas to secure these services in centers or institutions, which are consequently placed under heavy strain (3). PWDs in rural areas are only 2% obtaining treatment (4).

Most of the world's populations live in less developed regions and it has been estimated that rehabilitation services are reaching no more than 2% of the total disabled population in these regions (19).

In a comprehensive survey representing 33 countries with half the world's population, estimated there to be 14 million physically handicapped persons, of whom one in six needed some form of special device (20). However, only 1% had any form of assistance whatsoever (9).

Adults with disability in all countries have difficulty obtaining appropriate training and education, finding jobs that pay adequately and accessing the employment environment. Children with disabilities seldom enjoy the same educational opportunities as other children. In a situation of poverty children with disabilities are more likely to become malnourished, are often weaker and have higher mortality rates. Disadvantaged groups such as women and persons with disabilities are particularly affected by poverty and have the highest illiteracy rates. Poverty is a variable which has a direct effect on programs and priorities of community projects as it limits both the development of programs and access to them (9).

2.3 The perspectives of disability

Knowledge barrier

There were no enough and exactly previous data about knowledge of DP's family. In developing countries, all parents teach their children. The roles of the family are very important, the parents have to have sufficient experience working

with their own children that they are ready to take on responsibilities but the parents may unknowingly take on the roles of therapists and teachers; especially, when the parents involve with disabled children. Another reason, mostly in families who are poor and uneducated or marginalized in some way, is the lack of education and information on disability. In community also in DP's family, awareness about DP sometimes was low or not exiting (21).

Attitude barrier

In many communities, social attitudes are often worse the situation of DPs. Many people though that a disabled person was sent to a family as punishment for sin. DPs are hidden away and considered less than whole people. Members of community, in turn, seldom got a chance to see how capable DPs can become, and so there is little incentive to develop new services. Improving the quality of life of DPs who live in developing countries is a difficult and challenging work. In several researchers have pointed out that DPs in the world, particularly in developing countries, are often the victims of negative social attitudes and are subject to stigmatization, neglect and sometimes exacerbation of the disabling situation. Practically, attitudinal barrier of DPs and the families has been one of the most important difficulties and is still continuing program for CBR program (22).

Attitude of DP toward society and their family

In developed countries and also in developing countries, DPs do not want to be isolated from the world. DPs always want to be accepted by society and want to be treated like normal human beings. They do not want to be offered a job simply. They want to work to become an asset rather than a burden. They want to have the same opportunities as everyone else. Practically, there are many jobs where DPs are as good as anyone else (23,24).

Low family income, needs and sources for DCs, and health services and other services for DCs

Poverty and disability are closely intertwined are these two issues must be tackled together. An estimated 80% of the world's disabled people live in the developing world. It is often noted that DPs are poorer as a group than the general population and that people living in poverty are more likely than others to be disabled. A 1993 study by the Policy studies Institute in the UK found that one- sixth of DPs were poor, where they have no opportunities to learn how to take care DPs and the proportion increased to almost a half when the extra payment of disability was considered. A recent study of men with disabilities in Germany concluded that, with substantial transfer and employ programs, the population with disabilities still faces a substantially higher risk of poverty than the rest of the population (25).

In developing countries, a study showed that DP's family members were the main source of assistance for DPs. Of the DPs, 43% were assisted by their children, 39% by parents, 26% by sibling, and 16% by spouse. The greatest needs of DPs from their families were care and assistance in daily living, activities and in time of sickness as well as financial support for necessary equipment. Most of DPs had varieties of need and assistance such as the need to work, to receive medical care, to receive education and have legal assistance. Among the people and groups in the community, the most important that DPs perceive as having significant roles in providing help were health personnel and commune Administrative Organization (13,26).

Physical rehabilitation is the process of recuperation that employs several medical concepts such as physical therapy, and any activity concerned with the movement of body parts (27). The caregivers can participate in helping the psychiatric patients to regain their physical ability by encouraging the patients to exercise, such as walking, swimming and jogging etc.

Psychological rehabilitation is the process of recuperation that provides education about how to control emotions, ideas and the mind to many service users or psychiatric patients (27). The caregivers can help and support the patients by accepting patients' individualism, and respecting patients' rights. Furthermore,

positive reinforcements are essential for the patients when they express their emotions and thoughts properly.

Social rehabilitation means the recuperation that skill training helps the patients to adjust relationship themselves, with their family and others (27). The family institution is considered one of the most important and basic institutions for patients in rehabilitating their social skill. The treatment can be done by letting patients participate in family activities such as dinners and family recreation. It will, therefore, give the feeling of self – value to the patients.

2.4 Situation of disabled people in Vietnam

Community-Based Rehabilitation Program has been implemented in Vietnam since 1987. The Ordinance on Disabled Persons issued in 1998 identified the Community-Based Rehabilitation as one of the measures for caring, supporting people with disabilities. Currently, Community-Based Rehabilitation Program has been carried out in 46/64 provinces nationwide. 10 Departments of CBR at central level and 51 Departments of CBR at provincial level have been founded.

The Community-Based Rehabilitation System in Vietnam has been jointly implemented by concerned Ministries, namely Ministry of Health, Ministry of Labor, Invalids and Social Affairs, Ministry of Education and Training, Committee for Protection and Care for Children.

Community-Based Rehabilitation Program in Vietnam is under direction by the Ministry of Health and implemented by the network of local health workers. The CBR Program focuses on four major areas relating to people with disabilities: health care - rehabilitation, education for children with disabilities, employment and improvement of other social conditions. Currently, 54 provincial hospitals have departments of community–based rehabilitation. The CBR Program for local people with disabilities has also been implemented at the inter-commune and districts health clinics in 46 provinces/cities **(**28).

From Vietnam Child Disability Survey, in 1998, there are currently approximately 5 million people with disabilities in Vietnam, accounting for over 6% of the total population. In terms of households, 7.93% of total households count a disabled as family member. 87.27% of PWDs live in rural areas, only 12.73% in urban areas. It is to be noted that nearly 20% of PWDs are multi-disabled, such as mute and deaf, blind and deaf, incapacitated in their movements as well as in their sight or intellectual capacity. A majority of families with a disabled member live an average to poor life, almost all live in the fold of their families (80% in urban, 70% in rural areas) about 30% have income-generating activities to support themselves and their families. Those with severe disabilities and critical family problems receive social welfare and other support in kind from the community. Although State and community support to PWDs is still moderate in terms of quantity, it is nevertheless an important source of income for PWDs to ensure a daily quality of life (29).

In the community-based survey, half of all reported disabilities in children were classified as severe disabilities. In the survey of eight institutions, the vast majority of children with disabilities (90 percent) who were living in the institutions had severe disabilities. Multiple disabilities were fairly common in children with disabilities. The average number of disabilities in CWDs was 1.48 disabilities per CWDs living in households and 1.64 disabilities per CWD living in an institution. Hearing and speech disabilities tended to often occur together in the same child, as did speech disabilities and fits/strange behavior disabilities (29).

Female children generally had lower reported disability prevalence rates than male children. This finding may be the result of both lower risks among female children for some specific disabilities and also possible underreporting of disabilities in female children (29).

Nearly 68% of PWDs need the assistive devices and rehabilitation, but only 12% have the means to purchase orthopedic equipment. A majority of them live in rural communities. With the lack of specially-designed vehicles, and the poor

transportation conditions in rural areas, PWDs face serious difficulties in terms of transportation and communication.

Although about one-fifth of CWDs were found to be using rehabilitative aids and devices such as prosthetics, orthopedics, hearing and vision aids, and wheelchairs, the rate of usage of these devices was quite low, considering that half of all CWDs living in households had severe disabilities. The vast majority of devices used were some type of glasses or vision aids. Less than ten percent of children with movement disabilities and less than two percent of children with hearing disabilities used any kind of rehabilitative aid or device whatsoever. The vast majority of rehabilitative devices being used were purchased rather than received through donation (29).

Around 35.8% of PWDs are illiterate; 25.36% have completed primary education, 21.46% basic secondary education. Almost all disabled (97.64%) do not receive any vocational training, except for a limited number in urban areas.

The education level of children with disabilities was generally very low. In the community-based survey, almost half of the school-age children (aged 6-17 years old) with disabilities were illiterate (45.5 percent). Over one-third of CWDs aged 6-17 had never attended school and another one-sixth of the school-aged CWDs had dropped out. In the institution-based survey, the education situation of CWDs was somewhat better. Only five percent of the CWDs had never attended school, although over one-fourth of the CWDs in institutions had dropped out of school. In the institutions, 85 percent of children with disabilities aged 15-17 had not finished primary school. Very low proportions of the old CWDs living in households or in institutions had completed secondary school. For both CWDs living in households and those living in institutions, non-attendance at school and dropping out of school appear to be mostly a function of family poverty, lack of education programs for CWDs, inaccessibility of schools to CWDs, and feeling ashamed or lacking confidence because of the disability.

Around 58.18% of PWDs are active in various jobs; 30.4% are still unemployed and wish to have a stable job (30).

From both the community-based survey and the institution-based survey results, it appears that vocational training for children with disabilities and employment opportunities for older CWDs are quite limited. Apparently, in many regions, inadequate attention and resources have been allocated to appropriate vocational training and job creation programs to meet the needs of the vast majority of CWDs who have employment aspirations for the future. For both CWDs living in the community and those living in institutions, the rate of vocationally-trained disabled children was very low. In the community, it was found that tailoring was one of the few professions some children with disabilities were able to pursue successfully. The fact that over 90 percent of CWDs hope to have a meaningful job in the future, highlights the need to greatly increase the opportunities and provide the means for them to achieve their life goals, and help integrate them more into the community (29).

Only 5 percent of CWDs living in households in urban areas and 10 percent of CWDs living in households in rural areas received any form of financial support from the government and or the community, such as monthly allowances, free or subsidized education, and/or free health cards. The level of support varied by region, with one-fourth of all CWDs in the North West region receiving support compared to only two percent of all CWDs in the South East region receiving support.

Awareness of local rehabilitation services was very low among children with disabilities living in households (from the community-based survey). About one third of all CWDs living in households have never sought treatment for their disability. Seeking treatment for child disabilities varied by region and urban-rural residence, with 90 percent of CWDs living in urban areas of the Red River, Delta region seeking treatment, compared to only 29 percent of CWDs living in rural areas of the Central Highlands seeking treatment.

Children with disabilities who were attending school or attending work/vocational training were far more likely to have friends than those CWDs who did not attend school or did not go to work/vocational training. Thus, it seems that

fuller participation and greater opportunities for CWDs in education, vocational training, employment and daily community activities will help to minimize their social isolation, maximize their integration in the community, and ultimately lead them to more fulfilling and economically and socially productive lives.

In the institutions, 6.5 percent of the CWDs had been abandoned by their families, another 2.6 percent had no families (orphaned), and 9.1 percent had no contact with their families. However, most of the institutionalized CWDs had weekly contact with family members. Contact with family varied according to type of disability, with more than one-third of children with fits/strange behavior disabilities reporting they had no contact with family members.

As awareness of, and support for, children with disabilities and a range of rehabilitative services for them are still quite limited; a nation-wide communication campaign on the topic of children with disabilities should be conducted.

Expansion of the MoH community-based rehabilitation programs and of inclusive education programs are needed so that these programs can be more closely linked together and scaled-up nationwide to reach all districts in all provinces.

The Government has decided to pursue more vigorously the inclusive education approach to educating children with disabilities. However, in cases of severe and multiple disabilities, additional special schools may need to be built and existing facilities upgraded, to better meet the needs of children with severe and multiple disabilities. The goal should be that the vast majority of children with disabilities should have at least a primary education. To achieve even this modest goal will require a greater commitment and effort on the part of all those involved.

Quality orthopedic devices and other rehabilitative aids and devices for children with different types of disabilities need to be made much more widely available. Geographic, social and economic access to these devices and aids is uneven.

Because most child disabilities are caused by either congenital defects or diseases that are preventable, much more proactive public health efforts are needed to reduce the incidence of all types of child disabilities in the future (29).

In the last years of the 20th century, there was a marked change in awareness in Vietnam toward support of PWD, Viet Nam recognized the need to participate together with people with disabilities in every support activity, to cooperate with them instead of acting for their benefit or on their behalf. This change in awareness is profoundly meaningful. It claims a belief in the self help capacity of PWD and the need for their participation in policy-making, planning, implementation and monitoring activities (31).

A country report in 2000 showed that the network of rehabilitation departments in hospitals play a significant role in assisting the local level and the technical field. However, at this level only 10%- 15% of DCs are fully rehabilitated. Especially, in the grassroots level, the health services for DCs still lack or scare heath personnel and equipment (32).

Table 1 The proportion and distribution of rehabilitation personnel and disabled people in different administrative level.

Level	Proportion of rehabilitation personnel	Proportion of DP
Central	70%- 80%	1%- 5%
Provincial	5%- 10%	5%- 10%
District	1%	10%- 15%
Community	0%	75%- 80%

Source: Tran Trong Hai& Nguyen Thu Nhan, Institute for the protection of children, health, Vietnam.

2.5 CBR in Vietnam

The synopsis history of CBR development in Vietnam

The CBR program in Vietnam started in 1987. Referring to the success achieved in Tien Giang province (South of Vietnam), and realizing the weakness in the traditional way of providing services on the rehabilitation for disabled people, the government of Socialist Republic of Vietnam has adopted CBR approach as a national strategy to deal with disabled-related matters. In Vietnam, the CBR program has its own local touch, both differing from the model of the WHO manual, and from other CBR programs in the word. It is not only different from these; it also varies within Vietnamese context, from province to province, although there is an overall framework giving the program consistency (33).

The results after 10 years of the National CBR program (34)

- 25 provinces, 56 districts, and 630 communes covered by MOH's CBR program;
- Population surveyed of 4,410,000 persons;
- The disability ratio of 5,4%;
- Percentage of PWD who need rehabilitation was 30%;
- Children with disabilities were 30-40%
- The ratio between male and female, who have disability 44% and 56% respectively.

Among 118,919 disabled persons in need of rehabilitation:

- Achieving good results in rehabilitation: 96,324 (81%)
- Achieving fair results: 33,295 (19%)

Among 96,324 disabled persons achieving good results:

- Adult: 62,610 (65%)
- Children: 33,714 (35%)

Of which:

- Adult integrated in society with jobs: 21,230 (34%)
- Children having access to school 10,788 (32%)

The fact is that, with CBR approach, about 70% of the disabled people can be rehabilitated right at the community. Moreover, in its efforts, the CBR program has educated people on disability prevention as well.

2.6 Caregiver

Who is a caregiver?

One of the most challenging aspects of parenting can be the realization that your child will need assistance throughout his lifetime because of developmental disabilities, a mental or physical condition or an illness or disability that resulted later in life. Advances in medical care now enable many people who face challenges because of their physical or mental condition to live into adulthood and old age. In most instances, there are options that allow persons with disabilities to live independently in the community with appropriate supports. However, if you are a caregiver to your adult child, you will want to plan for the possibility that you may not always be able to meet his needs or ensure his welfare.

Family caregivers stimulate patients' rehabilitation and recovery to return to normal or close to normal conditions and to ensure happy living in society. For example, family caregivers help the patient exercise their limb muscles, walk unassisted, and do some self- care activities such as taking a shower, getting dressed, having a meal, and urinating and having bowel movement in a toilet.

Family caregivers provide emotional and psychological support. Cognitive impairment, total dependent on others, and loss of self- care efficacy can easy lead to emotional stress. Some patients are worried that they have to be burden on others, and others may be afraid of being neglected. Caregivers have to understand and accept the patients' feeling of inferiority, loss of sense of self- worth, desperation, and neediness. They should also assess the patients' emotional status and encourage them to go on living.

Family caregivers act as coordinators between the patients and medical staff to ensure that the patients receive all the treatment they need and to reduce the conflicts that may arise between modern medicines and alternative medicines in which the patients believe. They also have to play a role of managers who facilitate treatment and care needed by the patients.

Talking the role of family caregiver, they also have to understand social expectation and the patients' expectation, as well as the scope of their roles and responsibilities to ensure that the patients are provided with effective care. If the caregivers do not have sufficient preparation, lack necessary caregiver's skills, or do not understand the role of caregivers, they may suffer from role ambiguity. Playing former roles while adjusting themselves for a new role can be a difficult task. If caregivers are unable to manage their time to perform several duties simultaneously, they may experience role conflicts and feel that they are incapable of carrying out different roles effectively. Thus, they can develop anxiety, lack self- confidence, and suffer from stress, especially during the first six months, of care when caregivers are still adjusting themselves to the new roles while at the same time learning about problems related to care (35).

Some caregivers are not confident in their caregiver's ability and feel guilty that they cannot help the patients improve their conditions; hence a worry that the patients' conditions may be worsened .

Caregivers have to plan in advance if they want to go out, and they cannot go out for a long time and leave the patient alone or with others. As a result, their participation in social activities and their relationships with family and friends will be adversely affected. Caregivers may feel uneasy or unhappy with the changing lifestyle (36).

With special education, employment opportunities, housing options, medical care, supportive services and financial support and legal arrangements in place, your child may have the tools to be as independent as possible. Membership organizations

that work to improve conditions for persons with disabilities might also be able to help (37).

Some factors affecting to caregiver' jobs (37)

Gender

- More women than men are caregivers. An estimated 59% to 75% of caregivers are female.
- Research suggests that the numbers of male caregivers may be increasing and will continue to do so due to a variety of social demographic factors. One report documents a 50% increase in men becoming primary caregivers between 1984 and 1994.
- While men may be sharing in care giving tasks more than in the past, women still shoulder the major burden of care. For example, while some studies show a relatively equitable distribution of care giving between men and women, female caregivers spend 50% more time providing care than male caregivers. However, among caregivers age 75 years up, both sexes provide equal amounts of care.
- Other studies have found that women caregivers handle the most difficult care giving tasks (i.e., bathing, toileting and dressing) when compared with their male counterparts who are more likely to help with finances, arrange care, and other less burdensome tasks.
- A number of studies have found that female caregivers are more likely than males to suffer from anxiety, depression, and other symptoms associated with emotional stress due to care giving.

Age

- While caregivers can be found across the age span, the majority of caregivers are middle-aged (35-64 years old).
- The average age of family caregivers caring for someone aged 20 years up has been estimated at 43.

- Of those caring for someone aged 50 years up, the average age of family caregivers is estimated at 47.
- Many caregivers of older people are themselves elderly. Of those caring for someone aged 65 years up, the average age of caregivers is 63 years with one third of these caregivers in fair to poor health.
- Similarly, it has been shown that the number of hours dedicated to caregiving increases with the age of the caregiver:

Employment Status

- A significant portion of those in the workforce are also providing elder care to family members. From 25% to 35% of all workers report that they are currently providing, or have recently provided, care to someone 65 years up.
- Most caregivers are employed. Among baby boomer caregivers (aged 50-64 years old), an estimated 60% are working full or part-time. Among adult caregivers generally, the majority are employed:
- Working caregivers often suffer many work-related difficulties due to their dual care giving roles. Among working caregivers caring for a family or friend aged 65 years up, two-thirds report having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their care giving responsibilities. Difficulties due to work and care giving are even higher among those caring for someone with dementia.
- Working women caregivers may suffer a particularly high level of economic hardships due to their care giving. Women caregivers are likely to spend 12 years out of the workforce raising children and caring for an older relative or friend. One recent study found that women who had assumed caregiver roles during their working years were 2.5 times more likely to live in poverty when they became elderly compared to women who had not been caregivers during their lifetime.

Economic Value and Costs of Informal Care giving

Studies in United State revealed that:

- What is the estimated economic value of informal care giving? If the services provided by informal caregivers (i.e. family, friends, neighbors) had to be replaced with paid services, it would cost an estimated $257 billion (in 2000 dollars).
- At the estimated value of $257 billion nationally, informal care giving greatly exceeds the costs associated with home health care ($32 billion) and nursing home care ($92 billion) combined.
- Studies suggest that the cost of informal care giving in terms of lost productivity to U.S. businesses is $11 to $29 billion annually.
- Caring for older persons with dementia (as opposed to caring for someone with a physical disorder) costs more than $18 billion a year in additional time spent by family and friends.
- One study of community-residing Alzheimer's disease care recipients found that on average each care recipient receives $23,436 worth of informal care from family and friends. In comparison, only $8,064 of professional home care services per year are used by care recipients.
- As a result of their care giving, informal caregivers are estimated to each lose an average of $25,494 in Social Security benefits, an average of $67,202 in pension benefits and an average of $566,433 in wage wealth. Combined, the result is a loss of $659,139 over a lifetime.
- Long-distance caregivers spend an average of $392/month on travel and out-of-pocket expenses as part of their care giving duties.

Caregiver Assistance/Support

- Most people who need long-term care depend exclusively on their family and friends. The vast majority of adults (78%) in the U.S. who receive long-term care at home get all their care
- From unpaid family and friends, mostly wives and adult daughters. Another 14% receive some combination of family care and paid help; only 8% rely on formal care alone.

- Forty-eight percent of caregivers reported using at least one of seven outside services (e.g., transportation, home-delivered meals, etc.) to supplement their care giving.
- Caregivers are often unaware of the availability of support services. One recent study of Alzheimer's caregivers found that 75% had unmet needs; only 9% used respite services and only 11% participated in support groups. A study of California caregivers similarly found that 75% did not know where to access services that they would have used.
- Caregiver interventions benefit both the caregiver and the care recipient. Use of caregiver support services has been shown to have clinically significant outcomes in improving caregiver
- Depression, anxiety and anger. Specific caregiver interventions which appear to be most beneficial include those that work with both the caregiver and the care recipient, those that emphasize behavioral skills training, and those that are both multi-component and tailored to caregivers' specific needs.
- People with moderate dementia have been able to defer institutionalization by nearly a year when their family members receive caregiver support services, including counseling, information and ongoing support.

Study findings have reported that caregivers need information and skill training from experts regarding different care activities (38).

2.7 Theoretical model

Frederick Herzberg developed another popular theory of motivation called the two factor theory. Herzberg interviewed hundreds of workers about times when they were highly motivated to work and other times when they were dissatisfied and unmotivated to work. His findings suggested that the work characteristics associated with dissatisfaction were quite different from those pertaining to satisfaction, which prompted the notion that two factors influence work motivation (39).

According to this theory, motivation is comprised of maintenance factors which are extrinsic to the work itself, and include aspects such as company policies, supervisory practices, or wages/salary, and motivation factors which give positive satisfaction, arising from intrinsic conditions of the job itself, such as recognition, achievement, or personal growth (40).

Maslow developed a "hierarchy of needs" or an order of needs that need to be fulfilled in each person. If a manager embraces Maslow's hierarchy, he/she will motivate employees, keeping the order of needs in mind. The hierarchy of needs is shown below:

- **Self actualization** – need to grow and use abilities to the fullest; highest need
- **Esteem** – need for respect, prestige, and recognition from others as well as self esteem and personal sense of competence
- **Social** – need for love, affection, and belongingness in one's relationships with others
- **Safety** – need for security, protection, and stability in the personal events of everyday life
- **Physiological** – most basic of human needs; need for food, water, and sustenance.

Using this theory, managers can use the hierarchy to motivate people by satisfying the most important needs (41).

The implication of the two- factor theory for leaders is clear. The leader's role is to go beyond the removal of dissatisfies to the use of motivators to meet higher-level needs and propel employees toward greater achievement and satisfaction. You can evaluate your current or a previous job according to Maslow's needs theory and Herzberg's two- factor theory by answering the questions in Leader's self- Insight The following example illustrates how Ann Price strives to meet employees' higher as well as lower- level needs at Motek, a company that makes software for tracking the movement of goods in warehouses (39).

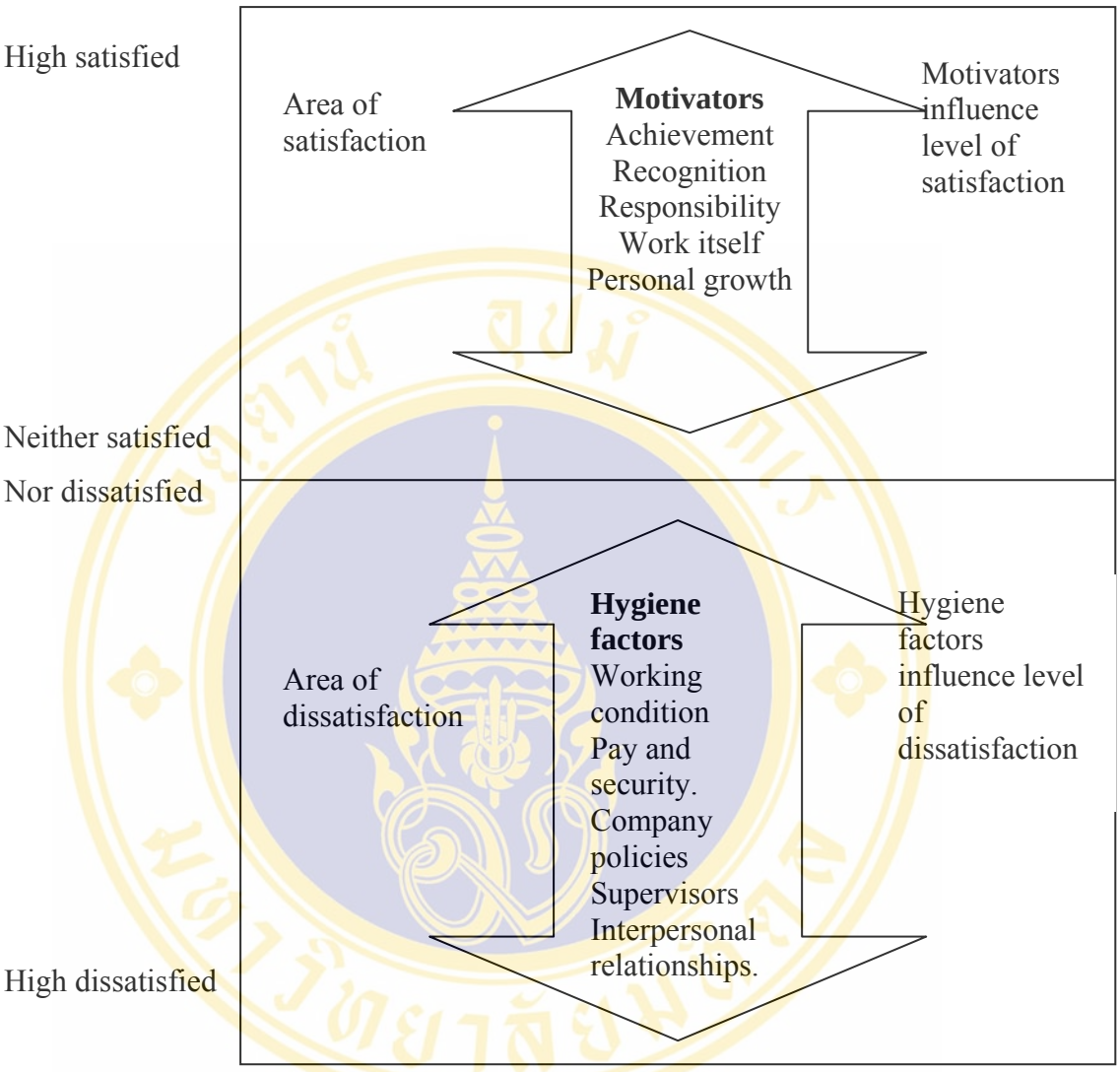


Figure 1 Herzberg's Two- Factor Theory

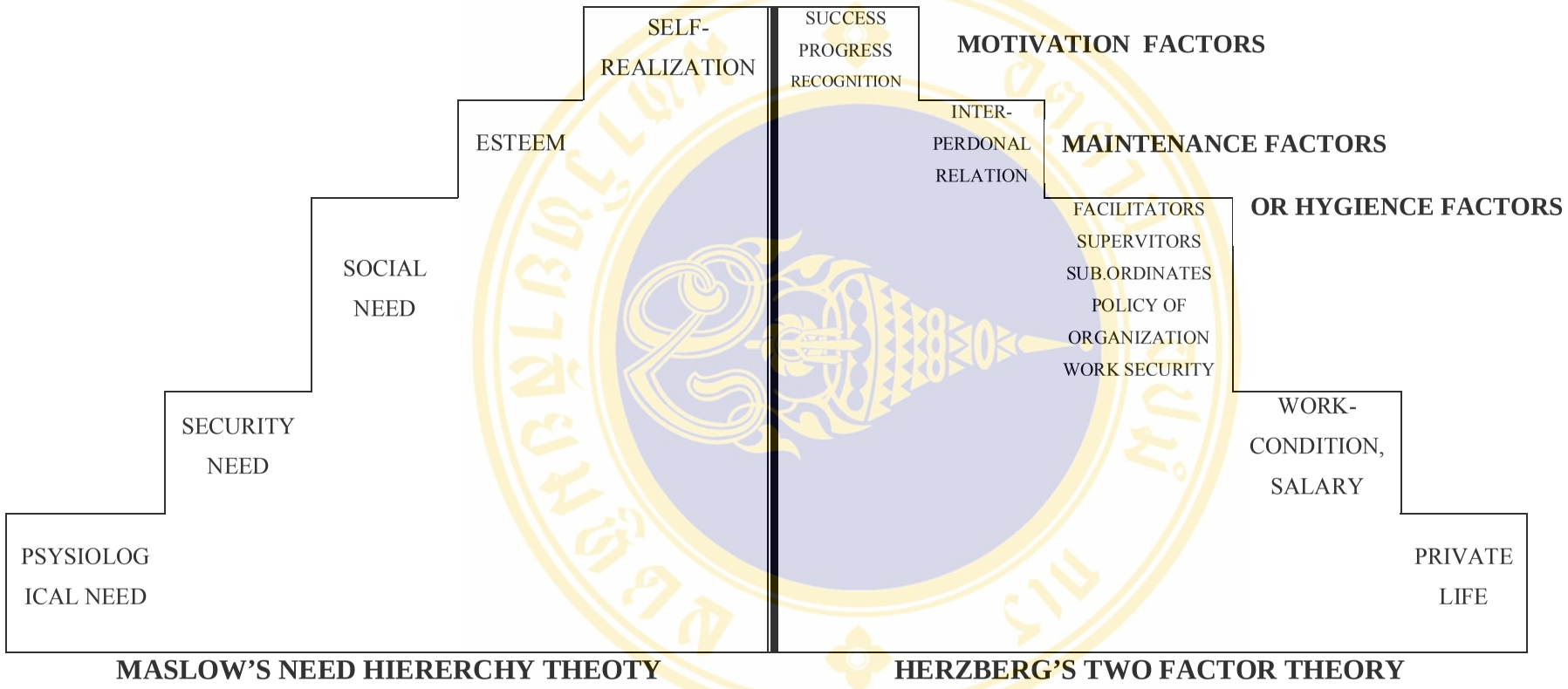


Figure 2 Comparison between Herzberg's Two Factor Theory and Maslow's need Hierarchy Theory

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Research design

This research was a cross-sectional study with the endeavor to provide basically general description the achievement of a Community Based Rehabilitation Program at Binh Son District, Quang Ngai Province, Vietnam in January 2008. The research was designed to collect the information relating to the caregiver's performance for disabled children living at Binh Son District where the CBR program has been implemented for five years.

The data was collected through the structured questionnaires by interviewing the respondents including sociodemographic factors, psychosocial factors (knowledge on CBR program and disabilities, attitudes toward CBR program and disabled children of caregiver), Motivational supports (maintenance factors and motivation factors), sources of information that the caregiver obtained the CBR program, and caregiver's performance.

3.2 Research area

11 communes in the east of Binh Son District were selected as the area where the program has been implemented for five years.

3.3 Research population

The target population in this study was the whole 179 caregivers who have directly participated in CBR programs and taken care of DCs living in the study areas. The sample of target population was randomly recruited from the caregiver's list documented at the district PFCC office.

3.4 Sample size

The sample size estimation in this study was based on the following formula (42)

$$n = \frac{Z^2 NP(1-P)}{d^2(N-1) + Z^2 P(1-P)}$$

Where:

N= Target population (total of the caregivers have attended the CBR program): 179

Z = Standard normal score at significance level at 0.05 = 1.96

p = 0.5 (Since there has been no study about caregiver's performance in Vietnam before)

d = degree of accuracy desired setting at 10% of "p".

$\Rightarrow$ n = Estimated sample size: 122

3.5 Sampling procedure

Step 1: There were 24 communes at Binh son District but only 11 communes in the eastern district carried out the CBR program. All 11 communes where the CBR program was implemented were purposively selected as the research site. Caregivers whose disabled children were under 16 years old were synthesized in the list of study participants in each commune.

Step 2: 122 caregivers were selected from 179 caregivers in 11 communes; thus there is a need to draw a 70 percent sample from the population (122/179). Based on the disabled children's list in each commune picked up 70 percent of the disabled children by the simple random sampling method. The disabled children were randomly selected each of the communes by the fishbowl technique as presented in table 2. The caregiver of each disabled children was taken for the interview. In case that there was not the caregiver at home during the time of interview, the interviewer went to the next household and came back later for interview.

Table 2 Number of DCs in 11 communes was selected to interview their caregiver

Commune	Total DCs attended the CBR	Total DCs selected by simple random sampling
Binh Phuoc	21	14
Binh Dong	12	9
Binh Thanh Tay	24	16
Binh Thanh Dong	15	10
Binh Thuan	13	9
Binh Phu	21	14
Binh Long	10	7
Binh Chau	16	11
Binh Tri	17	11
Binh Hai	18	12
Binh Hoa	13	9
Total	**179**	**122**

3.6 Research instrument for data collection

- A structured interview questionnaire was designed and used as a research instrument for data collection.

- Data were collected from the sample by face to face interview.

- The structured questionnaire for interviewing the caregivers was comprised 5 sections as follows:

Section 1: Sociodemographic factors of the caregivers (age, gender, occupation, educational level, relationship with caregiver, income, working experience, and training before enjoying CBR program).

Section 2: Psychosocial factors of caregivers (knowledge and attitudes toward CBR program and disabilities of caregivers).

The respondents were asked 5 questions about their knowledge on CBR program and 7 questions about disabilities. One score was given to the correct answer and zero for the incorrect answer. The total score was 5 for knowledge on CBR program, and 7 for knowledge on disabilities. The level of knowledge was classified into 3 groups: high, moderate, and low, based on the percentage of corrected questions that the caregivers answered "Bloom's cut off point" :

- High level: equal and more than 80%.
- Moderate: from 60% to less than 80%.
- Low: less than 60%.

The attitudes toward CBR program consisted of 10 statements regarding the CBR program and 13 statements regarding the disabilities. Answers for each positive question were scored from 1 to 3 points corresponding to disagree, neutral and agree. For negative questions, the scores were invested. The total score of each respondent was calculated as a sum of all scores received from those questions and level of attitudes was classified into 2 groups based on the median of score.

- Positive attitude: equal and higher than median.
- Negative attitude: lower than median.

Section 3: Motivation supports (maintenance factors and motivation factors).

The motivational supports on CBR program were consisted of 9 questions divided into two parts. Regarding the maintenance factors, there were 6 questions, and 3 questions concern the motivational factors. Scores of maintenance factors and motivation factors was calculated to know whether or not caregiver received the motivational supports. Score 1 was given for "yes" answers and score 0 for "no" answers. The statements for maintenance factors and motivation factors on CBR program were summed up and classified into 2 groups: high support and low support based on the median of score.

- High support: equal and over median.
- Low support: lower than median.

Section 4: Sources of information.

Section 5: Performance of caregivers for DCs under CBR program is evaluated by rehabilitation services that DCs received.

- Medical rehabilitation.
- Educational rehabilitation
- Vocational rehabilitation.
- Social rehabilitation.

There were 4 questions asked the respondents whether or not their DCs had received CBR services including rehabilitation services, educational rehabilitation, vocational rehabilitation and social rehabilitation. Respondent got 1 score with "yes" answer and 0 score for "no" answer. Four questions for getting CBR services were summed up and classified into 2 groups: good performance and poor performance groups based on the mean of score.

- Good performance: equal mean and over.
- Poor performance: less than mean.

3.7 Pre- test

Pretest for reliability of the prepared questionnaires was interviewed 30 caregivers at Nghia Hanh district where CBR program was implemented two years. Results of the pretest were also checked to find out either difficulties for interviewers as regards the questionnaire or difficulties for respondents answering the questions. According to the reliability method of questionnaire, Kuder- Richardson formula (KR) 20 was used to find out the reliability measurement of knowledge and Cronbach's alpha coefficient method was used to find the reliability measurement of attitudes.

Table 3 The reliability test results of questionnaire

Items	Analytical tools	Results
Knowledge:		
- Before adjustment (13 items).	KR 20	1.089
- After adjustment (13 items).		0.607
Attitudes:		
- Before adjustment (23 items)	Cronback's coefficient of Alpha	0.359
- After adjustment (23 items)		0.653

3.8 Data collection procedure

Data were collected from the sample by face to face interview. Data collection started from 4 to 27 January 2008 by 14 interviewers who were health volunteers of the CBR program in 11 communes of research area were trained how to interview and use questionnaires before the beginning of the data collection. There were five basic steps as follows:

- Contact the Managing Boards and Committee for Population, Family, and Children of Quang Ngai province, Nghia Hanh district, and Binh Son district to introduce the research proposal and ask for information background about the program
- Conduct the Pre- test in Nghia Hanh rehabilitation center and adjust the questionnaire.
- Synthesize the list of disabled children under 16 years old of each commune. Follow the criteria and choose the disabled children for sample size by using simple random sample theory.
- Conduct training for interviewers before data collection. Interviewers were trained basically on the orientation of the study; explanation of job responsibilities; explanation of questionnaire content; technique of filling out the questionnaire according to its context and sequence.

- Conduct and follow- up data collection in 11 communes of Binh Son district.

3.9 Data analysis procedure

After collecting data, the process of analysis was:

- Entering the data into the computer by using Epi- Data software.
- Analyzing the data using MINITAB software.

The presentation of the results of this study was divided into two parts as follows:

Univariate analysis: Descriptive statistics using frequency, mean, standard deviation, median, and percentage to describe the distribution of independent and dependent variables including: sociodemographic factors, psychosocial factors, motivational factors, sources of information, and performance of caregiver.

Bivariate analysis: Chi-square, Fisher's exact test were used to determine the significant relationship between dependent and independent variables. The critical significance level of all statistical tests was set up at $\alpha = 0.05$.

CHAPTER 4
RESULTS

This cross-sectional study was to identify the caregiver's performance and affecting factors for disabled children under CBR program. The study was carried out during January 5 to January 27, 2008. A total of 122 caregiver was randomly selected from 11 communes of Binh Son District in Quang Ngai Province. They were interviewed by structured questionnaire. The finding of the study were presented in two main parts; one was description of the caregivers' sociodemographic factors, psychosocial factors (knowledge on CBR program and disabilities, attitudes toward CBR program and disabled children of caregiver), motivational support (maintenance factors and motivation factors), sources of information, and performance of caregivers. The other was statistical analysis of factors related with the performance of caregivers. The relationship between the independent and dependent variables were tested by Chi- Square test. The level of significance for relationship was set at p-value = 0.05.

Part I: To describe independent and dependent variables:

Section 1: Sociodemographic factors

Section 2: Psychosocial factors.

- Knowledge on CBR program and disabilities.
- Attitudes toward CBR program and disabled children of caregiver

Section 3: Motivational support.

- Maintenance factors.
- Motivation factors.

Section 4: Sources of information.

Section 5: Performance of caregivers for DC under CBR program.

Part II: Relationship between caregiver's performance for disabled children under CBR program and Sociodemographic factors, Psychosocial factors, Motivation support, and sources of information.

4.1 Sociodemographic factors

The results in table 4 presented the distribution of the caregivers according to their sociodemographic factors, including age, gender, occupation, education level, relationship with disabled child, per capita income per month, working experience, and joining training course of CBR program.

The age of the respondents ranged from 22 to 73 years old with mean age of 41.72 years and standard deviation of 9.97 years. Age of respondents was classified into 4 groups: 25- 30, 31 – 40, 41 – 50, and 51 – 73. There were the highest percentage of respondents in 31 -40 group (40.98%). About one third (32.79%) of them were in the age group from 41 to 50. One fifth of them (17.21%) was more than 50 years old. The age group under 30 years old only accounted for 9.02% of the respondents.

Sixty three point one percent of the caregivers were female. Majority of the caregivers were farmer or fisher (82.79%) whereas only 4.92 percent of them were government officers. Vender and housewife accounted for 3.28 percent and 9.02 percent, respectively.

The education attainment indicated that almost all of them were belonged to low educational group (illiterate: 0.82%, primary school: 31.15%, and secondary school: 57.37%). Only 7.38 percent of caregivers had completed high school and a small proportion of the caregivers (3.28 percent) graduated from college or university.

The counting showed that the majority of caregivers was the parents (95.90%), only 2.46 percent and 1.64 percent were their relatives and grand father/mother, respectively.

According to the criteria of the Decision 170/2005/QD-TTg of Government, a rural household with the per capita income lower than 200,000 VND per month was considered as poor. The results presented that their capita income displayed a wide

gap ranging from 100,000 VND to 1,200,000 VND per month, median of the per capita income was 300,000 VND per month. Then, there were 35.25% would be classified as poor household. More than half of respondents (59.02%) reported that they had income from 200,001 to 500,000 VND, whereas only 5.74 percent of caregiver's family got high capita income from 500,001 to 1,200,000.

In terms of experience in working with CBR program, the duration of caregivers enrolled in the CBR program ranged from 2 to 60 month with a mean of 38.43 and standard deviation of 17.10. Table 4 showed that among 122 caregivers, two thirds of them (72.96%) had joined the CBR program from more than 2 years to 5 years, and one third percent of them (27.04%) participated in the CBR program from 2 to 24 months.

Majority of caregivers (72.95%) had not been received any training course regarding rehabilitation for disabled children before enrolling the CBR program.

Table 4 Sociodemographic characteristics

Sociodemographic characteristics	Number (n= 122)	Percentage (%)
Age (in year)		
- 25 – 30	11	9.02
- 31 – 40	50	40.98
- 41 – 50	40	32.79
- 51 – 73	21	17.21
Min – Max: 25 – 73. Mean ± SD = 41.721 ± 9.970. Median: 40.500		
Gender		
- Female	77	63.11
- Male	45	36.89
Occupation		
- Farmer/ fisher	101	82.78
- Vender.	4	3.28
- Housewife	11	9.02
- Government Officer	6	4.92
Education level		
- Illiterate.	1	0.82
- Primary school.	38	31.15
- Secondary school	70	57.37
- High school.	9	7.38
- College or University	4	3.28
Relationship with DC		
- Father/mother	117	95.90
- Relatives.	3	2.46
- Grand father/ mother.	2	1.64

Table 4 Sociodemographic characteristics (cont.)

Sociodemographic factors	Number (n= 122)	Percentage (%)
Income: (VND)		
- 100,000 – 200,000	43	35.25
- 200,001 – 500,000	72	59.02
- 500,001 – 1,200,000	7	5.74
Min – Max: 100,000 – 1,200,000. Mean ± SD = 313,066 ± 194,707		
Working experience (month)		
- 2 – 12	16	13.11
- 13 – 24	17	13.93
- 25 – 36	27	22.13
- 37 – 48	34	27.87
- 49 - 60	28	22.96
Min – Max: 2 – 60. Mean ± SD = 37.98 ± 16.72. Median: 38.50		
Training course before		
- Yes	33	27.05
- No	89	72.95

4.2 Psychosocial factors

Knowledge of caregivers on CBR program and disabilities

The results in table 5 showed the score of knowledge of caregivers toward CBR program and disabilities. From12 questions designed to assess knowledge of caregivers toward CBR program (5 questions) and knowledge toward disabilities (7 questions), it was found that high proportion of the caregivers revealed better knowledge on CBR program than one on disabilities, especially, knowledge on the cause of disabilities found to be quite low.

Table 5 Knowledge of caregivers on CBR and disabilities

Knowledge statement	Correct answer	
	Number (122)	Percentage (%)
Knowledge on CBR program:		
- Rehabilitation for DC is a long process and takes a lot of time.	116	95.08
- CBR program gives DC a chance to integrate with their community.	116	95.08
- CBR program is available to help DC to be rehabilitated at home and community.	116	95.08
- DC's families and communities can be trained by activities of CBR program to improve their knowledge, attitudes and skills to take care of DC.	106	86.89
- Everybody in the community can participate in the CBR program to help DC.	106	86.89
Knowledge on disabilities:		
- You know about disabled condition of your child	99	81.15
- Poverty is a main reason to cause the disabilities	10	8.20
- Unhealthy, and unsafe living environment are easy to cause the disabilities.	38	31.15
- Early detection and intervention is the best way to reduce the severe complication of disability.	111	90.98
- Each kind of disabilities has a particular method of rehabilitation.	104	85.25
- Early rehabilitation is the best way to restore the impaired organ.	109	89.34
- If rehabilitated everyday, DC can function more independently in their activities daily living.	113	92.62

Table 6 Level of knowledge on CBR program and disabilities

Level of knowledge	Number (122)	Percentage (%)
Knowledge on CBR program:		
- High	108	88.52
- Moderate	9	7.38
- Low	5	4.10
Min – Max: 1 - 5. Mean ± SD = 4.5902 ± 0.8308.		
Knowledge on disabilities:		
- High	23	18.85
- Moderate	60	49.18
- Low	39	31.97
Min – Max: 1 - 7. Mean ± SD = 4.7869 ± 1.062.		

Table 6 presented the level of knowledge on CBR program and disabilities among caregivers. Regarding the knowledge on CBR program, the range of correct answer was 1- 5 scores and the mean score of correct answers about CBR program was mean of 4.59 with standard deviation of 0.83. Most of the caregivers showed good knowledge on CBR program (88.52%), only 7.38% and 4.10% of the respondents were moderate and low knowledge on CBR program, respectively. Whereas the knowledge on disabilities of caregivers, a small proportion of the respondents had good knowledge (18.85%), the remaining respondents were 49.18 percent with moderate knowledge, 31.97 percent with low knowledge on disabilities. The range of correct answer was 1- 7 score with mean of 4.78, and standard deviation of 1.06.

Attitude of caregivers toward CBR program and disabilities

Attitude toward CBR program

Table 7 showed 10 statements of attitude of caregivers toward CBR program. The result in these statements demonstrated that most of the respondents had positive

Table 7 Attitude toward CBR program (n = 122)

Attitude statement	Percentage		
	Agree	Neutral	Disagree
- CBR program is convenient for DC living in rural areas	91.80	1.64	6.56
- CBR enable the family's member's willing to take care of DC.	99.18	0	0.82
- With support of CBR, DC can be rehabilitated at home	63.11	6.56	30.33
- CBR program can help DC's Families to save money and time for taking care of DC.	90.98	6.56	2.46
- DC can be benefited from CBR program by having opportunities to integrate themselves into the society.	83.61	6.56	9.84
- CBR program is a straightforward way to know how to take care of DC.	81.15	18.85	0
- CBR program can help DC to have a chance to participate in social activities, such as going to school and attending labor with family.	84.43	6.56	9.02
- The progress of CBR can make families feel happy even if it is very slow or little.	98.36	0.82	0.82
- CBR can change public awareness on capability and demands of people with disabilities positively.	81.15	16.39	2.46
- DC can be supported by CBR program with more convenience than by central hospital	86.07	6.56	7.38

attitude toward CBR program. From 81.15 to 99.18 percent of the caregivers agreed with the statements, except “DC can rehabilitate at home” statement that only 63.11 percent of the respondents agreed.

Table 8 presented the level of the attitude toward CBR program among caregivers. The correct answers ranged from 20 to 30 with median of 28 (In this part, the mean and the median are very closed but median is a round number) It was found that two thirds of the caregivers had positive attitude toward CBR program.

Table 8 Level of attitudes toward CBR

Level of attitude	Number (122)	Percentage (%)
Attitude toward CBR program:		
- Positive (≥ 28 points)	82	67.21
- Negative (< 28 points)	40	32.79
Min – Max: 20 - 30. Mean ± SD = 27.902 ± 2.330. Median = 28.000		

Attitude toward disabilities

Table 9 presented 13 statements of attitude toward disabilities among caregivers. There were 4 positive statements and 8 negative statements. From 13 questions designed to assess caregiver’s attitude regarding disabilities, it was found that high proportion of respondents (from 90.98 to 100 percent) agreed with positive statements, while the proportion of respondents had disagreement with negative statements was not high. Most of the caregivers disagreed with negative statements with proportion from 54.10 percent to 91.80 percent, whereas only 15.57 percent of them disagreed that life of disabled children is completely depended on their family and community and 26.23 percent disagreed that DC is a burden for families and social.

Table 9 Attitude toward disabilities (n = 122)

Attitude statement	Percentage		
	Agree	**Neutral**	**Disagree**
Negative:			
- Disability is a punishment for sin.	3.28	17.21	79.51
- Not all disabled can rehabilitate.	11.48	18.85	69.67
- DC is a worthless person.	22.13	5.74	72.13
- DC is a burden for families and society.	70.49	3.28	26.23
- Family feels very shameful for having DC.	22.95	1.64	75.41
- DC should be isolated from the family.	8.20	0.82	90.98
- Keep and hide DC in house, do not let anybody know about DC.	5.74	2.46	91.80
- Life of disabled children is completely depended on their family and community	84.43	0	15.57
- Whether the disability is mild or severe, the DCs are unable to attend labour.	36.07	9.83	54.10
Positive:			
- DC are equal to non- disabled children	96.72	1.64	1.64
- DC needs the care and protection from family members and community to integrate with their social.	100	0	0
- Though the progress is slow, DC will gradually function independently in his/her activities daily living.	90.98	7.38	1.64
- DC can enjoy the outdoor activities with other non- disabled children.	94.26	0.82	4.92

Table 10 showed the number and percentage of the level of attitude toward disabilities among caregivers. Respondents were asked 13 questions toward disabilities. The total attitude scores of respondents raged from 21 to 39, with median of 34. It was indicated that the positive attitude toward disability among caregivers was slightly over the negative attitude.

Table 10 Level of attitude toward disabilities

Level of attitude	Number (122)	Percentage (%)
Attitude toward disabilities:		
- Positive (≥ 34 points)	63	51.64
- Negative (< 34 points)	59	48.36
Min – Max: 21 - 39. Mean ± SD = 32.844 ± 3.713. Median = 34.000		

4.3 Motivational supports

Support for caregivers was considered one way to motivate their performance. This section presented characteristics of the two supporting factors, which were considered in this study. It included two factors: maintenance factor (support from family, health volunteers, leaders, and neighbors) and motivation factor (recognized by family, had achieved in helping DC, and feel very proud to enroll CBR program). The number and percentage of caregivers with “yes” answers was shown in table 11 for maintenance factors and 12 for motivation factors.

Table 11 Maintenance supports received by caregivers

Maintenance supports	Number (122)	Percentage (%)
Kinds of support from Family.		
- Encouragement	120	98.36
- Do caregiver's work	119	97.54
Kinds of supports received from HVs		
- Supervision of work	112	91.80
- Instruction on technical skill	114	93.44
Help received from local leaders	92	75.41
Help received from neighbors	106	93.44

Table 12 Motivation factors received by caregivers

Motivation factors	Number (122)	Percentage (%)
Recognized by family	118	96.72
Had achieved in helping DC	112	91.80
Feel very proud to enroll CBR program	117	95.90

Respondents were asked 6 questions regarding the maintenance factors and 3 questions concerning the motivational factors. Table 13 presented motivational factors to motivate caregiver's performance mentioned this research. The total maintenance scores of respondents ranged from 2 to 6 with median of 6, and motivation scores were 2-3, 3 respectively. It indicated that most caregivers received high support, for maintenance factor group (68.03%) was two times more than low support group (31.97%) and motivation factor group (87.70%) was 7 times more than low support group (12.30%).

Table 13 Levels get the motivational supports from CBR program

Motivational supports	Number (122)	Percentage (%)
Maintenance factors		
- High support	83	68.03
- Low support	39	31.97
Min – Max: 2 – 6. Mean ± SD = 5.4344 ± 0.0916. Median = 6		
Motivation factors		
- High support	107	87.70
- Low support	15	12.30
Min – Max: 1 – 3. Mean ± SD = 2.8443 ± 0.0404. Median = 3		

4.4 Sources of information regarding CBR program

The results in table 14 indicated that most of the caregivers (98.36%) obtained information about CBR program. Among them, 91.80% had received information from health volunteers, followed by media (59.02%), hospital or rehabilitation center (40.98), health center (36.89%), and a small proportion of caregivers received information from friends or neighbors.

Concerning the channel of media, about half of the caregivers got information about CBR program from television. One fifth of them got information from radio, and 13.93 percent of the respondents got information from medical magazine or newspaper.

Table 14 Information about CBR program

Variables	Number (122)	Percentage (%)
Received information on CBR program		
Yes	120	98.36
No	2	1.64
Sources of information about CBR*		
Health volunteers of CBR program.	112	91.80
Friends or neighbors.	8	6.56
Health center.	45	36.89
Hospital or rehabilitation center.	50	40.98
Media (specify)	72	59.02
Channel of media*		
Television.	60	49.18
Radio.	25	20.49
Newspaper or medical magazine	17	13.93

*** Multiple answers**

4.5 Performance of caregivers for disabled children under CBR program

The performance of caregivers in CBR program was measured by 4 domains of rehabilitation services including medical rehabilitation, educational rehabilitation, vocational rehabilitation, and social rehabilitation received by their disabled child. In medical rehabilitation divided two sub-domains which were health services and rehabilitation services, however, health services did not calculate on caregiver's performance. Table 15 showed that most of their disabled child (98.36%) received functional rehabilitation. About two thirds of disabled children (67,21% and 66.39%) were received health services and social rehabilitation, respectively. For the educational and vocational services, they were measured through the ability of the disabled children to attend the school (48.36%) and work with family to earn their living (36.07%).

Table 15 Rehabilitation services received by DC

Services*	Number (122)	Percentage (%)
Medical rehabilitation:		
- Health services:	82	67.21
- Functional rehabilitation	120	98.36
Educational rehabilitation	59	48.36
Vocational rehabilitation	44	36.07
Social rehabilitation	81	66.39

*** Multiple answers**

Each domain was calculated 1 score for "yes" answer, and 0 for "no" answer of respondent. The total score of each respondent was summarized of all scores calculated from 4 domains. Table 16 presented the number and percentage of DC's groups who received how many CBR services.

Table 16 Groups of rehabilitation services received by DC

Groups	DC received	
	Number (122)	Percentage (%)
Do not receive at all.	2	1.64
One CBR service	36	29.51
Two CBR services	24	19.67
Three CBR services	20	16.39
Four CBR services	40	32.79

Considering the overall picture of the caregiver's performance in all domains of CBR program, table 17 showed that the performance of the caregivers ranged from 0 to 4 with the mean score of 2.5 and standard deviation 1.2. The proportion of good

performance group with 3- 4 scores (49.18%) and the poor performance group (50.82%) was almost the same.

Table 17 Level of performance of caregivers

Performance	Number (n= 122)	Percentage
- Good (received 3-4 domains)	60	49.18
- Poor (received 0-2 domains)	62	50.82
Min – Max: 0 - 4. Mean ± SD = 2.484 ± 1.281		

Table 18 calculated the kinds of medical rehabilitation received by disabled children. It was found that less than half of DC had received medical services of all kinds. There were 42.62 percent of the disabled children received free examination, 38.52 percent of the disabled children were educated and consulted for medical problems, 36.07 percent of the respondents answered that their child received vaccination . 22.95 percent of the disabled children had recurrent exam.

For rehabilitation services, the proportion of DC who received services were even less than medical services, except for practical skills. More than two thirds of the disabilities (68.85%) received the practical skills. Followed by orthopedic surgery 40.16%, assistant equipment 36.07%, orthopedic devices 13,11%, and 8.20% of DC received money every month from CBR project.

Table 18 Kinds of medical rehabilitation received by DC

Kinds of medical rehabilitation	Yes		No	
	N	%	N	%
Medical services*				
- Vaccination	44	36.07	78	63.93
- Recurrent exam	28	22.95	94	77.05
- Free examination	52	42.62	70	57.38

Table 18 Kinds of medical rehabilitation received by DC (cont.)

Kinds of medical rehabilitation	Yes		No	
	N	%	N	%
Medical services (cont.)				
- Educational and consulting health	47	38.52	75	61.48
Rehabilitation services*				
- Practical skills	84	68.85	38	31.15
- Orthopedic surgery.	49	40.16	73	59.84
- Orthopedic devices	16	13.11	106	86.89
- Assistant equipment	44	36.07	78	63.93
- Others (money from CBR project)	10	8.20	112	91.80

*** Multiple answers**

In table 19 presented the reasons among 122 disabled children that were not received CBR services. Regarding the medical rehabilitation, 14.75% of the caregivers answered that they did not know the place to get services. 13.93% and 9.02% of the respondents said they had no money and had no time to take DC for services. There was one respondent said he does not believe in rehabilitation services.

The reasons for DC had not received educational rehabilitation were mainly due to the limitation on DC part, such as their condition were too severe, they were difficult to attend the class, and were too young (32.39%, 19,67%, and 17.21% respectively). The rests were due to limitation on the caretaker part.

Table 19 showed why DC were not received vocational rehabilitation. 32.79% of the caregivers responded that their child was too young. 28.69% of the disabled children were too severe. 16,39% of the caregivers did not allow DC to work. 4.10% thought unnecessary.

In terms of social rehabilitation, 24.59% of DC with severe disabilities couldn't enjoy social activity. 9.02%, 4.92%, 3.28%, and 0.82% of DC were too

young, no children contact with them, too shy, and no time to take DC to play ground, respectively.

Table 19 Reasons for not receiving CBR services

Services/ Reasons	Yes		No	
	N	%	N	%
1- Medical rehabilitation*				
Medical services				
- No help	10	8.20	112	91.80
- No time	11	9.02	111	90.98
- Unnecessary	8	6.56	114	93.44
- No money to get services	17	13.93	105	86.07
- Don't know the place of services	18	14.75	104	85.25
Functional rehabilitation				
- The caregiver couldn't remember how to do	3	2.46	119	97.54
- Don't believe in rehabilitation services.	1	0.82	121	99.18
2- Educational rehabilitation*				
- Economic status is too difficult	10	8.20	112	91.80
- Difficult for DC to attend the class	24	19.67	98	80.33
- Lack of study equipment	8	6.56	114	93.44
- Afraid of DC is being teased	7	5.74	115	94.26
- The condition of DC is too severe	40	32.79	82	67.21
- Family are not able to take DC to school.	18	14.75	104	85.25
- DC is too young	21	17.21	101	82.79

Table 19 Reasons for not receiving CBR services (cont.)

Services/ Reasons	Yes		No	
	N	%	N	%
3- Vocational rehabilitation*				
- The condition of DC is too severe	35	28.69	87	71.31
- DC is too young	40	32.79	82	67.21
- Family do not allow DC to work	20	16.39	102	83.61
- Unnecessary	5	4.10	117	95.90
4- Social rehabilitation*				
- DC is too shy	4	3.28	118	96.72
- No time to take DC to play ground	1	0.82	121	99.18
- No children contact with DC	6	4.92	116	95.08
- The condition of DC is too severe	30	24.59	92	75.41
- DC is too young	11	9.02	111	90.98

*** Multiple answers**

4.6 Relationship between the independent and dependent variables

Relationship between caregiver's performance and Sociodemographic factors

In order to simplify the statistical analysis, all of the variables of Sociodemographic factors were divided into two groups, such as age divided 2 group based on median (40.500), occupation group separated farmer/fisher group and others. Educational levels were divided into 2 groups: high educational level (high school and over) and low educational level (secondary and down). Relationship group was separated into the group of parents and the group of others. Income group was divided 2 groups based on the Decision of Government regarding poor household, the per capital income had under 200,000 per month was poor group. Working experience was also separated into 2 groups based on mean (38.40). As presented in table 20, it

showed the relationship between caregiver's performance and Sociodemographic factors of respondents.

Regarding age group, the Chi-square value indicated that there was no significant relationship between age group and the performance of caregivers (p-value= 0.270). However, there was a little bit difference from the proportion of old group and young group. It was found that 54.10% of the old group had good performance, as compared with 44.26% of the young group had good performance.
With respect to gender, although the proportion of the male had good performance was more than the good performance within the female group, there was no significant relationship between gender group and the caregiver's performance with p-value = 0.744.

In terms of occupation, farmer/fisher made up the largest proportion and 52.48% of them had good performance, while one third of non farmer group including vender, housewife, and government officer had good performance. However, the Chi-square value (2.549) showed that there was no relationship between occupation and the performance of the caregivers (p-value= 0.110).

Concerning the education level, there was no significant relationship between educational level and the performance of the caregivers with p-value= 0.722, even though high education group (53.85%) was more than low education group (48.32%) in good performance level.

Concerning the other interested variables such as relation, income, experience, and training, the Chi-square test for the relationship between those and the caregiver's performance was not statistically significant with p- value = 0,621, 0.747, 0.585 and 0.616, respectively.

Table 20 Relationship between caregiver's performance and Sociodemographic factors

Sociodemographic factors	Caregiver's Performance					
	Good		Poor		χ^2	P-value
	No	%	No	%	(DF)	
Age						
25 – 40	27	44.26	34	55.74	1.181	0.270
41 - 73	33	54.10	28	45.90	(1)	
Gender						
Female	37	48.05	40	51.95	0.106	0.744
Male	23	51.11	22	48.89	(1)	
Occupation						
Farmer/ Fisher	53	52.48	48	47.52	2.549	0.110
Others	7	33.33	14	66.67	(1)	
Education						
Secondary school down	53	48.32	56	51.38	0.127	0.722
High school and over.	7	53.85	6	46.15	(1)	
Relation						
Father/ Mother	57	48.72	60	51.28	0.244	0.621*
Others	3	60.00	2	40.00	(1)	
Income						
100,000 – 200,000	22	51.16	21	48.84	0.104	0.747
> 200,000	38	48.10	41	51.90	(1)	
Experience						
0 – 40 months	28	46.67	32	53.33	0.298	0.585
>41 months	32	51.61	30	48.39	(1)	
Training						
Yes	15	45.46	18	54.54	0.251	0.616
No	45	50.56	44	49.44	(1)	

*** Fisher's exact test.**

Relationship between caregiver's performance and psychological factors

Relationship between caregiver's performance and knowledge of caregiver on CBR program and disabilities

Table 21 described the relationship between the caregiver's performance and knowledge of respondents on CBR program and disabilities. The study results revealed that there was no significant relationship between the performance of the caregivers and knowledge of caregiver on CBR program with p- value = 0.384, on the contrary, there was a significant relationship between the performance of the respondents and the knowledge of the respondents on disabilities with p-value = 0.029. It showed that the proportion of good knowledge group (73.91 percent) had good performance was very high as compared with poor knowledge group (41.03 percent)

Table 21 Relationship between caregiver's performance and knowledge on CBR program and disabilities

Knowledge	Caregiver's Performance					
	Good		Poor		χ^2	P-value
	No	%	No	%	(DF)	
On CBR program:						
Good	55	50.93	53	49.07	1.916	**0.384***
Moderate	4	44.44	5	55.56	(2)	
Low	1	20.00	4	80.00		
On disabilities:						
Good	17	73.91	6	26.09	7.086	**0.029**
Moderate	27	45.00	33	55.00	(2)	
Low	16	41.03	23	58.97		

*** Fisher's exact test.**

Relationship between caregiver's performance and attitude of caregiver toward CBR program and disabilities

Table 22 presented that the proportion of positive attitude group had good performance was about 2.5 times higher than the negative attitude group did, however, the Chi-square value (2.852) showed that there was no relationship between caregiver's performance and attitude of respondents toward CBR program.

Table 22 also indicated that there was relationship between caregiver's performance and the attitude of respondents toward disabilities with p-value = 0.009. It was presented that the proportion of positive group (57.14%) got good performance was higher than negative group (31.58%).

Table 22 Relationship between caregiver's performance and attitude toward CBR program and disabilities

Attitude	Caregiver's Performance					
	Good		Poor		χ^2 (DF)	P-value
	No	%	No	%		
Toward CBR program:						
Positive	58	51.33	55	48.67	2.825	**0.093***
Negative	2	22.22	7	77.78	(1)	
Toward disabilities:						
Positive	48	57.14	36	42.86	6.841	**0.009**
Negative	12	31.58	26	68.42	(1)	

*** Fisher's exact test.**

Relationship between the caregiver's performance and motivational supports

Table 23 presented the relationship between caregiver's performance and the motivational supports such as maintenance factors and motivation factors.

Table 23 Relationship between caregiver's performance and motivational supports

Motivational supports	Caregiver's Performance					
	Good		Poor		χ^2	P-value
	No	%	No	%	(DF)	
Maintenance factors						
High support. (6 points)	41	49.40	42	50.60	0.005	**0.944**
Low support. (<6 points)	19	48.72	20	51.28	(1)	
Motivation factors						
High support (3 points)	57	53.27	50	46.73	5.827	**0.016**
Low support (< 3 points)	3	20.00	12	80.00	(1)	

The Chi-square value for relationship between the caregiver's performance and maintenance factors was not statistically significant (p-value = 0.944) whereas there was a significant relationship between motivation factors and the performance of the caregivers with p-value = 0.016. It presented that the proportion of the high support group (53.27%) had good performance was about 2.5 times higher than the low support group (20.00%).

Relationship between caregiver's performance and sources of information

Table 24 revealed the relationship between caregiver's performance and received information on CBR program of the respondents, sources of information, and channel of media.

There was no significant relationship between caregiver's performance and received information on CBR program with p-value > 0.05 (Fisher's exact test).

Regarding the sources of received information, the Chi-square test for relationship between sources of information and the performance showed that all of the variables (health volunteers, friend, health center, hospital, and media) were not related with the performance of the caregivers.

Concerning the channel of media, there was no significant relationship between the caregiver's performance and the channel of media received by respondents.

Table 24 Relationship between caregiver's performance and sources of information

Information factors	Caregiver's Performance					
	Good		Poor		χ^2 (DF)	P-value
	No	%	No	%		
Received information on CBR program						
Yes	59	49.17	61	50.83	0.001	1.*
No	1	50.00	1	50.00	(1)	
Source of information about CBR program**						
HVs						
Yes	55	49.11	57	50.89	0.003	0.957
No	5	50.00	5	50.00	(1)	
Friend						
Yes	5	62.50	3	37.50	0.608	0.436*
No	55	48.25	59	51.75	(1)	
HC commune						
Yes	24	53.33	21	46.67	0.492	0.483
No	36	46.75	41	53.25	(1)	

Table 24 Relationship between caregiver's performance and sources of information (cont.)

Information factors	Caregiver's Performance					
	Good		Poor		χ^2	P-value
	No	%	No	%	(DF)	
Hospital						
Yes	25	50.00	25	50.00	0.023	0.880
No	35	48.61	37	51.39	(1)	
Media						
Yes	32	44.44	40	55.56	1.577	0.209
No	28	56.00	22	44.00	(1)	
Channel of media**						
TV						
Yes	28	46.67	32	53.33	0.298	0.585
No	32	51.61	30	48.39	(1)	
Radio						
Yes	10	40.00	15	60.00	1.060	0.303
No	50	51.55	47	48.45	(1)	
Book						
Yes	6	35.29	11	64.71	1.524	0.217
No	54	51.43	51	48.57	(1)	

*** Fisher's exact test.**

**** Multiple answers**

CHAPTER 5
DISCUSSION

The study was to determine the caregiver's performance for disabled children and it's related factors under community based rehabilitation program in Binh Son district, Quang Ngai province. The sample was randomly recruited from the caregiver's list documented at the CPFC office of 11 communes where the CBR program has been implemented for five years. A total of 122 caregivers who have directly participated to CBR program and taken care of disabled children living in study areas were interviewed with 67 questions of 2 parts. The instrument used for data collection was pre-tested before the actual study to ensure the reliability of the study Knowledge and attitude questions were revised to make interviewees more understandable and to fit with capacity of the respondents. EpiData 3.0 software was used to enter the data into computer and Minitab software was run to analysis the data.

5.1 Performance of caregivers

The performance of caregivers was assessed and then divided into two categories, good and poor performance based on how many rehabilitation services DC received. The good performance group which DC received 3-4 rehabilitation services (48.18%) was quite equal with the poor performance group had that DC received only 1-2 rehabilitation services and not received at all (50.82%). Some caregivers who were rated as poor performance were due to the limitation of DC that they were not able to received services.

One third of disabled children (32.79%) had received the whole 4 domains of services, followed by 29.51% of them were gotten 1 domain, 19.67% and 16.39% of respondent answered that their child received 2 or 3 domains, respectively. Only 2 disabled children was not received rehabilitation services at all. The reasons for no

receiving any services were due to caregiver's DC was too severe and they do not believe in rehabilitation services.

Considering each domain of rehabilitation services, the results presented that the percentage of disabled children who received functional rehabilitation (98.36%) was quite high as compared with the result of research of Ho Chi Minh CBR program in 2002 was 86.7%. Out of disabled children who received functional rehabilitation had 68.85% of them received practical skills, followed by orthopedic surgery (40.16%), assistant equipment (36.07%), orthopedic devices (13.11%), and money from CBR project (8.20%).

While less than half of DC who received medical services of all kind was too low as compared with the target of project that all of the disabled children should receive vaccination (compared with 36.07%), recurrent exam (compared with 22.95%), free examination (42.62%), and educational and consulting health (38.52%).

There is a main reason that helps to explain this situation. Before the CBR program had not been implemented in this area, social and family attitude often worsens the situation of people with disabilities. Most of them thought that the disabled have to suffer their situation for all their life and DC's lives quietly depend on the family. They took care of DC with their skills by their own themselves. Disabled children had difficulties accessing health, so the family ignore health care for disabled. After participated with CBR program, their awareness have changed on capability and demands of people with disabilities, but some of the DC passed the age for vaccination. As a consequence, it made them realize that DC need to be taken care by health services and now more and more disabled children were received health services. However, there were still 6.56% of the caregivers answered that it is unnecessary for DC to be received the health services. One fifth of the caregivers did not know the place of services. One third of them were lack of the facilitating condition to help them taking DC to get health services.

For the educational rehabilitation, the study showed that 48.36 percent of disabled children attended the school/ kindergarten. This reflects that the awareness of family as well as society on the “Right of the Child”, especially the children with disabilities were high. Especially, since 2006, the Ministry of Education of Vietnam have promulgated a Decree regarding integrated education for people with disabilities so many DC had a chance to enroll the school.

The reason that DC did not go to school, 51.64% was due to the severity of DC’s condition, followed by being difficult for them to attend the class (19.67%), being too young (17.21%), and family who had not enough facilities to take DC to school (14.75%).

The percentage of DC received educational rehabilitation in this study was quite different from the assessment of Ministry of Health, 2001 which reported the percentage of the disabled children attended school was 56.3% at Quang Tri province and 49% at Vinh Long province. (43)

Regarding the vocational rehabilitation, this study showed that 36.07 percent of DC participated to work with their family to earn their living. Within the scope of this study, disabled children who participated with their family such as field work, looking after domestic animal, or household chores were to attend the vocational rehabilitation. Because, they were not enough age for labor (the labor Law of Vietnam stipulated that age labor is at least 18 years old), furthermore Binh son is a poor district, and lack of a lot of educational conditions so DC have no chance to attend the vocational courses.

Two majority reasons caused DC who could not participated to work with their family were that DC were too severe (28.69%) and too young (32.79%).

In terms of social rehabilitation, two thirds of disabled children attended the outdoor activities with non- disabled children. Outdoor activities were an important action which CBR program concerned. By these activities, the disabled children had a

chance to integrate into the society of children. In other hand, the non- disabled children understood thoroughly and sympathized with the difficult situations of disabled children. It also brought up the humane heart for non- disabled children on disabilities. The percentage of the DC enrolled social activities in this study (66.39%) was quite low as compared with the results of study in Ho Chi Minh city in 2002 (83.8%). The severe condition of DC was a main reason explaining why DC did not enjoy the social activities with non disabled children. DC under 5 years (9.02%) was also a reason that did not allow DC to enjoy the social activities.

5.2 Relationship between caregiver's performance and related factors

Sociodemographic factors

Considering the overall picture of the Sociodemographic factors of caregivers, a total of 122 caregivers, the youngest age was 25 years old and the oldest age was 73 years old, and the mean age was 41.7. Age was divided into 2 groups that were young group (25- 40 years old) and old group (41- 73 years old), and the percentage of caregivers of 2 age groups was quite the same. About two thirds of caregivers was female. Most of them were farmer/ fisher (82.79%), while only 4.92% of caregivers were government officer. Eighty nine percent of caregivers had low educational level (secondary school and down), whereas there were 3.28% of the caregivers graduated college or University. Almost caregivers were DC's parents and thirty five percent of them were poor household with their capita income under 200,000 VND per month. Two thirds of caregivers had joined the CBR program more than 2 years up to 5 years. Out of them, seventy three percent had not been received any training course regarding rehabilitation for disabled children before enrolling the CBR program.

Although there was not related between sociodemographic factors and performance of caregivers, the results were showed some suggestions as follows:

Age over 40 years was considered as having experience in child rearing, motivating skill and seriousness in implementation of the program. In this study, It

was observed that the percentage of old group had good performance was higher than the young group had good performance. In the age group, the percentage of the caregivers had good performance was higher than one had poor performance, contrary to the young group, the percentage of good group was lower than one of poor group.

Educational level also had a little bit difference from high level group and low level group. It was revealed that the caregivers who had high educational level were better performance than those who were low educational level. The caregivers with high education were able to perform their job better. Their ability to acquire awareness and to use it in CBR activities was better than those who had low education.

Similarly, the experience in working with CBR program, the interviewees who serviced for a long time had more experience or skill so they would be able to complete the task more effectively. The results of this study showed that the caregivers who had been working at least 41 months had better performance than those who had been working under 40 months.

Regarding the term of gender, occupation, relationship with DC, income, and training course before, in fact in Vietnamese families, women were responsible to take care of their children, and the caregivers who had a good occupation looked after DC better than those who were farmer/fisher, but this study showed that an opposite result. The caregivers who were DC's parents would pay DC attention more than the caregivers who were DC's relation. In Vietnam, most of the DC suffered their life with their parents but in this study the percentage of parents got good performance was still lower than the percentage of DC's relation did. For income, caregivers who got a high income had a lot of facilitating conditions to take care their children, however, in this study, the percentage of caregivers who had high capita income was lower performance than those who got low capita income. The last one, according to WHO, the training of caregivers plays an important role in achieving high performance, because its aim is to provide these caregivers with the proper knowledge and skills on the promotion, preventive and curative aspect of their job; prepare them

to deal with priority problems in the community and emphasize prevention. However, in this study, more than two thirds of the caregivers did not attend any courses regarding handicap before enrolling CBR program, the percentage of good performance of two groups, training course or no training course before enrolling CBR program was the same.

To explain this situation may be the sample size that was not enough to showed the relationship between caregiver's performance and above factors.

Psychosocial factors

The psychosocial factors were divided into 2 parts: knowledge and attitude of caregivers toward CBR program and disabilities. The results were showed as follows.

Knowledge of caregivers on CBR program and disabilities

Regarding the level of knowledge on CBR program, most of respondents answered right and fell in high knowledge, only one tenth of caregivers were moderate and low knowledge level. It was showed that, the percentage of caregivers who got high knowledge on CBR program in this study was higher as compared with the study in Ben Tre province in 2002 (75.5%), and study in Ho Chi Minh city in 2002 (46.8%). However, there was not related with the performance of caregivers.

For the level of knowledge on disabilities, there was a significant relationship between knowledge and the performance of caregivers with p- value = 0.029. It was suggested that the caregivers with good knowledge have a tendency to perform good performance, since they feel more confident and more motivated to perform their job better if they are equipped with good knowledge in the field in which they deal.

Attitude of caregivers toward CBR program and disabilities

The respondents were asked 23 questions toward CBR program and disabilities. Interviewees had to answer 10 positive questions toward CBR program and 13 questions toward disabilities with 9 negative questions and 4 positive questions. The result presented as follows.

For the attitudes of caregivers toward CBR program, there was not related with the performance of caregivers. Most of caregivers had right answers, except 30.33 % of caregivers disagreed that DC can be rehabilitated at home. More than 30 percent of DC were too severe. These conditions made caregivers feel pessimistic and it was obviously evidenced why the caregivers disagreed with this statement.

However, the percentage of caregivers had positive attitude in this study (67.21%) was quite high as compared with the research in Ben Tre, 2001 (58.5%). Although no relationship with the performance of caregivers (p-value = 0,093), the Chi-square result showed that the caregivers who had positive attitude were prone to perform their job better.

Regarding the attitude of caregivers toward disabilities, there was a significant relationship between caregiver's performance and the attitudes of caregiver toward disabilities with p- value = 0.009. It was suggested that caregivers who tried to find out how to help their DC got positive attitudes so they feel confident and motivated to perform their job better than the caregivers with negative attitude did.

The attitudes toward disabilities showed higher than that of the attitudes toward CBR program.

The positive attitudes toward disabilities among caregivers was slightly over the negative attitudes. This result was also similar to the research studied in Ben Tre in 2002.

Motivational supports

In this study, types of motivational supports for caregivers were divided into 2 types: maintenance factors and motivation factors. Maintenance factors were regarded as support from family, health workers, local leaders, and neighbors.

For the maintenance support, there was no doubt about the importance of caregiver's family support to their work, which played a significant role in caregiver's participation in the common undertaking. Most of respondents in the study areas received support from family in term of emotion such as encouragement to work, and physical like helping to do house work. In terms of more detailed supports from the health volunteers toward caregiver's work, it was well known that supervision plays an important role in strengthening caregiver's performance. As caregivers have limited rehabilitation training and skills they need to be carefully supervised and instructed. The support from health volunteers , therefore, emerged as an important factors influencing caregiver's work as CBR workers. More than 90% caregivers received support from health volunteers to take care their DC at home as enrolling CBR program. This study also indicated that among the kinds of support from the local leaders and neighbors explored in this study. Helping to solve problems and discussing plans or helping from neighbors to implement CBR program were the types of support that caregivers expected to receive. However, the percentage of caregivers who received support from local leaders was lower than other supports. This may be due to the leaders had not enough time to visit caregivers at their family. Another reason, some of the caregivers could not remember when the leader visited.

The result presented that the percentage of caregivers who received high support was 2 times more than those who received low support. Although there was not related between the performance of caregivers and maintenance factors (p- value = 0.944), it was founded that there was slightly difference from the percentage of caregivers had high support and low support in good performance group.

Concerning the motivation factors, since motivation factor is intrinsic on the job factor. It also demonstrated that the caregiver's personnel who has been respected from DC and their family, very proud to enroll CBR program can be let to the better

performance. The results showed that there was a significant relationship between caregiver's performance and motivation factors with p- value = 0.016. It was found that the caregivers who had been fully satisfied by motivation support will perform their jobs of taking care of DC better than the other caregivers who had low support. This finding was supported by Kasemsine S (44) who said that the person's action will occur as long as he has satisfied on the jobs, because the job satisfaction activates strength in a lead person moving his behavior in the correct direction to reach the settled goal.

Sources of information about CBR program

Most of the caregivers received information about CBR program, and the results also presented that the caregiver who received information about CBR program had better performance than those who did not receive information, however, there was not related between the performance of caregiver and the received information on CBR program.

Regarding the sources of information and channel of media, the results showed that almost caregivers received information from health volunteers of CBR program. More than half of the respondents got information from media. Out of them, there was half of the caregivers received information from television. The performance of caregivers was not related with source of information and channel of media with p- value >0.05. On the other hand, the results were found that the caregivers who got information on CBR program from most of the sources had good performance more than those who did not get any information from these sources, except from media. Similarly the contradictory between good performance group got information and one did get information from media, all of variables regarding the channel of media were not related with the performance of caregiver. This may be explain that some respondent misunderstood the questions so they will get confused. On other the hand, the simple size was too small so that it could not find out this relationship.

CHAPTER 6
CONCLUSION AND RECOMMMENDATION

6.1 Conclusion

Based on the findings of this study and its interpretation, the conclusion could be made in accordance with the specific objectives as follows:

Characteristics of caregivers

The study was conducted among the respondents with mean age 41.7 and ranging from 25 to 73 years old. Out of them, more women caregivers were than men. Like other poor areas in Vietnam, most of the caregivers were farmer or fisher and had low education. For the children with disabilities, parents take the primary responsibility of providing day- to- day care for them. One thirds of caregivers were poor household. Two thirds of caregivers had joined the CBR program more than 2 years up to 5 years and 72.95% of them have not received any training course regarding rehabilitation for disabled children before enrolling the CBR program.

The majority of the caregivers had high knowledge on CBR program, on the contrary of the disabilities only one fifth of the caregivers had good knowledge on disabilities. More than half of the respondents had positive attitude toward CBR program and disabilities.

Most of the caregivers have been supported from their family, health volunteers. Local leaders and neighbors, and respected from DC and their family to motivate their performance. They have felt very proud to enroll CBR program can be let to the better performance.

Ninety eight percent of the caregivers obtained information about CBR program. Ninety two percent of them got information from health worker source. More than half of the respondents got information from media source, half percent of them got information from TV channel.

Performance of caregivers

The performance of caregivers in this study was measured by 4 rehabilitation services received by their disabled child. The percentage of good performance caregivers whose child received 3 to 4 rehabilitation services was almost similar to the caregivers who had poor performance but for those caregivers who were rated as poor performance were due to the limitation on the part of DC that they were not able to received services.

Relationship between caregiver's performance and it's related factors

This study also revealed that performance of caregivers had relationships with some factors among the factors concerned in this study. From the specific objectives set up at the beginning of the study, it can be concluded as follows:

- Sociodemographic factors were not related to the performance of the caregivers.
- The caregivers who had good knowledge and attitude toward disabilities showed better performance than those who had poor knowledge and attitude toward disabilities. However, there found no relation between caregiver's performance and knowledge and attitude of caregivers toward CBR program.
- Motivation factors is a significant factors to motivate the caregivers to perform their jobs. On the other hand, the results could not find out the relationship between maintenance factors and the performance of caregivers.
- Most of caregivers received information on CBR program but it is not different from the group with good performance and poor performance.

6.2 Recommendation

Based on the findings and observation of this study, the suggested recommendation are as follows:

Recommendations

In order to increase the performance of caregivers in carrying out CBR program, the followings actions which are based on study results should be undertaken, since knowledge and attitudes toward disabilities is important for caregivers to perform their work in taking care of DC; therefore,

- Continuing educational programs for caregivers should be conducted regularly to improve their knowledge and attitudes toward disabilities. Projects have to train and re- fresh training every 3 months for caregivers.

- At each communes, monthly meeting among caregivers should be conducted. By this way, the caregivers have a chance to feedback officially the difficulties they met and share their experiences. It will provide the opportunity to strengthen the confident and interested of caregivers to take care for DC. On this occasion, knowledge and attitudes on the disabilities can be reminded by reading disabilities materials and the problems and experiences can be shared and exchanged among the caregivers.

- Making a closed linkage between institution based rehabilitation, community based rehabilitation and family based rehabilitation. By this way, caregivers can be more facilitated and easily accessed to the facilities.

- The supports from family, health volunteers, local leaders, and community to motivate the caregiver's role in order to take better care of DC should be encouraged through the activities of CBR. Evaluation and reward for

caregiver's promotion for the achievement of caregivers in taking care of DC should be one approach.

- The community should also enhance public awareness on capability and demands of people with disabilities positively by involve the DC in all community's activities.

Recommendation for further research

As the performance of the caregivers in this study has been found to be not so high as expected. There may be many factors affecting their performance, while the statistical tests could not determine which ones are the most powerful in predicting the performance of the caregivers. Moreover, some drawbacks such as small sample size, lack of time, and no data about DC's conditions before attending the CBR program could be covered in this study. Therefore, it suggested that:

- A similar research with a larger sample size and employing techniques of both quantitative and qualitative approaches that mentioned above to overcome the limitations of this study is recommended.

- Future research will estimate the quality services received by DC, and how well or badly caregivers help the DC received.

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APPENDIX

APPENDIX A

QUESTIONNAIRES

CAREGIVER'S PERFORMANCE FOR DISABLED CHILDREN AND IT'S RELATED FACTORS UNDER COMMUNITY BASED REHABILITATION PROGRAM IN BINH SON DISTRICT QUANG NGAI PROVINCE VIETNAM

Please make sure that every question is filled in the blank or put the mark (√) in the box (☐) which the respondent chooses.

Name of the respondent: ……..Number:……

Date of interview: ……../January /2008

Name of interviewer:……..

Name of disabled children……..... ☐ (1) Male ☐ (2) Female.

Place: …….Village……...Commune, BinhSon District, Quang Ngai

Part 1: Characteristics of caregivers

Section 1: Sociodemographic factors of caregiver

1- Age: years.

2- Gender: ☐ Male ☐ Female

3- What is your main occupation?

☐ (1) Farmer/ fisher. ☐ (4) Business

☐ (2) Vender. ☐ (5) Government Officer

☐ (3) Housewife ☐ (6) Others (specify)

4- What is your education status?

☐ (1) Illiterate. ☐ (4) High school.

☐ (2) Primary school. ☐ (5) College or University

☐ (3) Secondary school. ☐ (6) Others (specify)

5- What is your relationship with the CWD?

☐ (1) Father/ mother. ☐ (4) Grand father/mother

☐ (2) Relatives. ☐ (5) Others (specify).

☐ (3) Sibling

6- How much is the per capita income per month?.....VND

7- How long have you been working with the CBR program?..... Years/months

8- Before attended the CBR program, have you ever had any training courses regarding rehabilitation for disabled people?

☐ (1) Yes ☐ (2) No

Section 2: Psychological factors of caregiver

Knowledge of caregiver on CBR program

No	Statement	Yes	Not sure	No
9	Rehabilitation for DC is a long process and takes a lot of time.			
10	CBR program gives DC a chance to integrate with their community			
11	CBR program is available to help DC to be rehabilitated at home and community.			
12	DC's families and communities can be trained by activities of CBR program to improve their knowledge, attitudes and skills to take care of DC.			
13	Everybody in the community can participate in			

	the CBR program to help DC.			

Knowledge of caregiver on disabilities

No	Statement	Yes	Not sure	No
14	You know about disabled condition of your child			
15	Poverty is a main reason to cause the disabilities			
16	Unhealthy, and unsafe living environment are easy to cause the disabilities.			
17	Early detection and intervention is the best way to reduce the severe complication of disability.			
18	Each kind of disabilities has a particular method of rehabilitation.			
19	Early rehabilitation is the best way to restore the impaired organ.			
20	If rehabilitated everyday, DC can function more independently in their activities daily living.			

Attitude of caregivers toward CBR program

No	Statement	Agree	Neutral	Disagree
21	CBR program is convenience for DC living in rural areas			
22	CBR enable the family's member's willing to take care of DC.			
23	With supports of CBR DC can rehabilitate at home.			
24	CBR program helps DC's Families to save money and time for taking care of DC.			

25	DC can be benefited from CBR program by having opportunities to integrate into the society.			
26	CBR program is a straightforward way to know how to take care of DC.			
27	CBR program help DC to have a chance to participate in social activities, such as going to school and attending labor with family.			
28	The progress of CBR can make families feel happy even if it is very slow or little.			
29	CBR makes public awareness on capabilities and demands of people with disabilities changed positively.			
30	DC can be supported by CBR program is more convenient than central hospital			

Attitude of caregivers toward disabilities

No	Statement	Agree	Neutral	Disagree
31	Disability is a punishment for sin.			
32	Not all disabled can rehabilitate.			
33	DC is a worthless person.			
34	DC is a burden for families and society.			
35	Family feels very shameful for having DC.			
36	DC should be isolated from the family			
37	Keep and hide DC in house, do not let anybody know about DC.			
38	DC are equal to non- disabled children			
39	Life of disabled children is completely depended on their family and community			
40	DC need the care and protection from family members and community to integrate with			

	their society.			
41	Though the progress is slow, DC will gradually function independently in his/her activities daily living			
42	Whether the disability is mild or severe, the DC are unable to attend labor.			
43	DC can enjoy the outdoor activities with other non- disabled children.			

Section 3: Motivational supports

Maintenance factors

44- Did your family encourage you to take care of disabled child?

(1) Yes (2) No

45- Did family's members help you to do your work when you are taking care of DC?

(1) Yes (2) No

46- Did Health workers supervise your work?

(1) Yes (2) No

47- Did Health workers instruct any technical skills when they visited you?

(1) Yes (2) No

48- Did the local leaders help you to solve the problem regarding CBR program?

(1) Yes (2) No

49- Are neighbors glad to help you on attending the CBR program?

(1) Yes (2) No

Motivation factors.

50- You feel that your assistance to DC is recognized by your family and social.

(1) Yes (2) No

51- You feel that you had achieved in helping DC to recover.

(1) Yes (2) No

52- You feel very proud of yourself to be able to do CPR program work for the DC in family and social.

(1) Yes (2) No

Section 4: Performance of caregivers for disabled children under CBR program

Medical rehabilitation

53- Has your DC received health care services from CBR since last year?

☐ (1) Yes

☐ (2) No *(If No, go to question 55 for answering.)*

54- If yes, what kind of the health care services did your DC received? *(multiple answers)*

☐ (1) Vaccination.

☐ (2) Recurrent exam.

☐ (3) Free examination and treatment at health centers.

☐ (4) Educational and consulting health

☐ (5) Others (specify).

55- If no, why? *(multiple answers)*

☐ (1) Nobody to help.

☐ (2) No time

☐ (3) Unnecessary

☐ (4) No money for services.

☐ (5) Don't know where DC are supported

☐ (6) Others (specify).

56- Has your DC been received the rehabilitation services from CBR since last year?

☐ (1) Yes

☐ (2) No *(If no, jump to question 58 for answering.)*

57- If yes, what kind of rehabilitation services did your DC obtain? *(multiple answers)*

☐ (1) Practice the skills every day

☐ (2) Orthopedic surgeon.

☐ (3) Orthopedic devices.

☐ (4) Assistant equipment

☐ (5) Others (specify).

58- If no, why not? *(multiple answers)*

☐ (1) Couldn't remember how to do.

☐ (2) Don't believe these simple techniques will be effect.

☐ (3) No time

☐ (4) The condition of DC is too severe.

☐ (5) Others (specify).

Education rehabilitation

59- Has your CWD gone to school/ kindergarten/ nursery so far?

☐ (1) Yes

☐ (2) No

60- If no, why not? *(multiple answers)*

☐ (1) Economic status is too difficult.

☐ (2) Difficult for DC to access the class.

☐ (3) There is not enough study- equipment

☐ (4) Afraid of DC is being teased

☐ (5) The condition of DC is too severe.

☐ (6) Family are not able to take DC to school..

☐ (7) DC are too young (Under 6 years old.)

☐ (8) Others (specify).

Vocational rehabilitation

61-CBR provided work for CD to earn money?

☐ (1) Yes

☐ (2) No

62- If no, why not? *(multiple answers)*

☐ (1) The disabled condition of DC is too severe.

☐ (2) Too young (Under 10 years old)

☐ (3) Don't allow them to work (think that they cannot work)

☐ (4) Not necessary.

☐ (5) Others (specify).

Social rehabilitation

63- Has DC attended the outdoor activities for children since last year?

☐ (1) Yes

☐ (2) No

64- If no, why not? *(multiple answers)*

☐ (1) DC is too shy.

☐ (2) There is no time to take DC to play ground.

☐ (3) No children contact with his/her.

☐ (4) The disabled condition of DC is too severe.

☐ (5) DC are too young (Under 5 years old)

☐ (6) Others (specify).

Section 5: Sources of information about CBR program.

65- Have you ever got any information about CBR program?

☐ (1) Yes,

☐ (2) No. *(If no, thank you and stop to interview)*

66- If yes, where did you get the information of CBR program from? *(multiple answers)*

☐ (1) Health workers of CBR program.

☐ (2) Friends or neighbors.

☐ (3) Health center.

☐ (4) Hospital or rehabilitation center.

☐ (5) Media (specify)

☐ (6) Others.

67- By which channel did you get the information of CBR program?

☐ (1) Television.

☐ (2) Radio.

☐ (3) Newspaper or hand book

☐ (4) Others

Thank you very much for your co-operation.

BIOGRAPHY

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