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Original Research Article

Childhood asthma and quality of life: insights from ICMH, Dhaka

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ABSTRACT

Background: Asthma is a significant global health issue affecting both children and adults, negatively impacting various aspects of quality of life. In Bangladesh, one in thirteen children suffers from asthma, which hampers their daily activities. This study aimed to assess the health-related quality of life (HRQoL) in children with asthma.
Methods: A descriptive cross-sectional study was conducted among 116 children with asthma, aged 7−17 years, at the Institute of Child and Mother Health, Matuail, Dhaka, Bangladesh in 2020. Data were collected using the Pediatric Asthma Quality of Life Questionnaire (PAQLQ) through direct interviews with children, supplemented with sociodemographic information and incomplete responses from parents. Statistical analysis was performed using SPSS version 26.0.
Results: The overall PAQLQ score ranged from 2.48 to 6.52, with an average of 5.2. The greatest impairment was observed in the domain of 'Activity Limitation' (mean=3.6259), followed by 'Emotional Function' and 'Symptoms.' HRQoL decreased as asthma severity increased with age (r=-0.341, p=0.001). Uncontrolled asthma was associated with the lowest HRQoL scores (p=0.001) and a longer duration of suffering further impacted the PAQLQ score negatively.
Conclusions: Childhood asthma significantly reduces quality of life, as indicated by statistical findings. PAQLQ can serve as a valuable tool for routine assessment in clinical practice. Training asthma educators at district and upazila-level hospitals could improve HRQoL evaluation and management for children with asthma in Bangladesh.

Keywords: Childhood asthma, Children, Quality of life

INTRODUCTION

Quality of life reflects an individual's satisfaction, influenced by social, religious and personal values (WHOQOL).[1] It is influenced by economic, physical, psychological and social factors, which impact health and well-being.[2] HRQoL measures how illness affects a patient's self-assessed well-being, considering functional impairments and treatment outcomes.[3] Patient-reported outcomes (PROs) provide firsthand insight into health experiences without external interpretation.[4] Asthma, a chronic respiratory disease, affects over 250 million people globally, with cases expected to rise further in the coming years.[5] In Bangladesh, asthma prevalence is significant, particularly among children, with rates as high as 11.8% in coastal regions.[6] Asthma affects healthcare costs, school attendance and QoL. Since traditional measures don't fully reflect its impact, HRQoL assessments are crucial.[2] The study aims to assess the HRQoL in children with asthma attending the Institute of Child and Mother Health (ICMH). Specifically, it seeks to evaluate HRQoL using the PAQLQ, analyze patient-related factors, determine disease-related influences and identify the socio-demographic characteristics of the respondents.

METHODS

Study design

This study was designed as a descriptive cross-sectional investigation to achieve its specific objectives.

Study duration

Originally planned for January–December 2020, the study was extended to January 2021 due to the COVID-19 pandemic.

Study place

Conducted at the Institute of Child and Mother Health (ICMH), Matuail, Dhaka-1362, a premier center for child and maternal healthcare.

Study population, respondents and selection criteria

The study included children aged 7–17 years diagnosed with asthma and receiving care at the ICMH. Children were the primary respondents for the PAQLQ, while parents provided sociodemographic details and supplemented incomplete data. Inclusion was not restricted by sex, but severely ill patients and those with both asthma and COPD were excluded. Parental consent was required for participation.

Sample size calculation

The sample size was calculated using the formula $n=z^2pq/d^2$, where Z (1.96) represents a 95% confidence level, P (7.3%) is the estimated prevalence of childhood asthma in Bangladesh and d (0.05) is the precision level.[6] The calculation yielded 104 subjects, adjusted to 116 to account for a 10% non-response rate.

Sampling, data collection and analysis

Participants were selected using a convenience non-probability sampling method based on inclusion and exclusion criteria. Data were collected via a pre-tested semi-structured questionnaire, with the PAQLQ as the primary tool, translated into Bengali for accessibility. Parents provided consent and respondents' assent was obtained. Pediatric asthma data were collected from children, while sociodemographic details came from parents through face-to-face interviews, ensuring confidentiality. Quality control included post-interview reviews, data processing, coding and analysis using SPSS 26.0, employing descriptive and inferential statistics.

Ethical consideration

The study followed ethical guidelines, securing IRB clearance, permission and informed consent in Bengali, ensuring anonymity and confidentiality

RESULTS

Socio-demographic characteristics

Age of the respondents

Out of 116 children, 72 (62.1%) respondents were in the 7-10 years age group, 33 (28.4%) were in the 11-13 years age group and 11 (9.5%) were in the 14-17 years age group. The mean (±SD) age of the respondents was 9.9±2.353 years.

Sex of the respondents

The sex distribution of the respondents revealed that 60 individuals (51.72%) were male, while 56 individuals (48.28%) were female, resulting in a male-to-female ratio of 1:0.93.

Father's educational qualification

Among respondents' fathers, 55 (47.41%) had completed higher secondary or beyond, while 38 (32.76%) had secondary education. Additionally, 20 (17.24%) had primary education, 1 (0.86%) had studied below primary and 2 (1.72%) had no formal schooling.

Mother's educational qualification

Among respondents' mothers, 63 (54.31%) had completed higher secondary or above, while 25 (21.55%) had secondary education. Additionally, 20 (17.24%) had primary education, 4 (3.45%) had studied below primary and 4 (3.45%) had no formal schooling.

Father's occupation

Among the respondents' fathers, 28 (24.14%) were engaged in farming or day labor, while 29 (25.0%) held service jobs. A significant portion, 50 (43.1%), were involved in business and 9 (7.76%) pursued other occupations.

Monthly family income

Among the respondents' families, 54 (46.55%) had a monthly income between 10,000 and 20,000 Taka, while 62 (53.45%) earned above 20,000 Taka.

Presence of pet at home

Of the 116 respondents, 73 (62.9%) reported having a pet at home, while 43 (37.1%) indicated that they did not have any pets.

Passive smoking history

Among all respondents, 82 (70.7%) reported passive smoking exposure from their father, 14 (12.1%) from

another individual, while 20 (17.2%) reported no history of passive smoking exposure.

Family history of asthma

Among 116 respondents, 76 (65.5%) had a family history of asthma, while 40 (34.5%) did not.

Information related to asthma patient and asthma

Age of asthma diagnosis

The onset of asthma among respondents ranged from 3 to 9 years, with a mean age of 5.13±1.275 years.

Duration of asthma suffering

Asthma duration among respondents ranged from 1 to 12 years, with a mean of 4.77±2.493 years.

Hospitalization history

Among respondents, 68 (58.6%) had no asthma-related hospitalizations, 47 (40.5%) were hospitalized 1-2 times and 1 (0.9%) was hospitalized 4 times.

School absenteeism history

Among 116 respondents, 102 (87.93%) experienced school absenteeism due to asthma, while 14 (12.07%) did not.

History of other chronic illnesses

Among all respondents, 63 (54.3%) had no other chronic illness. Allergy was present in 29 (25%), respiratory tract infection in 9 (7.8%), protein-energy malnutrition in 7 (6.0%), gastroesophageal reflux disease in 3 (2.6%), cardiovascular disease in 3 (2.6%), diabetes mellitus in 1 (0.9%) and obesity in 1 (0.9%).

History of correct nebulization/inhaler use

All respondents had a history of nebulization/inhaler use. Among them, 92 (79.31%) used it correctly, while 24 (20.69%) used it incorrectly.

Drugs used in asthma control

Among respondents, 87.1% were using leukotriene receptor antagonists, followed by 52.6% on short-acting β2 agonists, 10.3% on systemic steroids, 8.6% on inhaled corticosteroids, 6.9% on long-acting β2 agonists and 5.2% on antihistamines.

Drug side effects

Among 116 respondents, 75 (64.7%) had no history of drug side effects. Reported side effects included sleepiness (11, 9.5%), palpitation (10, 8.6%), nausea/vomiting (8, 6.9%), tremor (6, 5.2%), throat irritation (3, 2.6%), dry mouth (1, 0.9%), headache (1, 0.9%) and other effects (1, 0.9%).

Presence of stressful conditions

Among 116 respondents, 87 (75%) had no history of stressful conditions, while 29 (25%) reported experiencing stress.

Level of asthma symptom control

Based on the GINA 2020 guidelines, 61 (52.59%) respondents had partly controlled asthma, 33 (28.45%) were well controlled and 22 (18.97%) were uncontrolled.

Number of consultations needed per asthma attack

Among respondents, 98 (84.5%) required only one consultation per asthma attack, while 18 (15.5%) needed multiple consultations.

Difficulty in consultation

Among respondents, 92 (79.3%) reported no difficulty in consultation, while 15 (12.9%) cited cost and 7 (6%) cited distance as barriers.

Information related to pediatric asthma quality of life

Table 1 shows the overall PAQLQ score ranged from 2.48 to 6.52, with a mean±SD of 5.2001±0.77028.

Activity limitation

1.20 to 6.20, mean 3.6259±1.11917.

Emotional function

2.63 to 7.00, mean 5.8006±0.74326.

Symptoms

2.70 to 6.60, mean 5.5069±0.71173.

Socio-demographic characteristics and pediatric asthma quality of life

Age and pediatric asthma quality of life

There was a decline in overall PAQLQ score with increasing age. A significant weak negative correlation was observed between age and PAQLQ score (r=-0.292, p=0.001).

Father's educational qualification and pediatric asthma quality of life

Table 2 shows a statistically significant association (p=0.001) between father's educational qualification and PAQLQ score.

The highest mean PAQLQ score was observed among respondents whose fathers completed secondary school (5.4531±0.61401), followed by those with higher secondary and above (5.2933±0.73942).

Table 1: Distribution of respondents by pediatric asthma quality of life (n=116).

	Overall PAQLQ score	Score activity limitation	Score symptom	Score emotional function
N valid	116	116	116	116
Mean	5.2001	3.6259	5.5069	5.8006
Standard deviation	0.77028	1.11917	0.71173	0.74326
Range	4.04	5.00	3.90	4.38
Minimum	2.48	1.20	2.70	2.63
Maximum	6.52	6.20	6.60	7.00

Table 2: Father's educational qualification and pediatric asthma quality of life (n=116).

Father's educational qualification		N	Mean	Standard deviation	Statistics
Overall PAQLQ score	No formal schooling	2	4.2609	0.24595	F=6.274, p=0.001
	Below primary	1	4.3913	0.00	
	Primary school completed	20	4.5978	0.79858	
	Secondary school completed	38	5.4531	0.61401	
	Higher secondary and above	55	5.2933	0.73942	
	Total	116	5.200	0.77028	

Table 3: Mother's educational qualification and pediatric asthma quality of life (n=116).

Mother's educational qualification		N	Mean	Standard Deviation	Statistics
Overall PAQLQ score	No formal schooling	4	4.2391	0.61743	F=2.982, p=0.022
	Below primary	4	4.7391	0.59296	
	Primary school completed	20	4.9870	0.83800	
	Secondary school completed	25	5.3478	0.64354	
	Higher secondary and above	63	5.2995	0.76340	
	Total	116	5.2001	0.77028	

Table 4: Hospitalization history and pediatric asthma quality of life (n=116).

	H/O hospitalization due to asthma	N	Mean	Standard deviation	t test	P value
Overall PAQLQ score	No	68	5.2084	0.67572	0.137	0.033
	Yes	48	5.1884	0.89479		
	Total	116				

Table 5: Other chronic illness history and pediatric asthma quality of life (n=116).

	H/O other chronic illness	N	Mean	Standard deviation	t test	P value
Overall PAQLQ score	No	63	5.3533	0.68556	2.382	0.022
	Yes	53	5.0180	0.83041		
	Total	116				

Table 6: Asthma medication side effects history and pediatric asthma quality of life (n=116).

	H/O side effects of asthma medications	N	Mean	Standard deviation	t test	P value
Overall PAQLQ score	No	75	5.3780	0.64891	3.526	0.001
	Yes	41	4.8749	0.87126		
	Total	116				

Mother's educational qualification and pediatric asthma quality of life

Table 3 shows a statistically significant association (P=0.022) between mother's educational qualification and PAQLQ score. The highest mean PAQLQ score was observed among respondents whose mothers completed secondary school (5.3478±0.64354), followed by those with higher secondary and above education (5.2995±0.76340).

Asthma patient, asthma and pediatric asthma quality of life

Duration of suffering and pediatric asthma quality of life

A decline in overall PAQLQ score with increasing duration of suffering was noted in this study. A significant weak negative correlation was observed (r=-0.341, p=0.001).

Hospitalization history and pediatric asthma quality of life

Table 4 shows the mean PAQLQ score was higher among respondents with no hospitalization history (5.2084±0.67572) compared to those with hospitalization history (5.1884±0.89479).

Other chronic illness history and pediatric asthma quality of life

Table 5 shows a statistically significant difference (p=0.022) in PAQLQ scores based on chronic illness history. The mean PAQLQ score was higher in respondents without chronic illness (5.3533±0.68556) compared to those with chronic illness (5.0180±0.83041).

Inhaler technique and pediatric asthma quality of life

A significant moderate positive correlation (r=0.667, p=0.001) was observed between inhaler use technique and overall PAQLQ score, indicating better technique was associated with higher quality of life.

Asthma medication side effects and pediatric asthma quality of life

Table 6 shows a statistically significant difference (p=0.001) in PAQLQ scores based on medication side effects history. The mean PAQLQ score was higher in respondents without medication side effects (5.3780±0.64891) compared to those with side effects (4.8749±0.87126).

Stressful conditions and pediatric asthma quality of life

Table 7 shows a statistically significant difference (p=0.001) in PAQLQ scores based on stressful conditions. The mean PAQLQ score was higher in respondents without stressful conditions (5.3948±0.56837) compared to those experiencing stress (4.6162±0.98682).

Level of asthma symptom control and pediatric asthma quality of life

Table 8 shows a statistically significant association (P=0.001) between asthma symptom control and PAQLQ score. The highest mean PAQLQ score was observed in well-controlled asthma (5.9433±0.32978), followed by partly controlled (5.2858±0.18179) and uncontrolled asthma (3.8478±0.42889).

Number of consultations and pediatric asthma quality of life

A significant moderate negative correlation (r=-0.656, p=0.001) was observed, indicating that as the number of consultations increased, PAQLQ scores decreased.

Difficulty in consultation and pediatric asthma quality of life

The mean PAQLQ score was higher among respondents without consultation difficulties (5.3918±0.64335) compared to those with difficulties (4.4656±0.78685). The difference was statistically significant (p=0.013; t=5.989).

Difficulty in obtaining Necessary Drugs and Pediatric Asthma Quality of Life

The mean PAQLQ score was higher among respondents without difficulties in obtaining necessary drugs (5.4119±0.69711) compared to those facing difficulties (4.9956±0.78778). The difference was statistically significant (p=0.009; t=3.010).

Table 7: Stressful conditions and pediatric asthma quality of life (n=116).

	Do you have any anxiety or stressful conditions	N	Mean	Standard deviation	t test	P value
Overall PAQLQ score	No	87	5.3948	0.56837	5.226	0.001
	Yes	29	4.6162	0.98682		
	Total	116				

Table 8: Level of asthma symptom control and pediatric asthma quality of life (n=116).

Level of asthma symptom control		N	Mean	Standard deviation	Statistics
Overall PAQLQ score	Uncontrolled	22	3.8478	0.42889	F=356.889, p=0.001
	Partly controlled	61	5.2858	0.18179	
	Well controlled	33	5.9433	0.32978	
	Total	116	5.2001	0.77028	

DISCUSSION

The study examined 116 children with asthma across three age groups (7-10, 11-13 and 14-17 years), with a mean age of 9.9±2.353 years. Most participants (62.1%) were aged 7-10. A significant weak negative correlation was found between age and PAQLQ scores (r=-0.292, p=0.001), with older children reporting lower QoL. Similar findings were reported in studies from Egypt and Serbia, where older children experienced greater activity limitations and exposure to environmental triggers.[7] Younger children adapted better by selecting less restrictive activities. However, studies from Jordan, the U.S., Germany and Sweden found lower QoL in younger children, suggesting adolescents may better manage their condition due to cognitive and emotional development.[7] The male-to-female ratio in this study was 1:0.93. Sarker et al found a male predominance among schoolchildren in Dhaka, likely due to convenience sampling.[6]

The association between paternal education and PAQLQ scores was statistically significant (p=0.001). The highest mean PAQLQ score was observed in children of fathers who completed secondary school (5.4531±0.61401), followed by those with higher secondary education and above (5.2933±0.73942).[6] The association between maternal education and PAQLQ scores was statistically significant (p=0.022). The highest mean PAQLQ score was observed in children of mothers who completed secondary school (5.3478±0.64354), followed by those with higher secondary education and above (5.2995±0.76340). Higher caregiver education may enhance awareness and coping strategies, leading to improved QoL in children.[7] Parental occupation showed no significant association with overall PAQLQ scores.[6]

This study found no significant association between family income and overall PAQLQ scores. However, higher income enhances access to treatment and healthcare, contributing to better QoL and psychological well-being. Previous studies have reported a positive correlation between high family income and QoL scores.[7] Among 116 respondents, 76 (65.5%) had a family history of asthma, while 40 (34.5%) did not. Similarly, a study by Hassan et al, in Bangladesh reported that 52% of respondents had a family history of asthma.[6] The study found that asthma onset ranged from 3 to 9 years (mean 5.13±1.275 years), while duration ranged from 1 to 12 years (mean 4.77±2.493 years). Longer disease duration negatively impacted overall PAQLQ scores, with a significant weak negative correlation (r=-0.341, p=0.001). This may reflect older patients' concerns about their future and activity limitations due to chronic illness, aligning with studies in Israel and Egypt. However, other studies found that prolonged asthma duration in adults correlated with higher QoL scores.[7] Hospital admission for asthma is primarily required for poorly controlled cases with frequent symptoms, leading to lower QoL scores. The mean PAQLQ score was higher in those without hospitalization history (5.2084±0.67572) compared to hospitalized cases (5.1884±0.89479), with a statistically significant difference (p=0.033). Similar studies in Egypt and Australia found a negative association between QoL in adults with asthma and hospital admissions.[7]

Most respondents (87.93%) reported school absenteeism due to asthma attacks, though no significant association was found with overall PAQLQ scores. However, previous studies in the United States and Egypt linked school absenteeism to lower QoL scores among asthmatic children and adolescents.[7] The mean PAQLQ score was higher in those without chronic illness (5.3533±0.68556) compared to those with a history of chronic illness (5.0180±0.83041), with a statistically significant difference (p=0.033). However, Al-Gewely et al found that associated chronic illnesses or obesity did not significantly impact QoL scores.[7]

Incorrect inhaler use (20.31%) correlated with poor asthma control, while correct usage was associated with higher PAQLQ scores (r=0.667, p=0.001). Similar studies in Muscat and Saudi Arabia linked poor technique to worsened asthma, emphasizing the need for education and reassessment.[8]

Respondents used varieties of drugs such as leukotriene receptor antagonists (87.1%), short-acting β2 agonists (52.6%), systemic steroids (10.3%), inhaled corticosteroids (8.6%), long-acting β2 agonists (6.9%) and antihistamines (5.2%). While 64.7% reported no side effects, others experienced sleepiness (9.5%), palpitations (8.6%), nausea/vomiting (6.9%), tremors (5.2%), throat irritation (2.6%), dry mouth (0.9%), headache (0.9%) and other effects (0.9%). PAQLQ scores were higher among those without medication side effects (5.3780±0.64891) than those with side effects (4.8749±0.87126) (p=0.001), consistent with findings by Alubisia et al.[8]

Among 116 respondents, 87 (75%) reported no stressful conditions, while 29 (25%) experienced stress related to study load, examinations and family conflicts. The mean

PAQLQ score was higher in those without stress (5.3948±0.56837) compared to those with stress (4.6162±0.98682), with a statistically significant difference (p=0.001). Similar findings were reported in previous studies.[8] Asthma management now prioritizes clinical control over severity. Among 116 respondents, 52.59% had partly controlled asthma, 28.45% well controlled and 18.97% uncontrolled. PAQLQ scores were highest in well-controlled cases (5.9433) and lowest in uncontrolled cases (3.8478), showing a significant association (p=0.001). Uncontrolled asthma caused frequent symptoms, activity limitations and anxiety, aligning with studies in Italy, Egypt and the U.S.[7]

Among 116 respondents, 84.5% needed one consultation per attack, while 15.5% required multiple. A significant negative correlation was found between consultation frequency and PAQLQ score (r=-0.656, p=0.001).[7] Out of 116 respondents, 79.3% reported no difficulties with consultations, whereas 12.9% faced financial barriers and 6% cited distance as a challenge. PAQLQ scores were notably higher among those without obstacles (5.3918) compared to those experiencing difficulties (4.4656, p=0.013).[7] 79.3% of the respondents had no consultation difficulties, while 12.9% faced cost barriers and 6% cited distance. PAQLQ scores were significantly higher in those without challenges (5.3918) than in those with difficulties (4.4656, p=0.013).[7]

Activity limitation was the most affected quality-of-life domain, as reported by Al-Akour et al and Farnik et al.[9,10] However, Al-Gewely et al found symptoms had the greatest impact, possibly due to low awareness or negative experiences with physical activity.[7]

Limitations

This study was conducted at a single tertiary care hospital, which may limit the generalizability of the findings to broader populations. Additionally, reliance on self-reported data introduces the potential for recall bias, particularly in retrospective accounts of symptom severity and treatment adherence. As a cross-sectional design, the study captures associations at a single point in time and cannot establish causal relationships between asthma-related factors and quality of life outcomes.

CONCLUSION

Activity limitation was the most impaired HRQoL domain. HRQoL declined with age and increased asthma severity, with longer disease duration lowering PAQLQ scores. Poorly controlled cases had more hospital admissions and lower HRQoL. Asthmatic children with other chronic illnesses had significantly lower HRQoL. Incorrect inhaler technique worsened asthma control, leading to more symptoms, greater activity limitations and reduced quality of life.

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