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ARAŞTIRMA MAKALESİ / *RESEARCH ARTICLE*

Quality of Life of Children Between 5 and 7 Years and Affecting Factors

5-7 Yaş Arası Çocukların Yaşam Kaliteleri ve Etkileyen Faktörler

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ABSTRACT

Aim: This study has been carried out as a descriptive research in order to determine children's quality of life and the factors affecting their quality of life.

Methods: The research data were obtained from 260 children between the ages of five and seven years and their parents in Türkiye's Karaman province between September 2019-June 2020. Data were collected using a questionnaire form and the child and parent forms for the Quality of Life Scale for Children. The study used frequencies, percentages, means, min and max values, Cronbach's alphas, t test results, ANOVA testing, the Mann Whitney U-test, and regression analyses to analyze the data, with the Bonferonni correction test being used in further analyses.

Results: Of the students examined within the scope of the study, 53.1% were determined to be girls and 50% to be six years old; their mean body mass index (BMI) was identified as 15.31 (SD = 2.61). The mean score from the child version of the Quality of Life Scale for Children was seen to be 71.23 (SD = 13.28), and the mean score from the parent version was seen to be 65.69 (SD = 14.11). The children's quality of life was determined to be affected by family income status, parents' educational status, the presence of chronic diseases in the parents, and the presence of any disease diagnosed in the child.

Conclusion: According to the research results, the children were found to have high mean scores for their overall quality of life, while the children's quality of life scores as evaluated by the parents were found to be at a medium level. The lowest mean for the children's and parents' forms were found to occur in the sub-dimension of emotional functionality. The children's quality of life was observed to vary according to certain variables such as the family income level, parents' educational level, the presence of a chronic disease in the parents, and the presence of any disease diagnosed in the child.

Keywords: Children's Quality of Life, Child Nursing, Nursing

ÖZ

Amaç: Bu çalışma çocukların yaşam kalitelerinin ve yaşam kalitelerine etki eden faktörlerin belirlenmesini amacıyla tanımlayıcı tipte gerçekleştirildi.

Gereç ve Yöntem: Araştırma verileri Eylül 2019 – Haziran 2020 tarihleri arasında Karaman ilinde 5-7 yaş aralığında öğrenim gören 260 çocuk ve ebeveynden elde edildi. Veriler, anket formu ve Çocuklar İçin Yaşam Kalitesi Ölçeği çocuk/ebeveyn formu kullanılarak toplandı. Verilerin analizinde SPSS 21.0 programı kullanılarak; sayı, yüzde, ortalama, min maks değer, Chronbach Alfa, t testi, ANOVA, Mann Whitney U ve Regresyon analizi, ileri analizde ise Bonferonni testi ile değerlendirildi.

Bulgular: Araştırma kapsamındaki öğrencilerin %53.1'inin kız, %50'sinin 6 yaşında, beden kitle indeksi ortalamalarının 15.31±2.61 olduğu belirlendi. Çocuklar için yaşam kalitesi ölçeği çocuk versiyonundan alınan puan ortalamalarının 71.23±13.28, ebeveyn versiyonundan alınan puan ortalamalarının 65.69±14.11 olduğu görüldü. Çocukların yaşam kalitelerinin aile gelir durumu, anne baba eğitim durumu, anne babada kronik hastalık varlığı, çocukta tanı almış herhangi bir hastalık varlığı durumlarından etkilendiği belirlendi.

Sonuç: Araştırma sonuçlarına göre çocukların toplam yaşam kalitesi yüksek puan ortalamalarının olduğu, ebeveynler tarafından değerlendirilen çocukların, yaşam kalitesi puanlarının ise orta düzey; çocuklar ve ebeveynler için en düşük ortalamanın duygusal işlevsellik alt boyutunda olduğu belirlenmiştir. Çocuklar İçin Yaşam Kalitesi Ölçeği değerlendirmesinde; çocukların, kendi yaşam kalitesinin yüksek, ebeveynlerinin ise çocuklarının yaşam kalitelerini orta düzeyde algıladıkları belirlendi. Çocukların yaşam kalitelerinin bazı değişkenlere göre (aile gelir durumu, anne baba eğitim durumu, anne babada kronik hastalık varlığı, çocukta tanı almış herhangi bir hastalık varlığı) değiştiği görülmüştür.

Anahtar Kelimeler: ÇİYKÖ 4.0 Jenerik Çekirdek Ölçeği, Çocuk Hemşireliği, Yaşam Kalitesi

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INTRODUCTION

Life quality is one of the most important universal goals that people, families, communities and societies aim to achieve today. One of the most important characteristics of human beings is that they always want better and more, and longing for the better. In other words, people interpret quality of life as the degree of satisfaction with life and their own life, based on their perceived living conditions. As a multidimensional concept that includes the physical, psychological, social and spiritual areas; it covers the welfare level of individuals, families or societies, and the level of access to this level of welfare. For this reason, wanting more and longing for more changes people's lives and understanding of life. This situation makes people's quality of life and their perception of quality of life different (1-3).

Quality of life, which is a current and important concept, is an interdisciplinary field of study that deals with the individual subjectively, the individual's life and economic conditions and social environment as a dimension, subjective feelings, satisfaction and dissatisfaction, positive and negative feelings of the individual as a feeling. It includes obtaining subjective satisfaction from the course of an individual's life and life opportunities, having objective functionality in one's social roles, and finding external resources. As a result, the concept of quality of life is a concept that emerged with the impact of efforts to understand and make sense of life (4-6).

Although there is no common standard or system of indicators in the examination of quality of life, it is related to the individual's life satisfaction and can be examined from two perspectives as objective and subjective. A measure of quality of life is an individual description that determines whether attributions characterizing life are positive or negative. For this reason, when talking about the quality of life of any society, not only the expected life expectancy or high income level, but also the sustainability of diversity in all dimensions and the level achieved should be expressed (2,7-9). It is different from each other and includes many dimensions, varies according to time, place and person, quality of life; making it a relative, subjective concept. Therefore, quality of life is a difficult concept to define and measure (5, 10, 11).

The quality of life of children is important in order for children, who are the architects of the future of societies, to grow up as strong, healthy and productive individuals in the future, to find life worth living, to form self- consciousness and to form a life purpose (12). Children with a high quality of life are likely to grow up as individuals who are strong, healthy and lay a solid foundation for the next generations. For this reason, it is important to know the factors that determine the quality of life of the child age group (3, 11, 13).

With this study, it will be possible to evaluate the quality of life in the 5 to 7 age group and to determine the affecting factors, and to support the factors that affect the quality of life positively, and to eliminate the negative factors that affect the quality of life. The data found in the light of the study will pave the way for child health nurses to make plans and implement them in order to determine the cultural, social and medical status of the child and his family, and to meet the determined needs. The obtained data will be a source for future scientific studies.

METHOD

This descriptive study was conducted to determine the quality of life of children between the ages of five and seven, with 260 children studying in kindergarten, primary and secondary schools (kindergarten in secondary school and students aged 5 to 7 in kindergarten) affiliated to Karaman Provincial Directorate of National Education and their parents. It was held between September 2019 and June 2020. The population of the study consisted of 2078 children in the 5 to 7 age group studying in Karaman. The sample size was calculated with the G*Power 3.1.9.2 program and its known score (73.73±16.08) at a significance level of 0.05 at a 95% confidence level within a two-point deviation (14). The sample size was determined as 243, taking into account data losses. The study was completed with 260 students and their parents. The children included in the study were evaluated according to the percentage of their participation in the population and were determined by the stratified sample selection method. The selection of the schools where the children to be sampled were studying was made by random method, taking into account the sample size. The papers on which the names of kindergartens, primary schools and secondary schools were written were selected by placing them in a black bag and mixing them, as a result of which 3 kindergartens, 3 primary schools and 4 secondary schools were determined by random method. The participation form, the parent consent form, and the Child Quality of Life Scale (PedsQL 4.0 Generic Core Scale) 5 to 7 years old parent form were sent to the students in the selected schools. Verbal consent was obtained from the children whose participation form and parental consent form were approved and whose PedsQL 4.0 Generic Core Scale 5 to 7 years old parent form was filled, and the PedsQL 4.0 Generic Core Scale 5 to 7 years old child form was administered. The form was applied to the children in the classroom environment, under the supervision of their teachers, using one-to-one face-to-face interviews. The answers from the children were marked by the researcher. The questionnaire took 15 to 20 minutes for each student. While conducting the research, it was assumed that all parents gave correct information about their children, that the children expressed their self-evaluations correctly, and that the schools to be included in the sample of the research met all the characteristics of the universe. Participation in the research was based on the principle of voluntariness; those who did not accept to participate in the research, who completed the forms incompletely or who wanted to quit during the research were not included in the research. The data were evaluated with SPSS 21.0 in computer environment with number, min-max value, percentage, mean, Chronbach Alpha, ANOVA, t test, Mann Whitney U and Regression analyses and Bonferonni test in advanced analysis, and $p<0.05$ was considered significant.

Data collection tools used in the research

In the study, the child and parent form of the PedsQL 4.0 Generic Core Scale by Varni et al. (14), and validated and found reliable by Yıldız Kabak et al. (15), was used.

Survey form

The questionnaire prepared by the researchers incleded 5 of the child's introductory characteristics (age, gender, height, weight and class), 10 of the family characteristics (mother-father's occupation, education level, parents' living together, family type, etc.) and the child's health. There were 4 questions about his or her condition (presence of chronic disease, diagnosed disease, medications that he used constantly, etc.).

PedsQL 4.0 Generic Core Scale 5-7 years old child form

The PedsQL 4.0 Generic Core Scale is a modular approach to health-related quality of life, and includes two parallel forms, the child form and the parent form. Elements for each of the forms are essentially identical, differing in developmentally appropriate language. For kids; there are forms for ages 5 to 7, 8 to 12, and 13 to 18, while for parents 2 to 4 years (toddler), 5 to 7 years (small child), 8 to 12 years (child) and 13 to 18 years (adolescent) forms, and the perceptions of parents and their children about the quality of life are evaluated. For the child self-report, the cut-off score for the PedsQL 4.0 Generic Core Scale Total Scale Score was 69.7 (parent score 65.4) (15).

The PedsQL 4.0 Generic Core Scale is a self-administered questionnaire that includes 4 subscales, including physical, emotional, social and school functions, in which different aspects of the child are evaluated. The bodily function has 8 items, and the remaining functions each contain 5 items. The child form is a 23-item scale prepared according to the triple Likert system. The children are asked to point out the corresponding numbers, showing the face shapes and how much trouble each of them is for them. 0 points; never a problem, 2 points; sometimes there is a problem, 4 points; it almost always indicates that there is a problem. The highest score that can be obtained in physical, emotional, social and school functions in the scale is 4 and the lowest score is 0. It can be said that the lower the scale scores, between 0 and 4, the lower the problem, and the higher it is, the higher the problem (16, 17).

PedsQL 4.0 Generic Core Scale 5-7 years old parent form

The PedsQL 4.0 Generic Core Scale is a self-administered scale that includes 4 subscales, including physical, emotional, social and school functions, in which different aspects of the child are evaluated by the parent. The bodily function has 8 items, and the remaining functions each contain 5 items. The parent form is a 23-itemscale prepared according to the five-point Likert system. Parents are asked to indicate the extent to which each of their children have had problems with their child in the past month by circling the relevant numbers. 0; never caused a problem, 4; it always states that there is a problem. A linear translation is applied in the calculation of the total score of the scale, the items are scored inversely and linearly 0; 100 points, 1; 75 points, 2; 50 points, 3; 25 points and 4; indicates 0 points. Thus, a high PedsQL 4.0 Generic Core Scale score is an indicator of a better quality of life (16, 17).

Ethical Aspect of Research

Ethics committee approval for this study was obtained from the Ethics Committee of the Faculty of Health Sciences, Karamanoğlu Mehmetbey University (Document Date and Number: 02.10.2019-E27537, Decision Date: 25/09/2019, Meeting Number: 07, Decision Number: 36).

RESULTS

It was determined that 53.1% of the children were female, 50% were six years old, their mean BMI was 15.31±2.61 (min=8.33, max=26.63), 42.3% of them were kindergarten students. The distributions regarding the demographics and some characteristics of the children are given in Table 1.

The min-max, mean, standard deviation scores and Chronbach's Alpha values of the children and their parents from the PedsQL 4.0 Generic Core Scale and its sub-dimensions are given in Table 2.

According to the comparison of the mean scores of the children and their parents from the PedsQL 4.0 Generic Core Scale total/sub-dimensions and their demographic and some characteristics; A statistically significant difference was found between the income status of the family (Table 3), the education level of the parents (Table 4-5), chronic diseases of the parents and the presence of any diagnosed disease of the child ($p<0.05$).

According to the comparison of the mean scores of the children and their parents from the total and sub- dimensions of the PedsQL 4.0 Generic Core Scale and the presence of chronic diseases diagnosed in their parents and themselves; it was determined that parents and children without chronic diseases had a higher mean score in the parent total and psycho-social functionality sub-dimension compared to those with chronic disease, and the difference was statistically significant ($p<0.05$).

There was no statistically significant difference between the mean scores of the children and their parents from the PedsQL 4.0 Generic Core Scale total and sub-dimensions, and age, gender, grade of education, presence of health problems of the child, birth order of the child, and presence of chronic diseases of the child ($p>0.05$).

According to the correlation of the scores of the children and their parents from the total and sub-dimensions of the scale, it was determined that the scores obtained from the total and sub-dimensions of the whole scale had a positive and significant relationship with each other ($p<0.05$). It was found that as each total score and lower neck scores increased, the other total and sub-dimension scores also increased. According to the evaluation of independent variables that may affect the quality of life of children with multiple linear regression

Table 1: Distribution of children's demographics and some characteristics (n= 260)

Demographics and some characteristics	Number (n)	Percent (%)
Age		
5	28	10.8
6	130	50.0
7	102	39.2
Gender		
Girl	138	53.1
Male	122	46.9
Class in which he studied		
Kindergarten	110	42.3
Kindergarten	64	24.6
First class	86	33.1
Presence of any health problems		
There is	17	6.5
None	243	93.5
Family income		
Income less than expenses	62	23.8
Income equal to expenses	172	66.2
Income more than expenses	26	10.0
Mother's educational status		
Primary school	72	27.7
Middle school	54	20.8
High school	84	32.3
University	50	19.2
Father's educational status (n=258) *		
Primary school	64	24.8
Middle school	52	20.2
High school	88	34.1
University	54	20.9
Mother's profession		
Housewife	205	78.8
Officer	13	5.0
Employee	26	10.0
Small business	6	2.3
Other (private sector employee, self-employed etc.)	10	3.8
Father's occupation (n=258) *		

analysis; it was seen that the quality of life of the children was affected by the education level of the father and the profession of the mother and it was statistically significant ($p<0.05$).

It was determined that the rate of mother's occupation and father's education level affecting the quality of life was 0.89%.

In the evaluation of independent variables that may affect children's quality of life according to parental evaluation, with multiple linear regression analysis. According to the evaluation of the parents, it was observed that the quality of life of the children was affected by the education level of the father and the

Officer	28	10.9
Employee Small business	135	52.3
Other (retired, unemployed, farmer etc.)	51	19.8
	44	17.1
Child's birth order	110	42.3
First child Middle child Last child	32	12.3
	118	45.4
Family type	246	94.6
The parents are alive and together Parents alive and separated Mother alive	11	4.2
father passed away Mother deceased father alive	2	0.8
	1	0.4
Presence of mother's chronic disease		
There is None	31	11,.9
	229	88.1
Presence of father's chronic disease (n=258) *		
There is None	25	9.7
	233	90.3
Presence of chronic illness of the child		
There is None	15	5.8
	245	94.2
The presence of medication that the child is constantly taking		
There is None	2	0.8
	258	99.2
Presence of the child's diagnosed disease	18	6.9
Yes (Asthma, Bronchitis, Anemia etc.) None	242	93.1

*** Those whose fathers passed away did not answer this question.**

profession of the mother ($p<0.05$). According to the evaluations of the parents, it was determined that the quality of life of the children was affected by the education level of the father and the profession of the mother by 16%. It was observed that the quality of life of children was not affected by age, gender, height, weight, BMI, class of education, presence of health problems, family income, mother's education status, father's occupation, number of siblings, child's birth order, family type, or the presence of chronic diseases in parents ($p>0.05$).

DISCUSSION

It was observed that the total score of the children from the PedsQL 4.0 Generic Core Scale was higher than the cut-off score of the scale. In general, it is seen that children's perceived quality of life is at a high level. In a study conducted with healthy children aged between 5.5 and 8.5 in England, the child self-report total score; children's quality of life scores were found to be high, similar to this study (18). When the studies in the literature were examined, it was seen that the quality of life scores of healthy children were higher than those of children with acute or chronic health problems (19-28). Similarly, in other studies, quality of life scores of children and adolescents were found to be statistically significantly lower than control groups (29, 30). The high quality of life scores in the study suggest that it may be due to the examination of healthy children within the scope of this study.

In the study, it is seen that the total quality of life score of the children is lower than the level of perceived quality of life of the children (65.69±14.11) according to the parents. In a study examining the quality of life of healthy children aged between 5.5 and 8.5 years in England, the quality of life scores evaluated by parents for their children were found to be higher than the quality of life scores obtained by children's self-reports (18). In the study conducted by Kook and Varni (21) in which sick and healthy school children aged 8-18 were examined, it was seen that the quality-of-life scores based on the evaluations of the parents were higher than the self-reported quality of life scores of the children in both groups. Upton et al. (31) found that healthy children had higher quality of life scores for parental evaluation, while self-reported quality of life scores were found to be higher in sick children. In the study of Hesapcıoglu et al. (32), no statistical difference was observed between the self-report of children and adolescents and the reports of parents in the areas of emotional and social functionality in quality of life scores. According to this, it can be said that children have a higher level of quality of life they feel, and parents see their quality of life at a lower level than their children.

Table 2: The min-max, mean, standard deviation scores and Chronbach Alpha values obtained from the total and sub-dimensions of the PedsQL 4.0 Generic Core Scale child and parent form

Children's Quality of Life Scale	Number of Items	Min-Max Scores	Mean±Standard Deviation	Chronbach Alpha
PedsQL 4.0 Generic Core Scale Child Evaluation Total	23	22-100	71.23±13.28	.82
Bodily Functioning	8	0-100	72.36±17.39	.66
Emotional Functioning	5	0-100	63.19±17.99	.64
Social Functioning	5	0-100	77.90±18.00	.63
Functioning in School	5	0-100	70.81±18.13	.66
Psycho-social Functioning	15	80-300	211.90±41.59	.78
PedsQL 4.0 Generic Core Scale Parental Evaluation Total	23	22-97	65.69±14.11	.83
Bodily Functioning	5	22-100	69.28±17.18	.69
Emotional Functioning	5	0-80	49.04±14.58	.67
Social Functioning	5	0-100	68.10±21.31	.66
Functioning in School	5	15-100	62.75±19.94	.64
Psycho-social Functioning	15	20-280	179.88±43.86	.79

Table 3: Comparison of the mean scores of the children and their parents from the total and sub-dimensions of the PedsQL 4.0 Generic Core Scale and the income status of the family

Family Income Status				
Scales and Sub-Dimensions	**Income less than expenses (n=62) Mean±SD**	**Income Equal to Expense (n=172) Mean±SD**	**Mean±SD Income more than Expenses (n=26) Mean±SD**	**F p**
PedsQL 4.0 Generic Core Scale Child Evaluation Total	67.01±15.11	72.45±12.53	73.24±11.76	4.268 **0.015***
Bodily Functioning	67.94±18.50	73.98±16.26	72.12±20.55	2.788 0.063
Psycho-social Functioning	199.52±47.88	214.91±39.85	221.54±30.42	3.987 **0.020***
PedsQL 4.0 Generic Core Scale Parental Evaluation Total	60.22±14.12	67.25±13.99	68.44±11.81	6.461 **0.002***
Bodily Functioning	63.46±17.08	70.64±16.90	74.16±16.47	5.317 **0.005***
Psycho-social Functioning	164.52±45.22	184.56±43.40	185.58±35.95	5.163 **0.006***

***Statistically significant since p<0.05.**

In the study, when the sub-dimension scores of the children were compared with the scale scores, it was seen that the physical and school functionality scores were higher than the scale scores, but lower than the emotional functionality and social functionality scores. In the reliability and validity study, physical and social functioning scores were high in the self-report sub-dimension scores; emotional, school and psycho- social functioning scores were found to be low (27). It can be stated that the absence of any health problems increases physical and school functionality. The low level of emotional and social functionality in children suggests that it may be due to the fact that children are in the first years of their education and training life.

Table 4: Comparison of the mean scores of children and their parents from the total and sub-dimensions of the PedsQL 4.0 Generic Core Scale for children and the educational status of the mother

Mother Educational Status					
Scales and Sub-Dimensions	**Primary school (n=72) Mean±SD**	**Middle school (n=54) Mean±SD**	**High school (n=84) Mean±SD**	**University (n=50) Mean±SD**	**F p**
PedsQL 4.0 Generic Core Scale Child Evaluation Total	70.55±1.52	67.95±14.28	73.16±10.71	72.52±13.83	1.928 0.125
Bodily Functioning	73.52±16.70	66.67±20.78	73.51±14.31	74.88±18.27	2.553 0.056
Psycho-social Functioning	206.88±48.69	205.93±38.09	218.93±33.58	213.80±45.44	1.566 0.198
PedsQL 4.0 Generic Core Scale Parental Evaluation Total	63.62±14.22	62.56±14.41	68.43±13.37	67.48±14.10	2.778 **0.042***
Bodily Functioning	68.71±16.44	64.99±18.48	70.54±15.94	72.63±18.26	1.952 0.122
Psycho-social Functioning	170.83±45.68	172.69±41.90	190.30±42.26	183.20±42.99	3.263 **0.022***

***Statistically significant since p<0.05.**

Table 5: Comparison of the mean scores of the children and their parents from the total and sub-dimensions of the PedsQL 4.0 Generic Core Scale and the educational status of the father

Father Educational Status					
Scales and Sub-Dimensions	**Primary school (n=64) Mean±SD**	**Middle School (n=52) Mean±SD**	**High School (n=88) Mean±SD**	**University (n=54) Mean±SD**	**F p**
PedsQL 4.0	68.78±13.68	68.48±13.34	72.62±14.21	74.40±10.40	2.849
Generic Core Scale Child Evaluation Total					**0.038***
Bodily Functioning	70.51±18.44	69.71±17.16	73.51±17.95	75.12±15.42	1.219 0.303
Psycho-social Functioning	203.59±43.36	203.46±40.48	216.42±43.93	222.04±34.27	3.029 **0.030***
PedsQL 4.0 Generic Core Scale Parental Evaluation Total	62.81±13.21	64.11±14.91	65.51±15.17	71.14±11.37	3.896 **0.010***
Bodily Functioning	67.29±15.98	66.53±18.15	68.82±17.42	75.52±16.27	3.195 **0.024***
Psycho-social Functioning	170.16±41.49	176.73±45.24	180.00±47.65	194.44±35.99	3.185 **0.024***

***Statistically significant since p<0.05.**

When the results of the evaluation of the parents' children's quality of life in terms of sub-dimensions were examined in the study, according to the scale mean scores, it is seen that their children have high mean scores in terms of physical functionality at school, and low mean scores in terms of emotional and social functionality. Although the subdimension scores of the evaluation results of the parents and children are similar, it is seen that the evaluation scores of the parents are

lower. Roizen et al. (23) found that while internal consistency among children's self-reports increased with age, it was found to be low in the self-reports between 5 and 7 years of age in surrogate reports. It was observed that social and psycho-social scores were high, while physical, emotional and school functioning scores were low (27). For the assessment of quality of life, both parents and children have high scores in terms of physical and school functionality, while they have low scores in terms of emotional and social functionality. It suggests that the reason why children's physical functionality is more at the forefront as a quality of life is due to the fact that bodily characteristics are at the forefront as a periodic feature, their emotional development has not yet been completed, or the developed emotions cannot be recognized or expressed by children.

In the study, it was observed that there were differences between the average scores of the families in the evaluation of both children and parents, according to the income status of the family. When the sub-dimensions were examined, it was found that the difference in psycho-social functionality was significant in the evaluation of the child and the parent, while the difference in physical functionality was significant only in the evaluation of the parent. In this respect, it can be said that children in families with lower income than expenditure think that their psycho-social functionality is lower than that of other income groups. In the study conducted with healthy and chronically ill children aged 5 to 7 years, it was found that children living below the poverty line in low socioeconomic status had lower total PedsQL 4.0 Generic Core Scale scores (65.38 and 70.29, respectively; p = 0.03) than their peers, and significant differences were found for children (23). A similar conclusion was reached in the study conducted by Aydıner Boylu and Paçacıoğlu (33), and it was reported that income status is one of the important factors affecting the quality of life. In the light of these studies, it was supported that a similar result was obtained and that low income status reduced the quality of life of children. It is thought that the income status of the families has an effect on the quality of life of the children. However, in the regression analysis, it was seen that the change in the income status of the family did not have a significant effect on the quality of life.

In the evaluation made by the parents in the study, it was seen that the educational status of the mother created a significant difference at a level that would affect the total score of the children's quality of life. In the evaluation made by the children, it was seen that the educational status of the mother did not make a statistically significant difference, and for the parents, the educational status of the mother made a significant difference in the psycho-social functionality sub-dimension. In a study examining the health-related quality of life of children aged 2 to 16 with chronic kidney disease, it was found that children's quality of life scores increased as the level of maternal education increased (24). Aytekin et al. (34), with children aged 3 to 6 years, found that the educational status of the mother had a statistically significant effect on the child's quality of life in the self-esteem sub-dimension. In this direction, it is thought that the educational status of the mother affects the quality of life of the children, but in the regression analysis, it was seen that the educational status of the mother did not have a statistically significant effect on the quality of life of the child.

In the study, while the educational status of the parents created a significant difference in the evaluation of the parents, in the evaluation of children, it was understood that only the change in the educational status of the father had a significant effect on the quality of life in the regression analysis. Considering the sub-dimensions, the educational status of both the mother and the father creates a significant difference in the psycho-social dimension in the evaluation of the parents. The educational status of the father creates the difference in physical and psycho-social functionality according to the evaluation of the parents, and in the psycho-social functionality according to the evaluation of the children. Aytekin et al. (34), in the study they conducted with children aged 3 to 6, found that the educational status of the father had a statistically significant effect on the child's quality of life in the social relations self-esteem subscale. In this respect, it can be said that the educational status of the father, being a university, affects the quality of life of children positively in terms of physical and psycho-social functionality. According to these results, it is important to increase the educational status of the father in order to increase the quality of life.

In the study, in the comparison between the presence of chronic disease in the mother or father and the quality of life of the children, it was seen that there was no statistically significant difference in the evaluations of the children, and there was a statistically significant difference in the psycho-social functionality sub-dimension in the evaluation made by the parents. In this direction, it has been stated by the parents that any chronic disease that may occur in the parents will negatively affect the psycho-social functionality levels of the children.

Although the presence or absence of chronic disease in children did not affect the quality of life statistically according to the children's self-reports, it was observed that there was a statistically significant difference in the psycho-social functionality sub-dimension of the parents. In a study conducted with healthy and chronically ill children aged 5 to 7 years, it was found that quality of life scores of children with chronic diseases were lower (23). Upton et al. (31), in a study conducted with healthy and chronically ill children aged 8-18 and their parents, found the scores of the children who were sick to be lower and significant than the healthy children in all parent report scales. Ferreira et al. (27) observed that the quality of life scale scores of children who were sick were lower. It is seen that chronic disease status decreases the total quality of life scores in other studies as in this study. However, in the regression analysis performed in the study, it was determined that the chronic disease status of the child did not have a significant effect on the quality of life. This study suggests that the psycho-social functionality dimension is higher in children with chronic diseases thanks to parental support.

In the study, bodily functionality and psycho-social functionality scores increase as the total quality of life score related to the evaluations of children and parents increases. In addition, it was observed that the psycho-social functionality score and the total quality of life score had a highly positive relationship for children and parents. Ferreira et al. (27) found that all correlations were positive for all scale sub-dimensions and types of total scores, parent scores and child scores were compatible. Roizen et al. (23) showed a significantly high correlation with the children's and parent reports and the children's self-reported general health report in the study conducted with children aged 5 to 7 years. An increase in the quality of life, an increase in psycho-social functionality or an increase in psycho-social functionality also increase the quality of life. In this study, there is a very strong positive relationship between the total score for children and the total score for parents, and the psycho-social functionality sub-dimension. In a study conducted with healthy children in England, the level of correlation between child self-report and parent report was found to be low (18). In another study examining healthy and chronically ill children aged 5 to 7 years, it was found that there was a moderate but significant correlation between the child report and the parent report PedsQL 4.0 Generic Core Scale scores (23). In a study in which children aged 6 to 18 years were examined regarding psychiatric problems, a significant relationship was found between child and parent evaluations (20). Amiri et al. (26) analyzed the PedsQL 4.0 Generic Core Scale in the 8 to 12 age group, and in the validity and reliability studies, a moderate to high significant relationship was found between the self-reports of children and the reports of their parents. In the parent and child forms of the PedsQL 4.0 Generic Core Scale, it was seen that it was consistent with the evaluation of the child and the child's self-report from the perspective of the parents, and in this direction, it was thought that the communication within the family was healthy.

CONCLUSION

It has been determined that the total score of the children from the quality of life scale is higher than the cut-off score of the scale, and the total quality of life score of the children according to the parents is lower than the perceived quality of life level of the children. In the evaluation of both children and parents, it was observed that there were differences between the average scores according to the income status of the family. In the evaluation made by the parents, it was determined that the education level of the parents, the presence of a chronic disease in the mother or the father, the presence or absence of a chronic disease in the child made a significant difference at a level that would affect the total score of the children's quality of life.

In line with these results; in the scale scores, it can be determined why the differences in compliance of the child and parent reports are caused, and measures can be taken for the determined situation. Child health and public health nurses have important duties to evaluate the quality of life of children holistically and to make improvements in all conditions in terms of the physical, emotional, social, school life and psycho-social aspects.

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Informed Consent: Written consent was obtained from the participants.

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