CHAPTER III

OBJECTIVES, RESEARCH QUESTIONS, OPERATIONAL DEFINITIONS, AND CONCEPTUAL FRAMEWORK

This chapter is comprised of objectives, research questions and operational definitions.

3.1 Objectives of the Study

3.1.1 General Objectives

The general objectives of this project are to provide recommendations to the responsible local government authorities related to improving accessibility to health services, alleviating depression, and improving the quality of life of adolescents in Klong Toey slum community. In addition, these recommendations may prove useful in other slum communities of Bangkok and in other situations in Thailand.

3.1.2 Specific Objectives

1. to determine the nature and extent of existing services (both governmental and non-governmental, including community organizations) for adolescents
2. to determine the health service needs and the utilization of existing health services, in terms of geographic accessibility, availability, affordability and acceptability for the overall group of adolescents studied, and by gender and stage of adolescence (age)
3. to compare the differences in terms of health service needs and the utilization of health services for the overall group of adolescents studied, and by gender and stage of adolescence (age)
4. to assess the depression level of adolescents using the Center for Epidemiologic Studies Depression Scale (CES-D);

5. to define the meaning of QoL as perceived by adolescents, and by gender to measure the quality of life of adolescents using the modified WHO/QoL instrument;
6. to develop an intervention/evaluation program to improve the accessibility of health services, alleviate depression and improve the quality of life of adolescents through community partnerships.

3.2 Research Questions

In this study, the age of adolescence is defined as 10-22 years. The study of Ratana Somrongthong and Chitr Sitti Amorn (2000) revealed that Thai adolescents should be defined older than the WHO's definition because of their culture and their economic dependency. The research questions for this study are as follows:

1. What is the nature and extent of existing health services (GO, NGO, including community organizations) for adolescents?
2. What are the determinants of accessibility of the above services in terms of geographic accessibility, availability, affordability and acceptability of adolescent health services between male and female adolescents and *in each sub-group of adolescence (early-age, 12-13; middle-age, 14-17; late-age, 18-22)?*
3. What are the differences in terms of service needs and utilization of health services between male and female adolescents and *in each sub-group of adolescence (early-age, 12-13; middle-age, 14-17; late-age, 18-22)?*
4. What is the level of depression of adolescents as measured by the Center for Epidemiologic Studies Depression Scale (CES-D)?
5. What are the perceptions of adolescents towards QoL?
6. What is the level of quality of life of adolescents, as measured by the WHO-QoL-BREF?
7. What strategy combines quantitative and qualitative information to develop an intervention program to improve accessibility, utilization, to alleviate depression, and to improve the QoL of adolescents?

8. What are the perceptions of the stakeholders towards the processes and contents of partnerships used to develop the intervention program.

3.3 Operational Definitions

Adolescent. In this study, an adolescent is defined as a person of either gender, aged between 12–22 years, living in Klong Toey Slum community > 1 year. As slums in Bangkok are places where easily affordable rental housing can be found, many migrants from rural areas prefer to stay there. This study seeks to exclude adolescent migrants and their families who stay for a short time. Therefore, adolescents who stay < 1 year are excluded from this study. This residential timeframe will ensure that the adolescent does belong to the community.

Adolescents' Health Needs. These include 4 aspects of health needs and health problems of adolescents:

1) *Sexual and reproductive health*: for both genders, development of sex organs, acne, masturbation, itching of genitalia, having sex (with lover, acquaintance, sex worker, client), family planning (contraceptive pill, condom, other methods), unintended pregnancy, abortion, burning urine, pus/discharge at genital organ, HIV/AIDS, perception of their body and shape, sexual harassment. The specific issues for males were wet dreams and frequency of orgasm. The specific issues for females were menstruation, dysmenorrhea, and irregular period;
2) *Injury and violence*: injury, road accident, home violence, fighting and rape;
3) *Mental health*: depression, stress, loneliness and sadness; and
4) *Substance abuse*: alcohol, smoking and drug addiction.

To understand the health needs of adolescents, this study combined real needs and felt needs. "Felt needs" means anything that they consciously desire about their needs (SIL International, 1999). Therefore, the questionnaire was designed to explore adolescents' health needs, both in terms of real needs and felt needs. To explore the felt needs, the subjects were asked about their heath needs/problems and their opinions

about the health needs and needs of other adolescents. This study attempts to determine both their objective and perceived needs.

Accessibility to health services. This study attempts to assess the accessibility of young people to health services in terms of utilization of health services (Robert, J Marc et al, 2001). In addition, accessibility in this study refers to four dimensions (WHO, 1996a), as follows:

a) *Geographic accessibility.* This dimension includes the distance from home to the health facilities (travel time from home to health facilities), the means of transportation that people use when visiting the health facilities, and the average number of operating hours per day of the health facility.
b) *Availability* means the quantity of need /demand relative to the quantity of health services.
c) *Affordability* is financial accessibility. This also means the resources to purchase or pay for health care relative to the price/cost of the care.
d) *Acceptability* means the characteristics of services and user attitudes, satisfaction, perceptions or expectations of services, including socio-cultural concerns. It also refers to privacy in the consulting room when young people need a consultation or physical examination.

Depression. Adolescent depression by definition is a disorder occurring during the teenage years marked by persistent sadness, discouragement, loss of self-worth, and loss of interest in usual activities. Depression can be a transient response to many situations and stresses (Franklin, D J. 2003). For this study, the Center for Epidemiologic Studies-Depression Scale (CES-D) was adopted as a measurement tool for adolescents' depression. The CES-D is one of the most frequently used standardized measures of depression in adolescents (Edman et al., 1999). In Thailand, the Department of Mental Health, Ministry of Public Health adopted this tool and has translated it into the Thai language for screening adolescents' depression (Umaporn Trungkasombaddi, 2000), and it was recommended for screening depression in Thailand (MoPH, 2002).

Quality of life. Quality of life means the perception of the individual's position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standards and concerns (WHO, 1996). It is a personal judgment, and, therefore, means different things to different people. Quality of life is a broad-ranging concept affected in complex ways by the individuals' physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships to salient features of the environment.

This study adopted the WHOQoL-BREF to measure the quality of life of adolescents. This instrument has been translated into the Thai language and had been tested for reliability and validity in Thailand (Suwat *et al.*, 1997).

WHOQOL-BREF. The short form Quality of Life assessment is comprised of 26 questions; it is available in 19 different languages, including Thai (WHO, 1996b). It consists of 4 domain scores and another two items that are examined separately; Question # 1 asks about the individual's overall perception of QoL and Question # 2 asks about the individual's overall perception of their health. The questions are as follows:

A. Domain I: Physical Health, composed of 7 facets incorporated within the domain
   - Activity of daily living
   - Dependence on medical substance and medical aids
   - Mobility
   - Energy and fatigue
   - Pain and discomfort
   - Sleep and rest
   - Work capacity

B. Domain II: Psychological, composed of 6 facets incorporated within the domain
   - Bodily image and appearance
   - Negative feelings
   - Positive feelings

- Self-esteem
- Spiritual, religion, personal beliefs
- Thinking, learning, memory and concentration

C. Domain III: Social relationship factors, composed of 3 facets incorporated within the domain
   - Personal relationship
   - Social support
   - Sexual activity

E. Domain IV: Environment, composed of 8 facets incorporated within the domain
   - Financial resource
   - Freedom, physical safety and security
   - Health and social care
   - Home environment
   - Opportunity for acquiring new information and skills
   - Participation in, and opportunity for, recreation
   - Physical environment
   - Transport

F. Individual's overall perception about
   - QoL
   - Health

Health Services. Health services include curative, preventive and promotive services for adolescents. In this study, the researcher focuses on the government health facility that is located in the slum community. There are some private clinics located in this community, as well. However, it was difficult to encourage them to participate as a partner in this study.

Community Organizations. Community organizations are composed of various groups that were initiated by the community for the community, for certain objectives; these include the following: housewife group, youth group, community leaders, and

community health volunteers. All of these groups are involved in health and development programs in the community.

Community partnerships. The community partnership approach uses *an agreement for* a common objective between various community organizations (e.g. community leader, housewife group, youth group, health staff, NGO staff, community health volunteers) in the study community working together to improve accessibility to health services and the quality of life of adolescents. In the partnerships, the community organizations, which consist of different individuals, professions and groups as mentioned above, can be pooled, permitting a more complete understanding of the problems of adolescents, improving the capacity to plan and evaluate and the development of comprehensive strategies for adolescent health programs.

3.4 Conceptual Framework

To assist understanding of the concept of this study, the conceptual framework is presented in figure 3.1. From the literature reviewed regarding adolescents' accessibility to health services in Thailand, there were few studies of this issue. However, of these, the results indicated that accessibility to health services has been related to, and determined by, several factors (Pimpawan Boonmongkol et al., 2000; MoPH, 2000). For this study, the demographic data, social relationships (family and peer relationships), accessibility (including geographic accessibility & utilization, affordability, availability and acceptability), health services, QoL and depression were explored. Due to shortages of time and budget, the current study only focused on developing an intervention to improve access and use of health services, alleviate depression and improve QoL through a community partnership. Figure 3.1 shows the conceptual framework.

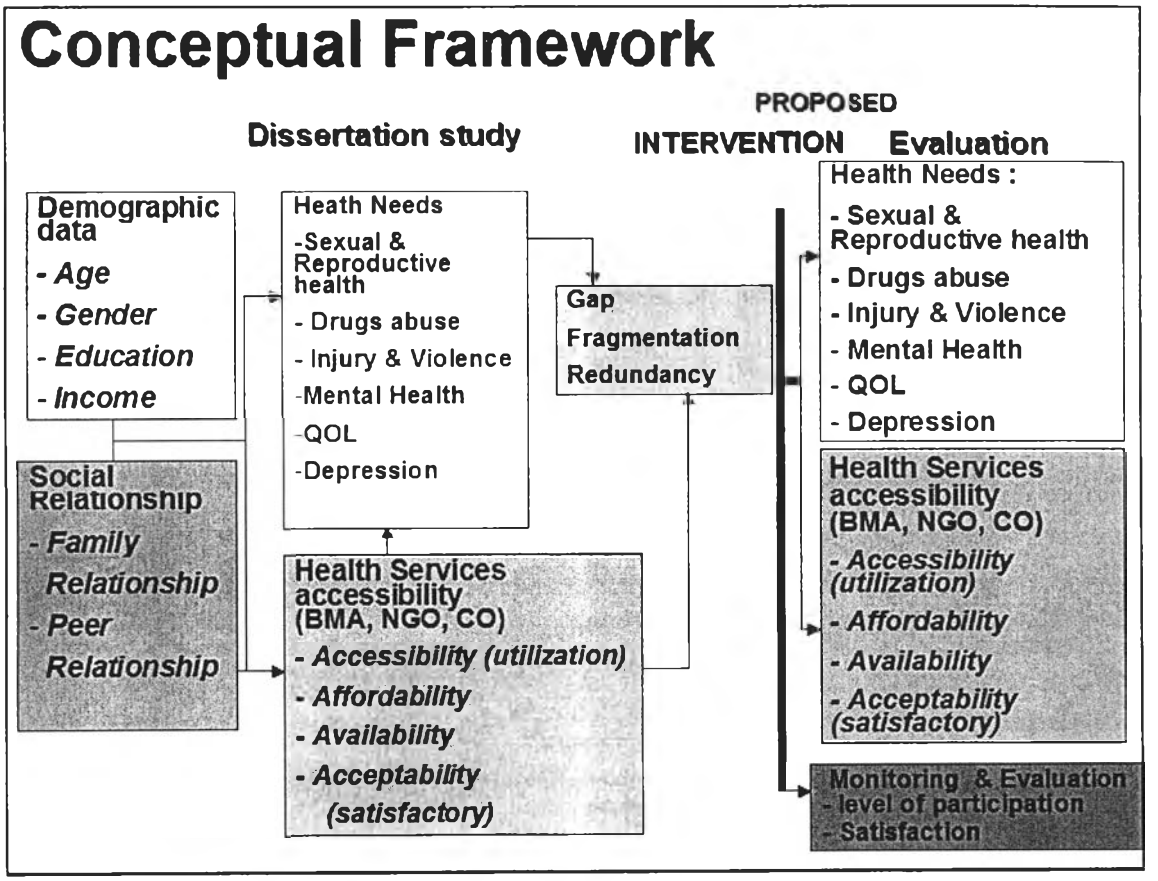

Figure 3.1: Conceptual Framework