

CHAPTER III METHODOLOGY

This chapter provides an overview of the methodology used in this research study. The chapter including the design, study setting, population and sample, instrumentation development and data management.

1. Study design

The community based descriptive study was applied to explore the study objectives.

2. Conceptual framework

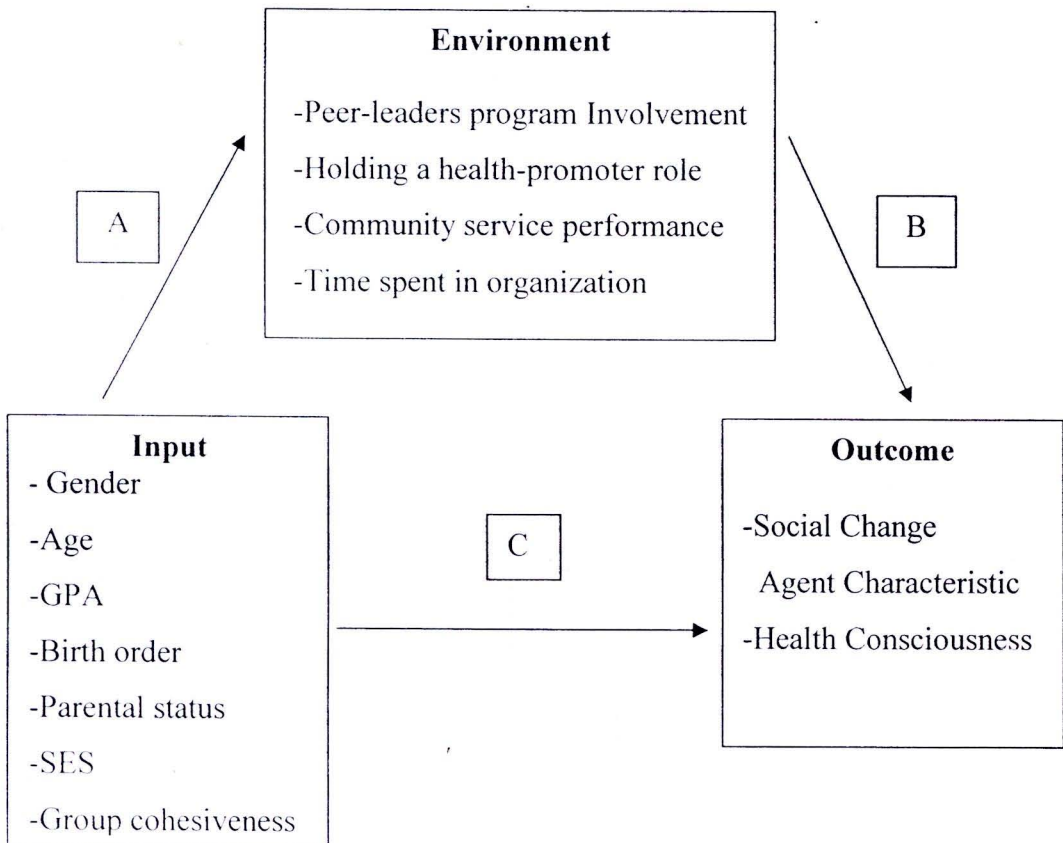


Figure 4 Conceptual framework

There are arrows between inputs (A) and environment (B); environment (B) and outcomes (C) and inputs (A) and outcomes (C), that means inputs (A) influence outcomes in two ways: They impact outcomes directly and also indirectly through influencing the environment.

3. Study setting

There are 3 high schools in the municipality area which are in the catchment area of Kalasin hospital, however; only 2 schools were selected as the study setting because of all 3 interested health programs for youth settled in. The schools divided in 7th grade level to 12th grade level and composed of the student which resided in urban 31%, suburban 38% and rural 31%. All were 100% Thai in nationality.

4. Population and samples

All 11th graders from study settings were targeted population (625 students: 344 female and 269 male), the subjects who met the inclusion criteria of this study during August-September 2010 were included as study population. The inclusion criteria were set for Peer Leaders and Non-Peer Leaders as following:

4.1 Inclusion criteria

For Peer Leaders: The eleventh graders who involved in any type of 3 programs (Friends' Corner, Smart Consumer and Volunteer-Minded Young Dentist) at least 1 year and still active, came to school the day data collection, willing to participate in this study and approved by their parents.

For Non-Peer Leaders: The eleventh graders who learned in the same schools as Peer Leaders did but did not involved in any program, came to schools the day data collection, willing to participate in this study and approved by their parents.

4.2 Exclusion criteria

4.3 Sample size calculation (All target population were recruited)

4.4 Sampling technique

5. Data management

5.1 Data collection

To obtain parent consent, the teachers or program staff gave 11th graders an envelope to take home to their parents. The envelope contained a letter explaining the details of this study, two consent forms (one returned to the school and one kept for the parent's records). The targeted population who met the criteria were included (n=613). 96% of the study population (n=588) came to schools the day data collected. Data collection was conducted by trained study staff or hired assistants, after the data collection, the author excluded the data from 68 subjects because their pattern of responses suggested that they did not answer seriously. Thus, the final respondent was 520 students. Time period for data collection and ensuring uniformity of administration was 1 month (August 2010-September 2010).

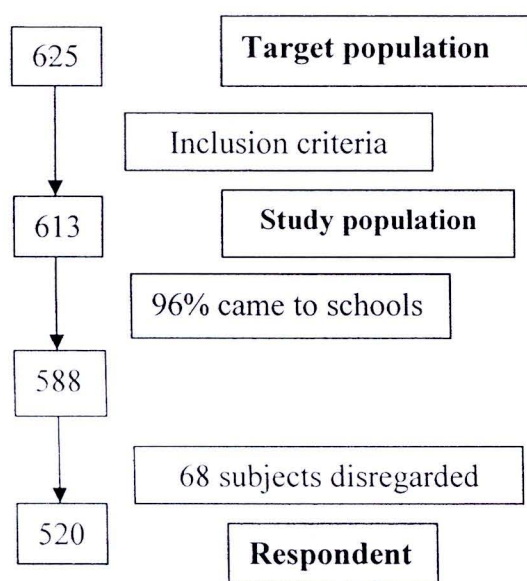


Figure 5 Study population flow chart

5.2 Data analysis

The data was verified through double entry data by Epi Info6 and was analyzed by the Statistical Package for the Social Sciences (SPSS) Version 17. The information was described with descriptive statistic (central tendency and dispersion) and the relation between key variables was reported with Pearson's Product Moment coefficient.



6. Ethical consideration

6.1 Because of the study population are vulnerable groups, parental and participants' consent were accomplished, if decided to participate they were always free to change their mind.

6.2 Both formal and informal opportunity for participants' rejection in a safe environment.

6.3 Participants' identity were not be revealed.

6.4 Participants can choose to answer the questions as they were able to.

6.5 Informing participants of the research outcomes and dissemination.

6.6 Ethical approval by Ethical Committee For Research In Human, KKU Version 1.1 HE531197.

7. Instrument

7.1 Instrumentation details

There were 2 measurements used in this study. Firstly, the Social Change Agent Characteristic Measurement (SCAM) which was modified from the revised version of Social Responsibility Leadership Scale revised version (SRLS-R2) of Tyree's (1998). SCAM was divided into 3 levels to measure the developmental outcomes of Social Change Agent Characteristic; individual level, group level and societal level. Individual level consists of 3 domains: self-consciousness, congruence and organizational commitment while group level consists of 2 domains: Controversy with civility, community connectedness. Society level consists of 2 domains: Citizenship and change. All of which contributed to the goal as "change".

Secondly, Health Consciousness Measurement (HCM) which was established from the concept of Health Consciousness of Gould (1988) and Dutta-Bergman (2005), aimed to measure health consciousness in young people. It composed of 4 domains: Proactive health, holistic health perception, health information consumption, personal health responsibility.

The questionnaire was divided into 3 parts: Part I was prepared in close-ended while Part II and III were prepared in Visual Analogue Scale. Part I including bio-demography of participants as: gender, parental status (lived together, divorced or

separated, widowed), birth order, academic achievement, SES. The other question in this part is the reason to participate in program which is opened-end.

Part II and III consist of the questions to measure their Health Consciousness and Social Change Agent Characteristic, respectively. To examine the magnitude of perception, the researcher used unmarked 100 mm of straight plain line that both ends indicated with “strongly true of myself” and “not at all true of myself” in each items and suggested the subjects to mark at the point that most relevant to their perception then the researcher would interpret into numerical scale.

7.2 Instrumentation development

7.2.1 Pre-test

After receiving ethical consideration approval in human subjects at Khon Kaen University, a pre-tests were administered to enhance reliability and validity of the instruments, as following: A pencil and paper survey was given to 14 eleventh-graders in order to determine rates of completion, clarify items, and gauge potential burden.

7.2.2 Pilot study

The pilot study was done by delivering the questionnaires to 40 eleventh-graders. The Alpha-Cronbach’s reliability coefficient of Health Consciousness Measurement and Social Change Agent Characteristic Measurement are 0.789 and 0.82, respectively.

8. Key variables of this study

The independent variables are gender, birth order, type of Peer Leader’s programs, parental status, academic achievement and SES.

The dependent variables are the developmental outcomes of leadership: Social Change Agent Characteristic and Health Consciousness.

Table 2 Health Consciousness Measurement (HCM)

Domain 1 Proactive health	
1.	Whenever health changes occurs, I am usually the first person to perceive them.
2.	Having meals on time is important for me.
3.	The taste of foods and drinks has been prioritized instead of their nutritional value.
4.	As it is the first meal of the day, breakfast should be valued as the most important meal.
5.	I prefer going to be bed and waking up early.
6.	Physical check up should be regular, although; there is no unusual symptom.
7.	I often apply exercises to my lifestyles such as walking or bicycling short distances instead of motorcycling or driving a car.
8.	Whenever something unusual has been noted I precede to seek for information via the internet, health journal etc.
Domain 2 Holistic health perception	
1.	I value a powerful mind equal to powerful physical strength.
2.	Even if I am a disabled person or have chronic illnesses, it does not matter because I live in a generous neighborhood and have a well-bonded family.
3.	Grief and anxiety can lead to illness.
Domain 3 Health information consumption	
1.	I myself generally update the health information.
2.	Two crucial characteristic of health information that I am usually concerned about is quality and credibility.
3.	I normally verify health information from a variety of credible sources.
4.	There is no need to force myself to do what it takes to stay healthy.
Domain 4 Health responsibility	
1.	I can prevent myself from illnesses if I take good care of myself.
2.	I generally take good care of myself which keeps me healthy.
3.	As the owner of my body, good health depends entirely on me.
4.	My appearance strongly reflects to the outcomes of myself care.
5.	Good or bad health is the outcome of health behavior.

Table 3 Social Change Agent Characteristic Measurement (SCAM)

Domain 1 Self-consciousness	
1.	I have my life's goal and know how to accomplish it.
2.	I can describe how I am whether it be similar or different from others.
3.	I can indicate both of my pros and cons.
4.	I do perceive myself value, no need to have acceptance from others.
Domain 2 Congruence	
1.	Although my values or my opinions are different from others, I still insist on them.
2.	My performance goes along with my thoughts.
3.	I generally, speak my mind.
4.	Though in a tough situation, I normally speak the truth.
Domain 3 Organization commitment	
1.	I devote my time and all of my capability as much as possible to my responsibilities.
2.	I normally committed to my promise.
3.	I do my best regardless of the outcome.
4.	I accept all things I do whether bad or good.
Domain 4 Controversy with civility	
1.	It is possible to have diversity in our team.
2.	I love to share ideas with others.
3.	Creative innovation comes from diversity.
4.	Even if there is a conflict, there is no need to have a winner or loser.
Domain 5 Community connectedness	
1.	I love to be involved in community service.
2.	Having a chance to develop my hometown is my pride.
3.	To help others is worth the value of life.
Domain 6 Change	
1.	Changes are common things happening in our lives.
2.	It is possible that the outcome of changes can be both positive or negative.
3.	I never give up, even if there are many obstacles.