The Development of Program for the Ability in Taking Care of Reproductive Health at Pondok School in the Southern Province

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NUR550017S

2012

ABSTRACT

The purpose of this study was to enhance the reproductive healthcare ability of teenagers at Pondok School in a southern border province of Thailand. This participatory action research was conducted from November 2011 to July 2012. The four specific objectives were: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after participating in the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after participating in the program, (3) to compare the self-confidence in reproductive health care of Muslim students before and after participating in the program, and (4) to study the Muslim students' ability level of reproductive health care after participating in the program. 51 students were included in the five steps of this program which were: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision development, and (5) documentation concluding and reporting. Additionally, there were a number of stakeholders participating throughout this study. These included an administrator, seven teachers from this school, and other outside participants who acted as facilitators, supporters, advisers, consultants, and supervisors.

The results indicated the following: (1) all mean scores for the tests of knowledge, physical and mental healthcare ability, and self-confidence regarding reproductive healthcare ability after completing the program were significantly higher than the mean scores before participating in the sexual and reproductive healthcare activities ($t = 5.587$, $p = .000$; $t = 5.455$, $p = .000$; $t = 3.472$, $p = .001$; and $t = 3.972$, $p = .001$), and (2) the ability of Muslim

students in reproductive healthcare after the program was at a high level (M = 46.02, SD = 8.765).

The findings suggest that the sexual and reproductive healthcare program is of value and benefit to Muslim students in the future, particularly for teenagers who might be pressured into becoming sexually active before normal maturity to deal with intercourse, contraception, abortion, and unplanned pregnancies.

ACKNOWLEDGEMENTS

We owe our gratefulness to Prince of Songkla University for the generous grant, the good facilitation and kind cooperation of the Faculty of Nursing, Prince of Songkla University and all teachers and students who participated in and conducted their activities regarding sexual and reproductive health care during eight months. We also would like to thank the consultants of the project, assistant professor Serm Thassri, Mr. Preeda Suwanmanee, and Mr. Kitipong Sandbaumhad who offered a lot of advice, suggestions, and recommendations throughout the study.

CONTENTS

CONTENTS (Continued)

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

OVERVIEW OF THE STUDY

Background

At present, all countries around the world are confronted with reproductive health problems such as sexually transmitted diseases (STDs), including HIV/AIDS; unintended pregnancy; abortion; sexual dysfunction; and sexual violence. Muslim youth constitute one of the most vulnerable groups within the teenager population worldwide. In one study by Rahmas and associates (2008), the health status of the majority of Muslim males in Indonesia was ranked at a moderate level. These were: physical functioning (73%), mental health (68.3%), and spiritual health (61.9%), respectively. Another study about the knowledge and risk behaviors of human papilloma virus (HPV) infection and cervical cancer by Juntasopeepun and colleagues (2011), in Thailand, reported that female college students had high levels of sexual risk behaviors. The youngest age of first sexual intercourse was 13 years. 39.8 percent had had sexual intercourse and only 18.1 percent used condoms regularly while having sex. Interestingly, 53% reported having never heard about HPV vaccines. The students' knowledge of HPV and cervical cancer was moderate. In America, male adolescents who had had an STD test in the past year was positively associated with age, and having had 3 to 5 or more than 10 sex partners and having had a previous STD. For females, STD testing was positively associated with having had more than two sex partners (3.3 to 5.8) (Cunningham, Kerrigan, Jennings, Ellen, 2009).

A study of sexual identity among adolescents demonstrated that some adolescents have grown up feeling insecure about their sexual identity which could lead to inappropriate sexual behaviors. Several factors identified in the study relating to sexual

identity development included (1) role models in the family, (2) the presentation of inappropriate sexual identity in the mass media, and (3) the influences of a consumerism society and peer groups. As a result of this study, important issues and concerns raised from adolescents, parents, teachers, and researchers suggested that a sexual identity prototype program for Thai adolescents is greatly needed and would be started with the adolescents themselves as well as creating a positive environment that enables adolescents to develop their own sexual identity (Fongkaew, Fongkaew, Wongpanarak, & Lirtmunlikaporn, 2007). Generally, the evidence-base of sexual risk behaviors is alcohol use. Kokaew, Takviriyanun, and Khampalikit (2010) indicated that approximately 80 percent of school adolescents had used alcohol. The minimum age of the participants' first use of alcohol was ten years old.

To solve the reproductive health problems of teenagers around the world, various health education and behavioral change techniques need to be employed. In England, Spencer and associates (2008) stated that the simplest recommendation for sex and relationship education is to ensure that young people can access a full range of sexual health services, including condom provision and confidential sexual health counseling within the school setting. Similarly in America, a group of citizens, concerned about the well-being of their community, recognized the high rates of HIV/AIDS and teenage pregnancy in their south Florida county and decided to take action. Supported by community leaders and using available resources within the county, this HIV/AIDS committee began a community-based participatory action project. The committee members worked to change the high school curriculum to include more comprehensive sex education for students (Weiss, Dwonch-Schoen, Howard-Barr, & Panella, 2010). In Nigeria, systematized HIV/AIDS education for student nurses is conducted at the

University of Ibadan. This program emphasizes the fact that it is very important for education about HIV/AIDS to be incorporated into undergraduate and in-service training programs for Nigerian nurses (Uwakwe, 2000).

Additionally, the findings from a literature review on the learning from a community action plan to promote safe sexual practice in a south Florida county demonstrated that the HIV/AIDS subcommittee has worked hard to address a significant health problem by using a community action plan. The members recognized that their job is not complete. The next action phase that should be undertaken by the group is peer-to-peer education (Weiss, Dwonch-Schoen, Howard-Barr, & Panella, 2010). Sriareporn and Prommachote (2011) presented a four–phase approach to develop health competencies in women of reproductive age. These four phases are: (1) research on women's health problems, (2) a plan for the development of teaching and activities, (3) the implementation of the plan, and (4) the analysis and evaluation of the plan. The findings showed that the development of such competencies in female leaders enhanced their knowledge and skills in promoting women's health. The participants were aware of their roles as female leaders and they were able to collaborate with health personnel in their community. The goal was to help strengthen women's self-care in the communities so that they could adopt healthier behaviors.

According to another evidence-base, using a quasi-experimental study, Fongkaew and colleagues (2011) conducted a youth-led program on sexual and reproductive health for early adolescent Thais. The educational program was designed to be taught over 3 days, outside the normal school hours. In brief, the challenges of the various reproductive health problems must be considered carefully for teenagers. Therefore, to enhance the ability regarding reproductive health care of Muslim students, this study is based on

various areas of sexual and reproductive health knowledge and methods such as participatory action research which is gaining in popularity as a way to improve performance, promote learning and develop the capacities of individuals, teams, and organizations. The use of participatory processes mobilizes and improves student leaders' ability to play a proactive role in the prevention of risky sexual behaviors and the promotion of sexual and reproductive health for their friends at school. It is a key mechanism to help the student leaders learn from practice to solve complex decisions and issues.

Objectives

1. To compare the physical health care ability of Muslim students regarding reproductive health before and after the program.

2. To compare the mental health care ability of Muslim students regarding reproductive health before and after the program.

3. To compare the self-confidence of Muslim students on reproductive health care before and after the program.

4. To study the ability level of Muslim students' reproductive health care after the program.

Research Questions

1. Is the Muslim students' physical health care ability regarding reproductive health after participating in the program higher than before?

2. Is the Muslim students' mental health care ability regarding reproductive health after participating in the program higher than before?

3. Is the self-confidence of Muslim students in reproductive health care after participating in the program higher than before?

4. Is there a high level of ability in the reproductive health care of the Muslim students after participating in the program?

Significance of the Research

The purpose of this study was to enhance the ability of Muslim students regarding reproductive health care in southern Thailand by using a specific program. The program gained from the participatory action research can be used as evidence for health care providers and teachers in their clinical, educational, administrative, and research endeavors. Generally, sexual and reproductive health education in schools is only partly compulsory, especially in the Islamic culture. From the findings of this study, the most challenging aspect is the implementation of reproductive health education within schools. Teachers and other schooling staff members could be better supported to notice, engage with and act upon students' moments of resistance to dominant discourses around youth, sexuality and gender norm.

The evidence-base from this study should have value for people in all levels of education, including secondary school, high school, college, and university. Teachers can use the results to guide their students and teach them about sexual and reproductive health by using five steps including: (1) searching knowledge, (2) determining and solving problems, (3) making decision and holding on, (4) developing vision, and (5) concluding and reporting. These could consist of several strategies such as lectures, discussions,

games, and videos on how to protect against pregnancy and how to avoid sexual problems such as STDs. It is learning by doing and is providing opportunities for the student leaders to contribute positively to society.

Indeed, the participatory method used in this study will allow many parties, including healthcare providers, educators and teachers, and local personnel at the district and sub-district levels, to address reproductive health problems effectively. One barrier appears to be the resistance of adults toward sex education program for teenagers, because of the adults' fear that such a program may increase sexual activities among teenagers. After finishing this study, teenagers will be better able to integrate resources, make good use of personnel, and appropriately time activities. This will result in high efficiency, strong teamwork, good time management, and the effective use of resources. The students can become highly competent, and will be able to play active roles once the adults provide opportunities for them. Finally, it will be useful for testing models in other Islamic schools when confirming the results of this study. In the future, it may be important to conduct a randomized control study (RCT) or a quasi-experimental, two groups design to evaluate and measure the sexual behavior outcomes of the students, and to compare the results with those from other private Islamic schools with a similar context.

Conceptual Framework

Participatory action research (PAR) was conducted in this methodology study. It consisted of a strong commitment and responsibility from the students who are the key participants in this study. The conceptual framework of the project is based on two main

aspects: the reproductive health program, and the outcomes from the reproductive health program (figure 1).

1. The reproductive health program

The reproductive health program or namely "doing by learning program" of this project consisted of the participation of stakeholders throughout all five distinct steps including: (1) searching knowledge, (2) determining and solving problems, (3) making decision and holding on, (4) developing vision, and (5) concluding and reporting, respectively. The key of this participation must consist of a strong commitment by the participants, with much responsibility on their part, as they are essential in each of the five steps which are detailed as following:

Step 1: Searching knowledge.

The first step is the process to gain more knowledge of sexual and reproductive health care for themselves and the community. Relevant data is obtained to assist in defining a health issue. This step consists of (1) identifying the need to know, (2) determining the ways to get the knowledge, and (3) validating and grouping data in a process of critical thinking to determine cues and inferences. Step 1 is assessing and analyzing the current problems regarding sexual and reproductive health.

Step 2: Determining and solving problems.

As part of program planning, it is important to search published literature for evidence of what works or does not in regards to sexual and reproductive health issues. This step must be analyzed to determine and identify existing or potential strengths/weaknesses or problems and their causes. It is to identify options and select the appropriate methods for the solution of sexual and reproductive health problems. Also, setting goals or outcomes, and planning interventions to accomplish these goals.

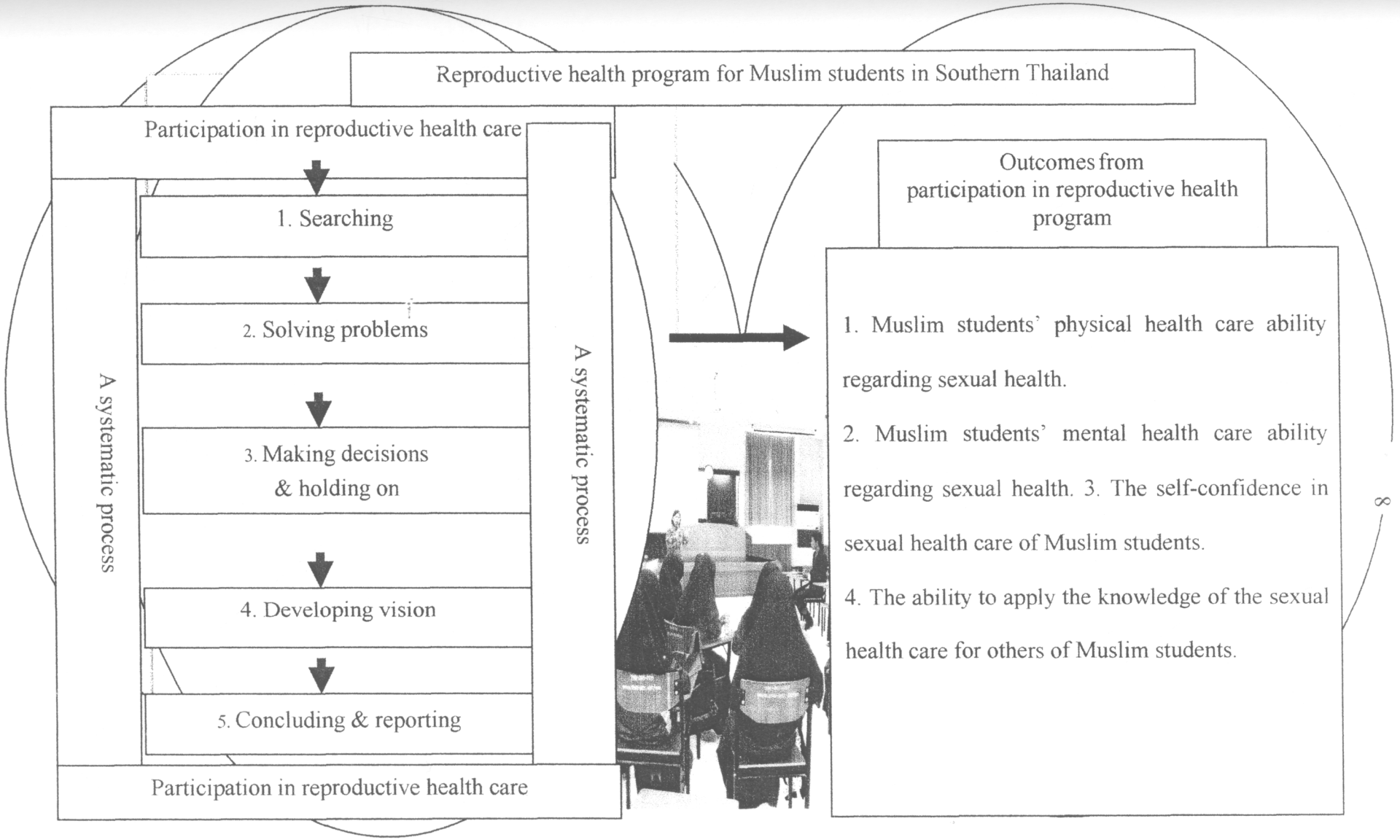

Figure 1 Conceptual framework of the participatory action research

Step 3: Making decision and holding on.

Before making a decision and holding on to the intervention of the program, there are many important aspects to be concerned with such as the feasibility of the intervention, for the appropriateness and suitability to the school, values and cultural beliefs, available communication media, and the context.

Step 4: Developing vision.

After completing three steps as mentioned above, this step is to improve the ability of thinking, planning, implementing, and evaluating into the future. It offers a body of knowledge, principles, and skills that place the students at the center of the educational enterprise. This step has become an important part for any program development. In this regard, the fourth step is used when the purpose is to evaluate how the program works. For example, is the program delivered effectively for the purpose of improving the way it is offered?

Step 5: Concluding and reporting.

The last step is to summarize the major inferences that can be drawn from the four steps including: (1) searching knowledge, (2) determining and solving problems, (3) making decisions and holding on, and (4) developing vision. Additionally, this process involves oral and written information on reproductive healthcare activities being presented to organizations and communities. It answers the questions raised by the research problem or stated purpose of the report and states the conclusions reached. Finally, it involves the following tasks: sharing and learning about, and reflecting on the reproductive healthcare activities.

2. The outcomes from the reproductive health program.

In this study, the outcomes are the conceptual framework including knowledge, skills, self-confidence, and the abilities the students possess when they have completed the reproductive health program.

Definition of Terms

Reproductive health program refers to a series of five steps in a systematic project to be carried out to meet the outcomes. It consists of: (1) searching knowledge, (2) determining and solving problems, (3) making a decision and holding on, (4) developing vision, and (5) concluding and reporting, respectively.

Reproductive health care ability refers to knowledge (means intelligence), skills (means capability), self-confidence (means assurance), and competences (means applying the knowledge), regarding (1) sexual and reproductive rights, (2) prenatal development, (3) sexual masturbation, (4) the structure and function of female and male reproductive systems, (5) sexual feelings and control, and (6) sexual values, sexual intercourse, STDs and HIV/AIDS, and contraception.

Summary

Globally, the high level of sexual activity among teenagers and the low incidence of contraceptive use are directly related to several problems such as abortion, teenage pregnancies, and STDs and HIV/AIDS. A participatory action research study was conducted in collaboration with one private Islamic school in a southern province in Thailand. There is currently no available program or strategy suitable for a Muslim

cultural context which aims to enhance and then maintain the reproductive health care of school students. Therefore, the purposes of this study were as follows: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after the program, (3) to compare the self-confidence of Muslim students in reproductive health care before and after the program, and (4) to study Muslim students' ability level of reproductive health care after completing the program. The findings from this study produced some positive results among the teenagers and allowed the creation of an intervention designed to develop the ability of teenagers regarding reproductive health care, with the specific goals being a reduction in the number of HIV/AIDS cases and less incidence among teenagers of unintended pregnancies and abortions.

CHAPTER 2

LITERATURE REVIEW

To enhance the reproductive health ability of teenager's caring in this study, a literature review was carried out on four main issues including: situational analysis of sexual and reproductive health in teenagers, religiosity and health in Muslims, health promoting program, and participatory action research.

Situational analysis of sexual and reproductive health in teenagers

Globally, among teenagers, risky sexual behavior has become a serious problem. For example, the finding comes from a new study lead by researchers at Ryerson University. The researchers found that nearly 42% of the teens reported they were sexually abused as children. Significantly more females (62%) said they were abused compared to males (26.9%). The youth who were sexually abused as children also cited more often coping and partner approval as motives for engaging in risky sex. Additionally, they found that using sex to get approval was linked to the age of the teenagers' first sexual encounter. These youth reported their first sexual encounter, on average, at age 14 years old (AIDS Patient Care and STDs, 2011). Sexual high risk behavior is particularly important for teenagers, who may be pressured to become sexually active before they have developed the maturity to deal with intercourse, contraception, abortion, and unplanned pregnancy (Murray, McKinney, & Gorrie, 2002). For instance, in developed countries, adolescent childbearing is more common in the United States (22% of women reported having had a child before age 20), than in Great Britain (15%), Canada (11%), Fance (6%), and Sweden (4%); differences are even

greater for births to younger teenagers (Darroch et al., 2001). In Russia, a cross-sectional study between 2009 and 2010 from women who had casual or multiple sexual partners in the previous three months was conducted. Many women rely on abortion as a primary birth control method. Although refusal to use contraceptives, including condoms, may undermine public health efforts to decrease HIV sexual risk behaviors. The findings revealed that of 87 participants, 45% had an abortion in their lifetime and 26% did not use condoms in the prior three months (Abdala et al, 2011).

At present, a number of factors identified that influence behaviors impacting on teenagers of reproductive and sexual health as well as the media include attitudes towards contraception, use of drugs and alcohol, peers and friends, level of knowledge, self-efficacy, family, religious, race, and culture (Figure 2) (Juntasopeepun, Suwan, Phianmongkhol, & Srisomboon, 2011; Kokaew, Takviriyanun, & Khampalikit, 2010; Siebold, 2011). Marvel and colleagues (2009) stated that drug and juvenile justice involved youths show remarkably high rates of human immunodeficiency virus (HIV)/sexually transmitted disease (STD) risk behaviors. Additionally, in New York City, the study of unprotected anal intercourse and sexually transmitted diseases (STDs) among heterosexual women in 2006 through 2007, the results of the 436 women studied, 38% had unprotected anal intercourse in the past year. Unprotected anal intercourse was more likely among those who were frequent drug or binge alcohol users, had an incarcerated sexual partner, had sexual partners with whom they exchanged sex for money or drugs, or had more than 5 sexual partners in the past year (Jenness, 2011).

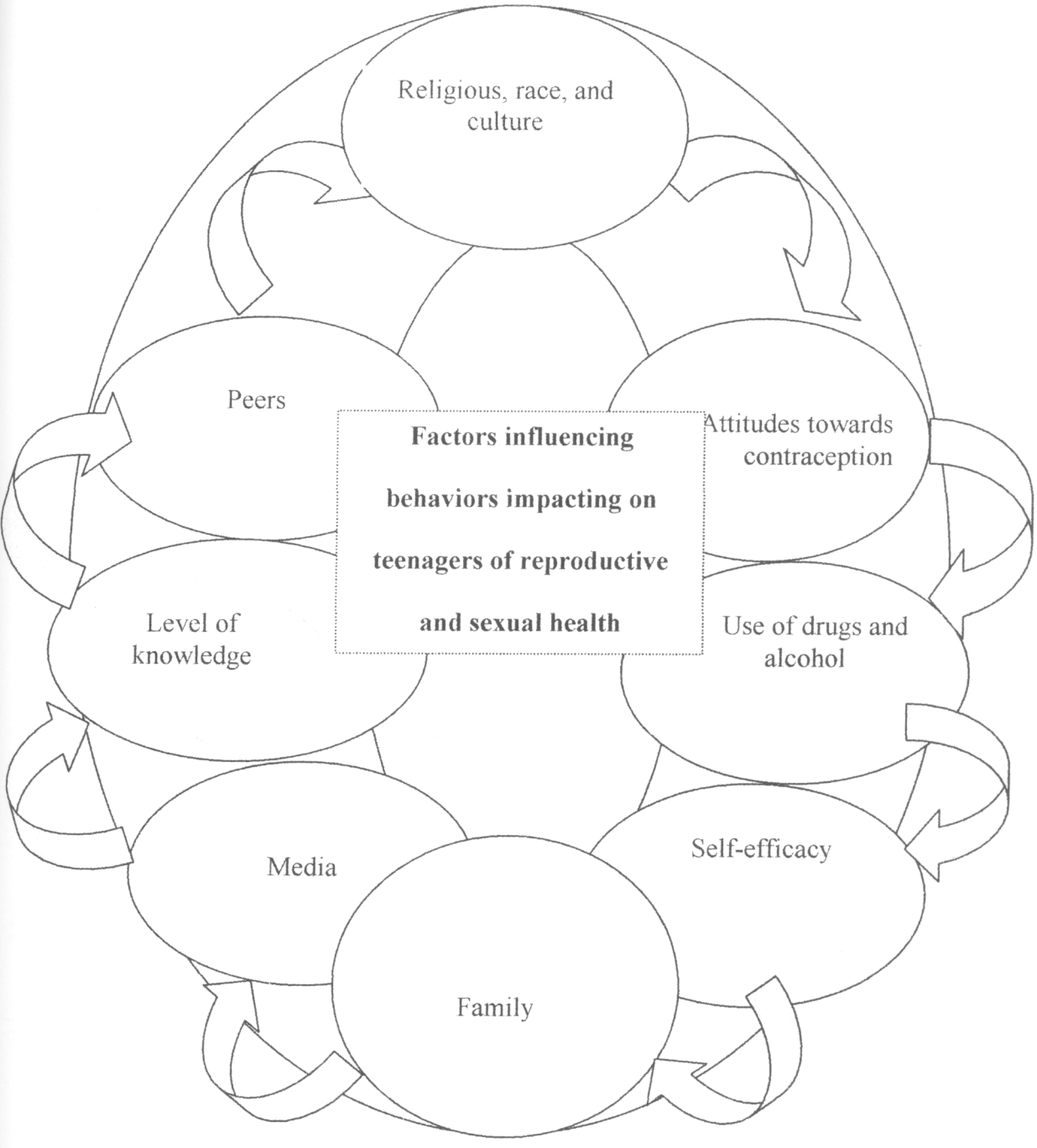

Figure 2 Factors influencing behaviors impacting on teenagers of reproductive and sexual health

In Thailand, the findings of a study of sexual identity among adolescents demonstrated that some adolescents have grown up feeling insecure about their sexual identity that could lead to inappropriate sexual behaviors. Several factors related to sexual identity development included (1) role models in family, (2) presentation of inappropriate sexual identity in the mass media, and (3) the influences of consumerism society and peer group. As a result of this study, important issues and concerns raised from adolescents, parents, teachers, and researchers suggested that a sexual identity prototype program for Thai adolescent is greatly needed and would be started with adolescent themselves as well as creating a positive environment that enables adolescents to develop their own sexual identity with environment from all stakeholders (Fongkaew, Fongkaew, Wongpanarak, & Lirtmunlikaporn, 2007). Another study among female college students (aged 18-24 years), results revealed that participants had high levels of sexual risk behaviors. 39.8 percent had had sexual intercourse and only 18.1 percent used condom regularly while having sex. Thirteen years old is the youngest age at first sexual intercourse. Moreover, 53% reported never heard about HPV vaccines. Their knowledge of HPV and cervical cancer was moderate. The mean knowledge score was 7.84 (SD = 3.98, range 0-15) (Juntasopeepun, Suwan, Phianmongkhol, & Srisomboon, 2011).

Interestingly, the evidence-based of the study "Risk factors, protective factors, and alcohol use among out of school adolescents in the community of Phichit Province, the results showed that approximately 80 percent of out of school adolescents had used alcohol. The minimum age of the participants' first use of alcohol was ten years old. The correlation between peer risk factors and adolescent alcohol use was founded significantly ($p<.01$) (Kokaew, Takviriyanun, & Khampalikit, 2010).

There is the descriptive study of first year university students, utilizing a survey questionnaire, explored sources of information including, but not limited to, the media,

factors influencing decision making and young women's health seeking behaviors in terms of reproductive and sexual health. Understanding of sexual and reproductive health was variable with only approximately half of respondents demonstrating an adequate understanding. The importance of family values, particularly mothers as role models, emerged as important determinants of behavior, while religious values were identified as important to only 15% of respondents. At the same time, pressure to engage in sex at younger and younger ages and continuing pressure to engage in unprotected and risky sex was a concern. Cynicism was expressed regarding the double standard perceived to be still operating in relation to young men's and women's sexual health. Young women in the study were forceful in identifying a need for a much better approach to education within schools directed at both sexes and one that is factual, relevant and all encompassing (Siebold, 2011).

Similarly to the study of comprehensive school-based health care, some of the most common major diagnostic categories were reproductive health problems (11%), and substance abuse problems (8%) (Anglin, Naylor, & Kaplan, 1996). The cross-sectional study of self-perceived risk of HIV infection and attitudes about preexposure prophylaxis (PrEP) among 405 sexually transmitted disease (STD) clinic attendees in South Carolina, Most participants reported 2–4 sexual partners in the past 3 months (41%). The majority of respondents had no previous history of non-injection drug use in the past year (70%). The majority of participants strongly disagreed (35%) with the statement "I believe I am at risk of getting HIV." Also, most participants strongly disagreed (38%) with the statement "If I had to it would be very difficult for me (or my partner) to both use condoms and take daily pills to prevent HIV infection." (Whiteside, Harris, Scanlon, Clarkson, & Duffus, 2011).

Religiosity and health in Muslims

Religiosity has been positively related to a variety of health behaviors such as in Muslim culture, abstinence from substance abuse or do not use birth control. Nguyen and associations (2012) found that religiosity was associated with positive cancer screening. Women who were high in social extrinsic religiosity may have been more active and more likely to participate in social events. These women were more likely to have connections to sources of health information within the faith-based community. Furthermore, women who believe that cancer is terminal could receive information about early detection and successful treatment rates for breast and cervical cancer. Women with fatalistic views of cancer due to beliefs of divine retribution from God or other forces could have their beliefs shaped through a similar lens.

Somjai and Chaipoom (2006) found that Buddhist and Muslim gynaecological cancer patients have the same high needs of psychosocial care, hope, and more information. However, the need for privacy in Muslim patients was much higher than in Buddhist. As one Muslim said, "When I arrived here, it was so strange. I worried about how I can pray. It is the most important. In brief, a meaningful and purposeful life enhances the psychological well-being of persons.

Moreover, religion is an area that is increasingly examined as to how it relates to psychological and physical adjustment. Religiosity has also been associated with the moral behavior of adolescents of various ethnicities including the Islamic (Frank & Kendall, 2001). To explore ethnic and generational influences among Chinese, Fillipino, and Euro American adolescents on emotional distress and risk behaviors, the results showed that ethnicity predicted depression and delinquency scores, while generation

within ethnic groups predicted somatic symptoms and substance use (Willgerodt & Thompson, 2006).

The term spirituality is a very broad concept and often associated with religion and religious beliefs and practices. It is whatever or whoever gives ultimate meaning and purpose in one's life that invites particular ways of being in the world in relation to others, oneself, and the universe (Wright, 2005). For instance, the study aims to investigate the religious belief in the principles and practices of faith in the Quran. The results were Muslims must profoundly respect both the principles of faith and of practice. The principles of faith consists of six items including, (1) faith in the unity of God, (2) faith in angels, (3) faith in prophecy, (4) faith in revelation, (5) faith in the afterlife, and (6) faith in destiny/divine decrees, and the principles of practice consists of five items including, (1) testimony of faith, (2) praying five times a day, (3) fasting, (4) almsgiving, and (5) pilgrimage. Moreover, there are some prohibitions such as consumption of pork, meat from animals that died naturally, or gambling (Tientong, Malangpoo, & Ratanakal, 2008).

Various research and development to solve environment problems were encouraged in communities. For instance, the study of participatory action research of the local community for environmental development on Muslim cultural tourism zone, the results were presented that the significant problems are lack of proper knowledge and behavior on environment. Such as waste management problems: (1) garbage in the house, (2) find garbage to sell, (3) bins in community is less, and (4) no comprehensive waste separation in the community (Theerapuncharoen, 2008). In addition, Sirisupluxana and Mungkung (2007) indicated that different ethnic groups had different levels of environmental awareness in resource utilization.

After an extensive review literature, religiosity is the presence of institutional organization and affiliation, expressions of particular beliefs, and rituals rooted in beliefs of the supernatural or divine. Health behaviors and religion are positively related. For instance, Muslims believe that limiting the number of children is prohibited by religion or Muslims do not accept terms such as "family planning" or "birth control" because they indicate limiting the number of children. Therefore, using the term "birth or child spacing" is recommended when teaching women about the advantages of contraceptives.

Health promoting program

Before mentioned the details of health promoting program in this section, there is one remaining question to ask before initiating the program: "Does it focus on health?" Anderson and McFarlane (2004: 282) said, "This may seem to be a strange question. You might wonder, don't all community health programs focus on maintaining, restoring, or promoting health? Sometimes, the answer is no." Not only focus on health, understanding differences in health risk factors across racial, religion, ethnic and sexual minority groups, as well as genders, is important for tailoring public health interventions.

Because rates of HIV/AIDS and STDs infection, unintended pregnancy, abortion and unintended birth are very high among teenagers around the world, it is important to identify programs or interventions that can reduce these problems in this population. Mojola and Everett (2012) revealed that interventions should also account for the findings on early adulthood shifts in sexual orientation. These shifts occur after many young adults have transitioned out of settings such as high school and college, where they were easier to reach with risk reduction programs. Additionally, interventions among youth in such settings should address risks faced by all youth, whether sexual-majority or sexual-

minority, thus equipping them to appropriately manage and assess their sexual health risk as they move into and through adulthood. After extensive literature reviews, these are several health promoting programs in various countries such as America, Portugal, Russia, Vietnam, Macao, and Thailand, respectively (Table 1).

Sexual and reproductive health promoting program in schools around the world is only partly compulsory (Spencer, Maxwell, & Aggleton, 2008). For example, in south Florida county, America, a group of citizens, concerned about the well-being of their community, recognized the high rates of HIV/AIDS and teenage pregnancy in their south Florida county and decided to take action. Supported by community leaders and using available resources within the county, this HIV/AIDS committee began a community-based participatory action project (sometimes called "participatory action research or action research"). Following a phone survey of over 1,000 residents, the committee determined that county residents were ready for change as well. Committee members developed and distributed a DVD to educate county residents about the importance of HIV testing and prevention. Additionally, they worked to change the high school curriculum to include more comprehensive sex education issues for students (Weiss, Dwonch-Schoen, Howard-Barr, & Panella, 2010). The action of committee members is a key mechanism to help them to solve complex decisions and issues. Jackson and Thurgate (2011) stated that action learning is a way to improve performance, promote learning and develop the capacities of individuals, teams and organizations.

In addition to health promoting program, there was the intervention-the Women's Reproductive Assessment Program (WRAP). It used a counseling model adapted from motivational interviewing, following such principles as expressing empathy and supporting self-efficacy. This model emphasized three elements: (1) exploring discrepancies between pregnancy intention and contraceptive use, and between STD risk

Table 1 Health promotion program of sexual and reproductive

Health promotion program	Elements/Contents of program
1. Women's reproductive assessment program or WRAP	1. Three elements: (1) exploring discrepancies between pregnancy intention and contraceptive use, and between STD risk and condom use, (2) sharing information with participants, and (3) promoting behaviors to reduce risk.
2. Multidimensional family therapy or MDFT	2. It focused on the adolescents' sexual practices as part of a movement toward health and respect for self in both body and mind, and this is consistent with drug use. Building on the HIV/STD multifamily groups, MDFT therapists addressed HIV/STD prevention in ongoing adolescent, parent, and family sessions (the entire course of therapy ranges from 4 to 6 months), deepening the knowledge and skills learned in the groups.
3. Youth-led educational program	3. It was designed to be taught over 3 days, outside the normal school hours and consisted of eight sessions that ranged from 60 to 180 minutes in length. During each session, the male and female students were divided in the gender-based sessions where they discussed sexual and reproductive health, played games and practiced skills. The contents in this program were: (1) sexual and reproductive rights, (2) puberty related physical changes reproductive organs and sexual hygiene, (3) masculine and feminine gender roles, and (4) skills to use, regarding sexual and reproductive health, when associating with peers.

and condom use, (2) sharing information with participants, and (3) promoting behaviors to reduce risk. The focus of the initial WRAP session was to encourage women to adopt consistent, effective contraceptive use, and condom use for the prevention of STD, including HIV infection. The initial session also offered women the opportunity to obtain, or receive a referral for, any type of contraceptive. If intervention participants elected to start or change contraceptive methods, their primary care provider was notified and the information was added to their medical record. Two months after the enrollment session, WRAP health educators conducted a booster session either in person or by telephone for intervention participants. A longer interval may have allowed them to forget the counseling messages or become discouraged. During this contact, educators focused on the client's progress toward or barriers to meeting specific risk reduction steps and adopting consistent, effective contraceptive and condom use (Petersen, Albright, Garrett, & Curtis, 2007).

Existing evidence-based family-focused models had not systematically incorporated HIV/STD prevention. Therefore, Marvel and colleagues (2009) described the latest advances in developing more effective HIV/STD prevention for juvenile justice-involved, substance-abusing teens utilizing a concept and process with a strong tradition in family therapy. It was called Multidimensional family therapy or MDFT. MDFT aims to promote adolescents' healthy development in all domains of functioning, including sexual relationships and behavior. Adolescents are encouraged to take responsibility for their sexual practices and protect themselves from contracting HIV and other STDs. The focus on the adolescents' sexual practices is conceptualized as part of a movement toward health and respect for self in both body and mind, and this is consistent with drug use. Building on the HIV/STD multifamily groups, MDFT therapists address HIV/STD prevention in ongoing adolescent, parent, and family sessions (the entire course of

therapy ranges from 4 to 6 months), deepening the knowledge and skills learned in the groups.

Interestingly, in Portugal, the use of educational technology as a strategy for health education among the teenagers in a public school was provided between April and May of 2007. It was a cycle of four educational workshops held with 30 teenagers. The workshops had the intent to promote discussion/action from the participants on the themes: sexuality, gender, STD/AIDS and contraceptive methods. The results showed gaps in knowledge about the ways to infection by STDs and appropriate use of contraceptive methods. Another relates to issues of gender that seem to influence the quality of life of young people in the study. The use of educational technologies could arouse among adolescents, a rethink on the experience of sexual and reproductive health from the perceived vulnerabilities. In this context, the nurse should produce/readjust new technologies that support the educational process in health education, valuing the skills and aspirations of adolescents (Gubert et al., 2009). Furthermore, the use of educational game as a strategy for health promoting program in adolescent group was presented in a public school of Fortaleza-CE in June 2009 in Portugal. It was a successful experience for having favored the execution of the educational process putting together information, discussion, reflection, interaction and group participation, where the adolescents could clear their doubts, fill out gaps of knowledge regarding subjects like sexuality and prevention of STD and AIDS and interact with each other in an informal way, facilitating the participation of all in the learning (Barbosa, Dias, Pinheiro, Pinheiro, & Vieira, 2010).

In Russia, Programs to increase contraceptive use including condom use among women at high risk for STD/HIV are needed. Abdala and associations suggested (2011) programs to reduce sexual HIV risk and abortion rates must address alcohol misuse and target women with who may be economically disadvantaged.

In Vietnam, various strategies and resources are essential for health promoting program. Like to promote AIDS prevention activities in several techniques are important in order to cater for different groups. For instance, health education programs focusing on peer education and support are necessary for protecting and empowering young migrant female sex workers (Rush, Watts & Rushing, 2005). Another study among Vietnamese women in the United States about the relationship between religiosity and cancer screening, the results concluded that educational programs in faith-based communities could maximize the potential of social events in making breast and cervical cancer information visible to the community. For example, traditional Vietnamese holidays and festivals are celebrated on church and temple grounds. Health information booths with information on cancer topics in the Vietnamese language could be distributed during these events. The study's findings suggested that certain facets of religiosity may impede cancer screening behavior, particularly for less acculturated women. Information provided in intervention sessions could incorporate the potential role of God in helping cancer survivors. Interventions conducted in faith-based set-tings might also incorporate prayer or meditation in helping women reduce anxiety surrounding breast or cervical cancer (Nguyen, Hood, & Belgrave, 2012). Finally, in Macao, a researcher found that HIV/AIDS materials should be diversified to allow for the assessments of target groups (Debyasuvarn, 1996).

Using a quasi-experimental study, Fongkaew and colleagues (2011) conducted a youth-led program on sexual and reproductive health for Thai early adolescents. The educational program was designed to be taught over 3 days, outside the normal school hours. It consisted of eight sessions that ranged from 60 to 180 minutes in length. During each session, the male and female students were divided in the gender-based sessions where they discussed sexual and reproductive health, played games and practiced skills.

The examples of contents in this program were (1) sexual and reproductive rights, (2) puberty related physical changes reproductive organs and sexual hygiene, (3) masculine and feminine gender roles, and (4) skills to use, regarding sexual and reproductive health, when associating with peers. Supporting by evidence in Northeastern, Thailand, from the research's title "Program to improve appropriate attitudes and sexual behaviors in 8th grade youths using Moh-Lam folk dance", it aims to construct and develop the trail to build up appropriate attitudes and sexual behaviors of Thai Northeastern youths. By using local wisdom, namely Moh-Lam, the experimental group had a higher knowledge score and higher appropriate sexual intention behaviors after 1 month of the experiment. Their satisfaction toward the trial promoting appropriate attitudes and sexual behaviors by using local wisdom, Moh-Lam, was at a high rank of 97.91 percent. In brief, the trial was effective (Srinedpat, Buddhipornopas, Kaewkietpong, Kewpoung & Wannasin, 2007). Lastly, another study of AIDS prevention activity among health officers, community leaders, parents and youths in a community of southern Thailand, the findings revealed four steps in participation of this project. It consisted of: (1) situation analysis and decision-making, (2) planning, (3) acting, and (4) evaluating (Hassman, Limchaiarunruang, Singchangchai & Wiriyapongsugit, 2006).

Generally, to develop the health promoting program, all health care providers such as nurses or health workers need to organize knowledge, analyze factors and situation, develop the strategies and manage the resources. For example, early adolescents can be highly competent and able to an active role as "change agents" when adults provide social, cultural, and political environments that are supportive of them and recognize younger people's place as stakeholders in society (Fongkaew, Rutchanagul, & Fongkaew, 2005). Pender and colleagues stated "Clients often give important cues concerning the behaviors they wish to change. For example: I feel very sad when I think of how little

time our family spends together (Pender, Murdaugh & Parsons, 2002). Furthermore, increased attention to the provision of information and services could yield significant gains in reducing unplanned and births among adolescents (Darroch et al., 2001). Increased screening for history of intercourse, counseling and testing for HIV and STDs would likely reduce STD infections (Jenness, 2011). In brief, finding reasons to enjoy the moment and allowing oneself to experience the caring of others enhances health and well-being regardless of physical diagnosis (Arnold & Boggs, 1999).

Participatory Action Research

Participatory Action Research or PAR refers to a research approach based on the premise that the use and production of knowledge can be political and used to exert power (Polit & Beck, 2008). Moreover, Leonard (2004) stated empowering a community through PAR. It consisted of three essential components. First, participation is an active process, not a process in which one group or organization imposes its values on the community, but a process of mutuality in which all have a voice. Second, participation invoives choice, implying people have the right and the power to make decisions that affect their lives. Third, the decisions made through participation must have the possibility of being effective and there must be social systems to allow decisions to be implemented. More details of participation in another view, action or participation is impelled by an accumulated sense of need. Finally, to explore the potential for social activities to help solve HIV problems in the communities, the model for solving HIV problems consists of two parts: (1) Strengthening community relationships, and (2) Developing volunteer teams and organizations to activate intervention, determine the variety of revolving capital resources, increase networking among groups, create and improve the

attractiveness of activities, especially considering the solutions for both economic and HIV problems (Chanchai, Rungsisakorn, & Saengchan, 2006). Finally, Polit and Beck (2008) mentioned PAR in term of a collaboration between researchers and study participants in the definition of the problem, the selection of an approach and research methods, the analysis of the data, and the use to which findings are put. In brief, most changes must aim at improving community health through active partnerships between community residents and health workers from a variety of disciplines (Shuster & Goeppinger, 2008).

Summary

After extensive review literature, sexual and reproductive health is an important issue for a teenager group of all countries worldwide. This is due to the high level of sexual activity, the low incidence of contraceptive use, and high level of alcohol use. To solve these problems, it should be noted that many health promotion programs may be implemented based on the identification of local, regional or national health problems. For example, in Thailand, sexual and reproductive health program aims to reduce teenage pregnancy, abortion, HIV/AIDS and STDs.

CHAPTER 3

METHODOLOGY

This participatory action research was conducted from November, 2011, to July, 2012. The main objective of this study was to enhance reproductive health ability of the Muslim students for caring in one private school southern border province, Thailand. Four specific objectives were: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after participating in the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after participating in the program, (3) to compare the self-confidence in reproductive health care of Muslim students before and after participating in the program, and (4) to study the Muslim students' ability level of reproductive health care after participating in the program. This chapter consists of seven parts as followings: (1) research setting, (2) key participants, (3) data collection methods and instruments, (4) the research process, (5) ethical considerations, (6) trustworthiness of the study, and (7) data analysis, respectively.

Research setting

This participatory action research (PAR) was conducted in one private Muslim school in Pattani province, southern bordered Thailand. It involved collaboration and participation with many groups, both inside and outside the school. The school in this study is quite oldest and most famous of Islamic institution. It was established more than 100 years. At the beginning of this school, it was only for religious class. In 1956, the

school was changed by integrating the religious and ordinary course together. The location of this school is in the rural where there area is unrest in the south of Thailand.

Key participants

This school had students in two groups including religious students and ordinary students. In 2012, there are 960 students who studied in the second year to the 10th year of a religious group (Table 2) and 928 students who studied in the secondary school levels or Mattayomsuksa 1-6 or grade 7-12 (Table 3). They were from all sub-districts where their locations are near this school.

Table 2 Number of rooms and students in the religious group of the research setting

Level	Room (n)	Students		
		Male (n)	Female (n)	Total
1st year	-	-	-	-
2nd year	8	149	136	285
3rd year	4	69	106	175
4th year	3	62	85	147
5th year	2	28	102	130
6th year	2	26	76	102
7th year	1	20	37	57
8th year	1	2	33	35
9th year	1	6	7	13
10th year	1	5	11	16
Total	23	367	593	960

Table 3 Number of rooms and students in the ordinary group of the research setting

Level	Room (n)	Students		Total
		Male (n)	Female (n)	
Grade 7	6	102	133	235
Grade 8	4	59	96	155
Grade 9	5	67	120	187
Grade 10	3	43	78	121
Grade 11	3	41	94	135
Grade 12	3	38	57	95
Total	24	350	578	928

The key participants were 51 students and seven teachers who volunteered to participate in this study. The criteria for recruiting student participants were (1) their ability to communicate in Thai language, (2) their educational grade point average (GPA) of less than 2, (3) enrolled in grades 8 and 11, (4) had parents or guardians who consented to participate, and (5) assented to participate.

Additionally, in this study, there were various groups outside the school which helped facilitate and support the student participants, and gave consultation at each five step of the program. For instance, two healthcare providers from the district health office participated and shared their ideas concerning the implementation phase of the study. Moreover, throughout of this study, a religious expert and two other consultants gave suggestions and advice concerning sexual and reproductive health care. They also made recommendations on all the steps of the sexual and reproductive healthcare projects which were developed by the students.

Data collection methods and instruments

This participatory action research (PAR) involved the use of both qualitative and quantitative methods. Therefore, the various data-collection activities undertaken in this study included conducting focus groups, engaging in participant observations, conducting a workshop, and facilitating group meetings and presentations. In addition, questionnaires (open and closed), individual and group interviews, and field notes were devised in order to improve the sexual and reproductive healthcare activities in this study. Data was collected throughout the course of the study (November, 2011, to July, 2012), and throughout the five steps of program which were: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting.

The data collection methods consisted of the following: (1) the sexual and reproductive healthcare test, (2) the questionnaires on the ability of the physical and mental health care regarding sexual and reproductive healthcare activities, (3) the questionnaires on the self-confidence regarding sexual and reproductive healthcare activities, and (4) the questionnaires on the ability's level of the sexual and reproductive healthcare activities. These were provided to student participants at the beginning and the end of the PAR.

Finally, the opinions of the students regarding their participation in the study, the opinions of the teachers regarding the students' participation in the study, and participant observations, were conducted throughout this study. Field notes and photographs were used to gather data during the sexual and reproductive healthcare activities in the study. The data were transcribed and analyzed simultaneously during the data analysis process.

The instruments in this study were including: (1) demographic data form, (2) the sexual and reproductive healthcare test, (3) the ability of the physical regarding sexual and reproductive healthcare questionnaire, (4) the ability of the mental regarding sexual and reproductive healthcare questionnaire, (5) the self-confidence regarding sexual and reproductive healthcare questionnaires, and (6) the questionnaires on the ability's level of the sexual and reproductive healthcare activities. Additionally, the open-ended questions on the opinion of teachers regarding the students' participation in the study, and the opinion of students regarding their own participation in the study were developed and provided to them throughout this study. These instruments are described below, and can be seen in Appendix A.

1. Demographic data form: Information obtained consisted of each participant's; sex, age, education (level and grade), living situation, and gaining the sexual and reproductive healthcare knowledge. Furthermore various experiences relating to this study was used to obtain more background of the student participants such as: (1) writing sexual and reproductive healthcare project, (2) developing the instrument for collecting the data, (3) collecting and analyzing the data, and (4) presenting and reporting the project.

2. The sexual and reproductive healthcare test: This was a-22 item instrument used to assess participants' knowledge about sexual and reproductive healthcare. The examples of the items were: (1) Which is the sexual right?, (2) 、 、 Which is the care after menstruation in Muslim culture?, and (3) How does living together before marriage.? Each participant was asked to response those items. Every correct response, received a score of 1, while every incorrect response received a score of 0. Scores were ranged from 0 to 22. Higher scores mean a better level of sexual and reproductive healthcare knowledge.

3. The ability of the physical regarding sexual and reproductive healthcare questionnaire: This consisted of 15 closed items; each item was worded as a statement, which had to be rated on a five-point Likert scale, ranging from a level of activity "none" to "very often." Each item was summed for a total score ranging from 0 to 60. Prior to calculating the total score, four negatively focused items had their response scores reversed (Item No4, 5, 11, and 15). For interpretation, the total scores were categorized by using the score range divided into five levels (Table 4). The examples of the items were: (1) Observe the abnormality of reproductive health organ such as mass of breasts, or discharge from vagina, (2) Avoid living alone with the opposite sex, and (3) Drinking alcohol or beer. Each participant was asked to response those items. Higher scores indicated a higher ability of the physical regarding sexual and reproductive healthcare.

4. The ability of the mental regarding sexual and reproductive healthcare questionnaire: This consisted of 15 closed items; each item was worded as a statement, which had to be rated on a five-point Likert scale, ranging from a level of activity "none" to "very often." Each item was summed for a total score ranging from 0 to 60. For interpretation, the total scores were categorized by using the score range divided into five levels (Table 4). The examples of the items were: (1) Accept of changing by age such as breasts, or mustache, (2) Wrong doctrine, if having the opposite sex as boyfriend/girlfriend, and (3) Accept of dressing as Muslim culture such as dress up Hijab in Muslim girl. Each participant was asked to response those items. Higher scores indicated a higher ability of the mental regarding sexual and reproductive healthcare.

5. The self-confidence regarding sexual and reproductive healthcare questionnaires: The scale consisted of 15 closed items; each item was worded as a statement, which had to be rated on a five-point Likert scale, ranging from a level of feeling "none" to "very high " Each item was summed for a total score ranging from 0 to

60. Prior to calculating the total score, one negatively focused item had it response scores reversed (Item No 13). For interpretation, the total scores were categorized by using the score range divided into five levels (Table 4). The examples of the items were: (1) If not sure for the abnormality of reproductive health organ such as itching, I can consult my family, (2) If having the problems of homosexual, I can consult my family, and (3) I concern about my boyfriend/girlfriend regarding to have sexual intercourse. Higher scores indicated a higher feeling of self-confidence regarding sexual and reproductive healthcare.

6. The questionnaires on the ability's level of the sexual and reproductive healthcare activities. This scale consisted of 15 closed items; each item was worded as a statement, which had to be rated on a five-point Likert scale, ranging from a level of opinion or activity "none" to "very often." Each item was summed for a total score ranging from 0 to 60. For interpretation, the total scores were categorized by using the score range divided into five levels (Table 4). The examples of the items were: (1) Apply the sexual and reproductive healthcare knowledge for planning to their friends, (2) Analyze the data for sexual and reproductive healthcare planning, and (3) Advice about the sexual and reproductive healthcare to friends in the school. Each participant was asked to response those items. Higher scores indicated a higher feeling or activity of sexual and reproductive healthcare.

7. The opinion of teachers regarding the students' participation in the study: This related to the objectives of the study. The teachers' opinion questionnaire consisted of open-ended items focusing on their observations and feelings about the students' participation throughout this project. Examples of questions on this questionnaire were: "What are changing after students' participation in this study?"

Table 4 Criteria to interpreted the mean scores of the scale regarding sexual and reproductive healthcare

Scale	Item	Score range	Very low	Low	Moderate	High	Very high
Item	1	0 - 4	0 - 0.80	0.81 - 1.60	1.61 – 2.40	2.41 – 3.20	3.21 - 4.00
Physical	15	0 - 60	0 - 12	13 - 24	25 - 36	37 - 48	49 -60
Mental	15	0 - 60	0 - 12	13 - 24	25 - 36	37 - 48	49 -60
Self-confidence	15	0 - 60	0 - 12	13 - 24	25 - 36	37 - 48	49 -60
The ability	15	0 - 60	0 - 12	13 - 24	25 - 36	37 - 48	49 -60

8. The opinion of students regarding their own participation in the study: This related to the five steps of program which were: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting. This consisted of open-ended items focusing on their feelings about their own participation in all steps and on the benefits from participation in the study. Examples of questions on this questionnaire were: "What benefits did you get from participating in this study such as knowledge searching?"

The test and questionnaires were developed from the literature review by the researchers in this study. Then, five experts reviewed them for content validity. For this study, using split-half and Cronbach's alpha coefficient, the reliability of the instruments were followings: (1) the sexual and reproductive healthcare test was 0.773, (2) the ability of the physical regarding sexual and reproductive healthcare questionnaire was 0.760, (3) the ability of the mental regarding sexual and reproductive healthcare questionnaire was 0.8447, (4) the self-confidence regarding sexual and reproductive healthcare questionnaires was 0.8708, and (5) the questionnaires on the ability's level of the sexual and reproductive healthcare activities was 0.9312, respectively.

The research process

Using the PAR method, the enhancement of the student's caring ability programme in this study was designed and involved into five steps including: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting. It was conducted over a period of nine months, from November, 2011, to July, 2012. Various strategies were

provided in each step and a different group of participants involved for its specific purpose. The details of the research process were followings (Figure 3):

Firstly, build trusting relationships within the research team, the consultants for the study, the teachers from the school, and the health care providers and local officials at the sub-district of setting. Additionally, the key concepts of this program were informed and discussed among them. For examples, "Does this program disturb the studying of students?" Or "Who were the student participants in this study?" Finally, in this first step, two teachers were chosen to serve as collaborators with the research team to enhance the capacity of the student participants for sexual and reproductive healthcare.

Secondly, the aim was to recruit students to be leader participants in conducting the sexual and reproductive healthcare activities. This step involved consideration of student levels and the criteria for students to participate throughout the study. According to the selection criteria, the leaders participating in this study were divided into two groups, a group of students from Mattayom 2 (grade 8) and a group of students from Mattayom 5 (grade 11). They were judged and invited to have leadership ability due to their high intelligence quotient (IQ) and emotional quotient (EQ) scores, as well as the fact that they had no problems concerning grade point average. Also, they were confident and capacity in thinking, taking action, and expressing themselves.

Thirdly, the aim was to discuss, analyze, and present the objectives of the research study focusing on three main important topics: (1) the sexual and reproductive health problems in teenagers such as sexual and reproductive rights, sexual development, religious and sexual and reproductive health, sexual values, skills regarding sexual relationships, unwanted pregnancies, abortion, HIV/AIDS, and other STIs, (2) the five steps of conceptual framework for conducting the sexual and reproductive healthcare activities including: (2.1) knowledge searching, (2.2) problem solving, (2.3) decision

making and holding on, (2.4) vision developing, and (2.5) documentation concluding and reporting, and (3) the concept of participation for all steps of research methodology. Additional knowledge and skills which were necessary for the student participants to conduct their sexual and reproductive healthcare activities in the school and community were taught to them. These included the skills, and accompanying knowledge, necessary to develop sexual and reproductive health plans and instruments, create a SWOT analysis, and collect and analyze data.

Fourthly, the aim was to enhance the sexual and reproductive health ability of the Muslim students for caring themselves, friends, and others. This was done, the four educational sessions, using various methods, such as group discussions and group activities, video, lectures, debates, brainstorming sessions, and oral presentations. Finally, at the end of this phase, four sexual and reproductive healthcare projects were developed by four different groups of students. The project names were as follows: (1) "IT and New teenager," (2) "We Know You Know," (3) "Muslimah", and (4) "Anti Sex Premature." The student participants carried out the four sexual and reproductive healthcare plans as mentioned above in their school and other school. This was supervised by the teachers and researchers. Also, it was the first opportunity for them to think, do, and evaluate their projects by themselves.

Lastly, in this study, evaluation of the student's projects occurred continuously and consistently. Evaluation methods included reflection sessions, experience-sharing sessions, individual and group interviews, observations by participants, workshops, and questionnaires. The evaluation covered both processes and outcomes (for example, the strengths and weaknesses of the study). The credibility of the final step was established by prolonged participation with participants, the triangulation of information from multiple data sources, and reflection and feedback sessions. In these sessions, the

participants had the opportunity to confirm, rethink, and verify their ideas about the accuracy of the processes by which sexual and reproductive healthcare activities were conducted in their school and near the school.

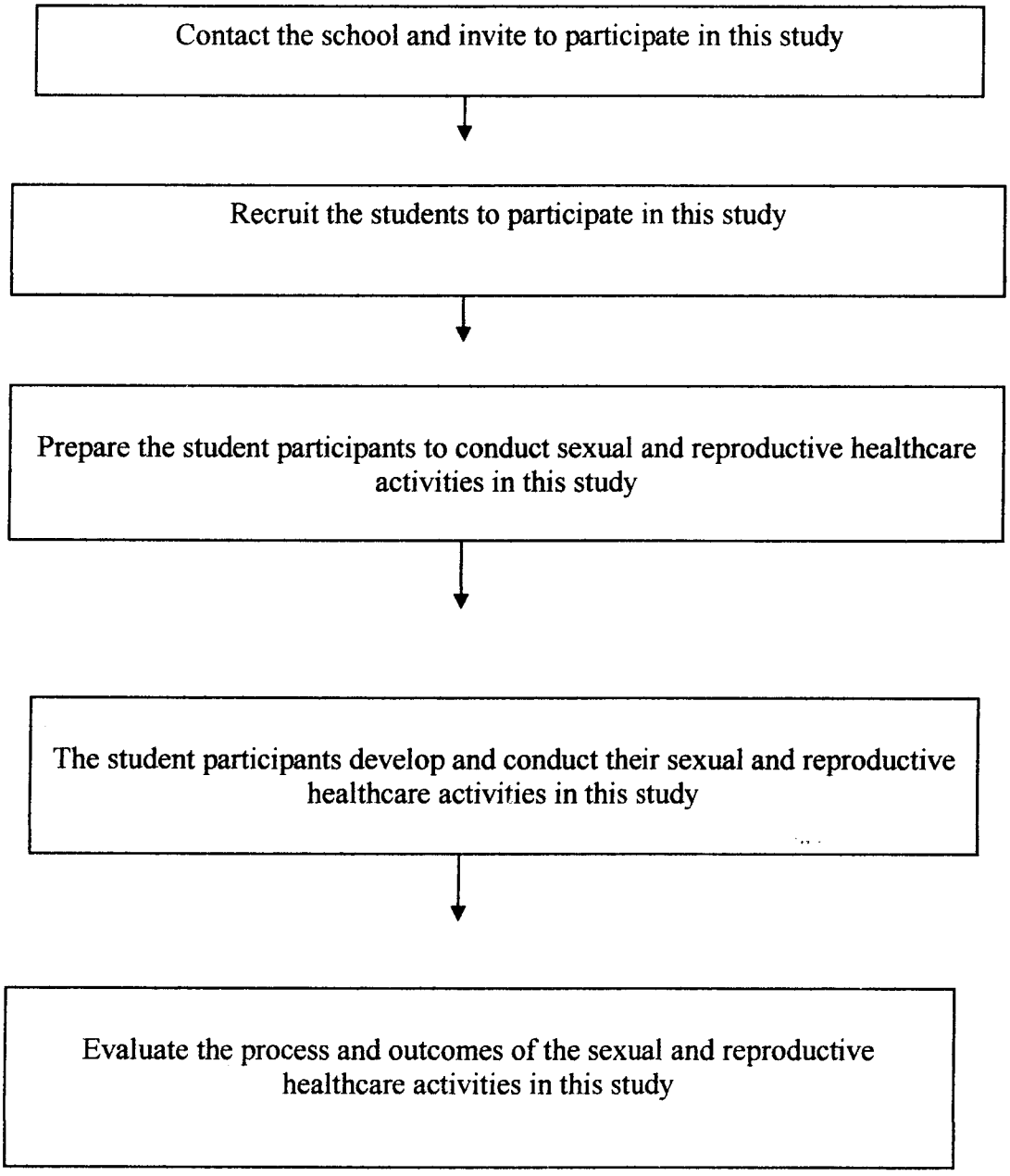

Figure 3 The research process to enhance reproductive health ability of student participants in this study

Ethical considerations

Ethical approval to conduct the study was granted from the Faculty of Nursing, Prince of Songkla University on human rights. In addition, the teachers, healthcare providers, and local officials were contacted for permission and cooperation to conduct the study on the Islamic school. Furthermore, the student participants and their parents or guardians were contacted to obtain their consent to participate and permission in the research study. Parents or guardians consenting and students assenting were asked to return the respective signed forms, to the students' respective teachers, within one week after receipt of the forms. Finally, Protection of subjects' rights was maintained, as a full oral explanation was given to them. It addressed the following areas: (1) the title of the study, (2) the purpose of the study, (3) an assurance of their anonymity, (4) the fact that participation was voluntary and that withdrawal was an option at any time, (5) the usefulness of the results of the study to the school, and (6) the names, telephone numbers, and addresses of the researchers.

Trustworthiness of the results

Trustworthiness of the data was established through use of credibility, appropriateness, consistency, auditability, and conformability. Credibility in this study was strengthened by its prolonged, nine-month timeframe (from November, 2011, to July, 2012), and by the persistent observation. In addition, to prevent bias, multiple data sources were used to confirm the accuracy of the findings, which bolstered the trustworthiness of this study. Data sources included workshops, individual and group interviews, and a research diary. Before writing the final paper, the researchers had the

participants ensure that the research findings matched their feelings, opinions, and experiences. In brief, this study was approved and revised at all steps by various groups, including the student participants, teachers and students, healthcare providers, consultants, and the researchers themselves.

The data analysis

Both quantitative and qualitative data were collected in this study. Concerning quantitative data, test and questionnaires were used to measure the enhancement of the sexual and reproductive healthcare ability of student participants' caring by using pre-test and post-test scores. These were compared with a t-test. Concerning qualitative data, content analysis was conducted in order to support the purpose of the study in terms of the following: (1) the ability of the student participants after participating in the sexual and reproductive healthcare activities, (2) the self-confidence of the student participants after participating in the sexual and reproductive healthcare activities, (3) the knowledge application of the student participants after participating in the sexual and reproductive healthcare activities, and (4) the feelings and opinions after participating in the sexual and reproductive healthcare activities. The process of qualitative data analysis included five phases, in which the researchers had to perform the following tasks: (1) identify the main themes, (2) assign codes to the main themes, (3) classify the responses into the main theme categories, (4) check for agreement, and (5) integrate the themes and responses into the text of the report. At the end of this study, the analyzed data were presented to all participants including student leaderships, teachers and administrator of the school, health care providers and local officials of the research setting, and the consultants of the project.

Summary

This participatory action research was conducted in one private school southern border province, Thailand from November, 2011, to July, 2012. The main objective of this study was to enhance reproductive health ability of the Muslim students for caring by using the five steps which were: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting. 51 students acted as key leadership participants throughout this study. Additionally, there were various groups inside and outside the school which helped facilitate and support the student participants, and gave consultation at each step of the program. Data was collected from the start to the end of the study. Effectiveness of the program in this study was assessed via a pre and post-test evaluation regarding (1) the sexual and reproductive healthcare test, (2) the questionnaires on the ability of the physical and mental health care regarding sexual and reproductive healthcare activities, (3) the questionnaires on the self-confidence regarding sexual and reproductive healthcare activities, and (4) the questionnaires on the ability's level of the sexual and reproductive healthcare activities. Also, the opinions of the students regarding their participation in the study, the opinions of the teachers regarding the students' participation in the study, and participant observations, were conducted throughout this study. Field notes and photographs were used to gather data during the sexual and reproductive healthcare activities in the study. The data were transcribed and analyzed simultaneously during the data analysis process.

CHAPTER 4

RESULTS AND DISCUSSION

The purpose of this study was to enhance reproductive health ability of teenager's caring in a Pondok school or a private Islamic school, southern border province, Thailand. This participatory action research was conducted from November, 2011, to July, 2012. Four specific objectives were: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after participating in the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after participating in the program, (3) to compare the self-confidence in reproductive health care of Muslim students before and after participating in the program, and (4) to study the Muslim students' ability level of reproductive health care after participating in the program. This chapter consists of the results of the study following the four objectives as mentions and a discussion regarding the objectives of the study.

Results

The results in this chapter consist of: (1) the student characteristics, (2) the program for the ability in taking care of reproductive health, (3) the knowledge scores of the student participants after the sexual and reproductive healthcare activities, (4) the ability of the physical health care regarding reproductive health of Muslim student participants after the sexual and reproductive healthcare activities, (5) the ability of the mental health care regarding reproductive health of Muslim student participants after the sexual and reproductive healthcare activities, (6) the self-confidence of the reproductive health care of Muslim student participants after the sexual and reproductive

healthcare activities, and (7) the ability's level of the reproductive health care of Muslim student participants after the sexual and reproductive healthcare activities.

1. The student characteristics

The key participants were 51 students who volunteered and involved in all steps of participatory action research (PAR). In this PAR, the program included five steps which were: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting. Additionally, there were more stakeholders participated through out this study. These included an administrator, seven teachers from this school, and other outside participants who would act as facilitators, supporters, advisers, consultants, and supervisors.

The majority of the students were female (86.30%) and 16-18 years old (54.90%). Their age mean was 15.71 years old. 58 percent of them were studying in tertiary level or Mattayomsuksa 5 or grade 11. Most of student participants had their educational grade point average (GPA) of more than 3 (82.36%). The majority of the students reported that they were living with their parents (74.50%) and never gain the knowledge of sexual and reproductive health care (64.70%). Furthermore, they had no experience of leadership similar to the context of this study (84.30%), writing the project (96.10%), collecting the data (98.00%), analyzing the data (92.20%), presenting the project (98%), and reporting the project (88.20%). Finally, all of them never had experience of developing the instrument for collecting the data to evaluate the project (100%) (Table 5).

Table 5 Number and percentage of student characteristics (n = 51)

Demographic data	Number	Percent
Sex		
Male	7	13.70
Female	44	86.30
Age (Year) Mean = 15.71 SD = 1.689		
13 - 15	21	41.20
16 - 18	28	54.90
19	2	3.90
Educational level		
Secondary level (Mattayomsuksa 2 or grade 8)	21	41.20
Tertiary level (Mattayomsuksa 5 or grade 11)	30	58.80
Educational Grade Point Average, Mean = 3.20 SD = 0.943		
2.00 – 2.99	6	11.76
3.00 – 3.84	42	82.36
Missing	3	5.88
Living with		
Father and mother	38	74.50
Father or mother	9	17.60
Father and others or mother and others	4	7.90
Gain sexual and reproductive health knowledge		
No	33	64.70
Yes	18	35.30
Experience of sexual and reproductive health care leadership		
No	43	84.30
Yes	8	15.70
Experience of writing the sexual and reproductive health care project		
No	49	96.10
Yes	2	3.90

Table 5 (Continued)

Demographic data	Number	Percent
Experience of developing the instrument for collecting the data		
No	51	100.00
Experience of collecting the data		
No	50	98.00
Yes	1	2.00
Experience of analyzing the data		
No	47	92.20
Yes	4	7.80
Experience of presenting the project		
No	50	98.00
Yes	1	2.00
Experience of reporting the project		
No	45	88.20
Yes	6	11.80

2. The program for the ability in taking care of reproductive health

The participatory action research (PAR) was conducted in this methodology study. It consisted of a strong commitment and responsibility of students who are key participants in this study and participation from stakeholders throughout all five steps including: (1) searching knowledge, (2) determining and solving problems, (3) making decision and holding on, (4) developing vision, and (5) conclusion and reporting respectively. To enhance reproductive health ability of teenager's caring in a Pondok school, three components in the model are required: (1) students' inspiration and need, (2) qualified and capable teachers, and (3) internal and external support (Figure 4).

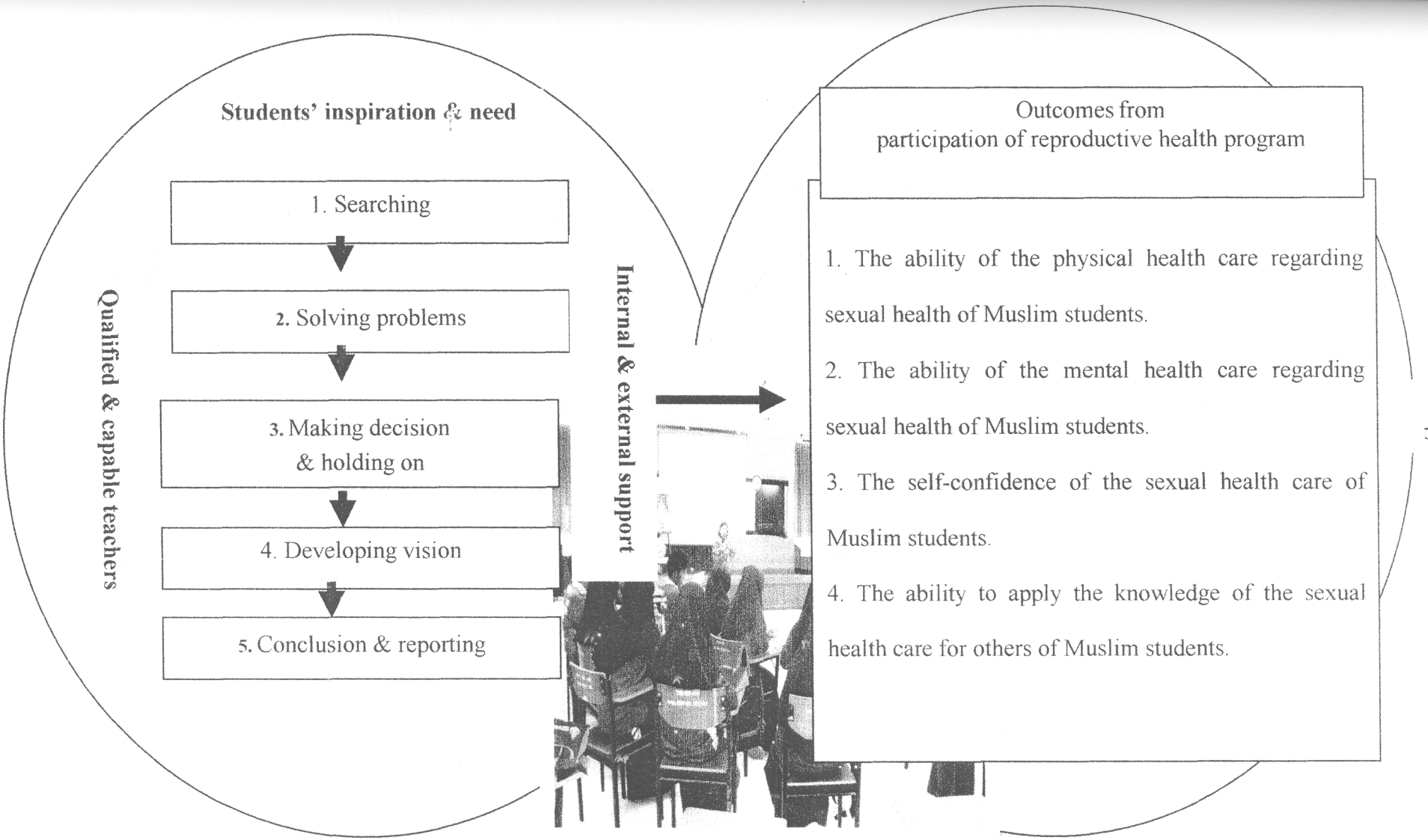

Figure 4 Reproductive health program for Muslim students in Southern Thailand

3. The knowledge scores of the student participants after the sexual and reproductive healthcare activities.

After the sexual and reproductive healthcare activities, the mean score of the knowledge test of the student participants (M = 15.49, S.D. = 2.353) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 13.57, S.D. = 2.326) (t = 5.587, p = .000) (Table 6).

4. The ability of the physical health care regarding reproductive health of Muslim student participants after the sexual and reproductive healthcare activities.

After the sexual and reproductive healthcare activities, the mean score of the ability of the physical health care regarding reproductive health of Muslim students (M = 46.24, S.D. = 9.408) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 38.45, S.D. = 10.118) (t = 5.455, p = .000) (Table 6).

5. The ability of the mental health care regarding reproductive health of Muslim student participants after the sexual and reproductive healthcare activities.

After the sexual and reproductive healthcare activities, the mean score of the ability of the mental health care regarding reproductive health of Muslim students (M = 43.92, S.D. = 7.238) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 39.88, S.D. = 9.421) (t = 3.472, p = .001) (Table 6).

6. The self-confidence of the reproductive health care of Muslim student participants after the sexual and reproductive healthcare activities.

After the sexual and reproductive healthcare activities, the mean score of the self-confidence of the reproductive health care of Muslim students (M = 36.25, S.D. = 8.165)

was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 31.25, S.D. = 8.499) (t = 3.972, p = .001) (Table 6).

7. The ability's level of the reproductive health care of Muslim student participants after the sexual and reproductive healthcare activities.

After participating in the program, the ability of the reproductive healthcare of Muslim students was at high level (M = 46.02, SD = 8.765) However, for each items, they were at high to very high level (Table 7).

Table 6 Comparison of the knowledge, the physical ability, the mental ability, and the self-confidence scale of student participants before and after the sexual and reproductive healthcare activities (n = 51).

Scale	Mean	SD	t	*P*
I: The knowledge of sexual and reproductive health care				
Before the sexual and reproductive healthcare activities	13.57	2.326		
After the sexual and reproductive healthcare activities	15.49	2.353	5.587	.000
II: The physical ability of sexual and reproductive health care				
Before the sexual and reproductive healthcare activities	38.45	10.118		
After the sexual and reproductive healthcare activities	46.24	9.408	5.455	.000

Table 6 (Continued)

Scale	Mean	SD	t	*P*
III: The mental ability of sexual and reproductive health care				
Before the sexual and reproductive healthcare activities	39.88	9.421		
After the sexual and reproductive healthcare activities	43.92	7.238	3.472	.001
IV: The self-confidence of sexual and reproductive health care				
Before the sexual and reproductive healthcare activities	31.25	8.499		
After the sexual and reproductive healthcare activities	36.25	8.165	3.972	.001

Table 7 The ability's level of the reproductive health care of Muslim student participants after the sexual and reproductive healthcare activities (n = 51).

Scale	Mean	SD	Level
1. Using the knowledge of reproductive health care for planning of benefit to friends in the school.	3.27	0.874	Very high
2. Accessing information about reproductive health care for planning of benefit to implement for friends in the school.	3.08	0.845	High
3. Analyzing the data for planning of reproductive health care.	3.02	0.927	High
4. Planning about reproductive health care to implement for friends in the school.	2.88	0.980	High
5. Writing a reproductive health care project.	3.00	0.800	High
6. Implementing a reproductive health care project.	3.02	0.836	High
7. Conveying and sharing knowledge of reproductive health care to friends in school.	3.14	0.825	High
8. Leadership of implementing a reproductive health care project.	3.02	0.883	High

Table 7 (Continued)

Scale	Mean	SD	Level
9. Helping their friends in school, when they have a reproductive health problem.	3.22	0.730	Very high
10. Giving advice their friends in school, when they have a reproductive health problem.	3.35	0.688	Very high
11. A good member of a group to implement for a reproductive health care.	3.12	0.765	High
12. Persuading friends who are risk to safe from a reproductive health problem.	3.07	0.973	High
13. Developing a tool to assess the performance of reproduction health care.	3.07	0.973	High
14. Analysis of the performance issues of reproductive health care.	2.90	0.831	High
15. Improving the implement of reproductive health care by using the evaluation data.	3.29	0.879	Very high
Total	46.02	8.765	High

Not only the results as mentioned above, the effectiveness of the program in this study were assessed by using the opinion of teachers and students after participating in this study. The study findings revealed as followings:

1. The opinion of teachers after participating in this study

After participating for nine months in this study, teachers who acted as facilitators, supporters, advisers, consultants, and supervisors presented that their student participants were improve for all aspects including the knowledge, the physical ability, the mental ability, the self-confidence, and the ability's level of the sexual and reproductive healthcare. For instances, the statements were:

"Before participating in this study, the student participants have quiet a little of sexual and reproductive health knowledge in terms of physical and mental. But at present, they have more their knowledge. This is because of learning by doing. First, they take care themselves, and then share their knowledge to their friends. Also, all the sexual and reproductive healthcare projects which were developed, implemented, and evaluated by the student participants were outcomes after completing the study."

"The student participants have more their self-confidence of sexual and reproductive healthcare for themselves and their friends. They asked and consulted many questions of sexual and reproductive health issues. Also, they watched these contents from television and searched them from the internet."

"This project is very good and suitable for teenagers. It is not only for the student participants but also for the teachers to have an opportunity in participating during a year of the study. Furthermore, need another project like this if possible in the future."

"The problem in this study is about the works and responsibilities of the teachers who have involved a lot in their school. However, this project is good for all students.

Right now sexual and reproductive health is serious problems in Private school or Ordinary school such as premature of sexual intercourse."

2. The opinion of students after participating in this study

Compared to before participating in this study, the student participants reported their feelings and opinions on various aspects including:

"At the beginning of this project, I do not understand how to develop the sexual and reproductive healthcare projects. I consult many groups of people such as teacher, and a senior and a friend. I need a lot of suggestions. I want more times to develop, implement, and evaluate the project. In brief, I am glad and very happy to participate in this study."

"During this project, I search more knowledge of sexual and reproductive health issues from the internet and books in library such as the incidence of teenagers in terms of sexual intercourse or how to protect from premature intercourse. To develop the project in this study, my teachers and group members help a lot especially provide all facilities such as computer, to do the power point for presentation."

At the last day of the project participation or closing ceremony (July, 26, 2012), students revealed their positive feelings such as (Appendix B):

"Participating in this project, I get a lot such as the knowledge to take care myself and others."

"In this project, I am the chairman. So this position helps me to be the leadership. Moreover, all participants cooperate and help together until we success of our goals."

"The sexual and reproductive health project is important for me. The knowledge from participation in this study is helpful for me and my friends. I need it to be continued for the others."

Discussion

The purpose of this study was to enhance reproductive health ability of teenager's caring in a Pondok school or a private Islamic school, southern border province, Thailand. Therefore, after completing a sexual and reproductive health program, the results indicated that all mean scores for the tests of knowledge, physical and mental healthcare ability, and self-confidence regarding reproductive healthcare ability were higher significantly than the mean scores before participating in the sexual and reproductive healthcare activities ($t = 5.587$, $p = .000$; $t = 5.455$, $p = .000$; $t = 3.472$, $p = .001$; and $t = 3.972$, $p = .001$), and the ability of the reproductive healthcare of Muslim students after the program was at high level ($M = 46.02$, $SD = 8.765$). The results may be explained in regards to three reasons as followings: (1) the process of sexual and reproductive health program, (2) a strong commitment and much responsibility of student participants, and (3) the social regulation of sexuality in Islamic societies.

1. The process of sexual and reproductive health program.

In this study, PAR was the methodology to enhance reproductive health ability of student's caring in a Pondok school, southern border province, Thailand. Jackson and Thurgate (2011) stated that action learning is a way to improve performance, promote learning and develop the capacities of individuals, teams and organizations. The action of participants is a key mechanism to help them to solve complex decisions and issues. Kiessling (2004) mentioned that knowledge building and behavioral change can take place by participation in education activities. Moreover, active participation during interactive sessions seems to influence subsequent practice. Supporting by the evidence in south Florida county, America, a community-based participatory action project was conducted to reduce teenage pregnancy and HIV/AIDS problems. Committee members in

this project developed and distributed a DVD to educate county residents about the importance of HIV testing and prevention. Furthermore, they worked to change the high school curriculum to include more comprehensive sex education issues for students (Weiss, Dwonch-Schoen, Howard-Barr, & Panella, 2010).

Thassri and colleagues (2008) recommended a PAR in the process for the enhancement of teenagers to promote AIDS prevention activities in southern Thailand. In this study, the students' leaders learned various aspects from participation including: (1) analyzing the current AIDS situation, (2) writing the projects of AIDS prevention activities, (3) conducting an AIDS education program, and (4) evaluating AIDS projects. In addition, Williams and colleagues (2006) conducted an HIV/AIDS educational program involving a five-day workshop. The workshop was comprised of didactic lectures interspersed with activities designed to elicit discussion on the participants' values and personal feelings concerning HIV/AIDS. Generally, several researchers used PAR as the methodology to develop a program for health promotion (Chotibang, Fongkaew, Mo-suwan, Meininger, & Klunklin, 2009; Sukwatjanee et al., 2011; Thassri et al., 2000).

Furthermore, all participants involved and participated throughout the program by using five steps including: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting. Similar to the findings of the previous study named "multidimensional family therapy or MDFT", aimed to promote adolescents' healthy development in all domains of functioning, including sexual relationships and behavior. Adolescents are encouraged to take responsibility for their sexual practices and protect themselves from contracting HIV and other STDs. The focus on the adolescents' sexual practices is conceptualized as part of a movement toward health and respect for self in both body and mind. Building on the

HIV/STD multifamily groups, MDFT therapists address HIV/STD prevention in ongoing adolescent, parent, and family sessions, deepening the knowledge and skills learned in the groups (Marvel, Rowe, Colon-Perez, Diclemente, & Liddle, (2009).

In this program, the PAR was designed to the participants over nine months (from November 2011 to July, 2012). Throughout this period, participants and stakeholders, including an administrator and teachers from the school, health care providers and local officials from sub-district, and an expert from the province, worked collaboratively. This process may be help to create thoughts and knowledge, feelings, and changes in the participants' ability. Marvel and associations (2009) conducted multidimensional family therapy course ranged from 4 to 6 months. While three months after a youth-led education program on sexual and reproductive health for Thai early adolescents revealed significant differences between the experimental and control groups, in terms of knowledge and attitudes toward sexual and reproductive health; pros of sexual involvement; and attitude toward condom use (Fongkaew, Settheekul, Fongkaew, & Surapagdee, 2011).

Finally, various strategies and materials were provided during the process of sexual and reproductive health program. In this study, the students' participants learned much of their sexual and reproductive health care by workshops, conferences, oral presentation, poster presentation, and games. Similar to the enhancement of teenagers to promote AIDS prevention activities in Songkhla province, the strategies used for improving students' knowledge consisted of various methods such as group discussion and presentation (Thassri & Benjakun, 2009). Debyasuvarn (1996) stated that HIV/AIDS materials should be diversified to allow for the assessments of target groups. Indeed, Fongkaew, Rutchanagul, and Fongkaew (2005) stated participatory techniques help young Thai adolescents develop a secure sense of sexual responsibility and a concern about their

reproductive health rights, and strengthen their capacity to play a major role in educating their peers.

2. A strong commitment and much responsibility of student participants.

Most of the student participants in this study had their educational grade point average (GPA) of more than 3 (82.36%). It means that they were responsible for their role. Similar to participating in this program, at the beginning, they often complained and worried to conduct their sexual and reproductive health care activities. These may be from more than 80 percent of participants did not have experience like this study (Table 2). For examples; 84.30% of student participants had no experience of leadership similar to the context of this study or 96.10% of student participants had no experience of writing the project. Finally, all of them (100%) never had experience of developing the instrument for collecting the data to evaluate the project.

This is congruent with prior research regarding to promote sexual and reproductive health and prevent HIV/AIDS in young Thai students. The project suggested that early adolescents can be highly competent, and able to play an active role as "change agents" when adults provide social, cultural, and political environments that are supportive of youth and recognize younger people's place as stakeholders in society (Fongkaew, Rutchanagul, & Fongkaew, 2005).

3. The social regulation of sexuality in Islamic societies.

The school in this study is the Islamic Institute, the oldest, and one of the most famous institutions of southern bordered province, Thailand. Therefore, the context of this study was in Islamic societies. Religion is an important factor influencing student's sexual self-understandings, being relevant both to sexual education and public health. Recognition of this issue will facilitate understanding of the cultural foundations of sexuality among Muslims and assist health providers in suggesting more culturally

compatible forms of healthcare. For instance, Khoei, Whelan, and Cohen (2008) suggested that the concept of sexual obedience within marriage is regarded as symbolic of an idealized Muslim femininity. Sexual obedience demonstrates women's high level of religious commitment but is also an indicator of modesty and self-respect. While some participants felt that it was a woman's duty to satisfy her husband on any sexual occasion, they did not utilize notions of subordination in their sexual lives. For other informants, however, concepts of subordination were more salient and tied to conservative religious leaders' interpretations of Quranic concepts and Iranian women's understandings of these same interpretations.

Smerrecnik and associations (2010) studied about Muslim adolescents' views on sexuality. The results revealed that: (1) sex before marriage is a sin in Islam, and (2) the mothers-to-be are to blame for their unintended pregnancies; they should have anticipated the consequences before acting upon their impulses or desire. In contrast, non-Muslims argued that this may not always be possible and that not consequences can be predicted. Presently, discussion, teaching and learning about sex, sexuality and sexual health, are not taboo or opposed in Islam. As this study, participants can talk, share ideas, and present of their sexual health care projects. Moral ideologies can be reconciled with lived realities and new interpretations and practices can arise, as local coping strategies for the HIV and AIDS crisis reveal (Beckmann, 2010).

Summary

The results in this PAR indicated the following: (1) all mean scores for the tests of knowledge, physical and mental healthcare ability, and self-confidence regarding reproductive healthcare ability after completing the program were higher significantly

than the mean scores before participating in the sexual and reproductive healthcare activities ($t = 5.587$, $p = .000$; $t = 5.455$, $p = .000$; $t = 3.472$, $p = .001$; and $t = 3.972$, $p = .001$), and (2) the ability of the reproductive healthcare of Muslim students after the program was at high level ($M = 46.02$, $SD = 8.765$).

The findings suggested that the sexual and reproductive healthcare program was valuable and beneficial to Muslim students in the future particularly for teenagers who might be forced to become sexually active before the normal maturity to deal with intercourse, contraception, abortion, and unplanned pregnancy. For Muslim participants, this program is quite good opportunities that may not always be possible in their everyday lives. It is hopeful that by exploring Islam and sexuality in cross-cultural perspectives both Muslim and non-Muslim students will deepen their knowledge and understanding of how Islam and sexuality are negotiated in multiple contexts.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

In this chapter, a conclusion of the study which was divided into the following two parts was presented including: (1) conclusions based on the purpose of this study, and (2) recommendations for future health practice, education, administration, and research. Finally, strengths and limitations of the study were described respectively.

Conclusions

Regarding the purpose of the study, the participatory action research was conducted from November, 2011, to July, 2012 in one rural private Islamic school of border province, southern Thailand where the location of it is unrest. Four specific objectives were: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after participating in the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after participating in the program, (3) to compare the self-confidence in reproductive health care of Muslim students before and after participating in the program, and (4) to study the Muslim students' ability level of reproductive health care after participating in the program. There were 51 students who participated as the key participants in this project. In addition, an administrator and teachers from this school and other participants outside the school such as health care providers from the health officer, local officials from the sub-district, and an educator from the Educational Service Area Office in the research setting province acted as facilitators, supporters, advisers, and

supervisors for the students to conduct sexual and reproductive healthcare activities from the beginning to the end of the study. The results are presented as follows:

1. The student characteristics. The majority of the student participants were female and 16-18 years old. Their age mean was 15.71 years old. 58 percent of them were studying in tertiary level or Mattayomsuksa 5 or grade 11. Most of student participants had their educational grade point average (GPA) of more than 3. They were living with their parents and never gain the knowledge of sexual and reproductive health care. Furthermore, they had no experience of leadership similar to the context of this study, writing the project, collecting the data, analyzing the data, presenting the project, and reporting the project. Finally, all of them never had experience of developing the instrument for collecting the data to evaluate the project.

2. The program for the ability in taking care of reproductive health

The participatory action research (PAR) was conducted in this methodology study. It consisted of a strong commitment and responsibility of students who are key participants in this study and participation from stakeholders throughout all five steps including: (1) searching knowledge, (2) determining and solving problems, (3) making decision and holding on, (4) developing vision, and (5) conclusion and reporting respectively. To enhance reproductive health ability of teenager's caring in a Pondok school, three components in the model are required: (1) students' inspiration and need, (2) qualified and capable teachers, and (3) internal and external support.

3. After the sexual and reproductive healthcare activities, the mean score of the knowledge test of the student participants (M = 15.49, S.D. = 2.353) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 13.57, S.D. = 2.326) (t = 5.587, p = .000).

4. After the sexual and reproductive healthcare activities, the mean score of the ability of the physical health care regarding reproductive health of Muslim students (M = 46.24, S.D. = 9.408) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 38.45, S.D. = 10.118) (t = 5.455, p = .000).

5. After the sexual and reproductive healthcare activities, the mean score of the ability of the mental health care regarding reproductive health of Muslim students (M = 43.92, S.D. = 7.238) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 39.88, S.D. = 9.421) (t = 3.472, p = .001).

6. After the sexual and reproductive healthcare activities, the mean score of the self-confidence of the reproductive health care of Muslim students (M = 36.25, S.D. = 8.165) was statistically higher than the mean score before the sexual and reproductive healthcare activities (M = 31.25, S.D. = 8.499) (t = 3.972, p = .001).

7. After participating in the program, the ability of the reproductive healthcare of Muslim students was at high level (M = 46.02, SD = 8.765) However, for each items, they were at high to very high level.

In brief, the effectiveness of the program in this study was assessed by using the opinion of teachers and students after participating in this study. From teacher's opinions, after participating for nine months in this study, teachers who acted as facilitators, supporters, advisers, consultants, and supervisors presented that their student participants were improve for all aspects including the knowledge, the physical ability, the mental

ability, the self-confidence, and the ability's level of the sexual and reproductive healthcare. Similarly to the student's opinions, they reported that participation in this study can help them to gain more knowledge of sexual and reproductive health issues. Also, they can use it to self-care themselves and others.

Recommendations

The program in this study was based on the participation of inside and outside school stakeholders, for instance students, teachers, school administrators, health care provider, and local officials. The results from this study will be useful for teenagers in the private Islamic school, if modified to suit other settings where there are similar contexts. For instance, there are teachers and an administrator at the school in an excellent position to provide, advice, support, and facilitate resources such as timing, material, space for sexual and reproductive healthcare activities in the research setting. Indeed, the creative program can also be applied for practice, education, administration, and research.

1. Practice

This program can be used as a health promotion in school, especially teenager Muslim students. For example, student participants in the school can develop their ability to conduct sexual and reproductive healthcare activities by using PAR, and a five step of working process consisting of: (1) knowledge searching, (2) problem solving, (3) decision making and holding on, (4) vision developing, and (5) documentation concluding and reporting.

2. Education

The administer team and teachers in the school can integrate this program into the curriculum of study such as the subject of health or conduct it in term of

extracurricular activities and learner development activities. With regards to this study, nursing students at graduate level in the university can learn from this program as evidence base to guide them in thesis or dissertation.

3. Administration

In this study, one of the major concept, participation with a strong multisectoral approach including health care provider, educator, local sub-district personnel, teacher and student, they can integrate all resources, use of personnel, timing of activities that resulted in high efficiency, working together, appropriate time and resource usage, to promote sexual and reproductive healthcare activities for students in school.

4. Research

Using the sexual and reproductive healthcare program in this study, the researchers who are interested in participatory action research can modify and apply it to similar settings, populations, and contexts. Participation of stakeholders both inside and outside the school such as students and teachers is essential and important for this program.

Strengths and limitations

The sexual and reproductive healthcare program in this study revealed the positive results for enhancing the ability of Muslim student participants to care themselves and their friends from sexual and reproductive health problems such as premature sexual intercourse, unwanted pregnancy, and abortion. It will succeed if the evidence based policy environment both inside and outside the school is created using participatory action research and better knowledge of cultural and behavior factors to make services more responsive to the needs of the target groups. All of the sexual and

reproductive healthcare activities used in this program should be given serious consideration when developing future sexual and reproductive healthcare program.

Like all studies, this program has limitations. First, it was based on the specific context, private Islamic school. Therefore, the results from this study may not be generalized to other schools such as Buddhist school or not be applicable to teenagers who do not study in school. It may be applicable to the schools where they have similar situation and context. Thus, generalizability to other population is limited. Secondly, it would be of interest to compare the effectiveness of this type of program between control group and experimental group if the study consists of a two-group design (control group and experimental group).

Summary

To recapitulate, the sexual and reproductive healthcare program was conducted from November, 2011, to July, 2012 in one rural private Islamic school of border province, southern Thailand. The location of this school is unrest. Four specific objectives were: (1) to compare the physical health care ability of Muslim students regarding reproductive health before and after participating in the program, (2) to compare the mental health care ability of Muslim students regarding reproductive health before and after participating in the program, (3) to compare the self-confidence in reproductive health care of Muslim students before and after participating in the program, and (4) to study the Muslim students' ability level of reproductive health care after participating in the program. 51 Muslim students participated as the key participants in this project. In addition, an administrator and teachers from this school and other participants outside the school acted as facilitators, supporters, advisers, and supervisors for the students to

conduct sexual and reproductive healthcare activities from the beginning to the end of the study.

The effectiveness of the program in this study was assessed by using various methods such as (1) the sexual and reproductive healthcare test, (2) the questionnaires on the ability of the physical and mental health care regarding sexual and reproductive healthcare activities, (3) the questionnaires on the self-confidence regarding sexual and reproductive healthcare activities, and (4) the questionnaires on the ability's level of the sexual and reproductive healthcare activities. Also, the opinions of the students regarding their participation in the study, the opinions of the teachers regarding the students' participation in the study, and participant observations, were conducted throughout this study. Field notes and photographs were used to gather data during the sexual and reproductive healthcare activities in the study.

The findings indicated the following: (1) all mean scores for the tests of knowledge, physical and mental healthcare ability, and self-confidence regarding reproductive healthcare ability after completing the program were higher significantly than the mean scores before participating in the sexual and reproductive healthcare activities ($t = 5.587$, $p = .000$; $t = 5.455$, $p = .000$; $t = 3.472$, $p = .001$; and $t = 3.972$, $p = .001$), and (2) the ability of the reproductive healthcare of Muslim students after the program was at high level ($M = 46.02$, $SD = 8.765$). In brief, the sexual and reproductive healthcare program in this study was valuable and beneficial to Muslim students in the future particularly for teenagers who might be forced to become sexually active before the normal maturity to deal with intercourse, contraception, abortion, and unplanned pregnancy.

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APPENDICES

APPENDIX A:

Instrument

เครื่องมือเก็บข้อมูลนี้ใช้ในโครงการการวิจัย เรื่อง โปรแกรมการพัฒนาความสามารถในการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ของวัยรุ่นในโรงเรียนเอกชนสอนศาสนาอิสลามจังหวัดชายแดนใต้ **ประกอบด้วย 6 ตอน**

ตอนที่ 1 ข้อมูลทั่วไป
ตอนที่ 2 ความรู้เกี่ยวกับการดูแลสุขภาพทางอนามัยการเจริญพันธุ์
ตอนที่ 3 การปฏิบัติเพื่อการดูแลสุขภาพทางร่างกายของอนามัยการเจริญพันธุ์
ตอนที่ 4 การปฏิบัติเพื่อการดูแลสุขภาพทางจิตใจของอนามัยการเจริญพันธุ์
ตอนที่ 5 ความมั่นใจในการดูแลสุขภาพทางอนามัยการเจริญพันธุ์
ตอนที่ 6 ความสามารถในการนำความรู้เกี่ยวกับการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ไปใช้ประโยชน์

<u>ตอนที่ 1 ข้อมูลทั่วไป</u> โปรดเติมข้อความหรือเครื่องหมายถูก (✓) ลงในช่องว่างให้ตรงกับความเป็นจริง

1. เพศ (...) ชาย (...) หญิง
2. อายุ.....ปี
3. กำลังศึกษาชั้นมัธยมศึกษาปีที่.....เกรดเฉลี่ยล่าสุด.....
4. อาศัยอยู่กับ.....
5. เคยได้รับความรู้เกี่ยวกับ**<u>การดูแลสุขภาพทางอนามัยการเจริญพันธุ์</u>**
   (...) ไม่เคย
   (...) เคย โปรดระบุรายละเอียดดังนี้
   5.1 ได้รับความรู้จากแหล่งใด (เช่น โรงเรียน โรงพยาบาลหรือสาธารณสุข)
.....
   5.2 เนื้อหาที่ได้รับคือเรื่องใด (เช่น เอดส์)
.....
6. เคยเป็นแกนนำหรือทำกิจกรรมเกี่ยวกับ**<u>การดูแลสุขภาพทางอนามัยการเจริญพันธุ์</u>**
   (...) ไม่เคย
   (...) เคย โดยทำที่ใด
      (...) โรงเรียน
      (...) อื่น ๆ โปรดระบุ.....

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

7. เคยเขียนโครงการ/แผนงาน

(...) ไม่เคย

(...) เคย โปรดระบุชื่อโครงการ.....

8. เคยสร้างเครื่องมือเพื่อเก็บข้อมูลสำหรับประเมินผลโครงการ

(...) ไม่เคย

(...) เคย โปรดระบุชื่อเครื่องมือ.....

9. เคยลงมือเก็บข้อมูลสำหรับประเมินผลโครงการ

(...) ไม่เคย

(...) เคย โปรดระบุชื่อเครื่องมือ.....

10. เคยลงมือวิเคราะห์ข้อมูลจากการทำโครงการ

(...) ไม่เคย

(...) เคย โปรดระบุการวิเคราะห์ข้อมูล เช่น ค่าความถี่ ค่าร้อยละ ค่าเฉลี่ย.....

11. เคยนำเสนอผลการดำเนินงานของโครงการ

(...) ไม่เคย

(...) เคย โปรดระบุชื่อการนำเสนอผลงาน.....

12. เคยทำรายงานของโครงการ

(...) ไม่เคย

(...) เคย โปรดระบุชื่อรายงาน.....

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ตอนที่ 2 ความรู้เกี่ยวกับการดูแลสุขภาพทางอนามัยการเจริญพันธุ์

โปรดทำเครื่องหมายกากบาท (X) ในข้อที่ตรงกับคำตอบถูกต้องเพียงคำตอบเดียวในแต่ละข้อ

1. ตัวเลือกใดเป็นสิทธิพื้นฐานทางเพศของบุคคล
   ก. สามารถควบคุมต่อเหตุการณ์ที่เกี่ยวข้องกับชีวิต
   ข. สามารถเลือกและตัดสินใจในการใช้ชีวิตอย่างอิสระ
   ค. สามารถรับผิดชอบต่อเหตุการณ์ที่เกี่ยวข้องกับเรื่องเพศ
   ง. สามารถตัดสินใจอย่างอิสระต่อเหตุการณ์ที่เกี่ยวข้องกับชีวิต
2. ตัวเลือกใดเป็นสิทธิพื้นฐานของบุคคลเกี่ยวกับการเจริญพันธุ์
   ก. การกำหนดวันคลอดบุตร
   ข. การกำหนดวิธีคลอดบุตร
   ค. การเว้นระยะห่างของการมีบุตร
   ง. การได้รับบริการสุขภาพที่มีมาตรฐาน
3. ตัวเลือกใดเป็นสุขภาพทางเพศ
   ก. ควบคุมพฤติกรรมของตนเอง
   ข. มีความเชื่ออัลลอฮฺที่ทรงวางไว้โรคเดียวคือ โรคชรา
   ค. มีความสามารถในการตอบสนองต่อความต้องการของตนเอง
   ง. ปราศจากความเชื่อที่ไม่ถูกต้อง อันนำไปสู่สัมพันธภาพทางเพศที่ไม่เหมาะสม
4. ตัวเลือกใด<u>ไม่ใช่</u>การให้บริการสุขภาพการเจริญพันธุ์
   ก. การช่วยทำแท้ง
   ข. การรับฝากครรภ์
   ค. การให้คำแนะนำก่อนมีบุตร
   ง. การให้คำแนะนำก่อนแต่งงาน
5. เด็กหญิงเมื่อเป็นวัยรุ่น พบการเปลี่ยนแปลงร่างกายอย่างไร
   ก. มีขน
   ข. เสียงแตก
   ค. หน้าท้องแตก
   ง. หน้าท้องขยาย
6. ลักษณะใด<u>ไม่ใช่</u>การเปลี่ยนแปลงเมื่อเป็นวัยรุ่นชาย
   ก. มีขน
   ข. เสียงแตก
   ค. มีกลิ่นตัว

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ง. มีกลิ่นปาก

7. ปัญหาใดเกิดจากการมีเพศสัมพันธ์โดยไม่ได้ป้องกัน

ก. ตั้งครรภ์

ข. คลอดผิดปกติ

ค. ตั้งครรภ์นอกมดลูก

ง. คลอดไม่ครบกำหนด

8. ตัวเลือกใดเป็นเหตุผลสำคัญของการไม่ไปเที่ยวกับเพศตรงข้ามตามลำพังในวัยเรียน

ก. เสียเวลาเรียน

ข. อาจทะเลาะกัน

ค. ความปลอดภัยทางเพศ

ง. ไม่มีผลกระทบ หากรู้จักคิดให้ดีก่อนไปเที่ยว

9. วิธีใดเป็นการแก้ปัญหาดีที่สุด หากนักเรียนต้องอยู่กับเพศตรงข้ามตามลำพังในห้องเรียน

ก. ปรึกษาเพื่อน

ข. ปรึกษาคุณครู

ค. รีบออกนอกห้องเรียน

ง. ทำตัวตามปกติเหมือนไม่มีอะไรเกิดขึ้น

10. เหตุผลสำคัญที่สุดของนักเรียนวัยรุ่นที่ไม่ควรมีแฟน

ก. ขาดความระวังตัว

ข. ไม่สามารถทำนิติกรรมด้วยตนเอง

ค. ขาดความรู้เกี่ยวกับการวางแผนครอบครัว

ง. พัฒนาการทางด้านร่างกาย จิตใจ และสังคมยังไม่สมบูรณ์

11. เหตุผลสำคัญที่สุดของการตรวจสุขภาพก่อนที่จะแต่งงาน

ก. หาความผิดปกติทางจิตใจ

ข. ตรวจความแข็งแรงของร่างกาย

ค. ตรวจหาโรคที่ถ่ายทอดทางพันธุกรรม

ง. ตรวจหาความพร้อมของเชื้ออสุจิและไข่

12. การเปลี่ยนแปลงทางจิตใจที่สำคัญที่สุดของวัยรุ่นเกี่ยวกับเรื่องเพศคืออะไร

ก. สนใจตัวเอง

ข. สนใจเพื่อน

ค. สนใจเพศเดียวกัน

ง. สนใจเพศตรงข้าม

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

13. ตัวเลือกใดไม่ใช่สาเหตุทำให้วัยรุ่นมีจิตใจหมกมุ่นกับเพศตรงข้าม

ก. เพื่อนชักจูง

ข. ขาดประสบการณ์

ค. สื่อและเทคโนโลยี

ง. การเปลี่ยนแปลงของร่างกาย

14. การกระทำใดเป็นสาเหตุของความรุนแรงทางจิตใจมากที่สุดของผู้หญิง

ก. ทุบตี

ข. ข่มขืน

ค. ใช้ทำงาน

ง. ไม่สามารถกำหนดได้ เพราะขึ้นอยู่กับแต่ละคน

15. ตัวเลือกใดไม่ใช่ผลกระทบด้านจิตใจของผู้หญิงที่ตั้งครรภ์โดยไม่ได้แต่งงาน

ก. อับอาย

ข. ความรู้สึกมีคุณค่าลดลง

ค. ความรู้สึกทางเพศลดลง

ง. ขาดความเชื่อมั่นในตนเอง

16. อะไรเป็นสาเหตุสำคัญที่ไม่มีการแจ้งความเพื่อดำเนินคดีกับผู้ที่ข่มขืนหญิง

ก. อับอาย

ข. เสียเวลา

ค. ไม่อยากเป็นข่าว

ง. ไม่มั่นใจในความปลอดภัย

17. ตัวเลือกใดไม่ใช่ผลกระทบทางจิตใจ เมื่อผลการตรวจเลือดหาโรคติดต่อทางเพศสัมพันธ์เป็นบวก

ก. โกรธ

ข. รู้สึกสูญเสีย

ค. ไม่อยากมีเพศสัมพันธ์

ง. ความรู้สึกทางเพศลดลง

18. ศาสนาอิสลามได้กำหนดการบรรลุนิติภาวะที่เกี่ยวข้องกับการเจริญพันธุ์อย่างไร

ก. มีการแต่งงาน

ข. ผู้ชายอายุ 15 ปี และแต่งงาน

ค. ผู้หญิงอายุ 15 ปี และแต่งงาน

ง. ผู้ชายเริ่มมีฝันเปียก ผู้หญิงเริ่มมีประจำเดือน

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

19. การดูแลหลังมีประจำเดือนตามหลักศาสนาอิสลามเป็นอย่างไร

ก. อาบน้ำวายิบ/ยกหะดัษ

ข. อาบน้ำชำระร่างกายตามปกติ

ค. อาบน้ำชำระร่างกายมากกว่าปกติ

ง. อาบน้ำชำระร่างกายให้นานกว่าปกติ

20. ตามหลักศาสนาอิสลาม ชายและหญิงสามารถอยู่ด้วยกันก่อนแต่งงานหรือไม่

ก. ได้ เพราะขึ้นอยู่กับสถานกาณ์

ข. ได้ เพราะปัจจุบันมีการเปลี่ยนแปลง

ค. ไม่ได้ เพราะถือว่าเป็นซินา มีความผิด

ง. ไม่ได้ เพราะยังไม่เป็นที่ยอมรับทางสังคม

21. เหตุผลสำคัญที่ศาสนาอิสลามไม่มีคำว่า "แฟน" <u>ยกเว้น</u>

ก. เพื่อป้องกันการทำแท้ง

ข. เพื่อป้องกันการท้องก่อนแต่ง

ค. เพื่อป้องกันการทอดทิ้งทารก

ง. เพื่อป้องกันปัญหาครอบครัวแตกแยก

22. ตามหลักศาสนาอิสลามชายและหญิงที่ไม่ใช่สามี-ภรรยาต้องปฏิบัติตัวอย่างไร

ก. ไม่มีข้อกำหนด

ข. ชาย-หญิง อยู่ตามลำพังได้อย่างอิสระ

ค. ชาย-หญิง ไม่สามารถอยู่ตามลำพังได้อย่างอิสระ

ง. ชาย-หญิง อยู่ตามลำพังได้อย่างอิสระ หากตกลงที่จะแต่งงานกัน

ยังมีต่ออีกนิด.....

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ตอนที่ 3 การปฏิบัติเพื่อการดูแลสุขภาพทางร่างกายของอนามัยการเจริญพันธุ์

นักเรียนมีการกระทำในเรื่องต่อไปนี้เพียงใด โดยโปรดทำเครื่องหมายถูก (✓) ลงในช่องที่ตรงกับการกระทำของนักเรียน

ข้อความ/ประเด็น	ระดับการกระทำของนักเรียน				
	บ่อยที่สุด (4)	บ่อยมาก (3)	บ่อยปานกลาง (2)	บางครั้ง (1)	ไม่ทำ (0)
1. สังเกตความผิดปกติของอวัยวะสืบพันธุ์อย่างสม่ำเสมอ เช่น มีก้อนบริเวณเต้านม มีสารคัดหลั่งหรือตกขาวผิดปกติ					
2. ติดตามข่าวสารเรื่องเพศ เช่น การตั้งครรภ์ไม่พึงประสงค์ การติดเชื้อเอชไอวี					
3. ใส่เสื้อผ้าเหมาะสมกับข้อปฏิบัติทางศาสนาตามความเป็นผู้หญิง/ผู้ชาย					
4. หยอกล้อกับเพื่อนต่างเพศ					
5. แตะต้องตัวกับเพื่อนต่างเพศ					
6. ทำกิจกรรมการเรียนกับเพื่อนต่างเพศ โดยต้องใช้สติ เพื่อคำนึงถึงความถูกต้องและเหมาะสม					
7. หลีกเลี่ยงการพูดคุยกับเพศตรงข้ามที่ไม่คุ้นเคย					
8. หลีกเลี่ยงการอยู่กับเพศตรงข้ามโดยลำพัง					
9. ไม่อยู่ในที่ที่ลับตาคนกับเพื่อนต่างเพศ					
10. หลีกเลี่ยงการสัมผัสที่อาจนำไปสู่การมีเพศสัมพันธ์โดยไม่ได้ตั้งใจ เช่น กระแทกหรือจูงมือเพศตรงข้าม					
11. ทำกิจกรรมการเรียนกับเพื่อนต่างเพศโดยลำพัง					
12. ปฏิเสธการออกนอกบ้านเวลากลางคืนกับเพื่อนต่างเพศ					
13. หากต้องออกนอกบ้านกลางคืนกับเพื่อนต่างเพศ จะชวนคนอื่นไปเป็นเพื่อน					
14. ใช้สื่อต่าง ๆ เช่น อ่านหนังสือ ดูหนัง ดูทีวี หรืออินเตอร์เน็ตที่ช่วยให้ระมัดระวังตัวเกี่ยวกับภัยทางเพศสัมพันธ์					
15. ดื่มเหล้าและหรือเบียร์ในโอกาสพิเศษ เช่น ปีใหม่					

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ตอนที่ 4 การปฏิบัติเพื่อการดูแลสุขภาพทางจิตใจของอนามัยการเจริญพันธุ์

นักเรียนมีการกระทำในเรื่องต่อไปนี้เพียงใด โดยโปรดทำเครื่องหมายถูก (✓) ลงในช่องที่ตรงกับการกระทำของนักเรียน

ข้อความ/ประเด็น	ระดับการกระทำของนักเรียน				
	มากที่สุด (4)	มาก (3)	ปานกลาง (2)	น้อย (1)	น้อยที่สุด (0)
1. ให้ความสนใจกับเพื่อนต่างเพศเหมือนคนอื่นทั่ว ๆ ไป					
2. ยอมรับการเปลี่ยนแปลงที่เกิดขึ้นตามวัย เช่น มีหนวด มีหน้าอก					
3. พร้อมที่จะพูดคุยกับเพื่อนต่างเพศ					
4. ยอมรับความแตกต่างที่เกิดจากการเป็นหญิง/ชาย เช่น ฝันเปียก มีประจำเดือน					
5. ไม่สนใจที่จะคบเพื่อนต่างเพศแบบชู้สาวหรือเป็นแฟน					
6. คิดว่าทำผิดหลักศาสนาอย่างรุนแรง หากมีเพื่อนต่างเพศแบบชู้สาวหรือเป็นแฟน					
7. เมื่อรู้สึกไม่สบายใจกับเพื่อนต่างเพศแบบชู้สาวหรือเป็นแฟน ต้องปรึกษากับพ่อแม่หรือคนในครอบครัว					
8. พร้อมที่จะปรึกษากับพ่อแม่หรือคนในครอบครัว เมื่อมีปัญหาการแสดงออกตามความเป็นหญิง/ชาย					
9. พร้อมที่จะปรึกษากับคุณครู เมื่อมีข้อสงสัยเกี่ยวกับการเปลี่ยนแปลงตามวัยของเพศหญิง/ชาย เช่น หงุดหงิด มีฝันเปียก ขาดประจำเดือน					
10. ยอมรับข้อกำหนดทางศาสนาเกี่ยวกับการแต่งกายที่มิดชิด					
11. เต็มใจกับการปฏิบัติตามหลักของศาสนา เช่น การไม่อยู่กับเพื่อนต่างเพศตามลำพัง					
12. พร้อมที่จะดูแลตนเองให้ปลอดภัยจากการมีเพศสัมพันธ์ เช่น งดเที่ยวสถานเริงรมณ์กับเพื่อนต่างเพศ					
13. พร้อมที่จะปฏิเสธ เมื่อเพศตรงข้ามชวนไปเที่ยวตามลำพัง					
14. หากมีเพื่อนต่างเพศมาชอบ พร้อมที่จะปฏิเสธการกระทำที่ผิดหลักศาสนา					
15. หากตกอยู่ในสถานการณ์เสี่ยงต่อการมีเพศสัมพันธ์ พร้อมที่จะปฏิเสธการกระทำที่ผิดหลักศาสนา					

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ตอนที่ 5 ความมั่นใจในการดูแลสุขภาพทางอนามัยการเจริญพันธุ์

นักเรียนมีความรู้สึกในเรื่องต่อไปนี้เพียงใด โดยโปรดทำเครื่องหมายถูก (✓) ลงในช่องที่ตรงกับความคิดเห็นของนักเรียน

ข้อความ/ประเด็น	ระดับความรู้สึกที่นักเรียนมีอยู่				
	มากที่สุด (4)	มาก (3)	ปานกลาง (2)	น้อย (1)	ไม่มี (0)
1. เมื่อสงสัยเกี่ยวกับความผิดปกติของระบบอวัยวะสืบพันธุ์ เช่น คันบริเวณอวัยวะเพศ แน่ใจว่าสามารถหาข้อมูลเพิ่มเติมได้					
2. หากมีความผิดปกติของระบบอวัยวะสืบพันธุ์ เช่น คันบริเวณอวัยวะเพศ กล้าปรึกษาพ่อแม่หรือบุคคลในครอบครัว					
3. หากมีความผิดปกติของระบบอวัยวะสืบพันธุ์ เช่น คันบริเวณอวัยวะเพศ กล้าปรึกษาครูหรือผู้รู้เฉพาะ					
4. เมื่อถูกล่วนลามจากเพศตรงข้าม กล้าปรึกษาพ่อแม่หรือบุคคลในครอบครัว					
5. เมื่อมีปัญหาเกี่ยวกับรักร่วมเพศ กล้าปรึกษาพ่อแม่หรือบุคคลในครอบครัว					
6. เมื่อมีปัญหากับเพื่อนต่างเพศในทำนองชู้สาว กล้าปรึกษาพ่อแม่หรือบุคคลในครอบครัว					
7. เมื่อมีปัญหาเกี่ยวกับรักร่วมเพศ กล้าปรึกษาครูหรือผู้รู้เฉพาะ					
8. เมื่อมีปัญหากับเพื่อนต่างเพศในทำนองชู้สาว กล้าปรึกษาครูหรือผู้รู้เฉพาะ					
9. ไม่กังวลเรื่องการเปิดโอกาสอยู่กับเพื่อนต่างเพศตามลำพัง					
10. ไม่กังวลเรื่องวิธีการป้องกันตัวจากถูกล่วงละเมิดทางเพศ					
11. ตั้งใจเรียนหนังสือ โดยไม่กังวลเรื่องความรัก					
12. ไม่กังวลว่าจะเป็นโรคติดต่อทางเพศสัมพันธ์และเอดส์					
13. กังวลการคบเพื่อนที่อาจทำให้เกิดการมีเพศสัมพันธ์โดยไม่ตั้งใจ					
14. สามารถกล้าปฏิเสธความรักในวัยเรียน					
15. ศรัทธาต่อศาสนาในการปฏิบัติตัวของเพศชาย-หญิง					

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

ตอนที่ 6 ความสามารถในการนำความรู้เกี่ยวกับการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ไปใช้ประโยชน์

นักเรียนมีความคิดเห็นและกระทำต่อไปนี้เพียงใด โดยโปรดทำเครื่องหมายถูก (✓) ลงในช่องที่ตรงกับความเป็นจริงของนักเรียน

ข้อความ/ประเด็น	ระดับความคิดเห็นและกระทำของนักเรียน				
	มากที่สุด (4)	มาก (3)	ปานกลาง (2)	น้อย (1)	ไม่มี (0)
1. นำความรู้เรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ไปวางแผน เพื่อใช้เป็นประโยชน์กับเพื่อนในโรงเรียน					
2. เข้าถึงแหล่งข้อมูลความรู้เรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ เพื่อใช้วางแผนในการทำกิจกรรมกับเพื่อนในโรงเรียน					
3. วิเคราะห์ข้อมูลเพื่อใช้วางแผนการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
4. วางแผนเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ เพื่อกำหนดกิจกรรมที่จะทำกับเพื่อนในโรงเรียน					
5. เขียนแผนงาน/โครงการเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
6. ทำกิจกรรมตามแผนงาน/โครงการเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
7. ถ่ายทอดความรู้เรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์แก่เพื่อนในโรงเรียน					
8. เป็นแกนนำของโรงเรียนในการจัดกิจกรรมเพื่อการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
9. ให้ความช่วยเหลือเพื่อนในโรงเรียน เมื่อมีปัญหาเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
10. ให้คำปรึกษาแก่เพื่อนในโรงเรียน เมื่อมีปัญหาเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
11. เป็นสมาชิกที่ดีของกลุ่มในการทำงานเพื่อการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
12. ชักชวนเพื่อนที่เป็นกลุ่มเสี่ยง เพื่อให้มีการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ที่ปลอดภัย					
13. สร้างเครื่องมือเพื่อประเมินผลการทำงานเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
14. วิเคราะห์ข้อมูลจากผลการทำงานเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์					
15. ใช้ผลการประเมินจากการทำงานเรื่องการดูแลสุขภาพทางอนามัยการเจริญพันธุ์มาปรับปรุงการทำงานครั้งต่อไป					

ขอขอบคุณที่ให้ข้อมูลอย่างสมบูรณ์

APPENDIX B:

The opinion of students after participating in this study

ความรู้สึกที่มีต่อโครงการ

การเข้าร่วมโครงการวิจัยในครั้งนี้ ทุกคนที่เข้าร่วมได้จากการคัดเลือกของครู ครูเลือกผู้ที่มีความเป็นผู้นำ ซึ่งมีทั้งหมด ๗ คน หนูเป็นคนหนึ่งที่ครูเลือกให้เข้าร่วมโครงการวิจัยครั้งนี้ หนูรู้สึกดีใจมากที่ได้เป็นส่วนหนึ่ง ครั้งแรกเมื่อได้ไปที่หาดใหญ่ หนูรู้สึกตื่นเต้นที่จะได้พบกับอาจารย์จีรเนาว์ ทัศศรี อาจารย์ได้ให้ทุกกลุ่มทำวิจัย ตั้งแต่ที่นั่นเป็นทุกคนก็เลยเครียด พอกลับมาถึงโรงเรียน ทุกกลุ่มก็คิดหัวข้อของโครงการ และดำเนินโครงการ ระหว่างทำโครงการ มีทั้งความสุขและความทุกข์ บางครั้งก็ท้อไม่อยากทำ แต่พวกเราก็ไม่ถอย พวกเราพยายามทำต่อไปจนสำเร็จ.

ในการทำโครงการครั้งได้อะไรหลาย ๆ อย่าง ในเรื่องของความรู้ ที่สามารถนำไปปฏิบัติในการดำเนินชีวิตประจำวันได้ และสามารถนำความรู้ที่ได้ไปบอกกับคนอื่นได้.

สุดท้ายนี้ ขอขอบคุณ ดร. จีรเนาว์ ทัศศรี และคณะพยาบาลศาสตร์ จากมอ.หาดใหญ่ ที่ได้มีโครงการดี ๆ อย่างนี้ และอยากให้มีโครงการนี้ต่อไป

ความรู้สึกที่มีต่อโครงการ

เรียนคณะ รศ. ดร. จีรเนาว์ ทัศศรี ที่เคารพอย่างยิ่ง ดิฉันนางสาว

จากโรงเรียนฯ ซึ่งเป็นประธานกลุ่ม 3 ที่มีชื่อกลุ่มว่า IT and New Teenagers ก็ต้องขอขอบคุณ รศ. ดร. จีรเนาว์ ทัศศรี เป็นอย่างมากที่ให้เกียรติโรงเรียนหนูได้มีส่วนร่วมในการทำโครงการวิจัย โปรแกรมการพัฒนาความสามารถในการดูแลสุขภาพทางอนามัยการเจริญพันธุ์ของวัยรุ่นในโรงเรียนเอกชนสอนศาสนาอิสลามจังหวัดชายแดนใต้ จากการที่ได้เข้าร่วมโครงการครั้งนี้ รู้สึกประทับใจเป็นอย่างมากจนบอกไม่ถูก เพราะโครงการนี้เป็นโครงการที่ดี ให้ความรู้มากมาย จากที่ไม่ค่อยรู้เรื่อง กลับกลายทำให้หนูรู้จักอนามัยเจริญพันธุ์มากขึ้น ได้ร่วมกันทำกิจกรรมมากมาย ทั้งที่มหาวิทยาลัยสงขลานครินทร์ วิทยาเขตหาดใหญ่ และที่โรงเรียนเอง ซึ่งกิจกรรมที่โรงเรียนได้มีพี่เปิ้ลและพี่ผู้ช่วยมาสอน ทุกวันพฤหัสบดี ของสัปดาห์ พี่เปิ้ลเป็นคนใจดี สวยด้วยค่ะ ถ้าหนูไม่ได้มีโอกาสเข้าร่วมโครงการครั้งนี้ ก็คงไม่ได้รู้จักกับ รศ. ดร. จีรเนาว์ ทัศศรี และคณะ และยังไม่รู้จักการทำวิจัยต้องทำอย่างไร มีขั้นตอนอย่างไรบ้าง ทำให้กล้าคิดกล้าแสดงออก ซึ่งการทำกิจกรรมครั้งนี้หนูได้เลือกให้เป็นประธานกลุ่ม ทำให้ตัวเองมีภาวะความเป็นผู้นำ สามารถนำพาเพื่อนๆในกลุ่มไปถึงจุดมุ่งหมายที่ตั้งไว้จนได้ และทุกคนในกลุ่มก็ร่วมมือกันทำจนสำเร็จลุล่วงไปด้วยดี พร้อมจะนำเสนอให้คณะ รศ. ดร. จีรเนาว์ - ทัศศรี รับชมค่ะ ขอขอบคุณมากมากค่ะ

ด้วยความเคารพอย่างสูง

สมาชิกกลุ่ม 3

ความรู้สึกที่มีต่อโครงการ

ตั้งแต่วันแรกอาจารย์พาบอกกระผมว่าให้ผมเข้าโครงการอนามัยการเจริญพันธุ์ของ ดร. จีราพาร์ ทัศศรี ผมงงๆ เลยกลับมาถามอาจารย์ว่าอะไรคืออนามัยการเจริญพันธุ์ และ ดร. จีราพาร์ ทัศศรี คือใคร อาจารย์บอกกับกระผมว่า ถ้าอยากรู้ก็เข้าโครงการอนามัยการเจริญพันธุ์สิ ด้วยการที่ผมอยากรู้อยากลอง ผมก็ตัดสินใจขานเพื่อนๆ เข้าโครงการอนามัยการเจริญพันธุ์ จากนั้นอาจารย์บอกกระผมว่าจะพาพากระผมไปที่ มอ. หาดใหญ่ เพราะเจ้าของโครงการอยู่ที่นั้น ซึ่งกระผมเองดีใจมาก เพราะความจริงแล้วผมเองก็ไม่เคยไปเหมือนกันครับ. ก่อนผมว่าเข้าโครงการนี้ได้อะไรบ้าง ผมจะบอกว่าก็ได้หลายอย่างนะ ได้ความรู้เกี่ยวกับอนามัยการเจริญพันธุ์ว่าเป็นอย่างไร และได้เจอ ดร. จีราพาร์ และ มอ. หาดใหญ่เป็นอย่างไร (ฮันนี่นอกเรื่องอีก) ผมรู้สึกว่าโครงการนี้สำคัญต่อผมมาก เพราะเกี่ยวกับเรื่องอย่างกระผม ผมอยากบอก ดร. จีราพาร์ ทัศศรี ว่าเปิดโอกาสดีๆ แบบนี้ให้แก่ผมและเพื่อนๆ และความรู้ที่ผมได้จากโครงการนี้ผมจะนำไปทำประโยชน์ให้ได้มากที่สุด และของให้โครงการนี้มีการดำเนินต่อไปอีก เพื่อเปิดโอกาสดีๆ ให้แก่น้องๆ ที่ยังไม่มีความรู้อีกเรื่องนี้ครับ ขอบคุณค่ายโครงการอนามัยการเจริญพันธุ์ และ ดร. จีราพาร์ ทัศศรี