Health Improvement of Muslim Female Adolescents in Islamic Boarding School in Aceh Province, Indonesia: A Critical Ethnographic Study

Asniar

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Nursing (International Program)

Prince of Songkla University

2016

Thesis Title	Health Improvement of Muslim Female Adolescents in Islamic Boarding School in Aceh Province, Indonesia: A Critical Ethnographic Study
Author	Mrs. Asniar
Major Program	Nursing (International Program)

Major Advisor

.....
(Assoc. Prof. Dr. Urai Hatthakit)

Co-advisor

…….....
(Asst. Prof. Dr. Wantanee Wiroonpanich)

Examining Committee:

…….....Chairperson
(Assoc. Prof. Dr. Aranya Chaowalit)

.....Committee
(Assoc. Prof. Dr. Urai Hatthakit)

…….....Committee
(Asst. Prof. Dr. Wantanee Wiroonpanich)

…….Committee
(Assoc. Prof. Dr. Praneed Songwathana)

.....Committee
(Asst. Prof. Dr. Jom Suwanno)

The Graduate School, Prince of Songkla University, has approved this thesis as partial fulfillment of the requirement for the Doctor of Philosophy in Nursing (International Program).

…….....
(Assoc. Prof. Dr. Teerapol Srichana)
Dean of Graduate School

This is to certify that the work here submitted is the result of the candidate's own investigations. Due acknowledgement has been made of any assistance received.

……..…..Signature
(Assoc. Prof. Dr. Urai Hatthakit)
Major Advisor

……Signature
(Mrs. Asniar)
Candidate

I hereby certify that this work has not been accepted in substance for any degree, and is not currently submitted in candidature for any degree.

..…….Signature
(Mrs. Asniar)
Candidate

Thesis Title	Health Improvement of Muslim Female Adolescents in Islamic Boarding School in Aceh Province, Indonesia: A Critical Ethnographic Study
Author	Mrs. Asniar
Major Program	Nursing (International Program)
Academic Year	2015

ABSTRACT

This study explored the life-experience of female adolescents in an Islamic boarding school (*pesantren* or *dayah*) in Aceh Province, Indonesia. Using critical ethnography as methodology, this study applied five stages of Carspecken's critical ethnography to guide the whole process of data collection and data analysis. Involving 34 female adolescents as key participants and 10 associate participants, this study conducted multi-methods of data collection, including photovoice, participant-observation, focus group discussion, and in-depth interview to collect the data.

Also, this study employed reconstructive analysis to analyze the data. Prolonged engagement, peer debriefing, member check, inquiry audit, and audit trail was performed to maintain the trustworthiness of the study. Four categories emerged from the findings as follows: meaning of health; improving health of female adolescents; power relation in *dayah* and health; changes and prospective changes voiced by Muslim female adolescents on health improvement. The four categories were influenced much by the dimension of religion, which was identified as one of the power relations structured in *dayah*, as well as education and social dimension. The themes

emerged under these categories informed how *dayah* culture contributed to health practices at certain level, yet restricted the ability of female adolescents to improve their health. The findings contributed to add evidence about *dayah* which was considered as an under research area; and about Muslim female adolescents in *dayah* as the underserved population in Indonesia.

In addition, this study informed the decision makers in *dayah* and related stakeholders to pay more attention to the health improvement of female adolescents in *dayah*, which showed unique health practices and different health needs. Multidisciplinary and participatory interventions were recommended to plan, design, and evaluate the health improvement programs which are relevant to dayah *culture* and the health needs of Muslim female adolescents.

Keywords: adolescent; female; Islamic boarding school; Muslim; critical ethnography

ACKNOWLEDGEMENTS

First and foremost, all praises and thanks belong to Allah, the Almighty, the Most Compassionate, and the Most Merciful, for bestowing His blessings for me to accomplish this study. May peace and prayers be upon Prophet Muhammad, his family, his companions, and all those who follow his footsteps.

I would like to express my deepest gratitude to my major advisor, Assoc. Prof. Dr. Urai Hatthakit, for her enormous support and expert guidance throughout the study and writing of this thesis. I am very grateful to my co-advisor, Asst. Prof. Dr. Wantanee Wiroonpanich for her warm encouragement and insightful advices during this process. My great appreciation extends to the thesis examining committee for their graciousness in helping me to see the nuances of this study, and to understand the deeper levels of my work.

I am very grateful to the Government of Aceh for awarding me the Aceh Government Scholarship to accomplish my doctoral study, and to the Graduate School, Prince of Songkla University for funding my doctoral research and thesis writing. A very special thanks goes to Miss Katrin Gruenig, a great nurse who I always look up to, for the opportunities of post-tsunami field work in Islamic Boarding Schools in Aceh before I started my doctoral study, and for her sincere trust and endless support throughout this PhD journey. I would like to thank Professor Yi Myungsun for her supervision during my visiting program in Seoul National University. My thanks also go to my colleagues in PhD program, Faculty of Nursing, Prince of Songkla University for the friendship and togetherness that have made this journey one of adventure and joy.

My heart is full of gratefulness for all key participants for their willingness to allow me into their lives. I appreciate their trust as they shared their live experiences. My appreciation also goes out to all the associate participants for their cooperative involvement in this study. This study would not be possible without all their precious participation.

Most importantly, I would like to thank my big family for their big help and their beautiful prayers for me. I dedicated this achievement to my beloved parents, for always encouraging me to climb distant mountain peaks, and to reach the summit of my education. For my son, thank you very much for the long and patient wait, and for the hugs when I need them the most.

To the many others I have not mentioned here, I extend my warmest gratitude for their efforts and encouragement that enabled me to complete this journey. May Allah return all their kindness with His endless blessings.

Asniar

Contents

Page

List of Tables

Page

List of Figures

Page

Chapter 1

Introduction

Background of the Study

Considering the reported preventable and treatable death causes among adolescents (WHO, 2014), and realizing the great opportunity to improve their health and well-being, a global strategy for adolescent health as part of Global Strategy for Women's, Children's and Adolescents' Health for 2016-2030 was launched (Every Women Every Child, 2015). This global strategy focuses on reaching the highest standard of health and well-being for women, children and adolescent, including the ones in the most vulnerable settings, by attempting to achieve sustainable development goals (SDGs).

Some of the actions to achieve SDG are to invest in child and adolescent health and development; support women, children, and adolescents as agents for change; and remove barriers to realizing individual potential and protect them from violence and discrimination (Every Women Every Child, 2015). Meanwhile, in the recent report on adolescent health, the WHO (2014) stated that marginalization and other individual and environmental factors caused some adolescents to become vulnerable to poor health and developmental outcomes. Therefore, these vulnerable adolescents should be targeted in efforts to achieve SDGs.

Unfortunately, these vulnerable adolescents were often found not being included in national health information systems, and not being reached by health services while they considerably need the services (WHO, 2014). Wanat et al. (2010) reported

that this sort of conditions was found among adolescents living in residential institutions in Aceh province, Indonesia.

As one of the residential institutions in Indonesia, Islamic boarding schools are religious schools which are mostly located in rural areas, managed with limited funds, and often unable to provide students with appropriate learning facilities and good living conditions (Nilan, 2009). Islamic boarding schools, which are well-known as *pesantren* (or *dayah* in Acehnese), are a part of the Indonesian Islamic education system that provide six years of education by combining Islamic junior high school and Islamic high school in one integrated institution (Government of Indonesia, 2013; Government of Indonesia, 2014). Aceh is one of the provinces which has large numbers of *pesantren*. The province had 1,216 registered *pesantren* (Ministry of Religious Affairs, 2014). However, this large number of *pesantren* did not signify good quality, as students experienced insufficient access to educational resources and basic necessities (Wanat, et al., 2010).

Several conditions put female adolescents living in *pesantren* into a vulnerable group of the population. As female adolescents, they were considered more vulnerable than their male counterparts due to gender inequality existing in the institution (Husin, 2014), which might limit their ability to protect their health (WHO, 2009). *Pesantren* strictly applied Islamic teachings, some of which are applied in a way to justify androcentric or patriarchal attitudes (Roald, 2001) which could compromise the needs of female adolescents. *Pesantren* itself is considered as a high risk setting. Several studies showed that the students in *pesantren* often suffer from many health problems, such as diarrhea, acute respiratory infection, and skin infection (Fadlyana, Utja, Safitri, & Subarja, 2002; Rahmawati, 2009).

A pilot study conducted by the researcher in 2010 more specifically showed that female adolescents living in an *pesantren* in Aceh performed their daily practices in strict *sharia* law. Aceh province is the only autonomous province in Indonesia which has implemented *sharia*, the basic Islamic legal system which covers all aspects of the Muslim way of life, such as acts of worship, family law, civil law, and education (Government of Aceh, 2014). Nevertheless, the findings from the pilot study showed that the *pesantren* implemented *sharia* in a stricter manner than the surrounding community, which caused the female adolescents living in the *pesantren* had a different living experience from that of other Indonesian adolescents. In addition, the finding showed that the strict regulations which applied to female adolescents, as a form of power relation, might have impacted female adolescent's daily practices, including their way to improve their health status.

In the context of this study, power is defined as domination or the probability that a command will be complied with, which is related to all conceivable qualities of a person or all conceivable combinations of circumstances to impose will (Weber, 1978). According to Carspecken (1996), unequal power creates dominant values implied in social relationship in various presentations of power relations. Furthermore, Kincheloe and McLaren (2005) described that power may shape false-consciousness that prevents individuals or groups to make decisions that essentially affect their lives.

Issues regarding power relations may contribute to the unsuccessfulness of health promotion programs as indicated by Smerecnik, Schaalma, Gerjo, Meijer, and Poelman (2010) in their study about the current approaches to sex education among Muslim adolescents. The rigidity of norms applied, in particular in Muslim society, was

identified as the barrier, as well as the conflicting views on sexualities between the religious leaders and adolescents. This kind of power relation issue may also be found in the *pesantren* in this study which applied rigid norms, with influences of religious leaders being dominant.

However, less is known about how female adolescents improved their health in a *pesantren* and how power relations influence their practices to promote their health. *Pesantren* are an under-researched area, especially the case of *dayah* (a local term to refer to *pesantren*) in Aceh (Srimulyani, 2014), and particularly related to health. Therefore, this study focused on female adolescents living in a *dayah* in a rural area which provided limited resources and facilities and strictly applied *sharia* law. By conducting this study, the feasible strategies to improve the health of female adolescents was to be explored. For this reason, this study was a critical ethnographic study to obtain rich information about the culture of female adolescents living in *dayah*. During the process of this critical research, positive changes were expected to take place to ensure the equality and the participation of female adolescents to improve their health.

Purpose of Study

The purpose of the study was to explore how female adolescents practiced, developed, and made changes to improve their health in *dayah.*

Research Questions

The primary research question was "how do the female adolescents living in *dayah* improve their health?" The question was furthermore specified into the following questions:

1) What is the meaning of health for female adolescents living in *dayah*?

2) How do the female adolescents living in *dayah* describe ways to improve their health?

3) What are the power relations structured in *dayah* which influence their health improvement?

4) How do these power relations influence their health improvement?

5) What are changes they made and the need of health improvement in *dayah*?

Conceptual Framework

The philosophies underpinning this study were based on critical theory and the principle values of Islamic education. Critical theory is considered appropriate to be used since it addresses research as a step to initiate political action that can correct inequalities found in a society. In particular, it is concerned with issues of power and how those powers play their dominant roles. It also involves finding out the ways that some factors, such as economy, education, religion and cultural dynamics, interact to construct a social system. In other word, it tries to expose the forces that prevent individuals/groups from making their decision on the matters affecting their lives (Kinchloe & McLaren, 2005).

The philosophy of Islamic education was selected in the study to understand the life of female adolescents studying in *dayah*, and how *dayah* influence the health improvement of female adolescents. In Islamic civilization, education is an integral part of faith (Yasin & Jani, 2013) which is aimed to cultivate human beings to

abide in the teachings of religion which assures salvation and happiness in the hereafter (Nofal, 2000).

As the recipient of education, man is viewed as a rational soul that possesses an innate property to recognize and distinguish truth from falsehood (Al-Attas, 1980) to achieve his goal of life, which is attaining the greatest happiness of being close to God (Nofal, 2000). In Islamic epistemological context, the content of education is all knowledge which comes from God (Al-Attas, 1980) and the Quran as the main reference (Rayan, 2012). The process of education involves the concept of *adab* which emphasizes the awareness of responsibilities toward God, and continuously improves every aspect of man to complete his duties to himself and society with justice. These principles of the recipient, content, process of Islamic education are explained in the next chapter.

Critical theory and the principles of Islamic education were employed to guide data collection and data analysis. Using critical ethnography as methodological framework, which derived from critical theory, the study emphasized critical analysis of the broader context and the various types of power relations that characterized the *dayah*, as well as the way female adolescents improved their health while studying in the *dayah*, which applies the principle of Islamic education.

Definition of Terms

A *dayah* is a religious educational institution where students study and stay all day during the academic years of junior and senior high school. The term of *dayah* in this study referred to an integrated *dayah* which includes science and other conventional knowledge in their curriculum, besides the teaching of Islamic classical books.

Power relations are various presentations of social relationship which are influenced by values created by dominant role. In this study, the dominant power in dayah exercise their power which manifested as power relations.

Health improvement is all activities conducted by female adolescents to maintain and improve their health status, involving all aspects of their lives. The health improvement activities are practiced in *dayah*, which is managed and organized by the dominant powers by applying the principles of Islamic education.

Significance of Study

Adolescence is considered as a period to form lifelong health habits. Meanwhile, health is an essential requirement for adolescents to have good achievements in school and to engage in social activities which are considered as the major part of adolescent developmental tasks. Therefore, this study was expected to encourage adolescents to become more aware of improving their health, and on the things they can do to prevent problems and to achieve an optimal level of health.

Employing critical ethnography as the design, the study did not put the only focus on adolescent as the actor for their own behaviors, but it shifted the research focus on the socio-political context of the behaviors. The ultimate aim of critical ethnography is to generate valuable and practical knowledge for fostering social action and change. In other words, critical ethnography could set the stage for social action for positive change. Therefore, the results of the study were expected to initiate an action to gain positive changes, which later, would bring impact on their successfulness to attain an optimal level of health. The knowledge which was gained from this study could be used to inform *dayah* and the relevant stakeholders on the policy they might apply and

on the issues which they should take into consideration with regard to improving the health of female adolescents. Consequently, the results of the study would serve as a base of evidence for establishing policies and developing a school-health-improvement program, which would be culturally and religiously acceptable for female adolescents living in Islamic Boarding School.

Chapter 2

Literature Review

This was a state of knowledge review about Muslim female adolescents and the Islamic Boarding School (IBS) as their context of development. It served as a starting point to further explore how Muslim female adolescents care for themselves while passing through their developmental changes in a specific context of Islamic Boarding School, and to highlight their cultural patterns in dealing with typical issues of adolescent development. The review of literature is comprised of: (1) Muslim female adolescents and health; (2) factors influencing health improvement of Muslim female adolescents; (3) Muslim female adolescents and health in IBS; (4) Islamic education; and (5) critical theory.

Muslim Female Adolescents and Health

The WHO (2014) defined adolescents as people aged 10 to 19, and referred to adolescence as the second decade of life which shaped the health problems and health related behaviors of adult. According to Hockenberry and Wilson (2009), adolescence is a psychological, social and maturational process as a period of transition between childhood and adulthood, which is initiated by pubertal changes or gradual appearance of secondary sex characteristics. Steinberg (2011) also explained adolescence as a transition period which covers biological, psychological, social, and economic aspects.

Hockenberry and Wilson (2009) stated that adolescence is initiated by pubertal changes or gradual appearance of secondary sex characteristics. Moreover,

Steinberg (2011) outlined that the initiation of adolescence can be determined not only from biological perspective, but also from emotional, cognitive, interpersonal, social, educational, legal, chronological, and cultural aspects. Table 1 shows a variety of perspectives in determining the boundary of adolescence. These perspectives created a wide variation in determining the time when adolescence begins and ends. However, because there are varied aspects to determine adolescence, Steinberg suggested that the boundary of adolescence should be based on how one defines it.

Table 1

The Boundaries of Adolescence

Perspective	**The onset of period**	**The end of period**
Biological	Onset of puberty	Becoming capable of sexual reproduction
Emotional	Beginning of detachment from parents	Attainment of separate sense of identity
Cognitive	Emergence of more advanced reasoning abilities	Consolidation of advanced reasoning abilities
Interpersonal	Beginning of shift in interest from parental to peer relation	Development of capacity for intimacy with peers
Social	Beginning of training for adult work, family, and citizen roles	Full attainment of adult status and privileges
Educational	Entrance into junior high school	Completion of formal schooling
Legal	Attainment of juvenile status	Attainment of majority status
Chronological	Attainment of designated age of adolescence (e.g. 10 years)	Attainment of designated age of adulthood (e.g. 21 years)
Cultural	Entrance into period of training for ceremonial rite of passage	Completion of ceremonial rite of passage

Source: Steinberg, L. (2011). Adolescence (9th ed.). New York, NY: McGraw-Hill.

In Islam, adolescence has been described as a vital phase in which legal liability is started (Fadhlullah, 1995). Al-Mateen and Afzal (2004) explained that in the phase of adolescence, a Muslim become fully accountable for their deeds which are

accounted by God. Entering the stage of puberty, adolescents should practice Islam as an adult does, as stated in five tenets or pillars of Islam: the declaration of faith (the *shahada*), prayer (*salat*), alms (*zakat* and *sadaqah*), fasting in the month of *Ramadhan* (*saum*), and the pilgrimage (*hajj*), in order to reach paradise.

Besides the five pillars of Islam, as a fully accountable Muslim, adolescents should maintain a good attitude as a Muslim. To be fully accountable as an adolescent, Islam wants the parents to shepherd the spiritual, mental, and social aspects of children's characters before they reach the stage of adolescence, so the conflict during adolescence could be prevented (Fadhlullah, 2005). As a fully accountable Muslim, *sharia* or Islamic law applies to them.

Islam values females the same as males when worshiping God, and performing their responsibilities to find the way toward paradise (Qaradhawi, 2009). Thus, female and male adolescents have equal obligations and rights in practicing their religion in every aspect of their life. The following verse of the Quran states clearly about this equality:

> And the believing men and the believing women are protectors of one another. They bid doing good and they forbid doing evil, and they observe prayer and pay the stated alms, and they obey Allah and His Messengers. They are the people whom Allah will show mercy. Surely Allah is Mighty, and Wise. (At-Tawbah: 71)

The verses showed that Islam granted women rights. They were obligated to be devoted worshipers and to be rewarded equally. As females, they should live their lives based on what has been suggested in a number of verses in the Quran and Hadith (Qaradhawi, 2009). However, regarding practicing Muslims around the world, it is

difficult to distinguish between the Islamic ideal and cultural values because their interpretation of social issues in the Islamic teachings have always been influenced by their cultural patterns. This fact should not make people judge that the characteristics they found in a particular Muslim group to represent the ideal Islamic teaching (Roald, 2001).

These cultural values create diversity among Muslim groups. Thus, female Muslim adolescents would be largely affected by the social structures or cultural values in their community because of the way they live their life, as it is intrinsic to their religious practice (Abu-Ali, 2003).

Qaradhawi (2005) mentioned that the concept of worship in Islam is comprehensive and integrated, including the wholeness of religion and human life, and every other aspect related to human existence. Therefore, the concept of health in Islam is considered as part of the concept of worship. The Islamic concept of health includes: health equilibrium or moderation; health credit or reserve; principle of therapy or seeking medication; principle of "no harm is to be caused to oneself or to others"; and health promotion (Omran& Al-Hafez, 2010).

The other health related concepts in Islamic teaching are the complete well-being, and the essential matters of human life. Ayad (2008) explained that Muslims need to be fully involved in life by fulfilling the obligation to Allah and to society. For achieving that goal, it is necessary to have a complete emotional, physical, mental, and spiritual well-being. While the essential matters of human life are comprised of preserving faith; preserving soul; preserving wealth; preserving mind; preserving offspring; and preserving honor (Auda, 2010). These concepts might explain the health

behaviors of Muslim adolescents in their social context, such as in Muslim communities or Muslim schools.

All Muslim adolescents around the world, share the same religion, which is Islam, but they are distinguished by the culture where they live (Abdullah, Saleh, Mahud, & Ghani, 2010). Several studies showed how Muslim adolescents around the world were different in particular aspects, such as religiosity. A study about Indonesian adolescent religiosity implied that religion is closely related to other aspects of adolescent development (French, Christ, Lu, & Purwono, 2014). Moreover, French, Eisenberg, Vaughan, Purwono, and Suryanti (2008) described there are no gender differences in level of religiosity among Indonesian Muslim adolescents. However, other populations of adolescents showed different results. The female Kuwaiti Muslim adolescents have a higher level of religiosity than the male adolescents (Abdel-Khalek, 2007), while male Saudi adolescents have higher level of religiosity than the female adolescents have (Abdel-Khalek, 2009). Meanwhile, Abdel-Khalek (2014) found positive correlations between happiness, health and religiosity among Lebanese Muslim adolescents, which was consistent with Muslim adolescents in Western and Arabic countries. This evidence implied that religiosity as one of aspects associated with adolescent health.

Another difference between Muslim adolescents around the world are their distinct perceptions on health related aspects. A study among Bangladesh adolescents in a rural population revealed that the adolescents considered physical appearance as the only aspect of health (Khan, 2013), while in a study on Asian adolescents living in Singapore, conducted by Wee, Chua, and Li (2006), it was shown that the adolescents related health with physical, psychological and social domain. In addition, mental health was found as a more important factor for happiness than physical

health among Muslim adolescents in Lebanon (Abdel-Khalek 2014), while it was identified as a risk factor affecting American Muslim adolescent health (Ahmed, Patel, & Hasheem, 2015).

Ahmed, Patel, and Hasheem (2015) reviewed studies on the Muslim youth in America and found that young Muslim women, African-American Muslim youths, converted Muslim youths, and refugee Muslim youths are the underserved sub groups. The study emphasized the differences of developmental outcomes among Muslim youth sub-groups are caused by multiple, interactive personal and social developmental contexts, such as family, school, and community. In addition, Laird et al. (2007) emphasized that Muslim identity, as well as the current social and political context, shaped and affected the health of Muslim adolescents, which need cultural and institutional adjustments in health care services. These evidence confirmed that social factors at personal, family, community, and national levels significantly affected adolescent health (Viner at al., 2012). Therefore, efforts toward adolescent health need to consider the adolescent social developmental context in various sub-groups of adolescents, including Muslim female adolescents and their relevant social developmental context or their sub-groups.

Muslim female adolescents and health problems. Specific information about health problems among Muslim female adolescents globally was rare to find. Hence, the data from Indonesia, as the world's largest Muslim population (Pew Research Center, 2015), and other countries with large Muslim populations will be explained. In addition, reviews from particular countries will be used to reflect the health of Muslim female adolescents.

The Ministry of Health, Indonesia (2013) reported health problems which were prominent for female adolescents were anemia (22.7%) and teenage pregnancy (1.97%). For other health problems, the age group was not reported exclusively in the same range of age as the WHO's current definition of adolescents, which is 10-19 years old (WHO, 2014), therefore the trend of other health problems could not be concluded. In a previous survey conducted specifically among adolescents, the health problems commonly found among Indonesian adolescents were related to nutrition, infection disease, injuries and reproductive health. More than 30% population aged of 13-16 years were stunted (<2 SD height for age) and the percentage was slightly higher in the group aged 16-19 years (Rosso, 2009). In addition, 9.9% adolescents were overweight and 1.8% adolescents are obese (WHO Global School-Based Student Health Survey, 2007). In term of micronutrient deficiencies, anemia affected about half the population of 10-14 years. Furthermore, among infectious diseases, malaria was identified as a major cause of school absenteeism and lower educational levels in Indonesia (Del Rosso, 2009). Unintentional injuries were also experienced by 45.9% adolescents, which could also lead to school absenteeism (WHO Global School-Based Student Health Survey, 2007). However, this evidence did not particularly apply to Muslim Indonesian female adolescents.

India, as a country with the second largest population of Muslims in the world (Pewter research center, 2015) reported several dominant problems among female adolescents, including adolescent pregnancy (58.2%), anemia (56%), and low body weight (47%). Suicide was also reported as higher than any other age group (Sivagurunathan et al., 2015).

In addition, the data from the WHO regional office of South East Asia and Eastern Mediterranean might be used to learn about the general health problems of Muslim female adolescents. Indonesia, India, and Bangladesh, Pakistan, Egypt, Iran, and Morocco which are countries with large Muslim populations (Pew Research Center, 2015), and are grouped in these two regions respectively. According to the WHO (2014), one region with a high prevalence of underweight was South-East Asia, however Eastern Mediterranean countries manifested high rates of obesity. Related to physical activity, none of the countries showed a good level of recommended daily activity level from its adolescents. These facts implied risks of non-communicable diseases during adolescence and adulthood.

Muslim female adolescents and overview of health improvement. Studies on health practices of Muslim female adolescents mostly covered physical activities, reproductive health, and sexuality, which have not included all aspects of health improvement. Many studies describing health improvement of Muslim women, yet studies on particular Muslim female adolescents' health practices were limited. Some of them were described below.

Alamri (2013) described the participation in sport activities among Muslim female adolescents in Australian public health school. It was found that Muslim female adolescents struggled between their Muslim identity, Islamic dress codes, and the sporting requirements. Their strong attachment to Muslim identity and the inflexible rules and policies of school sporting activities were found as barriers to participate in sport. Thus, it was suggested that the schools in multicultural societies should understand and take an approach to accommodate the religious needs and cultural differences in term

of Islamic dress code and separate facilities for female adolescents, including the changing room and shower room.

However, Qureshi (2011) mentioned that many Muslim countries, such as Tunisia, Indonesia, Morocco, and Pakistan, allowed female athletes with various degrees of dress codes, like wearing head cover and loose sport costumes; while still maintaining conditions relevant to Islamic teaching, such as separate prayer and wash rooms, female officials/organizers/coaches, parental approval, and safe environmental conditions.

Related to reproductive health, ‘Uwaidah (2010) described that Islamic teaching described that the normal duration for menstruation is 15 days. During those times, the female adolescents are not allowed to pray, fast, touch the holy book of the Quran, spend time in mosque, and do *thawaf* or go around *the Ka’bah* during pilgrimage in Mecca. They will be allowed to do those kinds of practice when the menstruation stops or the period of menstruation exceeds 15 days and after they wash themselves thoroughly. If they had blood discharged after 15 days or during any time outside of their menstruation period, it is considered as a disease and they should seek for help. Huq et al. (2012) described the hygienic measures taken by female Muslim adolescents in Bangladesh. They used protective measures (sanitary napkins, old cloth, and cotton) and used a cleaning process (soap and water; other kind of cleaning).

Another issue frequently discussed about female Muslim adolescents was sexuality. Abu-Ali (2003) explicated that sexuality was significantly influenced by their religiosity, as well as a sense of ethnic pride and belonging. In other words, religion plays an important role in their development of sexual identity. Nevertheless, conflict in sexual

development might occur when they find contradictory values between their religious prescription and cultural values in the community.

The above evidence explains cultural values affecting female adolescent practices in physical activity, reproductive health, and sexuality. More studies are needed to explore other dimensions of health improvement among female Muslim adolescents.

Factors Influencing Health Improvement of Muslim Female Adolescents

Prior studies described factors influencing health improvement of female Muslim adolescents, including Islamic teaching, gender, family and cultural values, peer-influence and policy. Some studies are described below.

Islamic teaching. According to Omran and Al-Hafez (2010), in Muslim culture, adolescent health is considered as an integrated part of a framework of cultural and religious norm. Therefore, to perform their health promotion practice, female adolescents should consider all aspects, including good nutrition and dietary practices, healthy lifestyle, mental health, reproductive health and sexuality, and personal health and hygiene, within cultural and religious norms.

In addition, Omran and Alhafez (2010) mentioned that many issues related to female adolescents were stated clearly in the Quran and Hadits. The practices, such as major ritual impurity (*janabah*), menstruation, continence (keeping from indecent deeds), betrothal, marriage, sexual relations between married couples, were instructed in a serious legal framework, as well as the practices which violate the framework of Islamic teachings. However, in their transition period, the female adolescents tend to refer to other source of information, such as peer groups or media, which may provide them with inappropriate information related to their self-care need.

Therefore, Muslim female adolescent issues should become the concern of many parties, such as parents, teachers, and religious leaders. Female adolescents should successfully pass through their transition period in a process that is relevant to their religious and cultural norms.

Some studies showed that Muslim female adolescents benefited from the act of worship, such as prayers and reading the Quran. Davlatshoeva (2014) mentioned that the Muslim female participant in her study practiced prayer to calm themselves in dealing with stressful lives. Related to prayer, Sayeed and Prakash (2013) explained about it in a review of as follows:

> Daily prayer, referred to as *salah* in Arabic, is an act of worship specific and unique to Islam both its form and spirit. While the English word prayer conveys a general meaning of supplication or invocation, Salah is an act of submission to the Supreme Creator Allah and is expressed in a specific and well defined physical act embodying the spirit. (p224)

In other words, *salat*, which is also often referred as *salah*, has a different meaning from prayer in English. However, literature mostly addressed this specific act of worship as prayer. In a more recent study, the word *salat* was used (Doufesh et al., 2014); in this study, the word *salat* will be used onward in the text.

Doufesh et al. (2014) conducted a study about the effect of *salat* on "a relative power" (RPa) of electroencephalography (EEG) and autonomic nervous activity, and found the increase of parasympathetic activity and the decrease of sympathetic activity in Muslims during performing *salat*. This study proved that regular *salat* may improve relaxation, relieve anxiety, and reduce the risk of cardiovascular problems. Another act of worships which was identified benefiting Muslim female adolescents was

reciting the Quran. Reciting the Qur'an was believed to relieve mental distress by most Muslim adolescents in the Midwestern United States (Zubeir et al., 2011).

Gender. Several studies explored gender, power and their influence of health improvement on Muslim female adolescents in various settings. The studies revealed the presentation of power relations and how it imposed upon the health of female adolescents. Some of them will be discussed below.

Smerecnik, Schaalma, Gerjo, Meijer, and Poelman (2010) conducted a study on Muslim adolescents' view on sexuality using an internet based program which allowed the Muslim adolescents in the Netherlands, as well as the non-Muslim adolescents, to comment and responded to relevant issues on sexuality. The internet based program also involved an Imam to respond to participants' comments. The study showed that most male and female Muslim adolescents had their own standards of values which were different from the non-Muslim adolescents regarding the issue of sex outside marriage (including premarital and adultery), interreligious relationship, masturbation, and homosexuality. However, double morality was found to be perceived by the male adolescents, as they asserted that they should be given more freedom than female Muslim adolescents to apply the notion of standard accepted in Islam, although they valued the same standard. On the other hand, the female Muslim adolescents preserved the standard but quietly accepted the transgression expressed by the male adolescents. This fact showed how Muslim female adolescents had got used to tolerating the transgressed view of their male counterparts, even in the matters which were clearly defined as *haram* (sin) in Islam. This study showed that gender inequality effected the Muslim female adolescents' view on the sexuality.

A study of Smerecnik et al. (2010) also showed another interesting finding related to how the Muslim adolescents responded to the clarification on the interpretation of the Quran which was provided by the Imam. The Muslim adolescents rejected the Imam's interpretations of the Quran verses which were relevant to the issues being discussed. They seemed to hold more on their own interpretation which perceived Islam as conservative and restricted toward particular issues. This fact indicated that the Muslim adolescents, both male and female, hold on to the rigidity of norms applied in particular Muslim society. The conflicting views between the religious leaders and adolescents, who adopted the rigidity of norms applied in their society, were identified as a barrier to the project. The study showed the manifestation of power relation which inhibits the applied project for Muslim female adolescents.

Likewise, a study conducted by Verkuyten and Thijs (2010) mentioned that the high religious in-group identification was identified among early adolescents in the Netherlands, including negative feelings towards other religions. It confirmed that norms applied in particular Muslim society exerted great influence on Muslim adolescents' perspective on health related issues. This dominant value might result from male dominance, and might be considered as the presentations of power relations (Carspecken 1996) which structured in the particular Muslim society.

Family and cultural values. Davlatshoeva (2014) explored the health issues of female adolescents in a northeastern province of Afghanistan. The study portrayed the life of female adolescents in a country which has been torn by wars for decades and ongoing conflicts between ethnic groups. The study showed that the female adolescents were deeply influenced by their strong family and cultural values. Their healthy behaviors were fostered by family relationships which brought up their level of

nurturance and responsibility. In this study, the female adolescents who built less communication with family members, particularly mothers, experienced health-related concerns. In addition, family members were identified as an important source of health information, as their social world was shaped by their families. The strong family relationship was the dominant cultural value which affected the health of female adolescent.

Another kind of power relation which was identified in the study of Davlatshoeva (2014) are cultural values which are presented as specific cultural and religious customs that impact on their physical and mental health. The dominant cultural pressure which was expressed by the female Muslim adolescents is the obligation to wear *chodari*, a kind of veil made from non-breathable polyester material to cover the whole body. Although wearing *chodari* is valued as the symbol of respectability and protection, it also caused low vision, skin problems, headaches and restricted mobility. However, the female adolescents adopted religious customs which benefited their health. The religious customs mostly mentioned were prayer which was viewed as a calming activity during stressful events in life.

Peer-influence. Studies involving Muslim female adolescents showed the influence of peers, both in facilitating health improvement, and contributing to behaviors which deteriorated their health. Al-Iryani et al. (2013) described that peer educators played a key role in delivering health education on HIV prevention for Muslim female adolescents in Yemen. Meanwhile, the study conducted by Hamjah et al. (2012) found that peer-influence was one of the contributing factors relating to unsafe premarital sex, with most of the participants in this study agreed that friends are the most important people in their lives to share their problems with. A study about smoking behavior which

involved Muslim female adolescents also mentioned that peers significantly influenced on susceptibility and experimentation of the behavior (Islam & Johnson, 2003).

Policy. Since most of Indonesians are Muslim (Pew Research Center, 2015), all health programs, which were addressed by the government for adolescent health, have touched the majority of female Muslim adolescents. Del Rosso (2009) explained that national policies on school health have been initiated since 1950s, but the national school health program was released in 1984, which then revised in 2003. A memorandum involving four ministries: Ministry of National Education, Ministry of Religious Affairs, Ministry of Health and Ministry of Internal Affairs were established to form a coordinating team to develop the school health program, which was known as the Indonesian *Usaha Kesehatan Sekolah* (UKS).

Based on the guideline for health professionals to implement a school health program in Indonesia (Ministry of Health, 2006), the health education activities should: improve knowledge, behavior, and skill on healthy life; facilitate healthy life habits and the ability to prevent the negative influences of the neighborhood; and encourage a healthy lifestyle in order to implement daily healthy life. Nevertheless, this existing model of school health program has not been implemented successfully in Indonesia. Del Rosso (2009) described some problems found in the implementation of the UKS. The problems identified were limited human resources to run the program, limited facilities and infrastructure, inadequate cross sector and cross program collaboration and no optimum monitoring and evaluation. Those problems led to a low coverage and created barriers to implement school health activities in many schools, especially in rural areas.

The implementation of the school health program in Indonesia also did not improve the reproductive health of adolescents. Utomo and McDonald (2009) identified that adolescent's knowledge on the nature of sexuality and of safe sexual activity are limited because sex education is not provided by schools, except in a few cases where the approach to the subject is scientific or technical. In addition, Indonesian parents rarely educated their children concerning sex. Situmorang (2003) also mentioned that sex education was rarely found in school curricula. Discussing sex in public is still taboo, and at the state level there is a strong belief that sex should be treated as a private matter and not a public concern. Therefore, sexuality remains marginal in the health and education agendas in Indonesia.

As a response to the absence of government health programs addressed to adolescents, international non-governmental organizations (NGOs) played more active roles. As a result of the survey of international NGOs role in reproductive health of adolescents, Mepham (2001) described that international NGOs mostly facilitated education and information services for adolescents and 52% of them ran school-based programs. But the implementation of international NGOs lacked coordination with the government and local NGOs. This problem affected the quality and the accessibility of the programs.

In addition, Mepham (2001) mentioned that, although 80% of NGOs made efforts in advocacy and policy initiatives, their potential to force change is still underutilized. Partly, this is because NGOs are not formally organized, but also there is a lack of confidence and or resistance to work with government policy makers. Policy making was considered exclusively to be a national government issue and provincial voices often go unheard.

Muslim Female Adolescents and Health in Islamic Boarding School

Islamic education system in Indonesia. The Islamic boarding school was described by Walsh (2002) in her case study about an Islamic boarding school in central Java, Indonesia, having a high demanding curriculum. She mentioned that besides learning the subjects being taught in common public schools, the students in Islamic boarding school also learned the religious topics such as *tajwid, tafsir, tauhid, fiqih, usulfiqih, faraid*, religious comparison, Islamic history and how to read the *Quran*. The student activities were strictly scheduled, starting from early morning until late evening. Arabic and English became a very important skill for the students to learn, since there are 11 subjects being taught in Arabic and four subjects being taught in English. These conditions demand the students understand those foreign languages and at the same time understand the content in each topic. However, how this demanding schedule affects the student's health practice remains unclear.

This kind of strict regulation is commonly found in Islamic educational institution. Islamic teaching recognizes the need for discipline with children. Sometimes the institution may involve physical punishment with applying some condition in order not to abuse the children (Al-Mateen & Afzal, 2004). The obligation to follow regulations is also intended to respect their teachers (Al-Mateen & Afzal, 2004). In an Islamic boarding school, a teacher is also a religious leader which gives considerable influences on the life of adolescents in Islamic boarding school. Besides being a religious leader, other important elements which play important roles are mosques and Islamic classical books (Walsh, 2002). Those two elements contributed to the strict regulations applied in the Islamic boarding school.

Some studies revealed the conditions inside an IBS. In a study conducted in an IBS in Aceh described that the IBS experienced insufficient access to educational resources. Basic necessities were also considered as major concerns of the participants in the study. The children voiced their concerns about inadequacies in educational opportunities within the context of observing even greater inadequacies in basic life necessities, including nutritious food, clothing, personal hygiene, and even places to sleep. Unfortunately, the findings in the study showed the unresponsiveness of the institution who managed this boarding school (Wanat et al., 2010).

Some psychosocial problems were also documented in several studies. Wanat et al. (2010) described that the students in Islamic boarding schools expressed the feeling of lack of connection with outside world. Furthermore, Chen (2010), in her study about Muslim adolescent's studying in boarding school in China, mentioned that the students expressed strong emotions about missing their families at home.

According to Lee and Barth (2009), besides providing on-site education, the residential school such as IBS, should provide other important services such as counseling, spiritual development, independent living skill, computer, sports, leaderships, fine arts, and peer tutoring for students. Such activities help adolescents to overcome their problems in school. The poor access to the services could affect their health practice in meeting their health needs (WHO, 2009).

The studies about *pesantren* are an under-researched area, especially the case of *dayah (*a local term referred to *pesantren*) in Aceh (Srimulyani, 2014), and particularly related to health. The previous studies involving *dayah* in Aceh focused much on issues related to education Srimulyani & Buang, 2014; Shah & Cordozo, 2014), gender and power (Srimulyani, 2012; Srimulyani, 2014; Husin, 2014). Aceh was

mentioned in a classical ethnography conducted by Castles (1966) about Gontor, a first integrated *pesantren* in Indonesia. The study merely states that none of students from Aceh and West Sumatra were studying in *pesantren* at that time, with a consideration that Aceh and West Sumatra people might perceive that they already had a better Islamic education institution by that time. Aceh and West Sumatra were famous for having many famous Islamic scholars since long time ago.

Health Problem of Muslim Female Adolescents in IBS. Islamic boarding schools (IBS) have an image of a second-class school and "dumping ground" for children from poor rural families (Parker, 2008). The IBS itself is considered as a high risk setting. Several studies showed that the students in IBS often suffered from many health problems, such as diarrhea, acute respiratory infection, and skin infection (Fadlyana, Utja, Safitri, & Subarja, 2002; Rahmawati, 2009), such as scabies (Asra, 2010; Rina, Azizah, & Indriani., 2015). The IBS also was reported as one of sources of H1N1 infection transmission (Faisal, 2009).

Studies in some IBSs showed that the prevalent diseases might have resulted from the lack of knowledge and poor hygiene practice to prevent the prevalent disease. Rosandi and Sungkar (2014) mentioned that the students, in the IBS where they conducted the study, were lack in knowledge related to the cause, symptoms, transmission, and prevention of scabies. While Rina, Azizah, and Indirani (2015) identified that there was a significant correlation of the gender, the bedroom humidity, and cleanliness of bedding with scabies incidence in an IBS. In addition to the humidity and unclean bedding, the female students contributed in transmitting the infection by sharing cloths, towels, and praying equipment.

Health improvement of Muslim female adolescents in IBS. Studies explaining about the health improvement of Muslim female adolescents in an IBS in Indonesia were rare to find. Most of the health related studies in the IBSs focused on assessing the factors related to prevalent diseases in IBS and testing the intervention to modify the factors. Most of the studies were reported in theses or final reports, and few of them were published in journals. Some of them have been mentioned above. Some details related to health improvement were explained below.

Rosandi and Sungkar (2014) examining the effectiveness of health education in increasing IBS students' knowledge about scabies. The study measured the level of knowledge on etiology, clinical symptoms, treatment, prevention, and transmission of scabies before and after the health education session. Significant differences in knowledge before and after the health education sessions were found ($p<0.01$). The improvement in knowledge was expected to affect the students' attitude and practice toward the disease. However, no further researches were conducted to confirm the impact on students' attitude and practice to prevent the disease.

Rina, Azizah, and Indriani (2015) analyzed the infection and control of scabies in an IBS. They mentioned that most of the students showed good hand and nail hygiene which was not significantly related to the incidence of scabies in the IBS. The study found that the humidity of the bedrooms, the cleanliness of bedding, and gender showed significant relationship with the incidence of scabies. The IBS itself showed less efforts in prevention and promotion, and focused only on the curative efforts.

Strategies of Health Improvement for Muslim Female Adolescents in IBS. In order to improve the preventive and promotive services for the students staying in the IBS, the Ministry of Health launched the program of "*Pos Kesehatan Pesantren*"

(pesantren's health post) as one of the integral parts of school health programs. The program targeted the individuals in the IBS to aware of, plan, and utilize their local potencies according to their conditions, situations and needs, in coordination with the local health center (Ministry of Health, 2013). However, the IBS and the health center did not manage to build a good coordination. The health center merely participated in the annual health screening for the students in the IBS without any additional activities (Aswat 2013). This fact showed that *Poskestren* had not been well implemented. Nothing about *poskestren* was reported in the latest Indonesian health profile (Ministry of Health, 2015).

In fact, the IBS was identified as having potential to play a more active role in improving health. The study conducted by Sciortino, Natsir, and Mas'udi (1996) explained an innovative approach employed by a Muslim non-government organization (NGO), named "Indonesia Society for *Pesantren* and Community Development (P3M), in understanding women's rights, particularly related to reproductive and sexual health. The approach examined and re-interpreted the sacred texts of Islam to link with the issues of social justice, gender and reproductive health. The NGO involved the women from the IBS in rural areas and run workshops related to reproductive and sexual health. However, no other studies further emphasized the effectiveness of the approach, either reported any other related health approach. Nevertheless, the fact showed that studying in an IBS is definitely important because it has a role as a center of Islamic values reproduction. Moreover, with IBS's widespread and extensive networks, IBSs and their leaders are influential in connecting their communities with issues in the society (Srimulyani, 2012), therefore there is a chance for the IBS to be influential as well in the issues of health improvement.

Islamic Education

Education takes up an important place in Islamic civilization, since education is an integral part of faith (Yasin & Jani, 2013). In term of philosophy, Islamic education is different from the secular western system of education (Al-Attas, 1980; Yasin & Jani, 2013). In Islamic epistemological context, all knowledge comes from God; therefore, the truth in our rational and empirical investigation is confirmed by the Quran (Al-Attas, 1980) as the main reference (Rayan, 2012), whose meaning is reflected in the *Hadith*, *Sunnah*, and in the empirical things (Al-Attas, 1980). Hence, the Quran constitutes the source of Islamic education (Rayan, 2012). Describing Islamic education may not be detached from this Islamic principle of knowledge.

Describing the meaning of education in Islamic tradition, and its concepts involved is essential to formulate an education system and its application (Al-Attas, 1980). Al-Attas described the Islamic education based on three constituting fundamental elements: the recipient, the content, and the process. These three elements are used to outline the descriptions, while the explanation from other Muslim scholars will be added.

Recipient of education. The recipient of education, in the context of Islamic perspective, refers to man, who is viewed as a rational soul that possessed *aql*. *Aql* is described as an innate property, or a spiritual substance that binds and withholds objects of knowledge by means of words; which is used by man to recognize and distinguish truth from falsehood (Al-Attas, 1980). The role of man to reform and construct human life is what Islamic education seeks for. A balanced and equitable relationship between the individual, society and the world should be achieved (Rayan, 2012).

Nofal (2000) explained the view of Al-Ghazali, one of the most influential Muslim scholars, about Islamic education. Al-Ghazali stated that the most important characteristics of man are awareness and knowledge, and the virtuous man is the one who prefers the eternal hereafter than the transient world. In addition, Al-Ghazali explicated that, as the composite of human beings, society has a purpose to apply *sharia*, which includes the individual, political, social, and economic life in one integrated world view (Rayan, 2012).

Content of education. The second important element of education is the content. Al-Attas (1980) stated that the content refers to knowledge, which is explained below:

> Knowledge is the arrival of the soul at the meaning of a thing". The 'meaning of a thing' means the right meaning of it; and what is considered to be the 'right' meaning is in this context determined by the Islamic vision of reality and truth as projected by the Quranic conceptual system.

In addition, Al-Attas mentioned that:

> Knowledge consist of the recognition of the proper places of things in the order of creation, such that it leads to the recognition of the proper place of God in the order of being and existence.

This description of knowledge implied its spiritual dimension. Al-Ghazali explained that education includes all intellectual, religious, moral and physical aspects, and not merely to train the man and instill it with information. Helping man to achieve and to attain the happiness of the hereafter is the purpose of knowledge (Nofal, 2000). Therefore, all activities of physical, mental, psychological, and spiritual should be

included, and at the same time achieving the balanced and equitable relationship between individual, society and the world (Rayan, 2012).

Al-Ghazali furthermore explained two sources of knowledge. The first source is the human attribute of the senses and reason, which allows man to understand this material world. This human attribute is considered insufficient, and the second source, which is the divine properties of revelation and inspiration, is needed. These divine properties of revelation and inspiration bring human to understand the invisible world. This two source of knowledge resulted two type of knowledge which cannot be treated equal due to its different source, method or reliability. However, the comprehension of these two types of knowledge makes man know and get closer to God, which brings the greater happiness (Nofal, 2000).

Process of education. The third essential element of education mentioned by Al-Attas (1988) is the process, in which Al-Attas explained by the concept of *adab*. *Adab* is defined as:

> Recognition and acknowledgement of the reality that knowledge and being are ordered hierarchically according to their various grades and degrees of rank, and of one's proper place in relation to that reality and to one's physical, intellectual and spiritual capacities and potentials.

Al-Attas emphasized that the goal of education, in producing a good man could be achieved by instilling *adab*. Therefore, man should be aware of responsibilities toward God, and continuously improve every aspect of himself to complete his duties to himself and society with justice.

Based on these three elements explained above, Al-Attas (1980) defined the meaning of education as:

> Recognition and acknowledgement, progressively instilled into man, of the proper places of things in the order of creation, such that it leads to the recognition and acknowledgement of the proper place of God in the order of being and existence.

This definition implied the goal of education to lead the recognition and acknowledgment of the proper place of God. It is relevant with the opinion of Al-Ghazali who mentioned that the goal of education is cultivating man to abide in the teachings of religion which assures salvation and happiness in hereafter, while the other goals are considered only relevant to the transient world (Nofal, 2000).

According to Al-Ghazali, education is a process in which interaction equally affects and benefits teacher and pupil. The teacher obtains merit for teaching, while the student earns it from the acquisition of knowledge (Nofal, 2000). Al-Ghazali and his followers, Ibn Khaldun, emphasized the essential aspects of climate in teaching, and the kind of expected relationships in the Islamic traditions of education in their books. Both of them suggested that the teacher is a role-model who should set an example for their students, and should be obeyed and respected by the students. The teaching should cover all aspects of the personality and life, which is considered affective when the student could practice it. Rather than memorizing the contents, the teaching should be aimed to instill the right habits (Nofal, 2000; Cheddadi, 2000).

Critical Theory

Critical theory is considered as a theoretical insight which seeks for paths to elucidate power and oppression, as well as to comprehend how they structured the everyday life of human experience. It reveals social relationships in which powers play

its role in dominating and shaping consciousness of individual and groups in societies. The dominating powers and the false consciousness blocks those individual and groups to make decisions that essentially affect their lives (Kincheloe & McLaren, 2005).

The criticalist believed that it is impossible to isolate the facts in society from the domain of values and there are no producers of knowledge in any groups of society who are innocent or politically neutral (Foley & Valenzuela, 2005). It is also acknowledged that there are many forms of oppression which contributed to the privilege of the dominant powers and the disadvantage of others. In other words, it is recognized that claims to truth are always changed by situation and implicated in relation of powers (Kincheloe & McLaren, 2005).

Carspecken (1996) further explained the claims to truth in critical theory are fallible, depending on how they are regarded during a later historical period or after one cultural group experiences contact with another. In addition, critical theory considers that people's identities and their forms of thinking, as well as their beliefs are inseparable from oppressive relations. These are the reasons that critical researchers have a concern over a number of epistemological issues.

Acknowledging that powers were embraced in social relationships and presented in various forms, the critical epistemology covered three main things: theory of symbolic representation; an understanding of the relationship between power and thought and power and truth claims; and an understanding of what values are, what facts are, and how they are connected. Since the facts are affected by value, critical epistemology must state a considerably clear difference of both fact and value and how they interacted. With an extensive understanding of it, the researchers who use this

epistemology will be able to reduce bias in their studies and to evaluate other studies (Carspecken, 1996).

Among various critical theorists, Carspecken (1996) highlighted that Jurgen Habermas had developed the most rigorous formulation of critical epistemology. Carspecken concluded Habermas' thought by emphasizing that within the truth, the most important thing to be focused on is not whether they are true or false in the traditional sense, but rather whether they meet certain validity conditions necessary to win consensus in a cultural group. Thus, when the truth is to be examined precisely, they must be translated into validity claims.

Ray (1999) also explicated that Habermas rejuvenated critical theory and aimed to return critical theory to its goal to bring self-knowledge and self-reflection back to those whose perception is concealed with values imposed by the oppressive powers. Habermas regarded "critical" as penetrating a given context and that critical thought is a rational discourse and committed to rationality. The term 'self-reflective' mentioned above means to bend back upon the self in order to see something from a new perspective. In other words, in the critical process, people will be brought to account for their own conditions of possibility.

Furthermore, Ray (1999) explained three categories of cognitive interest which are included in critical theory as a framework of scientific knowledge. The three categories are: technical, practical, and emancipatory. Technical and practical knowledge were considered to have limitation to achieve mutual understanding toward the relationship between knowledge and human interest, thus Habermas explicated emancipatory knowledge as fundamental to critical social science. The ultimate goal of emancipatory knowledge is to create universal knowledge from autonomy and

responsibility by achieving liberation from the structured power. In achieving the liberation, scientific inquiry was conducted toward people's life experiences with reflection and critique to reveal domination of powers. Therefore, Ray emphasized that in critical research tradition, the researchers and participants involve in a critical reflective interpretation and dialectical process to examine values, ideologies, patterns, rules, characteristics, contradictions, oppositions, tensions, and ethical dilemmas which were found in participants' experience and communicative interaction.

The research tradition under critical theory was considered as a transformative endeavor to correct the injustices found in the investigated site. It moves every individual or parties in the site to understand their very own world and the way it is shaped in order for them to make a positive social change. This research tradition will make them gaining self-understanding and self-direction toward the transformation they need (Kincheloe & McLaren, 2005). One of research methodologies guided by the principles of critical theory is critical ethnography which engaged in cultural critique of cultural dominance and minorities (Cook, 2005).

Summary

Although adolescent is defined as people ages 10-19 years with different characteristics from adult, in Islamic teaching, Muslim adolescents become adult when they reached adolescence phase. They are fully accountable for their deeds which are accounted by God and should practice Islam as an adult do. In the context of Muslim female adolescents, the way they live their life, practicing Islamic teaching in every aspects of life, was affected by the social structures or cultural values in their community, as the interpretation of social issues in the Islamic teachings have always been influenced

by the cultural values. Besides Islamic teaching and cultural values, the other factors which affected their lives, especially the health practices, are gender, family values, peer-influence and policy. In this study, the life experience of female Muslim adolescents with these influencing factors were explored from the perspective of critical theory and Islamic education.

Chapter 3

Methodology

Research Design

The design of the study was Carspecken's (1996) critical ethnography. This type of critical qualitative research has been applied to study non-quantifiable features of social life. Carspecken also provided more methodological guide to implement the design for novice researchers. The five stages of Carspecken critical ethnography guided the whole research process, starting from data collection, data analysis and finding dissemination to set the stage for positive social changes. The five stages included: (1) compiling the primary record; (2) preliminary reconstructive analysis; (3) dialogical data collection and analysis; (4) describing system relations; and (5) explaining system relations.

Using this design, the study did not put the only focus on adolescents as the actor for their own behavior, like the other designs did, but it shifted the research focus on the socio-political context (Cook, 2005). Carspecken's (1996) critical ethnography endeavors to redefine social phenomena by revealing the connection between social phenomena and broader social and historical events. It may uncover the dominant structures, ideologies and hidden assumption and challenge them for positive changes. By using this design, it was expected to be able to explain the social behavior of female adolescents in improving their health, explore the structures underlying their behavior and seek for the positive social changes for their empowerment and emancipation. Figure 3 shows the steps of the research methodology.

The design was selected because Carspecken (1996) emphasized that in investigating phenomena of oppression, a rigorous epistemology is needed because the identities, form of thinking, and the beliefs of people are merged with the oppressive relation. The people inside this oppressive relation might not realize this condition. In this condition, the values influenced the facts. In addition, the forms of power implied the social relationship in this condition, which could be observed in various presentations. By conducting a critical epistemology, the researcher could identify the symbols from those various presentations, differentiate the facts and values, the facts and power, and how they relate each other.

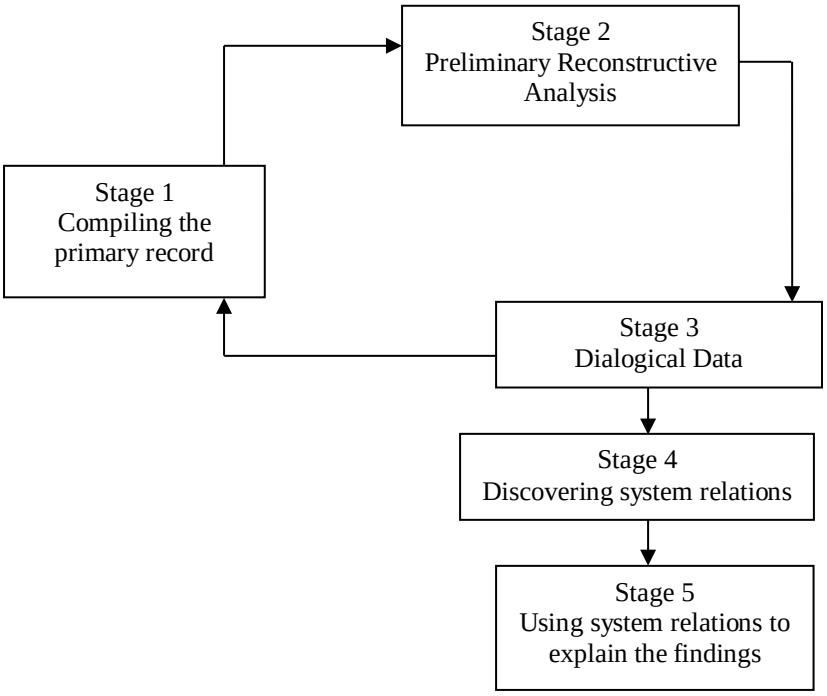

Figure 1. Five stages of Critical Ethnography (Carspecken, 1996)

Study Setting and Context

The setting of an Islamic Boarding School (IBS) was selected due to its uniqueness among other settings of adolescent groups in Indonesia. The IBS is a co-educational institution where students study and stay all day during the academic years of junior and senior high school. The Islamic boarding school, which is better known by the name "*pesantren*", is an Islamic institution of education which is aimed at producing religious leaders and maintaining the teachings of Islam separate from secular values (Amalik, 2008). According to the Indonesian Ministry of Communication and Information (2010), there were more than 63,000 IBS that contributed to the provision of basic education for youth in Indonesia.

According to the state legislation on the national education system (Government of Indonesia, 2013), the formal education could be provided either by means of the conventional education system or the religious education system. Based on the government regulation of the religious education system (Ministry of religious affairs, 2014), *pesantren* are acknowledged as part of the system which organizes *pendidikan kitab kuning* or *dirasah Islamiyah* (Islamic teaching based on Islamic classical books) and requires the students to reside in *pondok* (*dormitory*) inside the education institution during the length of their study.

Hidayat (2009) described the IBS as the oldest Islamic education institution in Indonesia. Many Muslim leaders, politicians and scholars graduated from this institution. In an IBS, the students live in specific communities applying Islamic values, norms, and cultures which may differ from the surrounding community. This suggests the students or adolescents in an IBS might have different lives from the other students or adolescents studying in regular schools and staying with their families.

Generally, IBSs are categorized into traditional IBS (*salafi*) and integrated IBS (*khalafi*). The traditional IBS delivers the teachings of classical Islamic books as the core of education, without introducing science or other conventional knowledge while the integrated IBS has included science and other conventional knowledge by applying the national curriculum designed for Islamic junior or senior high school.

An integrated IBS was selected for this study due to its accessible location and its permissible culture of accepting non-Muslim or Muslim outsiders to visit the school. Many IBSs are very remote and allow only very limited access to outside visitors. The people in the province of Aceh commonly addressed all IBSs, both traditional and integrated, as "*dayah*". The term refers to the complex of buildings which constitute mosques, teaching halls or classrooms, and dormitories. However, people are commonly aware that some *dayah* provided formal education in the morning and some *dayah* focused only on non-formal religious education. Furthermore, in this article the term *dayah* will be used to refer to an integrated *dayah* in order to reflect the local context.

Participants

Female adolescents were involved as key participants in this study. 34 key participants were recruited based on the inclusion criteria: (1) being a student at junior or senior high school; (2) staying in the Islamic Boarding School. In order to have diverse participant experiences, 22 students who stayed in IBS since junior high school, and 12 students who joined IBS at the level of high school, were included.

This study included 10 associate participants in order to have rich data. The associate participants comprised of the *dayah* principal, chaperone, *ustadzs* and *ustadzahs*, and two nurses who were responsible for school health promotion in the IBS.

This qualitative study applied the basic principle of sampling which was referred to data saturation. Data saturation means the sampling has achieved a point of saturation where the researcher finds no more new information and the repetition is established (Polit & Hungler, 1999). In other words, the number of participants depends on the point of saturation determined in the data analysis process. Therefore, the data collection and data analysis were conducted simultaneously.

Data Collection Methods

Carspecken's (1996) critical ethnography obviously separated data collection and data analysis method into different stages, except for stage 3 where data collection and data analysis was conducted simultaneously. Therefore, data collection was planned into two main phases. The first phase focused only on female adolescents in the IBS, which was conducted in stage 1 (compiling primary record) and stage 3 (dialogical data collection). The data collection methods used in the first phase were participant observation, photovoice, and focus group discussions (FGDs). The photovoice method employed seven photo-taking activities, 2 FGDs, and 3 in-depth interviews, which involved seven key participants. After photovoice was finished, 33 key participants were recruites to be interviewed in FGDs, and six of them were previously involved in photovoice. This 33 participants were participated in nine FGDs.

The second phase of data collection focused on the wider social group surrounding the group of study, which was conducted in stage 4. Stage 4 involved ten associate participants who participated in 11 indepth-interviews. Although the stages were separated under each phase, the stages were conducted interchangeably to give more opportunities for more exploration on the issues.

Compiling primary record. Stage 1 of Carspecken's critical ethnography showed the process of compiling a primary record or observation data from the researcher's standpoint. In this stage, researchers passively observed the group of female adolescents living in Islamic boarding school during their daily life at school and dormitory for the duration of one month. The activities observed included how they prepare themselves before the classes in morning and evening, their morning and evening classes, the extra-curricular programs, their hygiene practices, their meal time and their leisure activities at the dorm. At first, this type of data collection was planned not to involve the participants in any dialogues in order to make the process of data collection as natural as possible. However, in this setting, interacting with the participants was unavoidable, but the principal researchers tried not to interfere their activities.

The produced data set included the conversations and behaviors of participants in the view of researcher. The data were recorded in the participant observation form and analyzed in the stage 2 of this study. Field notes were prepared to describe the setting and the interaction that taking place in the setting, as well as to record the ethical note, aesthetic note, and personal note of the researcher during the data collection process.

Dialogical data collection. This type of data collection method applied a multi-interactive-method approach in collecting the data to gain an emic or insider's perception. The methods were photovoice, focus group discussion, in-depth interview, participant observation, and secondary data which were found in the setting, such as the announcement board in dormitory, the documents of student council, *dayah*'s document. The use of photo-voice in conjunction with other tools and methods were considered as an appropriate effort to empower the participants in the study itself.

This study used photovoice as a innovative research method to elicit information through independent photo taking and photo interviewing by participants. Several reasons were considered in using photovoice for this study. First of all, in this method, the photographs being used during interviews could elicit richer data than traditional interviews (Meo, 2010) and produced more in-depth analysis (Riley & Manias, 2006). This method effectively balanced power to achieve the empowerment or emancipation goal of the oppressed or marginalized group (Allen, 2008; Casteleden & Garvin, 2008; Dennis, Gaulocher, Carpiano, Brown, 2009; Meo, 2010; Oliffe & Bottorff, 2007; Royce, Parra-medina, Messias, 2006), especially in sensitive issues, both in the level of individual and level of peers (Blackbeard & Lindegger, 2007). Secondly, because photo-voice could be applied to study sensitive issues in the oppressed or marginalized group, such as female adolescents living in an IBS.

In this study, seven key participants were recruited to be involved in photovoice which included the activities of photo-taking and photo-interview. In the photo-taking process, the students were assigned to take photographs of any persons, places or events which were perceived to relate to how they care for themselves in their school or dormitory. Then, they selected the photos which were discussed later in the photo-interview. Subsequently, the photo-interview was conducted by using focus group discussions (FGD) and individual follow-up, in-depth interviews for sensitive issues. The photo-interviews were started from the first photograph until there were no more photographs to be discussed. The key participants were asked to describe what the photographs were about, the persons or objects in the photographs, the reasons why they took the photographs, and how they felt about the photographs.

Following photovoice, the researcher recruited 33 key participants, and six of them were previously involved in photovoice. These key participants were involved in nine FGDs. All FGDs and indepth-interviews were conducted in Bahasa Indonesia and recorded with an audio tape recorder. The guidelines were developed to help the researcher in asking the questions during FGDs and in-depth-interviews, however the researcher tried to make the conversation as natural as possible by following the participants' responses.

Verbatim transcripts were produced and some were translated into English to facilitate the consultation with thesis adviors. For each transcription produced in this study, every line of each page was numbered to systematically code the data. The researcher repeatedly read the transcription thoroughly to comprehend the data which also included the field note taken during the discussion. The meaningful statements and expressions in the transcript were highlighted and populated in separated table with certain code representing the line and the page they are extracted.

The multi-methods applied in this study, which included the observation, photovoice, FGD and interview, were considered as a form of triangulation which produced the rich and diverse data. To increase the trustworthiness, several techniques were performed to validate the data as described in table 3. In addition, researcher's reflexivity was applied to reduce the researcher's bias. As a result, at the end of stage 3, the study exposed the practical understandings which constructed the way female adolescents improved their health in an Islamic Boarding School.

Data collection for system analysis. During stage 4, the researcher conducted in-depth interviews and observation to explore the system relations between Muslim female adolescents as an individual with specific social elements which closely

related to their health improvement. In this case, the researcher conducted 11 in-depth interviews with the *dayah* principal, a nurse from nearby health center, and a nurse from another health center which located at the same district with the *dayah*.

Table 2

Data Collection Methods

5 Stage Model	Stage 1 Compiling primary record	Stage 2 Preliminary analysis	Stage 3 Dialogical data collection & analysis	Stage 4 Describing system relations	Stage 5 Explaining system relations
Research steps	Participant observation	-	Triangulation data collection	Examining social sites in the wider locale beyond primary research site	-
Purpose	- Record social routine as naturalistically as possible - Observing directly when and where action takes place		To validate researcher's interpretation and to enrich the data	To discover system relations	-
Participants	- Female adolescents - Teachers - School/dormitory staff	-	- Female adolescents - Teachers - School/dormitory staff - Principals	-	-
Site	Dorms Dining room Class room	-	Classroom school office Dormitories Mosque	outside of IBS	-
Methods	Field notes Audio-taping Video-recording Photographs	-	- Photo-voice with female adolescents: - Photo-taking	Interpreted data gathered with links to macrostructure	-

Table continued

5 Stage Model	Stage 1 Compiling primary record	Stage 2 Preliminary analysis	Stage 3 Dialogical data collection & analysis	Stage 4 Describing system relations	Stage 5 Explaining system relations
			- Photo-interview (FGD & individual interview) - FGD & in-depth interview with students - In-depth interview with teachers & principals		
Techniques to support objective validity claims	- Multiple recording device & multiple observer - Used flexible observation schedule - Prolonged engagement - Used a low inference vocabulary - Peer-debriefing - Member check	-	- Consistency check on recorded interview - Non-leading interview technique - Member check	- Peer debriefing - Comparing and contrasting with other research findings or theories	-

Data Collection Instrument

In addition to the researcher as the research instrument, this study used several additional instruments for various purposes. During the session of photo taking, the researcher used a demographic form (appendix A) and a camera. During the photo-interview and dialogical process, the needed instruments were a tape recorder, focus group discussion guide for photo-interview (appendix D), individual in-depth interview guide (appendix E), and associate informant interview guide (appendix F). For the purpose of observation, the researcher used participant observation form (appendix G). Throughout the research process, the researcher used field note taking forms (appendix H) to complete the documentation of the research process.

Researcher. In this study, the researcher is an Acehnese Muslim woman and attended Islamic schools since elementary level until high school level. The researcher had no experience to study in any *dayah* before, either formally or informally, however the researcher ever had some experiences visiting several *dayah* during fieldworks before this study. The research took advantage from the familiarity with the local language, Acehnese culture and some sort of experience in visiting *dayah*, to understand the studied phenomena.

During data collection, the researcher could understand when some participants spoke in Acehnese. Some interviews with associate participants were conducted in Acehnese, but all interviews with key participants were in Indonesian, since not all key participants could speak Acehnese. Some participants could speak more and looked more expressive while telling their stories using Acehnese than Indonesian, for such cases, the researcher asked them to speak in Acehnese. Nevertheless, during data

collection, many clarification and confirmation were needed as the participants used the words in different context from what the researcher previously understood.

As a qualitative researcher, the researcher tried to adapt the research methods with the emerging issues to explore in each stage of the study. The researcher learned how to decide when to pause or continue or go deeper to certain issues in order to get a complete understanding of the issues. Sometimes to go deeper to certain issues, the researcher needed to move from monological data collection to dialogical data collection several times. For example, while observing the key participants studying in their classroom, the researcher did not understand the terms and the *dayah* curriculum they were applying, then the researcher decided to do dialogical data collection by interviewing a teacher about the curriculum.

Demographic Information Form. In order to obtain the relevant personal information, a demographic information form was used. The participants who gave their consent to participate in the study filled the form as attached in appendix B. The form collected information about age, ethics, address, educational background, the date of arrival in the *dayah*, time of the first experience staying in the *dayah*, and family information of the key participants. This information provided the contextual background of participants and added on the rich description of the findings.

Interview guide. This study used three interview guidelines to be used for different purposes. Those interview guidelines were: photo-interview guideline (appendix D); FGD and in-depth interview guideline for key participant (appendix E); and associate participant interview guideline (appendix F). The photo interview guideline was utilized during individual in-depth interview or focus group discussion to explain the photos taken and selected by the participant. Each participant decided voluntarily

whether she would like to tell the stories behind the photos in FGD or in an individual in-depth interview.

Participant observation guide. This participant observation guide (appendix G) documented data about the setting and context by observing interactions or places located inside the school. It guided to record: the people involved in the event of investigation; artifacts such as documents related to the adolescent's health behavior; set of related activities conducted by people involved in the event of investigation; the time when the observation was performed, when the activities occurred during those times, and effect of time on social situation; the goal or the expectation of the event; and the feeling or emotions expressed and observed during the events. The researcher observed each interaction in the setting by changing the focus on different participant every five minutes. For each focus, the researcher made first priority of observation on a determined participant in a setting, second priority for another person interacting with the participant of the first priority, and the third priority for everything else that occurred around the participant of the first priority. A two hour-block of observation for different settings was performed each day.

Field Note Form. This form (appendix H) was designed to record the description of events, ethical notes, aesthetic notes, and the researcher's personal notes during the interactions with participants in the setting of the study. It helped to conductdata analysis and interpretation simultaneously with data collection. The researcher documented any things that came up along the process, such as which questions asked during interviewed that should be modified or which questions needed additional probing question because it seems difficult to answer. The field

notes also benefited the researcher in providing rich and time relevant information to understand the implications of the participants' statements.

Audio tape recorder. An audio tape recorder was used to record the focus group discussions, and individual in-depth-interviews with the participants' permission. The participants were allowed to ask for the audio tape recorder to be paused when they shared sensitive stories which they did not want to be recorded. Each recorded FGD and interviews were transcribed verbatim in its original spoken language. The audio files and transcripts were imported to NVivo for ease of data management.

Camera and video camera. The camera was used both by the key participants, as well as by the researcher. During photovoice, a camera was given to the key participants who were assigned to take photographs of any persons, places or events they perceived were related to how they were caring for themselves in their school or dormitory over a period of two days. The produced photographs later were discussed in photo-interviews.

The researcher used the camera to take pictures of cultural artifacts found during participant observations, such as the announcement posted in the mosque, list of duties, posters or leaflets of prayers, the pictures of Islamic text books, etc. Those pictures helped the researcher to provide rich description in the field note form and participant observation form.

The video camera was used to record several events occurred in Islamic boarding schools, such as festivals, extracurricular activities, and other group activities. The video was used with the verbal permission of the IBS's principal, teachers, or students involved in each events. The video helped participants to record more details of each events and put more descriptions in the participant observation form.

Data Analysis Method

Carspecken's (1996) critical ethnography described the steps for data analysis method exclusively in stage 2, 3 and 4. In each of stage 2, preliminary reconstructive analysis was applied. This preliminary reconstructive analysis involved two main steps: initial meaning reconstruction and pragmatic horizon analysis. Initial meaning reconstruction was initiated by reading all primary records compiled from stage 1 and focused on recurring patterns and unusual revealing events. The researcher paid attention to the recurring patterns and unusual revealing events to add an articulation of tacit meaning that could be captured from the data. This articulation of tacit meaning was done carefully with a low level of inference without using strict structure of language symbols. From this articulation of tacit meaning, the researcher produced several meaning fields or several relevant concepts (range of possibilities of meaning). Then the pragmatic horizon analysis was started.

Pragmatic horizon analysis was a process of recognition of meaning through the activities of position-taking. This process brought up the precision level of interpretation from the previous process. In other word, a high level of inference was employed. The researcher moved from various positions of participants consciously. At the same time, the researcher should make clear about the existing norms that were applied in understanding participant's actions. At the end of the process, the researcher had a holistic horizon of act which consisted of a shared understanding of symbol systems. An example of data analysis method is described in appendix I.

In order to check for bias and the partiality of the researcher, peer debriefing was conducted. Based on that, the process of study returned again to stage 1 twice during the data collection. It was conducted to further explore certain meaning

fields and revised the holistic horizon of act. When saturation was achieved, a member check was performed.

A system analysis was conducted in stage 4 and stage 5. The data from previous stages were compared with similar studies on Islamic boarding schools and also studies which covered broader social, political, historical and institutional factors. The similarities and differences found were explained by finding the related theories which could imply the relationship between female adolescents' experiences with social factors, such as gender, politics, religion, and economics. The description of each process is detailed in table 3.

An initial analysis of the original data in Bahasa Indonesian was conducted by the principal researcher. The transcripts of the first three FGDs were translated to English by the principal researcher, and were checked by two bilingual translators for the accuracy of translation. The data analysis was performed under periodic consultations with a researcher who was also the major thesis advisor. All researchers participated in systematic data analysis after the data collection was completed. The researchers tried to intuit what the participants actually shared beyond the words transcribed, carefully looked for the patterns of their experience, and conducted a number of discussions to develop the coding frame. The discussions highlighted and resolved the areas of disagreement to reach a final coding frame to code the entire data set. The initial subthemes, themes, and categories were reviewed by research advisors to ensure the credibility and saturation of the data. When saturation was achieved, member checks were performed by conducting two FGDs with the key participants to confirm the meaning fields. Eventually, these nuanced meanings were developed into final themes.

Trustworthiness

Trustworthiness of data is considered as the validity and reliability of qualitative research. The qualitative research is trustworthy when the research exhibits the accurate experience of the informants being studied (Streubert & Carpenter, 1999). The operational techniques to support accuracy of research include credibility, dependability, confirmability, and transferability (Guba, 1981; Guba & Lincoln, 1994; as cited in Streubert & Carpenter, 1999). In this study, credibility, dependability, confirmability, and transferability were applied to achieve the trustworthiness of the data. The details of techniques applied to every stage of this study are detailed in table 3.

Table 3.

Data Analysis Method

5 Stage Model	Stage 1 Monological data collection	Stage 2 Preliminary reconstructive analysis	Stage 3 Dialogical data collection & analysis	Stage 4 Describing system relations	Stage 5 Explaining system relations
Data Analysis Method	-	- Initial meaning reconstruction (low level of inference) - Pragmatic horizon analysis (high level of inference)	Pragmatic horizon analysis	Explore system relations between social sites	Interpreting system relations by comparing to existing social-theoretical model
Purpose	-	To gain holistic impression of meaning based on various positions of participants and other people in the setting	To confirm the theme and categories generated from stage 2	To discover system relations between social sites	To compare data to existing macro theories of society
Methods	-	- Coding - Preliminary reconstructive analysis - Pragmatic horizon analysis	- Photo-voice with female adolescents: - Photo-taking - Photo-interview (FGD & individual interview) - In-depth interview with teachers & principals	Interpret data gathered with links to macrostructure	Interpret results to confirm, extend or modify social theories

Table continued

5 Stage Model	Stage 1 Monological data collection	Stage 2 Preliminary reconstructive analysis	Stage 3 Dialogical data collection & analysis	Stage 4 Describing system relations	Stage 5 Explaining system relations
Techniques to support objective validity claims		- Peer debriefing - Member check	- Consistency check on recorded interview - Non-leading interview technique - Member check	- Peer debriefing - Match between researcher's reconstruction and those published by other researchers	-

Credibility involves activities to increase credible research findings (Lincoln & Guba, 1985; as cited in Streubert & Carpenter, 1999). Lincoln and Guba (1985; as cited in Barton, 2008) explained activities to establish credibility in ethnography which includes prolonged engagement, persistent observation and triangulation. In this study, the researcher conducted data collection for 9 months to get familiar with the culture being studied. The multi-methods of data collection were also applied, involving observation, photo voice method, focus group discussion and in-depth interview. Associate participants would also be involved to achieve triangulation.

Dependability is stability of data across the times and condition. One of techniques to achieve dependability is inquiry audit to review data and supporting documents thoroughly and in details which is performed by external reviewers (Polit & Hungler, 1999). The external reviewers were the experts in qualitative data analysis. In this study, researcher involved two experts from the Faculty of Nursing, Prince of Songkla University (thesis advisors), and one expert from the College of Nursing, Seoul National University (during overseas study) to evaluate the findings.

Confirmability refers to objectivity or neutrality of data when there is agreement achieved between two or more persons on the relevancy or the meaning of the data (Polit & Hungler, 1999). To achieve confirmability, the audit trail was performed by a systemic collection of all materials and documents to make inference from the data (Polit & Hungler, 1999). Conformability was also achieved by member check of each informant and asking for their verifications. To achieve conformability, researcher conducted several member checks with key participants at the end of stage 2 and stage 3. For checking possible bias of researcher, peer debriefings were performed two times during the initial data collection and at the end of phase 2. Peer debriefing was conducted

after pilot study, with the PhD students who attended the subject of advanced qualitative data analysis in Prince of Songkla University. Another peer debriefing was performed in early phase of data collection, with PhD students who attended the subject of advanced qualitative data analysis Seoul National University.

Transferability or fittingness is the probability that the study findings have meaning to others in similar situations (Streubert & Carpenter, 1999). To achieve transferability, the report of the findings was enriched with pictures, the real words of the informants and detail documentations during the research phases. Afterwards the detail findings and data analysis process were evaluated by external reviewers as mentioned in before.

Ethical Considerations

Prior to data collection process, the study approval was obtained from Institutional Research Board Committee, Faculty of Nursing, Prince of Songkla University. The informants were given a complete explanation and written description about the study, including objective, research method, potential risks and benefits for the participants. The informants were allowed to ask questions and to decline or accept participation in this study. They also could withdraw from the study at any time they wished. The participants gave either verbal or written informed consent before beginning the interview.

Since this study used both narrative and visual data, the ethical considerations became more prominent. The persons shown in each photo were informed about the possible publication of that photo in different types of publications, for example publication in a thesis, poster, presentation or journal. A multi-stage strategy was

implemented to anticipate these issues. In the consent letter sent to participants' parents, researchers mentioned their intention to ask students' authorization to use their images. After receiving their guardian's consent, two meetings were arranged with individual students to explain the proper process of photo taking and to do the photo interviewing. At the first meeting, the student was asked to sign the agreement form to ensure that they aware enough of the process, and to sign the consent form stating that the students are the owners of the photographs. In the second meeting, which was the photo interview, another consent form related to the copyrighted issue of the photographs was prepared (appendix C). The consent form clearly mentioned which photograph was authorized to be used, to be anonymized and to be published. These strategies ensured the participants' confidentiality and protected them from problems in the future.

Summary

Five stages of Carspecken's critical ethnography were applied in exploring the issues of social inequalities in *dayah* which influenced the health improvement of female adolescents. This study involved 34 key participants and 10 associate participants. The data collection methods used in the first phase were participant observation, photovoice, and focus group discussion (FGD), which involved 34 key participants. In total, one month participant observation, 7 photo-taking activities, three photo-interviews using FGDs, three photo-interviews using in-depth interviews, and nine FGDs were conducted. The second phase of data collection employed 11 indepth-interviews with 10 associate participants.

The data collection and data analysis were performed carefully through the stages by not taking any risk to impose researcher's bias and strengthen the

domination of oppressive power. Throughout the research process, critical ethnography shifted the research focus from female asolescents as an individual and a group of society to the cultural dominance and minorities in order to change it. Using this methodology, the study did not put the only focus on female adolescents as actors for their own behaviors, but shifted to the socio-political context surrounding the female adolescents' health improvement. Moreover, the female adolescents were involved to identify the issues of cultural dominance and strategies to change it. Therefore, by participating in this study, the female adolescents could be more aware and better informed about what happens inside their school which effected their health improvement, and their capacity to develop positive changes.

Chapter 4

Findings and Discussion

This chapter details the research findings and discussions on how the female adolescents living in the *dayah* improved their health. Starting with the description of participant characteristics and study setting, this chapter also contains the themes and categories which emerged from the data, and are followed by the discussion of each theme and category respectively.

Description of Participants

This study involved 34 key participants and 10 associate participants. All participants were aged 12-19 years old, stayed in the *dayah* either from junior high school or high school level and were able to speak Indonesian. Two key participants did not join until the end of the study because they moved to other schools in other districts. The table 4 described the characteristics of the participants.

The key participants were mostly Acehnese and came from each grade in the *dayah*, both in the level of junior high and high school. Their age ranged from 12-19 years old, and most of them still had parents who supported their study in *dayah*. Most of the participants started to study in the *dayah* since junior high school onward, and most of them had no previous experience of staying in a *dayah*, either traditional or integrated *dayah*.

Table 4

Characteristic of Key Participants

Characteristics	Number of participants
Age	
- Early adolescent (10-14 years of age)	15
- Late adolescents (15-19 years of age)	19
Level of education	
- Junior high school	15
- High school	19
Family background	
- Orphan	6
- Still have parents	28
Ethnic	
- Acehnese	32
- Others	2
Start of stay in *dayah*	
- Since junior high school	22
- Since high school	12
Had a previous experience of staying in *dayah*	
- Yes	9
- No	25

The associate participants were the principal of the *dayah*; three *ustadz*s, who one of them was in charge for *dayah* health post; four *ustadzahs*, who one of them was in charge as a chaperone of female dormitories; and two nurses from the nearby health centers. The characteristics of associate participants are described in table 5. The principal of the *dayah*, *ustadz*, and *ustadzah* provided general information related to curriculum, teaching and learning activities, infrastructure, facilities, and regulations of the *dayah*; while the two nurses provided information related the school health program implemented in their sub-districts and other relevant information about health services for female adolescents. The data provided by the associate participants helped triangulate the data given by the female adolescents, and contributed to building an overall picture of the life inside the *dayah*.

Table 5

Characteristics of Associate Participants

Characteristics	Number of Participants
Gender	
- Female	6
- Male	4
Educational Background	
- Studying in University	7
- Graduated from University	3
Occupation	
- Teachers in *Dayah*	8
- Nurse	2
Length of teaching experience	
- No experience	2
- Less than 6 years	6
- More than 6 years	2

Setting

The selected *dayah*, which is located in district of Aceh Besar, Aceh province, was established in 1966, when it began as a small place to facilitate "*mengaji*" (learning of the Quran) for kids and adults. After the tsunami disaster which devastated the province in 2004, this *dayah* began receiving refugee students from affected areas in Aceh. As a consequence, it eventually grew into a *dayah* with the supports from surrounding communities and several donations from government and non-government organizations. This *dayah* had 117 students, 48 females and 69 male students from various districts in Aceh.

The *dayah* consisted of the building for classrooms and teaching activities, including library, laboratories and offices for teachers; mosques, student dormitories, teacher's house, student's basic facilities and rooms for extracurricular activities. This *dayah* had 31 *ustadzs* (male teachers) and 35 *ustadzahs* (female teachers). Some of them resided in the teacher's house or shared the same room with the

students to act as their chaperon. The *dayah* organized the formal education in the form of Islamic junior high school and senior high school, and at the same time applied *pendidikan kitab kuning* or *dirasah Islamiyah.*

The teaching of general subjects took place in the morning, while the teaching of classical Islamic books took place in the evening. Learning activities in the morning start at 7:30 am to 1:30 pm, while learning activities in the evening start at 8:00pm to 11:00pm. Between these schedules, the students perform the religious activities together, such as praying, reading the Quran, and doing *dzikir* (Islamic chant). For evening classes, they studied *kitabs* (Islamic classical books) in addition to the Quran and *Hadiths,* except on Friday and Sunday evenings. The evening class for the first grade students was taught by *ustadzahs*, while other grades were taught by *ustadzs* who were more experienced and capable of teaching the advance level of *kitabs*.

The teaching of classic Islamic books addressed ten Islamic classical books, including the Quran, the Holy Book of Islam. On Friday evenings, female students did *shalawatan* (chants of prayers for prophet Muhammad) and male students practiced *Dalail Khairat* (chants from famous texts of prayer). On Sunday evenings, students practiced giving speeches in English and Arabic. In those activities, the 6th year students mentored their juniors. The instructional language for teaching in morning class was Indonesian but for daily conversation the students spoke in English or Arabic. The senior high school students of the *dayah* studied all the books mentioned in table 6, however the junior high school students only studied 10 books, not including the last three books.

Table 6

Name of Kitab (Islamic Classical Books) Learned in the Dayah

No.	Name of book	Description
(1)	*Al-Quran*	The holy Book or God's words, first source of Islamic jurisprudence which is considered to have beautiful compositions although containing original idea of Islamic teaching, especially about the existence of God
(2)	*Fiqh*	The interpretation and implementation of the *sharia*, God's revealed law
(3)	*Usul Fiqh*	The origin and nature of Islamic law as well as the structure of its legal system
(4)	*Nahwu*	The rules of Arabic to know the shape of words and things in a single word (*mufrod*) or when it was composed (*murokkab*)
(5)	*Sharaf*	Morphology of Arabic language
(6)	*Balaghah*	The science of the Arabic language concerned with how to express a particular meaning using correct, eloquent speech, in a manner the suits the occasion and the audience.
(7)	*Tauhid*	The unity of God as the basic belief of Islam
(8)	*Tasawuf*	A branch of Islamic knowledge which focuses on the spiritual development of the Muslims
(9)	*Hadits*	The secondary source of Islamic jurisprudence
(10)	*Tarikh*	The history of Islam, the prophet and the khalifa (the leaders of Islam after the last Prophet died), including the history of the Al-Qur'an
(11)	*Tafsir*	To understand the meaning of verses in Al-Qur'an
(12)	*Mantiq*	To understand the meaning of words mentioned in Al-Qur'an
(13)	*Ulumul Hadits*	To understand the trustworthiness of *hadits* and the narrator chains in quoting the *hadits*

The *dayah* students had to adhere to the compulsory activities started from the time to wake up for *shubuh* (early morning prayer) until the sleeping time at midnight as shown in the table 7.

Table 7

Daily Activities of Student in the Dayah

No.	**Time**	**Activities**	**Responsible person**
(1)	5.30 – 6.00	Morning wake up and *shubuh* praying together	Chaperone
(2)	6.00 – 7.30	Learning English/Arabic, taking a bath, breakfast, going to school	
(3)	7.30 – 12.45	Morning class	Academic staffs
(4)	12.45 – 13.30	*dhuhur* praying and *khutbah* (speech)	Chaperone
(5)	13.30 – 14.30	Lunch time and rest	Chaperone
(6)	14.30 – 16.00	Rest time (all students must be in their bedrooms)	Chaperone
(7)	16.00 – 17.00	Praying *ashar* and reciting *Surah Al-Waqiah* together	Chaperone
(8)	17.00 – 18.30	Sport, taking a bath, dinner and preparing for praying maghrib	Chaperone
(9)	18.30 – 19.00	Every student must be inside the mosque	Chaperone
(10)	19.00 – 20.30	Praying *maghrib* together	Chaperone
(11)	20.30 – 21.00	Evening class	Academic staffs
(12)	21.00 – 21.30	Praying *Isha* together	Chaperone
(13)	21.30 – 22.30	Evening class	Academic staffs
(14)	22.30 – 00.00	Self-study and prepare to sleep	Chaperone
(15)	00.00 – 5.30	Sleeping	Chaperone

Table 8

Extracurricular and Special Activities

No.	Day	Time	Activities
(1)	Friday	7.30 – 12.45	Cleaning day, learning with the head of *dayah*, preparing for Jumah prayer
(2)	Thursday	13.30 – 16.00	Girl scout's activities, additional class for students in the third grade of junior high school and high school (second semester as mentioned in lesson schedule)
(3)	Sunday	21.30 – 22.30	*Muhazarah* (coaching on giving speech or public speaking), etc
(4)	Friday	21.30 – 22.30	*Dalail Khaerat* and learning to do *dzikir mauled*
(5)	Sunday	20.30 – 21.00	Learning with the head of *dayah*
(6)	Friday	20.30 – 21.00	*Samadiyah* (Acehnese tradition of sending prayers for the deceased ones) and reciting *surah yasin*

Table continued

No.	Day	Time	Activities
(7)	Particular days	17.00 – 18.30	Additional class (as mentioned in lesson schedule)

The students' daily schedule started from *shubuh* prayer around 5.30 am. After that, they had *mufradat* (learning vocabularies of Arabic and English). Then, those who were assigned to do cleaning duty will do their duty and the other students get ready for school. They had breakfast before 7.30 AM, and then all students must gather at the school yard to pray together before going to their classes.

The teaching of general subjects took place in the morning, from 7:30 AM to 1:30 PM, delivering 22 subjects, including the religious subjects. Then students did *dhuhur* prayer, had lunch, and took a rest until the afternoon (*Ashar*) prayer time. In the afternoon, students did some activities, such as cleaning duty, laundry, ironing, and exercise. Each class had different activities in accordance to their schedule, except for Saturday where all of them participated in a girl scout activity. The sport field in each dormitory was used every morning for *mufradat* (learning vocabularies in English and Arabic). The cleaning duty was performed by two students each day. Their duties were to clean the yard of *dayah*, receive guests, and as duty guards. There was a schedule for cleaning duties and also for doing laundry and ironing. Students, who did not do laundry or ironing or did not have cleaning duties, must take a rest in their bedroom because they had evening class which was started after *maghrib* prayer until 11 pm.

In addition to the curriculums implementation, the *dayah* also organized the extracurricular programs. The program included *tahfidz* (memorizing Al-Qur'an), speech exercises in three languages (Indonesian, Arabic, and English), boy and girl

scout, vocational skill program (such as cooking, sewing, and mobile phone repairing class), arts, sports, and computers.

The classrooms, where the students studied every morning, was located close to the main gate of the *dayah*. When we entered the main gate of the *dayah*, on the left side was the complex of the classrooms for *Tsanawiyah* (junior high school), the classrooms for *Aaliyah* (senior high school), the offices of principal and teachers, and other facilities, such as library, toilets and sport field. The male and female students studied together in the same classroom for each grade. However, inside each classroom, a *hijab* (screen made from one wide piece of cloth) was stretched to separate the space for male and female students. The female area was closer to the classroom door. The teacher stood in front of *hijab* and interacted with both side of male and female students. This *dayah* did not have many classrooms like in other *dayah* with better facilities. Therefore, the male and female students were put together in the same room and having *hijab* to separate their space. This morning class was conducted until before the time to perform the midday prayer (*dhuhur*).

The teachers, who taught in the morning class, mostly did not teach in the evening class. The morning class teachers were the teachers assigned by the ministry of national education or ministry of religious affairs. Most of them graduated from the local Islamic university and taught the classes using Indonesian language. The students always addressed them as "*guru*" which means teacher. For the evening teachers, the students addressed them as "*ustadz*" for male religious teachers and "*ustadzah*" for female religious teachers. While for the teachers who taught both in morning and evening classes, the student addressed them as *ustadz* or *ustadzah*. The *ustadz* and *ustadzah* mostly were still studying in the local Islamic University. In the

morning, when the students of the *dayah* were studying in the morning classes, these *ustadzs* and *ustadzahs* studied in their universities. They met the students in the afternoon or evening and taught the *kitabs* (Islamic classical books). Most of them were alumni of this *dayah* who were recruited by the head of *dayah* foundation. Others were alumni from other *dayah* in Aceh Province or other provinces in Indonesia who applied to teach in this *dayah*.

This *dayah* had several senior teachers or religious leaders, who also taught the students and arranged a weekly class for the junior teachers to study Islamic classical books at the advance level. One of them was the head of the *dayah*, who was addressed as "*Abi*" by the students and other teachers. *Abi* is an Arabic word which means father. *Abi* stayed in the *dayah* with his wife and his two daughters. The students and the other teachers addressed *Abi*'s wife as "*ummi*" which means mother in Arabic. *Abi* was also the principal of *dayah* and was considered as the most respected person in the *dayah*. He was the person who decided all the regulations applied in the *dayah*. He graduated from a famous university in Egypt and his grandfather was the founder of this *dayah*. *Abi* was also the member of sub-district board and the member of *dayah* advisory board for district of Aceh Besar.

The complex of students' dormitories was divided into female and male section. Obviously, there were no physical boundaries to clearly define each section. In male section, there was a mosque to perform the prayers, while in the female section, there was a *mushalla* (small praying hall) which was smaller than a mosque. The mosque was mostly used by males to perform prayer five times per day in congregation (*jama'ah*) and other religious and social activities. On Thursday evenings or any special occasions, female students and *ustadzah* joined the prayers and the special

activities in the mosque. The mosque was also used by the male students for practicing the delivery of the religious speech on Sunday evenings, and for *shalawatan* (chanting) on Friday evenings.

In each section of the male and female area, there were some dorm rooms. In the female area, there were five dormitory rooms. In each room, the students from various grades were put together, except for students from the 1st grade of junior high school and 1st grade of senior high school that had a special room. Each dormitory room was occupied by 11 to12 students and guarded by one or two *ustadzah*s. Totally, there were eight *ustadzahs* stayed in *dayah* to supervise the students. Each student had a mattress for sleeping and a small cupboard to keep their belongings. They arranged the mattresses on the floor to sleep in the evening and stacked them in the corner during the day.

The *dayah* established a student council which some divisions: language, *ubudiyah* (related to activities in the mosque), security, cleaning, and health division. The male student also had a separate student council. The members of student council were the 5th grade students who were selected by the *ustadzah*s and approved by the principal of *dayah*. Each division was managed by two or three students who were supervised by an assigned *ustadzah*. Each division established the regulation and punishment which were discussed and approved by the *ustadzah* for each division, the chaperon and the principal of *dayah*. Each division had their own record to monitor every student, announced the students who violated the regulations every day, and decided the punishment.

Findings

The findings exhibited four categories which described the themes and subthemes. The four categories are the meaning of health; improving health of female adolescents; power relation in the *dayah* and health; changes and prospective changes voiced by Muslim female adolescents on health improvement.

1. Meaning of Health

The participants depicted a variety of health conceptions which centered on three themes: health as a need for successful life; health as a multidimensional composite of body, mind, soul and environment; and health is achieved through faith. These themes were detailed as follows.

1.1 Health as a need for a successful life

Health as a need for a successful life refers to perceptions on meaning of health as a need to achieve a successful life. The participants expressed how they viewed health in their life generally. They mainly perceived health from the consequences of its absence. A participant mentioned:

> Health is the most important thing for our life. If we are not healthy, doing anything will be delayed (Interview 2 Dian).

Most of the participants signified health as a need, since without health, they might not be able to achieve anything in their lives. On the other hand, having health leads to a successful life as reflected in terms of life earning:

> In my opinion, health is a need of the body. Everything starts from health. Even if a person is really rich, really beautiful, but if the health of that person is not good, nothing can be done. Because *rezeki* (life earnings) comes from health. If we are healthy, *rezeki* comes (FGD10 Wida).

That participant also related health as a need which influenced studying:

> For *dayah* students, if their health is not good, they definitely fail. Cannot study if we are not healthy. Because we need to balance between studying and being healthy. Otherwise, it cannot be synchronized. (FGD 10 Wida)

1.2 Health as a multidimensional composite of body, mind, soul, and environment

Health as a multidimensional composite of body, mind, soul, and environment referred to perceptions that the dimension of body, mind, soul, and environment composed health. The participants in this study explicated their understanding about health by describing the components of health as multidimensional, including body, mind, soul and environment. Most of the practices emphasized personal care (such as maintaining the cleanliness of their bodies and the environment around them); regular eating; regular exercise; and enough sleep. The following statements reflected this idea:

> A healthy person is the person who does regular exercise, and eat regularly. Having *empat sehat lima sempurna* (Indonesian proverb to explain a healthy diet which includes the main needs of body: carbohydrate, protein, fat, vitamins and minerals). (FGD 8 Naima)

> Maintaining health is the way to keep our body and mind healthy, including a tidy environment. If the mind is not healthy, it can cause mental disturbance, such as stress. (FGD7 Ratna)

> Because the healthy soul comes from the inside of healthy body. Therefore, health means our body and soul is protected from any kind of diseases. (FGD4 Raisa)

Based on their understanding on multidimensional composite of health, some participants voiced their concerns with certain dimensions, especially with the dimension of body, mind and environment. Some participants mentioned:

> In *dayah*, we sometimes skip meal, we can have *maag* (gastritis). I am afraid of it. (FGD 5 Nora)

> During exam period, having disease like *maag* could would have worse consequence than only suffering the disease. We cannot join the exam. That is why I worried much about it. (FGD 5 Dian).

> I am afraid of having depression during staying in *dayah*. Every day we have to think much, like studying and many other things. I have so many thoughts in my mind. I am afraid it will cause depression. (FGD 5 Farida)

> I think our school's environment is less supportive for a good health. Like in front of our bedroom, the waste drainage is placed there. I think it should be placed at the back of our rooms, because it is open and smells. It makes a lot of mosquitos. Also many cloths are hanging in our bedrooms, it causes a lot of mosquitos. (FGD 4 Raisa)

1.3 Health is achieved through faith

Health is achieved through faith referred to perceptions on the benefit of practicing of faith which supported health. In this study, participants practiced faith as another way to stay healthy. Their expression of faith was mostly demonstrated by the act of worship, such as *salat* (Islamic prayer). While the concept of *ibadah* (act of worship) in Islam is remarkably broad, involving all dimensions of life, performing the act of worship was believed to be beneficial to health, as mentioned by one of the participants:

> *Beribadah* (doing religious activities to worship God) is included in an effort to be healthy, because while doing it, we are also doing physical exercise. (FGD4 Laila)

Likewise, another participant expressed that the most frequent practice of preserving faith that they performed was *salat*. The *salat* performance was considered as a way to stay healthy, as this participant mentioned:

> Sometimes we do not realize that the movement during *salat* is including exercise. *Ruku'* (90 degrees of bowing), *sujud* (deep bowing, putting head on the praying matt), those are included as the exercise moves. (FGD 3 Hani)

Emphasizing the broad concept of *ibadah* (act of worship) in Islam and how it was believed to affect health, an associate participant added:

> For me, *akhlak* (Islamic moral values) is a part of health. If the students show good morals, it means they are healthy. Also when they have good *ibadah* (act of worships), it means they are healthy. (Teacher 2)

The *ustadzah* also emphasized that the practices to maintain health, such as keeping the body clean, was part of the Islamic faith:

> You know that the cleanliness is part of the faith. So, it is one of their faith (the students' faith). Taking a shower is part of cleanliness, right? The cleanliness of the body, clothes, bedroom, but they are not purified yet. Therefore, before the prayer, we are required to take ablution to purify them. If something is purified, it means already clean, right? So, you know, Allah does not like an unclean person. (Teacher 2)

Likewise, another teacher explained:

> Health really signifies in Islam, because one of requirement for *ibadah* (act of worship) is health. Health also affects how good or how proper we devoted ourselves to Allah. (Teacher 4)

In summary, the themes above show conceptions of health expressed by the participants. They reflected health as a need to achieve a good life, which could be attained by maintaining the body, mind, soul, and environment dimension, and by practicing their faith. This conception of health was also reflected in the way they improve their health as explained below.

2. Improving Health of Female Adolescents

This category explained the way female adolescents improved their health in conditions which facilitated health improvement and also inhibited health improvement. These conditions were resulted by productive and oppressive effects of

power structured in *dayah* culture. These powers themselves will be explained in the next category.

2.1. Health-facilitating conditions

This sub-category described the health-facilitating practices, which were considered directly or indirectly contributing to health of female adolescents. The themes that emerged under this sub-category were peer support, performing health practices guided by Islam, regulation and punishment to force healthy behaviors, and self-adaptation with limited resources and *dayah* culture regarding exercise.

2.1.1. Peer support

Peer support referred to the role of peers in providing support which facilitates health improvement. This theme highlighted the role of the peer as a caregiver, source of health information, and source of psychological support. The role of caregiver was performed by the members of student council in the *dayah*, while the role to give health information and psychological support was played by the female adolescents.

In order to assist in providing healthcare for students, *dayah* established a health division as part of the student association. Two female students were assigned to take care of their peers' health, including monitoring the practice of healthy behaviors listed as regulations, such as bathing, group exercise, and brushing teeth. The two students had not been given any prior training, yet already given a big responsibility to take care of their friends, including administering medicines. The

students obtained medicines from an *ustadz* who was in charge of the health post, as explained by an *ustadzah*:

> This was the first step we made to improve the students' health. Among the student council members, I assigned Nora and Aminah (students) to ask for drugs from *ustadz* M. When the stock is empty, they should ask to refill it. They are in charge of the health division, but they are not being trained. We directly give them responsibility. (Teacher 2)

One of the student council members explained furthermore:

> I am in charge for health division for girls. Every morning and afternoon I inspect the bedrooms. After that, if I found someone is sick, I report it to *ustadzah*. The *ustadzah* will ask some medicine from *ustadz*. (FGD5 Nora)

The practice of peers as caregivers actually was found as an effort to anticipate the barriers that *dayah* faced in providing health resources for the student. The barriers were explained in a separate sub-theme under the theme of barriers for health improvement practices.

While the health division of student council played their role as caregiver, the female adolescents took another role in providing health information for each other, which consequently motivated or encouraged the health-facilitating practices. Some participants mentioned:

> I learned about many things in *dayah* on how to maintain health, like *thaharah* and other things. I believe on it, so I practice it. I also believe in what my friend said. Like when they said something is good for health, most often I will take the words of their mouth. (FGD 4 Raisa)

> Before coming to study in *dayah*, at home in my village, I was so lazy to take a bath in the morning. I often did not take a morning bath, it is cold, especially when it is raining. I take a bath in the afternoon only. At home, I am alone, so lazy. But during staying here, the friends asked me to take a bath, so I do it diligently because my friends do it too. Even when it rains, I still took a bath. It is fun, because we have a big bath room. We take a bath together while wearing *basahan* (a cloth for bathing which covers chest to below knee). (FGD 4 Hani)

The participants explained the reason why they wore *basahan* during showering together in the female bathroom. The reason was they should cover their *aurat* (body parts which cannot be exposed). They said that actually the *aurat* between females are from navel to knee, but they feel embarrassed to expose their chest even between females. They got used to wear *basahan*, unless when they took a bath alone in an individual bathroom.

Another peer support practice between female adolescents was providing psychological support for each other, mostly during the stressful times, such as when they missed their families, during exams, and when they had problems. Some participants mentioned:

> I like to sit and study under that tree. I feel sleepy to study in my bedroom. But sitting here with friends, seeing my friends studying, I feel being encouraged to study too. (FGD2 Hani)

> I like to study together with my friend, especially with the seniors, they will help me. I often ask them something about my homework. (FGD2 Raisa)

> I often cry when I have problems or miss my family. Friends usually comes and asks me what happened. So I often shared my problems with them. (Interview5 Farida)

2.1.2. Health practices guided by Islam

These are health practices which are consistent with the principles of Islamic teaching. This study revealed that the *dayah* determined the accepted and recommended health practices which are congruent with *sharia* principles. *Sharia* principles were derived from the *Quran* (God's words, Holy book of Islam), *Hadiths* (Prophet Muhammad's words, deeds and his approval of certain deeds), and the interpretations in *kitabs* (Islamic classical books). Several health practices were listed in the regulation of the IBS. For other health practices which were not listed in the

regulations, the students tried to perform them based on the teaching of *sharia* that were delivered by the *ustadzs* and *ustadzah*s. This theme is detailed with two sub-themes: *ibadah* (act of worship) as a way to improve health; and *thaharah* (act of purification) for cleanliness.

2.1.2.1. *Ibadah* as a way to improve health

Ibadah, as a way to improve health, is referred to in religious practices aimed to worship God and to do good deeds, and was perceived to give benefits to health. *Ibadah* as a way to improve health, especially physical and emotional aspects, was explicitly mentioned by some participants. Offering *salat*, reciting the *Quran*, and performing ablution were kind of *ibadah* activities which were mostly expressed by the participants to help them cope for stressful condition. A participants explained:

> I saw most of my friends, they always take ablution, then read the *Quran* when they feel stressful. Sometimes I do it too. When I am stressed, I take ablution, recite the *Quran*. *Salat* too. That were just the regular *salat* like we always do could make me feel calmer. (Interview 3 Farida)

Another participant also said, "Praying makes my heart calmer. When I feel so stressful, I will get myself closer to Allah. I will stay longer in *mushalla* (praying hall, smaller than mosque) to pray and read the *Quran*" (FGD 10 Hasna). In addition, one of the teachers also emphasized the benefit of *salat* for health:

> *Salat* have movements that have a value of worships and value of health. We (teachers) often mentioned it in our speeches. We said (to students), if you are lazy to pray, like you do not wake up for *salat* before sunrise (*shubuh*), you will miss the exercise as well. If you do it, after wake up from sleep, it means you already do exercise. It is okay if you do not have time to go jogging in the morning, because you did the morning exercise already. That is the *salat shubuh*. (Teacher 2)

Before offering *salat* or reading the *Quran*, a method to clean and purify the body before performing prayers, known as *wudhu* (ablution), was practiced. However, some participants performed *wudhu* not only before prayers, as explained by a participant:

> One of the applied Islamic values is having ablution before going to bed or after taking a bath. That's what I do. Besides, even when I do not have time to take a nap before afternoon class or evening class, I feel fresh by having ablution. I do not feel sleepy. (FGD 3 Laila)

Furthermore, as one of the requirements to perform *salat* is to clean and purified the body, one of participants expressed how she was motivated to clean herself before offering *salat*, "because I am afraid that my prayers will be not accepted if I pray in an unclean condition, it becomes my motivation to clean myself" (FGD6 Rosna). Since the participants involved in *salat* at least five times each day, she was motivated to stay clean and purified to prepare herself for *salat*.

2.1.2.2. *Thaharah* for cleanliness

Thaharah is the practice of cleaning and purification in Islam which is mentioned in the *Quran* and *hadits*. The *kitab* provided detailed information on the subject, covering various aspects, including cleaning the body, cloth and any articles attached on the body, and environment; and how to purify them properly as the precondition in performing the acts of worship. The participants studied the methods of *thaharah* during staying in the IBS and practiced it in their daily life. The practice of *thaharah* in the IBS might be found so strict compared to the one practiced by the conventional Muslim community. For instance, the way of washing clothes. One participant explained:

> After washing the clothes, I rinse them three times. For the first and the second rinsing, I use a big bucket of water, but for the last rinse, it should be done by flowing water. I use a small bucket to pour the water to each cloth. Those clothes are considered clean and purified. (FGD 3 Hani)

Tharahah also included the way of cleaning particular body parts, such as trimming nails, brushing teeth, and bathing; or cleaning practices during menstruation. In other words, *thaharah* was also practice as a method of personal hygiene. When the participants started to stay in IBS, some of their previous personal hygiene habits could not be continued during their stay in the IBS. A participant said,

> Previously I do not know that it is not allowed to grow my nails. The reason is that if we do the prayers, when we perform ablution, the water of ablution is difficult to reach the area under the nail. (Dian)

Moreover, she indicated that she implemented what she learnt from the *kitab* that was taught by her *ustadzahs*:

> The way of cleaning my body after having menstruation was explained in the kitab. I start to apply it when staying in *dayah*, *ustadzahs* teach us about how to clean the blood (of menstruation). (Dian)

Another participant also explained what she applied:

> When we clean *softex* (sanitary napkins), we always clean it thoroughly. Never throw it away in dirty condition. We wash it first. (FGD 3 Raisa)

In general, the students tried to implement the practices derived from the *Quran*, *hadits* and *kitab*, such as the practice of brushing teeth, as explained by an *ustadzah*:

> Brushing teeth is mentioned in *hadith*. “If it is not burdened my followers, then I would ask them to brush their teeth in every praying time”. The students know about it. Moreover, in the *kitab* of *fiqh* (explaining the interpretation and implementation of sharia law), that thing is called “*bersugi*”. Back then, it was called *bersugi*. (Teacher 2)

2.1.3. Regulation and punishment to force healthy behavior

Regulation and punishment to force the healthy behavior referred to practices of creating and applying regulation for the students to perform certain health behaviors, which were entitled to punishment for missing in performing the behaviors. The regulation and punishment in this IBS were found to be hierarchical, respectively from the principal, senior *ustadzahs*, the head chaperone, *ustadzahs*, and the student council. The head chaperone, who was also one of the senior *ustadzahs*, assigned the student council to monitor the implementation of *due* regulations under her and several *ustadzahs*' supervision. Since Islamic values are embedded in every dimension of Muslim daily life, the regulations were made in coherence with *sharia law*. Several regulations were added to improve the implementation of *sunnah* (non-compulsory but recommended) practices, making them compulsory behaviors in the IBS.

Furthermore, the students perceived this implementation of regulation and punishment as an important thing. A participant clearly expressed her opinion about this issue, "Punishment is needed, otherwise the students will just do what they want," (Laila). Her opinion showed that she understood the purpose of regulations and punishment in *dayah*.

In this *dayah*, the student council was given authority to act as peer supervisors in ensuring that the regulation was well applied, and that all students who violate the regulation must face the consequences. Every day the members of student council monitored the students in applying the regulation. The students who violated the regulation received punishment which was announced in one session called "*mahkamah*".

Without any excuses, all students, including the final year students of junior high school who had a more packed schedule than those in the first and the second year, should perform all duties managed by the student council. The final year students still need to do all the duties even though they faced difficulties to manage them with all their extended studying hours in the afternoon. Most of them felt burdened with this strict regulation which cannot tolerate their condition. One of the participants expressed:

> Now we are in the grade 3, because we have the additional afternoon classes, we only ask their consideration (student council) to lessen the duties for us, such as the duty to clean the mosque and yards. We cannot do that again. It makes us often being late to catch the other fixed schedule. We even often skip meal (dinner) because we have to complete all the duties before the evening class started. (FGD7 Wida)

They already complained to the student council, but no response to decrease their afternoon duties. They never reported to the *ustadzahs*, but the *ustadzah* asked them to discuss it with the student council.

Related to this strict regulation and punishment, one of the teachers explained the reason behind its implementation in the *dayah*:

> If we never applied punishment, then things will not work. Sometimes it looks like a very simple thing to do, like brushing teeth. But if they do not do it, they will have toothache. It is going to be a big problem. Then we made those expected behaviors into the regulations. Maybe after doing it in a year, and we continuously implement it like this, they will get used to do it. Later on, it becomes their habit. (teacher 2)

2.1.4. Self-adaptation with limited resources and *dayah* culture regarding exercise

Self-adaptation with limited resources and *dayah* culture regarding exercise referred to ways to accommodate the limited resources and to follow the

accepted culture of *dayah* in performing exercise. The culture built in *dayah*, which applied strict dress code and gender segregation, as well as the limited resources for exercise, were found to result in less convenient conditions for the female students to perform sport or other kind of exercises in the IBS. They were not allowed to do exercises in the area where the males could see them, and even in a secluded outdoor area for the females, the participants needed to wear a long skirt or sarong. One of the participant said, "In this *dayah*, we have to wear a skirt, so it is so hard to move for exercise" (FGD 4 Raisa). However, another participant emphasized that they got used to the strict dress code and kept doing the exercise while wearing it. She said, "We do the group exercise while wearing skirt. We got used to it. The others keep doing exercise even with wearing sarongs" (P301 Dian).

Actually, the participants were allowed to wear trousers indoors of their dormitory, as mentioned by one of them, "It is allowed to do exercise in our bedroom. We are allowed to wear the trousers in closed indoors" (FGD 11). However, none of them were observed performing exercise while wearing trousers inside the bedrooms of the dormitory. With the limited resources, only few of them performed exercises outside the dormitory while wearing skirts or sarongs beside the regular group exercise on Friday morning.

A participant expressed, "we do not exercise often. Only when we have the subject in school" (FGD 3 Laila). Another participant confirmed:

> Not everybody does exercise in the morning. Some students have to do their scheduled duties (cleaning and so forth). The others are doing it (exercise) when waiting for their turn to use the bathroom. Some of them do exercise, some just jogging around like that (wearing sarong). (Dian).

Related to the less exercise performed by the students, some participants expressed their concerns on its consequences on their health:

> I often feel back pain now. We always sit for a long time to study every day. I also feel my body is getting stiff. Maybe because we do not exercise often. (FGD 3 Laila)

> I feel my condition is getting weaker. I often feel weak. I think my immunity is decreasing. I have a lot of activities, but have less exercise. (FGD3 Hani)

The above statements showed that some participants were able to find an acceptable way of exercise in *dayah*, however with that acceptable way of exercise, less participants performed it frequently. Even in conditions where they already felt the consequences of it, less frequent exercises were still observed.

2.2. Health-inhibiting conditions

The sub-category of health-inhibiting conditions described the barriers which were perceived by the participants in improving their health. These barriers were identified as the following themes: stressful living and studying environment, lack of motivation, and limited health resources. The themes are described below.

2.2.1. Stressful living and studying environment

Stressful living and studying environment referred to feelings of stressful toward living arrangement and studying environment. The students described that the environment of living and studying in *dayah* was stressful. They faced hardships while studying, as they had to follow the 24 hours-scheduled activities in *dayah*. The teaching of general subjects took place in the morning, from 7:30 AM to 1:30 PM, delivering 22 subjects, including the religious subjects. The teaching of

classical Islamic books took place from 8:00 PM to 11:00 PM, addressing ten Islamic classical books, including the Quran. Since three different curricula applied in an integrated *dayah,* students had to meet all three standards of graduation. The three applied curriculum were: the conventional general education curriculum, the Islamic-based educational curriculum (*madrasah* curriculum), and the *pesantren* curriculum. In a photo interview, Raisa reflected how the long hours of study affected her:

> Yes, it is quite hard. Physically, it is not too hard, but for the mind is such a headache, really a headache. It seems like a never ending burden giving me a headache. For example, during the afternoon while we are already in the morning class for 8 hours, especially after physics, chemistry, math for 3 hours. Then the class continued with chemistry and other lessons. My head cannot bear it. (FGD 3 Raisa)

In addition, the society puts high expectations on the *dayah* students to be religious scholars. This high expectation became one of the participants' biggest concerns. Raisa expressed her worries:

> My concern is that I may fail later, after I spent a long time learning *kitab* (the Islamic classical books). That will be such a waste. However, if after graduating from this school, I could master all the *kitabs*, that will be really great. Especially for the ones who do not study in *salafi* (traditional *dayah*), only a few people (who study in modern *dayah*) could do it, that will make me proud.

According to one of *ustadzahs* who taught and stayed in the school, she understood that the students might feel overwhelmed with studying, but felt that they should follow the regulation. She mentioned:

> If we look at them, they looked tired with these conditions of studying hard. But, even if they do not like it, they have to follow it, with *Ustdazah*'s guidance. They should follow the regulation even though I saw that they looked so saturated. (Teacher 3)

2.2.2. Lack of motivation

This study explicated the lack of motivation as barrier for the female adolescents to improve their health. The findings have shown that students tended to have a mindset of doing a behavior because it was part of regulations or part of their compulsory schedule. For the other behaviors which were not listed in the regulations, they seemed to have no motivation to do it. During this study, as the student organization changed every year, the regulation was also changed. During a certain period of student organization, brushing teeth before bed was not listed as the regulation anymore. At that time, not all students performed it, as being explained by a participant:

> Final year, there was a regulation to brush teeth before going to sleep. But this year, there is no more such regulation. Before, it was made as a regulation because many students got toothache. The student organization in this year, I am not sure why they did not make like that anymore. It seems that they are lack of attention about it. (FGD3 Raisa)

Beside the issue of brushing teeth, performing exercise also became an issue in which the students showed less motivation to do it as it was not listed in the regulation. A participant mentioned:

> Physical exercise is not required for us to do anymore, since we are in the 6th grade now. But previously, before going to sleep, I exercised a bit, like doing sit-ups, not regularly, every other night. I did it often. Now I have stopped it. Lazy. (FGD 3 Laila)

2.2.3. Limited health resources

As typically found in most of *pesantrens* in Indonesia, the way of life inside *pesantrens* was full of austerity. The students had to adjust to the lack of facilities and resources. They had no choice but to share those limited facilities and resources among themselves. Meanwhile, the strict regulations did not allow them to

access the resources outside the *dayah*. This condition seemed unfortunate for the students, because they needed to seek for healthcare and other health-related resources to prevent and treat their health problems.

The health problems commonly reported by the participants were fever, cough, cold, toothache, menstruation pain, shortsightedness, gastritis, and *sesak* (difficult to breathe). Below were some quotes from participants about their common diseases:

> The problems that my friends usually had are headache, dizzy, also like cough, fever. No one ever had malaria here. Only fever that they often get. (Dian)

> The most often is stomachache, headache, toothache. Also eye problems, short-sightedness. If the season of fever comes, many people have a fever, during rainy season. Many people get fever during rainy season. (FGD5 Nora)

> I often have *asam lambung* (gastritis). During I stayed here, already in one semester I experienced it five times. (FGD6 Rika)

Beside those mentioned common diseases, the participants complained that they felt stressful. Most of the causes were being away from family, studying hard, and *mahkamah* (punishment sessions). One participant mentioned, "memorizing all lessons and *mahkamah* makes me feel stressful" (FGD6 Rita). Another participant also expressed:

> When the first time I came here. I often miss my family. Sometimes I cried when I miss them. (FGD1 Hani)

One of the teachers also confirmed that she often found the students looked stressful:

> When they joined the school for the first time, all *ustadzah*s must really have been exhausted to take care of them. Not for nothing else, but to control the students, sometimes we found someone crying over there, someone just sat and looked stressful. Maybe they missed their hometown. Just when they first came here. After passing one semester, it is already a safe period of having a hard time. (Interview 4 teacher)

In addition, with the long lists of compulsory activities as mentioned above, the students described experiencing many hardships while studying which made them stressful. Since three different curricula apply to a *dayah*, which are the conventional national curriculum, the Islamic educational curriculum, and the *pesantren* curriculum, students had to meet all three respective standards of graduation. They had to study in the long hours and still had to do many other compulsory activities. This condition was confirmed in some photos taken by the participants. In a photo interview to tell the story of their photos, a participant reflected how the long hours of study affected her:

> Yes, it is quite hard. Physically, it is not too hard, but for the mind is such a headache, really a headache. It seems like a never ending burden, giving me a headache. For example, during the afternoon while we are already in the morning class for 8 hours, especially after physics, chemistry, math for 3 hours. Then the class continued with chemistry and other lessons. My head cannot bear it. (FGD2 Raisa)

Furthermore, the teachers reported not only that those common diseases and psychological distress suffered by the student, but also the lack of personal care was observed:

> Student F, previously, she is so lazy to take a shower. Now, after all, maybe she already feels that she has become a senior, she is better. She was so lazy to take a shower, to wash her clothes. She made us focus on her a lot. “You have to take a shower three times a day, you have to wash your clothes now, or you cannot sleep before finishing it”, we even told her like that. Moreover, she ate a lot. It doesn’t mean that it’s not good if they eat a lot. But it will affect their studying. During the class, she slept. So, the effect is decreasing her health, she didn’t protect it, everybody did the same. Then when doing prayers, they became *masbuk* (being late in joining the prayers). Already being negligent. Looked lazy all day. Moreover, from what we have experienced, the students, who are fat, always behave like that. (Teacher 2)

Despite of various reported health problems as mentioned above, the health-related resources were provided at a minimum level. The health related

resources such as nutrition, sport and recreation, health information and health care facilities were far from satisfying condition, while the additional external resources were unavailable to be accessed to compensate the lack of resources inside the *dayah*.

Related to nutritional resource, daily meal was provided by the school, however, the menu was less varied. During participant observation, I saw that their dinner meal was rice and one dish (fish in yellow spicy sour soup or *asam keueng*), no vegetable or fruit were served. A participant said:

> Once a week, we will get vegetable soup. We called it "teardrop soup" because it is so clear, barely to find the vegetable. (FGD 3 Raisa)

Another participant added, "I think our school meal is far from what we call well-nourished food, like what we studied at school. There is no fruit, no milk, very less vegetable" (FGD4 Hani).

The participants also reported that many students complained about their meal, especially the new students. One of the participants mentioned:

> Many of new students complain about the food. Like, always mackerel is served. Most of them, because of this, they do not want to eat. (Interview2 Dian)

This issue also confirmed by one of *ustadzah*:

> I want the students not to skip their meal. It is very often. I am sad to see the students. I ask them, "why you do not eat?" They said that it does not taste good. (Interview5 Farida)

In addition, the sport and recreational resources for female students in the *dayah* were in an unfavorable condition. In female dormitory, a volleyball and badminton court were built in the front of female dormitory, but no activities of playing volleyball or badminton were observed. Actually equipment for sports was provided before to be used in the girl's area, and they also have volleyball and a badminton court

in front of their dormitory. However, after the equipment was broken, the students never tried to get a new one, as explained by one of the participants:

> Some activities such as playing volleyball existed before. Now, it is no more. The ball is broken. No one reported it to the student council and make a claim for a new one. Because not reported, they were not provided anymore. We do not know how the previous student council managed it, but we could not find the equipment anymore. (FGD5 Farida)

Regarding health information, participants complained that living in *dayah* made them less exposed to outside world's information, especially about health which they had many curious about. Some participants expressed:

> I want to know anything related to health and what we have to do if we get sick, something like that. (FGD 1 Raisa)

> I want to know about how to prevent the diseases like I said before is important. (FGD 1 Hani)

The *dayah* strict regulations set boundaries for the students to experience the world outside the *dayah*'s environment. They were banned from going outside the school gate, except for acceptable reasons. Even on Fridays, which was *dayah*-day-off, they were not free to go outside. In addition, the students were also not allowed to bring in a mobile phone or smart phone which they could use to access some health information. There was also no television, radio or newspaper for the students. Those media were available only for the teachers and could only be used with their permission. The participant expressed her concern about this condition:

> Like our condition in *dayah*, it is so hard to go out. I mean, here, we never learned about the internet. Moreover, the girls are not allowed to go to internet shops outside the school without good reasons. If we do without getting the permission, we will be punished. I wish we could have internet access here. (Hani)

In addition, the books available in library were also limited and could only be accessed during morning school times. The participants still needed to share

that limited time with the boys, since the schedule were set up each day for each group of gender. Therefore, the chance to read the books to get more information were also limited. A participant explained:

> The library has the books that I love to read. About women related to *fiqh* and Islamic teaching. But those books are not allowed to be borrowed, should be read there. Unfortunately, I could not go there every day. The library only opens until 12 pm, every other day for girls. So, there is a separate boy schedule and girl schedule for library. I wish I could go and read every day, not only in the morning, but also in the afternoon when I have spare time. (FGD12 Anita)

Meanwhile, the healthcare in the *dayah* was provided at a very minimum level. Many health problems were experienced by the students, but the participants concerned that their health problems were not being treated well in the school. A participant said:

> Sometimes that the *ustadzah* (the teacher who is in charge of the student's health) gives us medicines, and then she goes somewhere else. Sometimes we don't know what to do because she is not around. So we take care of the sick student by ourselves. I think she gives the same medicines for all kinds of diseases. (Raisa)

Actually the school already had a health post with simple equipment and very basic medicine for students. The health post was managed by an *ustadz* who was an alumni and studying in a nursing school at the time of the research. Since the school applied strict gender segregation, two female senior students were assigned to work with the male teacher in managing the health care of other female students. They took care of the sick students and asking for medicine for the health post. However, these inexperienced and untrained students often faced difficulties to take care of their friends. They also expressed that it was hard for them to contact the male teacher when they needed his help,

> We need an *ustadzah* who take care about student's health. Not only the student organization who take care of it. In *dayah* we cannot independently and directly

> take action when we need help. The *ustadz* who handles the health post is a male, we cannot directly contact him to seek for healthcare. (FGD 11 Sarah)

According to an *ustadzah*, *dayah* tried to give healthcare for student, but they only had limited resources. She explained how the *dayah* usually handled the condition when a student was sick, as follows:

> When the students get severely sick, we will contact the parents to bring them back home. If the disease is a common one, M (the *ustadz* that was in charge for health post) will take care of them, otherwise the student will be taken to the nearby health center. M is still studying in school of nursing, so he cannot do much either. Sometimes the students just pretended to be sick, so if we take them to health center, we could confirm if they are really sick. Some of them get scared of being injected, so when we take them to the health center, they will stop pretending to be sick. If during several days the students did not get better, that is our responsibility to find better treatment. We will take them to a *mantri* (the nurse who opened a clinic)

As summary, power relations in the *dayah* produced health-facilitating conditions as productive effects, and health-inhibiting conditions as oppressive effects. Both effects manifested in the way female adolescents improved their health. The form of power relations that produced these effects are explained in the following section.

3. Power Relations in *Dayah* and Health

According to Carspecken (1996), unequal power creates dominant values implied in social relationships in various presentations of power relations. This study attempted to understand the power relations embedded in the *dayah*, which influenced the way that female adolescents improved their health. The emerging themes were gender, religion, power of knowledge and information, and financial pressure. However, that way of labelling the findings does not mean to separate the interrelating domain of values in social interaction taking place in *dayah*, since the criticalist believed that it is impossible to isolate the facts in society from the domain of

values (Foley & Valenzuela, 2005). The following description of power relations in *dayah* was aimed to explain how these power relations operated in *dayah*.

3.1 Gender

Gender was one of the power relations which showed dominant influence in the way female adolescents improved their health while studying in the *dayah*. This *dayah* was led by a male, had more male senior *ustadzs*, and more male students. While the female students were required to reach the same level of expected education outcome as their male counterparts, they lacked chance to improve their ability.

The lack of chances resulted from the lower number of female *ustadzahs* who could teach and frequently give guidance for female students, especially in the evening classes, as well as the sports and extracurricular activities. The *kitabs* were mostly taught by the senior *ustadzs* and the culture of teaching placed the female students at the back of the row during studying in the mosque, and caused them to feel embarrassed to ask questions as it was considered culturally inappropriate. One of the participants explained:

> Male teachers were generally more qualified, but accessible only to male students, so under such a circumstance female students have lesser opportunity to learn from capable teachers as well as engaging in a wide range of sports and activities. That was what happened all the time. We had been asking to be given more *ustadzah*s who could teach Islamic classical book and lead extracurricular activities, but until now we did not get them yet. (Laila)

During a photo interview, while explaining a picture about their extracurricular activity with an *ustadzah*, a participant mentioned, “This is one of the extracurricular activities conducted by *ustadzah* R. I like the one like this. We can sing

and have fun. We can distract our mind a bit from our lessons" (Raisa). Laila added, "yes, I like it too. But we are lacking *ustadzahs* who can lead us in this kind of activities".

Gender difference furthermore was highlighted in the form of strict gender segregation. When an *ustadzah* who was in charge of female health post quitted her job, the *ustadz* who was in charge of male students' health was assigned to also take care of the female students, and two female senior students were appointed to work with him in managing the health care for other female students. However, since gender segregation was applied strictly, the *ustadz* could not enter the female dorm to take care of the sick female students, and the assigned female students could not directly contact the male teacher when they needed his help. Nora, who was one of the assigned students expressed:

> We need a health post that is managed by an *ustadzah*, because the *ustadz* who handle the health post now is a male, we cannot directly contact him to seek for treatment.

3.2 Religion

Religion influences all dimensions of life for Acehnese people, which is legalized by the implementation sharia law in Aceh (Government of Aceh, 2014). In *dayah*, religion prescribed the gender role, rules and laws, the process of education, and social expectation on *dayah* students. The gender role in *dayah* which was interpreted as dominant male role was a manifestation of power relations in term of religion. Other manifestations could be observed in the form of strict dress code and gender segregation as part of rules in *dayah*. While the process of education adopted the

curriculum of Islamic boarding school as mentioned in the regulation of Ministry of Religious Affairs number 13 (Government of Indonesia, 2014).

Compared to the life of common Acehnese people, the daily life inside *dayah* demonstrated the implementation of *sharia* law in a strict manner, such as requiring a stricter dress code for the female students, segregating the sport activities for male and female students, and obligating the *sunnah* (non-compulsory but recommended) religious practices as compulsory ones. One of *ustadzah* explained:

> When students got used to do something, it becomes their habit. Just like praying. In the beginning, they sometimes are lazy to pray. We needed to tell them, "stand up and start the *sunnah salat* (voluntary but rewarded act of worship). After that, they stood up to pray. Then, day by day they will get used to do it. That was the first step. The second step was, because just few students did it, we finally made it as regulations, the *sunnah salat* become compulsory to do in *dayah*, (Teacher 2).

This study explicated that the religion characterized the daily activities performed by the participants as either group or personal activity. Starting from the classroom, it already looked different from the common classroom. During a photo interview, the participant pointed to a picture she took in a classroom and said:

> This is the class of the students of *Tsanawiyah* (Junior High School). There is *hijab* (curtain) to separate the boys and the girls. That is the regulation from *dayah*. If the class do not stretch the hijab, the head of *dayah* will get mad on them if he finds it out. (FGD 1 Raisa)

The way they dressed was also influenced by the Islamic teachings, a participant said, "We cannot wear long trousers. If we want to pass the boy's dormitory, we should wear socks and cannot wear the *paris* veil (a thin layer of head scarf)" (FGD1 Rina).

As one of religion based schools, many form of religious activities were observed in *dayah* as compulsory activities performed in group, which were different

from the common Muslim adolescents. A participant explained her daily schedule which included many religious activities:

> In the school (morning class), we learn until 12.30 AM. When we hear *adzan* (the call for middle day *salat*), we directly go back to dorm. So we stop studying until 1.30 PM. We directly go back to dorm when we hear *adzan*. Not like students in other schools who go back home at 1.30 PM or 2.00 PM, here at least until 1 PM. If there is *adzan*, we go back directly. After that, we pray. Before praying, we do *wudhu'* (ablutions). Some students take shower, some do not. Then we directly perform *dzuhur* (middle day *salat*). After *dzuhur*, some students recite the Quran. After that, we go back to our dorm and have lunch. After lunch, all students have to take a rest until 2.30 (PM). Before that, some students study, some do not. Just for whom who like to do it. From 2.30 (PM) until before *Ashar* (afternoon *salat*), we have to take a rest. Then, after *ashar*, we do *wudhu*, *salat*, and read *Walqiah* (a chapter in the Quran). Then, the students who are in duty for cleaning will start their duty. They sweep all over the schools. There is general cleaning duty and also specific cleaning duties, such as in the bedroom, in *mushalla* (small mosque), in bathroom. Basically, afternoon is the time to clean the environment, just to be healthy. Then, it is time for dinner at 5.30 (PM) or 5.45 (PM). After that, we have to go to *mushalla* (small mosque), reciting the Quran until *adzan* for *maghrib* (salat performed before the sunset). After *maghrib*, we recite the *Quran* in *mushalla*. We should finish 2 chapters. When we hear *adzan* for *Isya* (evening *salat*), we do *salat*, then directly go to classroom for evening class until 11 (PM). (FGD 3 Laila)

As mentioned in above statement, the students in *dayah* performed most of the religious activities in congregation in the mosque or *mushalla*. Mosque and *mushalla* became their center of activities, not only for religious activities, but also for educational activities, both for the students and the surrounding community. In other words, religion considerably influence the process of education.

The *dayah* also offered some activities which could be joined by the villagers around the *dayah*. The community was also benefited from religious learning sessions which was provided by *dayah* for the women in nearby villages. In addition, during participant observation, several Islamic festivals were also being performed in the *dayah*; such as *maulid nabi* (the celebration of Prophet Muhammad's birthday), and the *dzikir akbar* (a big group of people reciting selected versus of the Quran and

prayers, which followed by religious speech from religious leaders). The community was also which invited to participate in those festivals. *Dayah* also offered a regular session in each Friday for female villagers to learn the Quran, *Hadith* and *kitab* from the *ustadz* and *ustadzah* in *dayah*. Such religious tradition maintained by *dayah* implied that *dayah* induced a great influence, not only for the students, but also the community.

In addition, religion also shaped community expectation on *dayah* to graduate students with better religious knowledge than other students from conventional schools. The society considerably anticipated that the *dayah* students exhibited extensive religious knowledge, which become the source of motivation for the students to study hard even in the stressful studying condition. One of participants expressed:

> My concern is that I may fail later, after spending a long time learning *kitab* (the Islamic classical books), that would be such a waste. However, if after graduating from this school, I could master all the *kitabs*, that would be really great. Especially for the ones who do not study in traditional *dayah*, only a few people (who study in integrated *dayah*) can do it, and that would make me proud. (FGD4 Raisa)

3.3. Power of knowledge and information (pressure of ruling hierarchy)

The figures of authority in *dayah* were the principal, *ustadz, ustadzah*, and the members of student council. The principal was at the top of power structure, and was followed by the senior *ustadz* and *ustadzah*s, the junior *ustadz* and *ustadzah*, and the student council. The student council members applied the command given to them by those in the higher level of power. The division of power followed a hierarchy, from the principal down to the members of the student council who shaped the life in *dayah* by imposing the boundaries which should be obeyed by all students. The

boundaries included the strict regulations in religious and educational activities, strict full day schedule, and limited access to the outside world and to external sources of information. The ruling hierarchy in *dayah* preserved these boundaries by implementing full day monitoring and supervising of students.

Related to the hierarchy of power relations in *dayah*, a member of student council explained:

> When there are any problems, we (student council) always talk to *ustadzah* first. We never directly report to Abi (the principal of *dayah*). *Ustadzah* will report to the senior *ustadzah*, who is a sister of Abi. She will talk to Abi. The senior *ustadzah* has a very important role. (P303 Farida)

The head chaperone also confirmed:

> My job is to monitor what happen daily, then reported it to the coordinator. The coordinator is the senior *ustadzah*. Any obstacles or barriers that I find, I will report it to her. If we cannot handle it, then we will report to Abi. I never directly report to Abi. (Teacher 2)

The head chaperone assigned the student council to manage the students in performing their duties and implementing the regulation in *dayah*. The student council members, who were in second grade at high school, were given authority to act as peer supervisors in ensuring that the regulations were well adhered to. All students who violated the regulations must face the consequences. They received punishment which was announced in a session called "*mahkamah*". Without any excuses, even for the final year students who had more packed schedule than those in first and the second year of junior high or high school. The final year students still needed to do all the duties even though they faced difficulties to manage with their extended studying hours in the afternoon. One of the participants expressed:

> Now my friends and I are in the grade 3, because we have the additional afternoon classes, we just ask their consideration (student council) to lessen the duties for us, such as the duty to clean the mosque and yards. It makes us often

> being late to catch the other fixed schedule. We even often skip meal (dinner) because we have to complete all the duties before the evening class started. (FGD7 Wida)

Likewise, another participant, who was also a final year student, complained:

> Punishments are piling up each day. The language division gave punishment, security division too, cleaning division too. I do not know which one I should do first because they are many. (FGD7 Hasna)

Mahkamah were found to be one of the biggest concerns for female adolescents, especially for the students in the first grade of junior high school and the first grade of high school. Most of them were newcomers and had not got used to the culture of *dayah*. During participant observation, I saw a first grader who cried a lot during a *mahkamah*. Later I asked other students in an FGD, she explained what happened:

> About the junior who cried that afternoon during *mahkamah*, it is because she was punished to wear *mahkota bahasa* (the crown of language). She was caught many times violating the regulation of language. She has to put on the crown in the next day during the flag ceremony, in front of all students, including the boys. The crown is a red veil, so contrast with our white uniform. She will stand alone far from her group during the ceremony. (FGD7 Hasna)

The punishment given in *mahkamah* were given by the student council who once were the regular students and also faced *mahkamah* before. Even for them, *mahkamah* was a stressful experience as expressed by one of the student council member, “Before I join the student council, I also feel so stressed about *mahkamah*” (FGD7 Fitri).

Related to the policy of *dayah*, the dominant powers in *dayah* considerably focused on the regulation implementation and did not put much attention on the growth and development need of female adolescents, such as risk behaviors preventions, promoting healthy lifestyle, and health education on adolescent specific

health issues. During the study, the school policy related to the subject of physical and health education were found to be changed, but yet not to benefit the female adolescents. According to the participant, *dayah* changed the policy by eliminating the subject of health education, as explained below:

> Since 2015, no more the subject of physical education in every class. I think in other school are still being taught, but here, it is gone, because Abi (the school principal) did not allow it. But since the subject is still included in the national final test, then we still need to study it. Abi told us to study about it by reading the book by ourselves. Abi changed the lessons with other more important lesson, because we just wasting our time by watching the boys playing sport. The girls just wandered around, doing nothing, because the girls cannot do the sports at the school yard. That is why the subject was changed to be Arabic. (FGD12 Sari)

The participant understood that one of obstacle faced by *dayah* is that it is difficult to find female teachers to teach and guide them. Most of existing female teachers were alumni of *dayah* and were very young. One of participant explained her concerns about the lack of female teachers:

> During these times, I know that *dayah* has been developed, becoming more beautiful than before. Before, it looked so *salafi* (traditional *dayah*). However, in the term of teacher, the past time is better than the present time. I am afraid that this *dayah* could be totally changed because lacking of teachers. Besides that, many female teachers are really young. They cannot understand how their students are. They are just around our age. Therefore, the students do not obey them. There should be teachers who have characteristic like a mother. The one that we respect, not the one that we are afraid of. (FGD4 Raisa)

The other participant added:

> I know it is hard to get female teachers. It is easier to get male teachers. I know *dayah* already trying to find. But female teachers are very difficult to stay in IBS. They left *dayah* when they got married. (FGD4 Hani)

The participants understood the difficulties faced by *dayah* to find teachers for them, however, they expressed the need of it:

> One of the way to improve our condition here is there should be more teachers to take care of us, more seniors to guide their juniors. If the teachers do not

> teach us, do not guide us, we are left alone. They are by themselves and we are by ourselves, how could we develop ourselves. (FGD4 Laila)

In terms of knowledge, one of the *ustadzah* explained that the Islamic teaching covers every aspects of human life, including health:

> Many parts of *kitab* are related to health, such as the part explaining about how to clean the body; *nikah* (marriage); *haid* (menstruation); etc. She said that the books might not contained in details about health, but the *ustadz* will explain more in the class. (Teacher 1)

This statement reflected that the students' knowledge on health was influenced much by interpretation given by their religious teachers, especially the *ustadz* who was capable to teach the advance *kitabs*.

3.4. Financial pressure

Another condition that the participants feel powerless about was the financial condition. They understood that what *dayah* provided for them did not meet their expectation because of the financial reason, as expressed below:

> The meal provided by the school is not as good as we expected, maybe because of the school fee. The school fee in this *dayah*, from what I know, is the lowest one. I mean the amount is the least. In another *dayah*, it is 500 thousand rupiahs, and "Others is 350 thousand rupiahs. For senior students, like us, we just pay 250 thousand rupiahs, all in. When we think about it, when we count by ourselves, it would not be enough. (FGD4 Hani)

Another participant added:

> Even we could delay to pay. In other school, if the students do not pay the school fee on time, they will directly be dropped out. Our *dayah* gives a lot of consideration. (FGD4 Laila)

The data shows that the participants realized their poor financial conditions, and that *dayah* already provided a lot for them and gave much consideration. Subsequently, this condition restrained them to complain, as expressed

by one of the participants: “With this condition, that *dayah* already helped us a lot, we feel embarrassed to complaint for better provision of facilities or other needs” (FGD4 Raisa).

In summary, this category showed how gender, religion, power of knowledge, and financial pressure created impacts on the way female adolescents improved their health. In this context, the power of gender was exercised in the educational domain, while financial pressure was considered as a form of power in social domain. Religion was described as the most dominant power influencing the education and social domain in *dayah*.

4. Changes and Prospective Changes Voiced by Muslim Female Adolescents on Health Improvement

By applying critical ethnography as a methodology, process of research itself might be able to emancipate and empower the participants in a certain level. According to Hardcastle, Usher and Holems (2006), critical ethnography was constructed based on the principles of critical theory that put emancipation as its focus. The emancipation will be achieved by exposing patterns of power and domination with a purpose to empower people and transform the political and social realities.

In this study, some changes were observed during the course of the study. The changes might not be in a level that we could imply their emancipation and empowered condition, however a slight improvement was noticeable, even though they were induced by the *dayah* principal and the *ustadzah* as the dominant powers.

In addition, the Muslim female adolescents had gained awareness on their needs, which can be seen from their vision on possible prospective changes that

they perceived as the solutions to overcome their impoverished conditions. Most of the themes described prospective changes below were voiced by them, except the theme of collaborating with the health center or other stakeholders which was explicated by the principal, *ustadzah*, and the nurse in the health center. The Muslim female adolescents might not think of the opportunities of collaboration with outside resources as their access to outside world was restricted, and the dominant powers in *dayah* played as gatekeepers for the Muslim female adolescents to seek for health care.

4.1. Changes induced by dominant powers

Changes induced by dominant power referred to noticeable changes for health improvement which were induced by the dominant powers to support health improvement of female adolescents in *dayah*. In this context, the dominant powers were the *dayah* principal and the *ustadzahs*. The changes which already took place in *dayah* could be observed from the improvement of facilities of sport for female adolescents. The decision taken by the *dayah* principal to use the donations for building sport facilities for female adolescents should be viewed as a good start of positive changes. At the beginning of the study, no sport fields were provided for female adolescents to play any kind of sports. One of ustadzah mentioned:

> The two sport fields located between *mushalla* (praying hall) and the dormitory is newly built. One is volley ball court and another one is for badminton. It was built during the last fasting month. (Teacher 1)

In addition, the *dayah* principal confirmed about it. He explained:

> We got some donations, so it was decided to use it for installing some sport fields and equipment for female adolescents' dormitory. (Principal)

Another change was found related to the provided meals for the students. Previously, the students complained a lot about the meal provided by *dayah*, as explained in the sub-theme of limited resources. Later during the study, the staffs who were in charge for the student's meal was replaced due to the complaints. Many negotiations and discussions were initiated by the senior *ustadzahs* to accommodate the students' complaints about the food. One of ustadzah described on this issue:

> The student greatly complained about the food. So we, the *ustadzs* and *ustadzahs* here tried to discuss with them many times, but it seemed that they were difficult to accept our feedback. I do not think that the fund was the problem, because anything that they materials that they requested, the other staff from *dayah* always bought it for them. The menu was decided by ustadzahs. Their job was only to cook, but it was so hard to deal with them. So finally *dayah* decided to replace them with new cooking staffs. (Teacher 2)

In addition, a participant commented on the improvement on the meal after the replacement of the cooking staff:

> Now we have new cooking staff, and also a new kitchen. Actually the menu is the same like before, but it is more delicious and more suitable with students' taste. Previously, the vegetable or fish were unwell-cooked and looked unclean. It caused the students to not eat, often skip meal. The old cooking staffs were stingy, they always told us not to take many foods. And when there were so many leftover food, they cooked it again and gave to us. The new cooking staffs are so kind. We could take a lot food and they never cook again the leftover food, so we get the fresh one every day. We prefer the meal now than before. (Farida)

At the end of the study, the *ustadzahs* requested some health education sessions to be held for the students in *dayah*, both for males and females. Therefore, three health education sessions were conducted in *dayah* by coordinating with health division of *dayah*'s student council and the *ustadz* who was in charge for the *dayah* health post. The first two health education sessions were about the basic first aid. Two students were selected from each class, except the final year class of junior high school and high school, because they were busy with additional afternoon classes. In total, 10

female and 10 male students participated in two sessions of health education. They were expected to help health division of student council to be school health volunteers.

Another session of health education was conducted only for female students. 24 female students attended the session and discussed about reproductive health and possible exercise to be performed in female student's dormitory. Two short videos about female reproductive health and simple basic yoga was played and followed by discussion session. The students looked enthusiastic and asked a lot of questions. Some of them re-demonstrated the movement of yoga as shown by the videos. Some the students commented after the re-demonstration:

> I think the movements were easy and enjoyable to do and it was possible to do it in our dormitory because we can wear trouser in our bedroom. I will try to do it later. (Riza)

> If I do it in our bedroom, it might bother other students, but it looked easy to do the movements. Maybe I will try to do it when I have time and when there is no one in my bedroom. (Yulia).

The change was also found out at the end of the study that the health center nurse came to *dayah* to conduct health education session on female reproductive health. A participant explained:

> During the last health education session given by the health center nurse, we were taught about how to clean the intimate part properly, after that we practice it, because we already know the advantage of it. (FGD 12).

4.2. Voicing prospective changes

Voicing prospective changes referred to expressing the perceived feasible actions to improve the health of female adolescents in the future. The Muslim female adolescents and the associate participants shared their visions on changes which are possible to take place in *dayah*. Those prospective changes included rescheduling of

additional compulsory activities, health care post managed by *ustadzah*, improved health information resource, skillful teachers and peer caregivers, and collaboration with the health center or other stakeholders. The prospective changes were explained below.

4.2.1 Rescheduling of additional compulsory activities

Rescheduling of additional compulsory activities referred to efforts in changing the schedule of additional compulsory activities to give more time allocations for students to perform health improvement practices. As described above, students in *dayah* had limited time to do health improvement activities such as exercise. From morning until evening, they had a bunch of compulsory activities, which includes studying activities and religious activities that they must do in a congregation. In addition, they still need to do several additional compulsory activities assigned by the student council, which includes the duties for cleaning the dormitory, bathroom, yard and *mushalla* (the small mosque in the female area). Moreover, if they break the regulation, they must do the punishments which were applied by the student council. The students mentioned that if their afternoon time was not spent with performing their punishments or other additional compulsory activities, they might have more opportunities to do exercises. A participant explained:

> A special time should be scheduled every day for exercise. For example, in the afternoon. What we did here, after *Ashar* (afternoon pray) is for *mahkamah*, the punishment time. It should be scheduled for exercise. (FGD12 Mirna)

Other participant also suggested, “The punishment time, if possible, should not be conducted in the afternoon, maybe after finish *ngaji* (evening class)” (FGD12 Rita).

4.2.2 Establishing a health care post managed by *ustadzah*

Establishing a health care post managed by *ustadzah* referred to setting up a health care unit which is managed and organized by *ustadzah* to provide basic health services for female students. The participants expressed their need for a health care post which is specially managed by an *ustadzah* and located in female dormitory. This strategy was expected to overcome their barriers to health care access. During the study, many changes of *dayah* policy related to health were found. At the beginning of the study, there was no health care post in *dayah* and no health division in the student council. To take care of student's health, one *ustadzah* was appointed to take care of female students, and one *ustadz* for male students. Afterwards, the *ustadzah* resigned from the job. Until the end of this study, there was no *ustadzah* who was assigned to be in charge of female students' health. Trying to overcome this problem, the *ustadz* in charge of male students' health was assigned to also take care of the female students, and two female senior students were appointed to work with him in managing the health care for other female students. However, since gender segregation was applied strictly, the *ustadz* could not enter the female dorm to take care of the sick female students, and the assigned female students could not directly contact the male teacher when they needed his help. One of the assigned students expressed, "we need a health post that is managed by an *ustadzah*, because the *ustadz* who handle the health post now is a male, we cannot directly contact him to seek for treatment" (FGD5 Nora)

One of the participants also added:

> I want the girls to have our own health post, not to be put at the same place with the boys, with *ustadz*. We need an *ustadzah* to take care about it, and in our dorm we also need to have health post like the boys'. We should have an *ustadzah* for health division too. (FGD 11 Fitri)

4.2.3 Improving health information resource

Improving health information resources refers to efforts to improve sources of health information for students by providing frequent health education sessions, library with health books, and other kind of health information resources. As mentioned above, library in the *dayah* provided limited books and could only be accessed during morning school times. Therefore, the participants expected that *dayah* should provide an additional library in the female dormitory to give more time for student to access the health books, magazines or boards which can be accessed anytime in female student's dormitory. By expressing this concern, participants showed that they aware of the need on health literacy, and identified the possible solution for themselves who were restricted in access to outside source of information, as well as having limited time to access the school library, as explained in the theme of limited resources.

Actually, they had much interest to learn more about health, as mentioned by one of participants, "I want to know anything related to health and what we have to do if we get sick, something like that" (FGD1 Raisa). Another participant added, "I want to know about how to prevent the diseases like I said before" (FGD1 Hani). Unfortunately, there was not much health education materials or health education sessions were provided by *dayah*, neither by the nearby health center, even though the media such as films or health education sessions was acceptable to be held occasionally in *dayah*. One of participants implied:

> The health education session like the one being conducted by the health center staff should be conducted frequently. For example, once in a month. Or every two months. So we could have more information. (FGD 12).

4.2.4 Training *ustadzah* and peer caregivers

Training *ustadzah* and peer caregivers referred to providing the skill for teachers and peer caregivers to improve the health of female students. Skillful teachers and peer caregivers were needed to manage the healthcare post, and to facilitate health improvement activities, such as health education, exercise sessions, or stress reduction activities. One *ustadzah* emphasized that the influence of religious teachers in delivering health messages to students:

> Some *ustadz*s and *ustadzah*s indeed directly relate their teaching to health, with other things. For example, actually, in the *Quran* there are some kinds of foods which are explained as healthy foods. Everything is there in the *Quran* but we never read it thoroughly. Such as *tiin* (fig) and *zaitun* (olive) were mentioned in Al-Quran. They are very good foods, aren't they? I ever explained to the students, why Allah makes fig and olive as special fruits. Why do not you ever think about that? They should be a special reason. If all *ustadz*s and *ustadzah*s have good knowledge about it, then they can tell more about it, and the students will definitely apply the teaching. (Teacher 2)

She furthermore added:

> I teach the evening class as well, the *dayah* lessons (the classical Islamic book). Therefore, I have observed it, if the one who teaches is *salafi* teacher (graduated from traditional Islamic boarding school), the students will apply the same as that teacher teaches. I do not know why, if the teachers are the ones who already studied in the university, their understanding was different. Maybe they have more extensive insight. I do not know the reason for sure. Not every *ustadz* and *ustadzah* relate the Islamic teaching to health value, only the parts that we know. I do not mean to blame that they are wrong, or doing the wrong method. It is not like that. They might have the basis of *salafi* education. *Teungku-teungku* (Acehnese word to address male religious teachers) from the traditional *dayah*, they teach the student without any knowledge acquired from university level of education. Actually, they have knowledge, but their insight is limited, so they cause the students having different interpretation. When we checked about it, the students were found to have wrong interpretation. Long time ago, it was even worse, the evening teachers blamed the morning teachers when they had different opinions. The students learned about *fiqh* in the evening from the original Islamic classical books while in the morning, they learn *fiqh* from the school text books which taught different things. Yes, there was contradicting, I wonder what is the cause of the contradicting. (Teacher 2)

Beside the lack of teachers' skill in delivering the health message, she also concerned about the teacher's skill in taking care of sick students and how hard for the health division of student council to manage it. She explained:

> The health division, the ones who are in the organization, of course they might want to have free time. They cannot be burdened all the time with the sick students until the sick students get recovered. It cannot be like that. However, we the teacher is lacking in the skill. If suddenly a student gets sick, and getting worse, we do not know how to take care of her. We should have more skills to do that. (Teacher 2)

In addition, the participants were also keenly aware of this problem. They complained the slow response of the responsible member of student council when they sought for care of a sick student. A participant mentioned:

> The health division member should be more responsive when we report that someone is being sick. They should give a help soon. They should check it first, not always get suspicious thinking that the student pretends to be sick. Sometimes the student already badly sick, high fever, but nothing is done. They should be trained to help the sick student or how to check if a student really sick. (FGD11 Hasna)

One of the student council members responded:

> Actually the health division members have already tried to do it. But when we report to *Ustadzah*, we have to wait for a long time until we get the medicine. We have limited stock of medicine; so what else we can do. We also have no skill to take care of the sick students. We want *ustadzah* also pay more attention on it, not only the student council members. We need to be trained and *ustadzah* also involve more. (FGD 11 Sarah)

Furthermore, another participant added:

> We should have more responsible persons for health division, maybe one in every dormitory room and should be trained well to help the students. (FGD11 Riza)

4.2.5 Collaborating with the health center or other stakeholders

Collaboration with the health center or other stakeholders refers to efforts to collaborate between *dayah*, health center and other relevant stakeholders in improving the health of female adolescents in *dayah*. Based on the interviews with teachers, the school principal and the nurses in health centers, there were possibilities to make a good collaboration with nearby health center or private health clinics to improve access health care services for *dayah*, including health improvement activities. Actually *dayah* already sought for health care for the students in health center several times, however they felt unsatisfied with the services, as explained below:

> Actually it is free to get treatment in the health center, but because of we had a bad experience before, we did not trust them anymore. Once, some children were being sick. So we visited the health center several times. First, no doctor was available, so the nurse treated the student and gave the medicine. Later, when the doctor came and checked the treatment, the doctor said that the nurse gave the wrong medicines. Therefore, we did not trust the service in the health center anymore. The doctor often is not there either. In this *dayah*, when the students get sick, we will go to that *mantri*'s (a nurse who run a medical treatment clinic) private clinic in the afternoon. That is better than visiting the health center. (Teacher 3)

Furthermore, the principal of *dayah* also mentioned that not only *dayah* that feel unsatisfied with the service in the health center, the community also complained a lot about the health center. The teacher explained:

> I got disappointed, a bit angry with them. The health center staffs are civil servants, but they acted so proud as if they are better than others. The villagers reported a lot about them. The villagers often seek for medical treatment from the other health centers in other sub-districts because they were unsatisfied with the health service in our sub-district's health center. (Principal)

Actually, health care for students, including the *dayah*, is part of the national school health program, however, the program was not implemented in all schools in the sub district. A teacher explained:

> The nearby health center does not implement school health program for this *dayah*. So I was thinking what we can do here in *dayah*. Last time I tried to make a program with the health division of student council, but nothing has been done yet. For the plan, we want to make it on Friday, Friday is a day off in *dayah*. For the seminar, we want to invite expert to give health education about reproductive health. These students, for this kind of problems, such as about menstruation, they do not openly talk about that, even we live together like this. Besides, we only have limited knowledge. Just from what we learned from books or teachers in *dayah*. More than that, we know nothing. We want to have many seminars to give health information. (Teacher 2)

From the interview with a nurse in the nearby health center, she admitted that the school health program implementation had not touched the *dayah*. She explained:

> Actually the school health program has been implemented since this health center was established. Already a long time ago, but for the adolescent health program, it was started in Aceh since 2008. But, maybe because it was not a main program, I think the district health office paid less attention. It was just like a dormant program. Nothing was implemented. Then, in 2012 there was one NGO who worked on cases of adolescents after tsunami, such as drugs, HIV/AIDS cases, also about violence among adolescents. They made some investigations and found that actually there was already a program related to adolescent in the health center, but it was not implemented. They collaborate with the provincial health offices and the program was started again in all districts with their support. For this district, only 4 health centers are covered, including this health center. So we already started the program for about a year, simultaneously with the school health program, and only cover the public junior and high schools. (Nurse 2)

Related to the reason why the program had not touched the *dayah* yet, she furthermore explained:

> The *dayah* has not included in the planning yet, because we have limited budget. But I see that the *dayah* is potential to run the program. I ever visited them and found that they already have a room with equipment for healthcare post. The teachers seemed cooperative too. We already conducted two health education sessions there, and the students seemed so eager to ask questions. I

> hope I could get more budget and more staffs to run the program. Only me and three other nurses run the program for all schools here. We have 14 elementary schools, including the Islamic ones; 4 junior high schools; one Islamic junior high school; four high schools; and four *dayah*. Actually, we should cover all, but so far we could only cover four schools for the adolescent health program. I think in the future, in the planning, we can include the *dayah* as well. I will try to get more support for budget from sub-district office. (Nurse 2)

In summary, this category showed the noticeable changes taking place during the study, and prospective changes which were perceived as feasible actions that should be taking place in the future. The themes highlighted that the research process involving participatory methods could increase the awareness of the participants on their needs and the actions which could be taken to improve the disadvantaged conditions for health improvement.

In general, the findings of this study covered four main categories as explained above. However, although the findings were organized in such way, it was obvious that these following categories: meaning of health; improving health of female adolescents; and changes and prospective changes on health improvement of female adolescents; were influenced by the category of power relations. As mentioned before that it is impossible to isolate the facts in society from the domain of values (Foley & Venezuela, 2005), however in figure 2, the findings are reorganized into a scheme to show the power relations and its interrelating domains. Accentuating the domains of power relation into religion, gender, social and education would portray the whole findings in a more understandable way. The issues under each domain were derived from the findings under each theme in category of power relations. However, some issues which were previously described in separated themes, such as power of

knowledge and information, and financial pressure were relocated under the domain of social to emphasize this domain in the power relations.

Figure 2 shows the power relations structured in *dayah*. The arrows in the figure show how they influenced the female adolescents in improving their health. Religion was portrayed as the most dominant power which affected education and social power, and these three dominant powers subsequently affected gender. This study highlighted that the power relation formed by religion, education, social, and gender were deeply embedded in the culture of *dayah* as a part of the Indonesian educational system, and exerted its influence on the conception of health, the health improvement practices, as well as on the changes and the prospective changes.

The dominant role of religion strongly structured in *dayah* can be observed from the expected gender role of each parties in *dayah* culture. How the principal, ustadzhs, and ustadzahs interacted with students, as the recipient of Islamic education, was always aimed to deliver the content of Islamic education which reflected in all dimension of life. As the principle of Islamic education was applied in *dayah*, the austere living condition was being cultivated to implant the moral values of Islamic education, as the virtuous man is the one who do not prefer the transient world than the eternal hereafter (Al-Ghazali, as cited in Nofal, 2000). Staying restricted to the outside world was selected and maintained by the dominant powers to prevent the unwanted influences for the implementation of Islamic teaching inside the *dayah*. However, this maintained status quo might prevent the positive influences to touch the Muslim female adolescents by being connected to outside world.

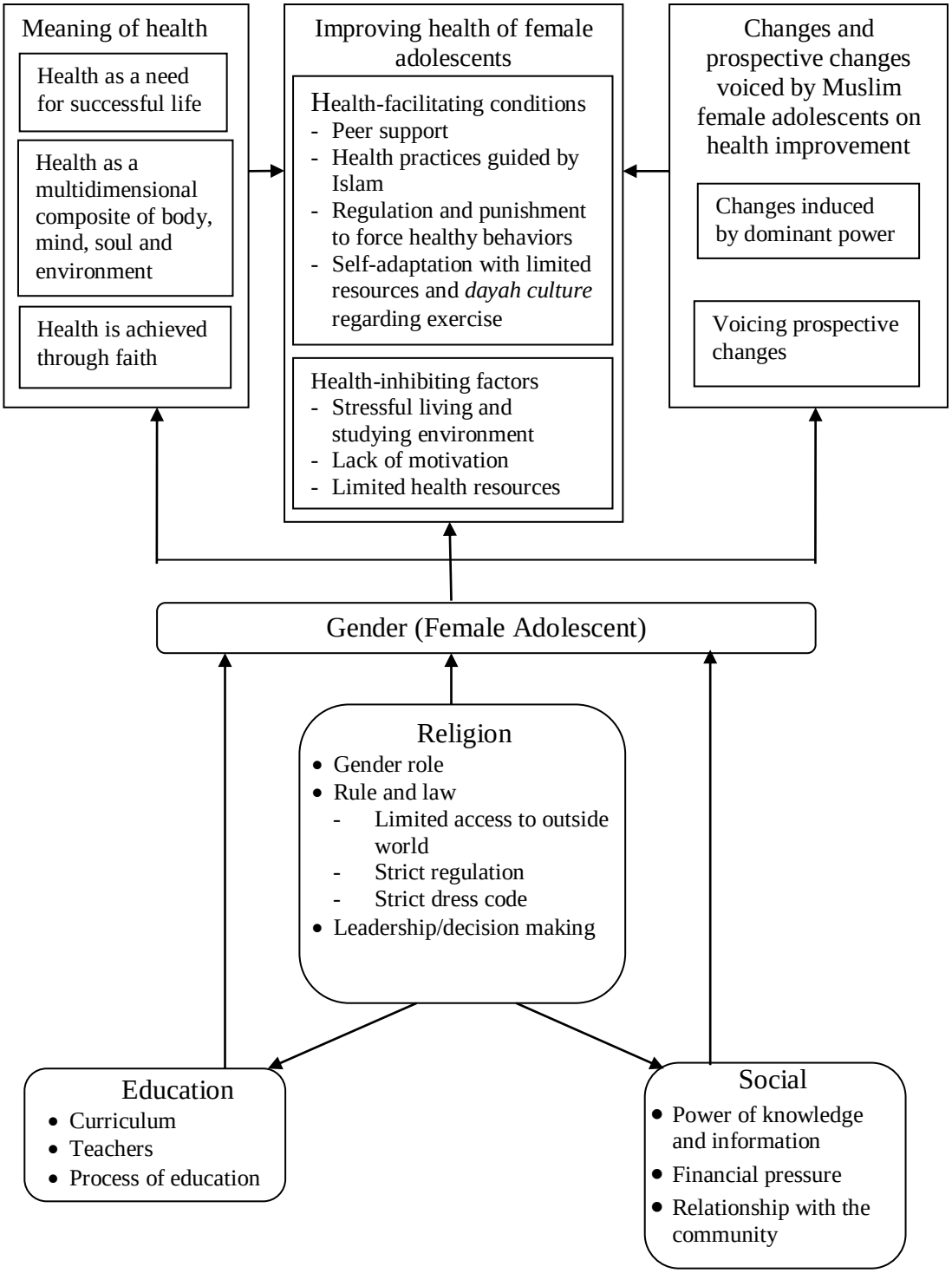

Figure 2. Power Relations and Health Improvement in the *Dayah*

In figure 2, the arrows explained that education and social power influenced each other, however, these two forms of power did not create any impacts on the power of religion. The combination of these powers, the most dominant and the less dominant ones played their roles toward structuring the dimension of gender for female adolescents, which in turn manifested in the ways of female adolescents improving their health within the health-facilitating conditions and health-inhibiting conditions. The combination of these powers also imposed the Muslim female adolescents' conception of health, the changes being made, and their voices on prospective changes for health improvement. At the same time, the conception of health affected the way of health improvement in those both facilitating and inhibiting conditions, and so did the changes and the prospective changes voiced by Muslim female adolescents on health improvement.

This study showed that the dominant role of religion created the power of knowledge which filtered the anticipated negative influence of outside world, but unfortunately the possible positive influence for health, as well as for growth and development, during the precious adolescence was also left out. This might lead to negligence to meet the health needs of female adolescents in achieving their optimal status of health, and gaining their maximum growth and development in adolescence. All parties living inside the *dayah*, including the female adolescents, might not be aware of how far this condition might lead to, however they expressed some awareness on the feasible change to improve the existing condition.

Discussions

The discussion below detailed each category emerged from findings of this study. The themes in each category were also explained and linked together to portray the whole picture of *dayah* culture and how the Muslim female adolescents living in such culture practiced, developed, and strived to make changes to improve their health.

1. Meaning of Health

This study shows how *dayah* culture, which is shaped by the power relations, influenced the female adolescents' conceptualization of health. They expressed considerably unique meaning of health which covered wide aspects, including valuing health as a need for a good life; perceiving that health comes from multidimensional aspects (body, mind, soul, and environment) and can be achieved through faith.

This meaning of health appeared different from the meaning of health which was described by the female adolescents in other studies. A study among Bangladesh adolescents in a rural population revealed that the adolescent considered physical appearance as the only aspect of health (Khan, 2013), while in the study conducted by Wee, Chua, and Li (2006) among Asian adolescents living in Singapore shows that the adolescents related health with physical, psychological and social domain.

The participants in this study valued the significant meaning of health as a need for achieving good life; which comes from maintaining body, mind, soul, and environment; and as a virtue which was gained through faith. At their young age, the

female adolescents could associate the positive contribution of health to their lives, while other adolescents might not be aware of, such as described in the study conducted by Thing and Ottesen (2013). They mentioned that the adolescent participants in their study did not associate their knowledge about health with their practices in daily life. Although they did sports and exercise, the reason for doing them was not for health. In other words, they did not consider health as an important issue at this point in their lives. Instead of health, they related their physical characteristics with a need for normalization. They were concerned more on losing weight and staying in shape, rather than staying healthy.

Furthermore, the participants in this study might have adopted the concept of multidimensional interrelationship between body, mind, soul and environment which they had learnt from their religious teachers and Islamic classical books. In Islamic teaching, Muslims need to fully involve in life by fulfilling the obligation to Allah and to society. For achieving that goal, it is necessary to have a complete emotional, physical, mental and spiritual well-being (Ayad, 2008).

Furthermore, this study highlighted the manifestation of religion as one of power relations, which could be implied from the emerging themes in the category of meaning of health, and the themes of health practices prescribed by Islam, definitely reflected their religiosity. A study about Indonesian adolescent religiosity implied that religion was closely related to other aspects of adolescent development (French, Christ, & Purwono, 2014). As adolescence was the time when the concept of health was fully developed (Coleman, 2011), it might explain the influence of religion values in their conception of health. In addition, according to the principle values of Islamic law, the essential matters of human life include preserving of faith, preserving of the soul,

preserving of wealth, preserving of mind, preserving of offspring, and preserving of honor (Auda, 2010). Since the participants were cultivated with these values during their stay in *dayah*, their conception of health was explicitly laden with this multidimensional value. This study showed the role of religion in affecting adolescents' concept of health.

2. Improving Health of Female Adolescents

The way that female adolescents improved their health was deeply affected by religion, education, and social power. These dominant powers appeared as productive discourses, yet oppressive at the same time. How these powers productively facilitated and oppressively inhibited health improvement are discussed below.

McHoul and Grace (1993) explained in more detail of what discourse is according to Foucauldian theory. The term discourse is defined as flows of power, or the concept of discipline. Discourses referred to "limited practical domains" which have their own "rules of formation" and "condition of existence". The institutions like school, prison, and hospital was viewed as disciplinary institutions that run disciplinary practices as forms of social control. In this study, *dayah* culture was considered as a disciplinary institution or official discourse that employed official techniques in terms of regulations, punishment, and normalization.

The official techniques put its effect on what was counted as truth. The official techniques continuously, uninterruptedly, and unconsciously subjected the participants by governing their gestures and dictated their behaviors (McHoul & Grace, 1993). In other words, the subjection was found to have taken place in *dayah*, and the

effects of subjection could be observed as productive, yet oppressive toward the health improvement of female adolescents in the *dayah*.

The productive discourses in *dayah* culture could be seen from the themes emerged, as *dayah* created circumstances which strengthened peer support among the students; educating the health practices guided by Islam; forcing health behavior with regulation and punishment; and pushing the female adolescents to adapt themselves with limited resources and *dayah* culture regarding exercise. While the oppressive discourses manifested as barriers for health improvement by creating stressful living and studying environment, impoverished students' motivation to initiate actions beyond their lists of compulsory activities, and provided limited health resources for students to sufficiently improve their health.

Similar to the other *pesantren* which offered the enjoyment of learning and relationships with teacher and friends (Nilan, 2009), *dayah* in this study made the participants valued their relationship with friends. They expressed the peer support that they received, particularly as a caregiver for their needs of healthcare, source of health information and psychological support, as well as encouraging health practices.

The peers are the first persons they sought for health care when they suffered from health problems. It indicates that participants' health service utilization started from receiving care from their peer. The peers in *dayah* performed their role in early detecting health problems and give basic health care for the female adolescents, although they were never trained before. However, studies mentioning peer as caregiver were rare to find. Prior studies mentioning adolescents as caregivers were mostly found at family setting (Collins, 2014; Heyman & Heman, 2013; Cluver et al., 2012). In a school setting such as *dayah*, the relationship of peer to peer was mostly

described as peer teaching (Reinhardt, 2012), peer educator (Abdi & Simbar, 2013; Bam & Girase, 2015; WHO/UNAIDS, 2015), peer support (Bownikowski et al., 2015), peer supervisor (WHO/UNAIDS, 2015), peer monitoring (Langford et al., 2014), and youth advocates (Sabella, Patchin, & Hinduja, 2013).

Meanwhile, WHO/UNAIDS (2015) explained that the access and the use of health services for adolescents was influenced by the gatekeepers; such as adolescent's parents, family members, legal guardians, teachers, and community leaders. In this study, the role of gatekeepers was played by *ustadzah*. They were the ones who decided when the students should get further health care outside the *dayah*.

As mentioned above, the power of religion affected the conception of health among the female adolescents. In addition, this study also showed that the power of religion simultaneously shaped female adolescent's health practices to become those which were congruent with *sharia* principles. Those health practices were described as *ibadah* as a way to improve health, and *thaharah* for cleanliness.

Related to *ibadah*, the participants in this study mostly explicated that *salat*, reciting the *Quran*, performing ablution (*wudhu*) as the acts of worship that they performed to improve their health. Those practices were used as a coping method, a form of exercise, and a motivation to stay clean. The benefit of *salat* which was implied by participants in this study was also found in other studies. Doufesh et al. (2014) conducted a study about the effect of *salat* on the "a relative power" (RPa) of electroencephalography (EEG) and autonomic nervous activity, and found the increase of parasympathetic activity and the decrease of sympathetic activity in Muslims during performing *salat*. This study proved that regular *salat* may improve relaxation, relieve anxiety, and reduce the risk of cardiovascular problems. Similar to a study conducted

by Mohamed et al. (2015), *salat* was found as the main coping strategy for the post stroke participants.

The other practices of *ibadah* which benefited participants' health was reciting the *Quran*. Reciting the *Quran* was also believed as relieving mental distress by most of Muslim adolescents in the Midwestern United States involved in the study conducted by Zubeir et al. (2011). In addition, reciting the Quran was found effective in reducing anxiety among hemodialysis patients (Babamohamadi et al., 2015). These evidences supported the benefit of reciting the Quran implied by the participants in this study.

The participants in this study furthermore mentioned that performing *wudhu* (ablution) gave them a positive effect. Moreover, *wudhu* was performed not only as part of preparation before *salat*, but also at other times, such as before bedtime and before classes. *Wudhu* itself was considered as one of *ibadah* practices which was performed by washing hands, face, and feet in a certain sequence. When being performed before *salat*, *wudhu* has an exclusive purpose of maintaining the physical cleanliness and spiritual purity to enter into a proper state of mind to communicate with Allah in *salat* (Sayeed & Prakash, 2013). Although most literature explained ablution as the precondition of *salat*, performing *wudhu* at other times, such as mentioned by the participants in this study, was a recommended practice (*sunnah*) (Al-Qaradhawi, 2009).

Meanwhile, *thaharah* was mentioned as a practice to maintain cleanliness by the participants in this study. *Thaharah* literally means cleaning or purifying. In Islamic teaching, *thaharah* refers to the purification of all kinds of uncleanliness attached in the body or its surroundings in order to be able to embark a prayer (Al-Hafidz, 2010). While *salat* is believed to be a means to purify the soul,

thaharah is considered as the outward purification to precede the *salat*. The outward purity is an essential condition to achieve the inward purity as the main goal of *salat* (Ali, 2011).

The means used to perform *thaharah* are water, the one that is purified and lawful for purification; and also dust, and stone to be used when water is scarce (Al-Hafidz, 2010). The participants in this study mentioned that they obtained more knowledge about *thaharah* in *dayah*. They understood more on how to use water for purification, and implemented it in their daily life in *dayah* in a stricter way than what they did at home. In other words, as doing so, they might achieve the better outward and inward purity during staying in *dayah*.

Meanwhile, beside the productive discourses of power relation as explained above, the oppressive discourse of power relations was also found in this study. The hierarchy of authority in *dayah* created the regulations and punishment to force healthy behaviors, barriers to exercise, stressful living and studying environment, and limited health resources, which might influence the cultivation of healthy habits during adolescence. Since adolescence is an essential period in the lifespan to form lifelong healthy habits (Givens & Carpenter, 2011), the *dayah* should play an important role in protecting adolescents from a range of health compromising behaviors and conditions.

The dominant powers in *the dayah* might have aware of this condition and established a list of regulations for students to perform the expected healthy behaviors, such as group exercise, cleaning the environment, regular shower, and brushing teeth. However, the punishment attached to the regulations was considered

oppressive by the participants. These regulations and the punishment added up their burden and increased the stressors they had to deal with while living in *dayah*.

In addition, the full day discipline which was similar to that of being applied in *dayah*, in fact had been implemented since long time ago. A classic ethnography conducted in the first established integrated *pesantren* in Indonesia described in detail how the full day discipline inside the *pesantren* was like. In the study, Castles (1966) depicted that the students studied and resided at the *pesantren* during their six years of study. The student activities were strictly scheduled, starting from early morning until late evening. Similar phenomena could still be observed at the time of this study.

Unfortunately, the strict schedule of full day activity in *dayah* might lead to activity related stress. Brown (2011) mentioned that early adolescent in his study experienced activity related stress due to involving in many discretionary activities and overscheduling. The participants in the *dayah* as well complained that the lengthy study hours and compulsory religious activities in this *dayah* were stressful for them

However, this issue might actually be solved by modifying the regulations in the *dayah*. The culture of *dayah* in Aceh actually was not rigid, and might be reformed to allow female students to benefit more from their school time in *dayah* while still respecting the values of Islamic teaching (Husin, 2014). Therefore, any concerns from students related to modification of regulation should be voiced to the decision makers in *dayah* to initiate the positive changes.

Regarding the limited health care resource in *dayah*, the similar condition was consistently presented in the study of Wanat et al. (2010). In their study, the participants also stressed that they received the limited health care. However, the

cause of the problem seems quite different from this study. In their study, the cause of limited health care was the lack of responsiveness from the *dayah* authorities when the participants reported cases of illness among the students; and limited number and time spent by the caregivers (staff of *dayah*), whereas the *dayah* in this study showed more responses to the health problem. The *dayah* offered better health resources in term of health post, a particular responsible teacher for student's health care, and established a health division in the student council who took care of the sick students. However, these efforts were considered still limited to meet the needs of the students.

3. Power Relations in *Dayah* and Health

Unequal power creates dominant values which implied in social relationship in various presentations of power relations (Carspecken, 1996). The dominant values that is imposed by power may shape false-consciousness that prevent individual or groups to make decisions that essentially affect their lives (Kincheloe & McLaren, 2005). Carspecken (1996) furthermore explained that the identities, form of thinking, and the beliefs of people are merged with the oppressive relation. The people inside this oppressive relation might not realize this condition. In this condition, the values influenced the facts.

In this study the power inequality structured in *dayah* culture, which represented by religion, education and social power, was revealed. The people who exercised these power might have wrongly perceived and insufficiently addressed the health needs of female adolescents. Besides the identified productive effects of *dayah*'s way in facilitating health practices, the subjugation of female adolescents' health needs obviously appeared. The female adolescents themselves might unaware of this

oppressive conditions and continuously showed lack of initiative and motivations to improve their health.

The power of religion played the biggest role in *dayah*, which was exercise through the rule and law which was implemented toward the female adolescents particularly, and in *dayah* culture generally. The rule and law created the pressure of discipline which affected education dimension and social dimension, including administrative hierarchy, financial pressure and relationship with community.

Meanwhile, the strict regulation in *dayah* created the pressure of discipline which was explained as "regimes of truth" and "power knowledge relations" in the form of charismatic pedagogy and strict rules (Nilan, 2009). Nevertheless, the strict regulation is commonly found in the Islamic educational institution. Islamic teaching recognizes the need for discipline with children. Sometimes this may on occasion involve the physical punishment with applying some conditions in order not to abuse the children (Al-Mateen & Afzal, 2004).

The obligation to follow the regulation was also intended to respect their teachers (Al-Mateen & Afzal, 2004). In Islamic boarding school, teacher is also a religious leader, which gave considerable influences on the life of adolescents in Islamic boarding school. Beside religious leader, other important elements which play important role in Islamic boarding school are mosques and Islamic classical books (Walsh, 2002). Those two elements contributed to the strict regulations applied in the *dayah*. The application of this strict regulation became the center of life in *dayah*, and considered as priority over other things. This condition created pressure toward the students to enforce the discipline above other kind of considerations. They might feel

reluctant to bargain or negotiate some tolerance for particular issues which might be considered as violating the regulation.

Furthermore, the religion, in this study, determined the education system which was adopted to manage the school. The principles of Islamic education were obviously implemented in *dayah*. The content and the process of education were organized to achieve the goal of Islamic education, which is to cultivate the recipient of education to abide in the teaching of religion to reach the happiness in hereafter (Al-Attas, 1988; Al-Ghazali as cited in Nofal, 2000).

Comparing with a traditional (*salafi*) *dayah*, the *dayah* in this study had adopted the Islamic education system in a more modern way, however the studying environment was still poorly managed. This *dayah* was also managed independently, which means that the *dayah* was not affiliated with the big Muslim organizations (Tan, 2014). However, although 50% of the overall population of *dayah* students were female, there were only very few female-led *dayah*. The fact that most *dayah* (including the one in this study) were male-led, and very few female teachers could achieve the high level of *dayah* teachers, contributed to gender imbalance among the teachers and leaders of *dayah* in Aceh (Husin, 2014). These facts decreased more chances to influence the gender-balanced policy in *dayah*, including the policy to ensure the fulfillment of female students' health need.

In addition, *dayah* in this study did not have many capable *ustadzahs* to teach Islamic classical books and lead extracurricular activities such as sports with female students. Especially, in the evening class, most of the teachers were male and always stood in the front of male students. The female students, who always sat at the back behind male students, felt embarrassed to ask questions during the lessons as this

was deemed to be culturally inappropriate. It was expected that female teachers would help address any questions the female students might have after class. The similar condition was found in the study of Wanat et al. (2010) who described that the study environment in *dayah* had lack of access to educational opportunities, such as limited books, not well-trained teachers, unresponsive institutions, and lack of student's personal growth. Therefore, to anticipate on this issue, the teachers and school principals should facilitate a more gender balanced studying environment in order to provide a better school climate, which would have important positive effects on adolescents' learning and achievement (Steinberg, 2011).

Related to social dimension of power relation in this study, social values were identified as one of barriers which hampered adolescents to access the health care (WHO/UNAIDS, 2015), which were confirmed in this study. In this study social dimension was observed to exercise its power in the form of gender role imposed for female adolescents, financial pressure, and the relationship with the community.

From the perspective of Erikson's developmental theory (Erikson, 1968), female adolescents are viewed as developing individuals who move through a psychological crisis to establish a coherent sense of identity. The maturational and social forces develop their identity, and make the development of an individual's identity not only a mental, but also a social process (Steinberg, 2011). In this study, *dayah* culture, as one of the social forces, played a big role to shape female adolescent's identity. In other words, while maturational forces are at work during female adolescents' six years of living in the *dayah*, *dayah* as a social force concurrently shapes the identity of female adolescents. *Dayah* determines which sorts of identities are desirable and which are not. The subjugation of their health needs and

other gender biased practices they experienced during their stay in the *dayah* might subsequently lead them to consider this inequality as an acceptable aspect of their identity.

As being mentioned before that the label of a second class school and "dumping ground" for children from poor rural families (Parker, 2008) was attached to *dayah*, the students in *dayah* mostly received much financial support from the *dayah* itself. As shown in this study, most of the participants paid only a few sum of money to cover all their daily necessities of living in *dayah*. The *dayah* even tolerated well for the students delayed of school fee payment. In some other *dayah*, the students were even exempted from paying the school and boarding fees, which were covered by the *dayah* owner (Srimulyani, 2014).

The students in this study, who mostly came from poor families, had no choice but to pursue this affordable form of education. They expressed a reluctance to complain about a lack of facilities because they paid very little in school fees, and some students were also in arrears with their payments. This phenomenon was also found in the study conducted by Nilan (2009). He explained that in this kind of institutions, "regimes of truth" and "power-knowledge relations" existed and could be observed as the form of charismatic pedagogy, strict rules, austere conditions, and the spare provision of resources in learning for these students with low-bargaining power. Despite of these facts, the study periods in this kind of institution was still perceived as an impressive experience by their students (Wanat et al., 2010; Nilan, 2009).

This study implied that the power relations, in some extents, had hampered female adolescents' ability to fulfill their educational, social and health needs. Compared to their male counterparts, they had less chance to improve

themselves at school as well as less chance to get treatment and consultation, and less chance to get health related information from outside world. However, despite a number of economic restraints that *dayah* faced, *dayah* should not leave the students' needs left unfulfilled.

Another identified manifestation of social power in *dayah* was the influence of *dayah* toward the community. This condition might open an opportunity of partnership with community in improving the health of female adolescents in particular, and the community in general. *Dayah* could use its role as a center of Islamic values reproduction, including notions related to women and gender issues in general (Srimulyani, 2012). A study conducted by Sciortino, Natsir, and Mas'udi (1996) applied an approach that involving IBS in an effort to improve sexual and reproductive health of women in rural area. The study showed that the approach was applicable in using the sacred text of Islam to link with the issues of social justice, gender, and reproductive health. Therefore, the *dayah* might as well apply the same approach in the issues of adolescent health, especially in adolescent health improvement. Designing and developing an updated approach would be an essential recommendation.

Moreover, the widespread and extensive networks of IBS are influential in connecting their communities with issues in the society (Srimulyani, 2012). It shows the hidden capacity of *dayah* to take a part in the effort of involving community in social issues. Considering health as one of social issues, *dayah* might build their capacity to play an active role in improving community health. *Dayah* could provide health education for the villagers, particularly in relevant issues of women health and gender, by linking the issues with the sacred texts of Islam. On the other hand, the support from community could provide opportunities for students in the *dayah* to

interact with outside realistic world. If this kind of interaction could be managed properly while keep being compatible with the culture in *dayah*, it might reduce their tension on their daily lives inside *dayah* and bring positive outcome on their health, as well as their growth and development as adolescents. Therefore, developing a partnership between *dayah* and community will be a considerably recommended intervention.

4. Changes and Prospective Changes Voiced by Muslim Female Adolescents on Health Improvement

Critical ethnography was applied in this study to achieve the goal of emancipation and empowerment in the whole research process as it endeavors to reduce the social inequalities in the oppressed groups (Carspecken, 1996). In other words, during the research process, some positive changes might have been appeared. This study revealed some changes taking place during the research process and prospective changes which were perceived by participants as solutions for further improvement.

The noticeable changes taking place during the study was induced by dominant powers in *dayah*. The principal and *ustadzahs* took decisions over a condition which benefitted the health of female adolescents, such as decision to use the donation for building the sport fields in female dorm, to response the complaints on meal for students. Although these decisions had not covered all aspects of female adolescents' health needs, the small changes might lead to further bigger changes.

Undoubtedly, policies for creating health-promoting schools play a key role in protecting adolescents' health, ensuring they have knowledge, skills, and access to health services (WHO, 2014). Such level of action might take a long time to

implement, however, the critical ethnography can have a catalytic effort towards those purposes. The major components of critical ethnography are a value-laden orientation, empowering people by giving more authority, challenging the status quo, and addressing concerns about power and control (Cresswell, 2007). Critical ethnography was constructed based on the principles of critical theory that put emancipation as its focus with a purpose to empower people and transform the political and social realities (Hardcastle, Usher, & Holems, 2006). In the context of *dayah*, such level of action might take a long way to be achieved, however, applying critical ethnography might have a catalytic effort towards this purpose.

The empowerment process was described as the nature of critical ethnography. Hardcastle, Usher and Holmes (2006) described that during the dialogical stage, researchers explored the insider's, or emic, perspective while positioning themselves as participants and interacting with them. This stage tries to highlight the practical understandings among the group on how they construct their actions. These practical understandings might not be aware of by participants. However, if these practical understandings were able to be brought up, they might have chances to be directed to positive changes.

The findings showed some changes related to sport facilities, improvement on provided meal, and organizing the health education sessions. The positive change also came from the health center nurse who visited the *dayah* and conducted a health education session for female adolescents despite mentioning that the *dayah* have not been included yet in health programs managed by the health center. These positive changes might only be in a small scale, however it might be a good start toward the empowerment and transformation purpose.

In this study, the increase of awareness could be noticed from the participants as they voiced prospective changes which might be initiated to improve the health of female adolescents. In this *dayah*, treating the sick adolescents was frequently brought up into the main focus, and subjugated the importance of preventing illness and disability, while experts in adolescent health care considered that finding the best way to prevent illness and disability is more essential than finding the best way to treat sick adolescents (Steinberg, 2011). Nonetheless, some possible changes were being discussed.

As explained above, in a traditional *dayah*, the core principle of education is the delivery of the teachings of classic Islamic books, without including conventional subjects such as natural science, social studies, or arts and sports in the curriculum. An integrated *pesantren* on the other hand include such subjects by applying the national curriculum designed for regular Islamic junior or senior high schools (Husin, 2014). In other words, the *dayah* in this study, as an integrated *dayah*, had implemented both national curriculum and curriculum of traditional *dayah*. It gave the students more subjects to learn in the classroom, more time to spend to finish their homework, and more time to study by themselves. Obviously they had the more burden than the other adolescents who studied in regular schools. In addition, they also must join the religious activities in congregation for all five time of compulsory prayers, reciting the Quran and *dzikir* (chanting) before or after each prayer. Between those activities, they still needed to involve in extracurricular activities (such as giving religious speech in Arabic or English, vocational trainings, and art performances), and perform the cleaning duties. Some of them even needed to attend the additional class for those in the final year, and the punishment they should take for skipping or being

late at one of those compulsory activities or violating the regulation. The punishment could be additional cleaning duties, additional memorization of parts from the Quran, *Hadiths*, or the classical books. Those discretionary activities and over scheduling stressed them out and might cause fatigue, headache, and other health problems which they already had complained.

The school should take the issues of activity related stress due to discretionary activities and over-scheduling into serious consideration when implementing its policies (Brown et al., 2011). Modifying the schedule or the study environment could be some of the efforts, as social environment or ethos of schools can contribute positively to physical and mental health (WHO, 2014). The students themselves implied that they enjoyed performing activities in the group more than individual activities. They suggested that the exercise activities in the group should be added to the schedule every day to attract more students to join. They might have been used to do everything in a group and seem less motivated to do individual exercise. Therefore, modifying their afternoon or morning schedule could be done to create more time and space, and motivate them to exercise or involving in other recreational activities.

Brown et al. (2011) mentioned that the participants in their study, who expressed being stressful from discretionary activities and overscheduling, demanded for more time to hang out with their friends. As spending time with friends were also considered as one of the most positive experience of staying in *dayah* (Wanat et al., 2010) or *pesantren* (Nilan, 2009), creating more structured group activities, such as group exercise or peer led activities, might become one of solution to deal with activity-related stress. The use of group activity therapy (GAT) might also be an

alternative, as GAT was considered effective to provide growth opportunities for students by means of structured, developmentally appropriate activities in a group setting (Paone, Malott, & Maldonado, 2008).

Meanwhile, establishing a health care post managed by *ustadzah* which was voiced by the female adolescents, considerably fit with the global effort to improve health care access and health outcomes for adolescents as WHO (2010) encouraged the provision of school health services to meet the special needs of female adolescents. Moreover, according to WHO (2014), the school should play an important role in protecting adolescents from a range of health compromising behaviors. Coleman (2011) also explained that schools are a suitable place for health promotion programs, therefore, besides providing a health care post for female adolescents, *dayah* should consider to apply school based programs which dealing with social relationship problems or life skills programs to prevent health compromising behaviors.

Soleimanpour et al. (2010) highlighted the impact of school health centers in increasing access to health service, as well as improving mental health outcomes, resiliency and contraceptive use among adolescents in Alameda County, California. This evidence showed that, even in a place with better health service resources, school health centers showed remarkable impact for adolescents. Soleimanpour et al. furthermore described that the adolescents in their study preferred to seek the service in the school health centers for the reason of confidentiality, free of charge services, convenience, and youth-friendly staff. This finding supports the prospective change suggested by the participants to improve health service utilization among their students in *dayah* by providing health care post managed by *ustadzah*.

Therefore, the female adolescents in *dayah* would find the health care post as a more convenient and accessible health care facility.

Another prospective change voiced by female adolescents was improving the health information resources. This study emphasized that improving health information for adolescents must involve their peers and teachers as the ones who dominantly influenced adolescents. Whitfield (2013) highlighted that adolescents picked their peers as one of the preferable informal sources of health information, while for the formal one, school-based sources were mostly selected. Therefore, *dayah* should create a program where peers could deliver health information, since adolescents listen more to information from their peers (Coleman, 2011).

In addition, *dayah* needs to provide other school-based resources as suggested by the participants in this study. Providing more health information media in a more convenient and in the full day access at female adolescents' dormitory might be helpful to improve their health literacy. Health literacy, which is referred to "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Nielsen-Bohlman, Panzer, & Kindig, 2004) is considered essential to improve health promoting behaviors among adolescents (Chang, 2010). Therefore, to encourage health promoting behaviors of adolescents in *dayah*, their health literacy should be enhanced by exposing them to health information resources. They should be well-informed about their own health, as well as where and when to find health service (WHO/UNAIDS, 2015).

One of the alternatives to encourage health promoting behaviors of female adolescents in the *dayah* is by improving the skill of ustadzah and the peer caregivers in *dayah*. Related to peer caregivers, they should also play an active role to

do mentoring and to led health education in *dayah*. Coleman (2011) emphasized that peer mentoring or peer led health education might become effective interventions to promote adolescents' health behaviors. However, before running the program, the adolescent mentors must receive appropriate training, as well as continuous support. Therefore, in this study, the student council that was given the responsibility of managing their peers, including those who will be in charge of the health post, should be trained properly on how to do peer mentoring or education. They also should be supported on an ongoing basis with good communication and well planned activities to improve their participation.

As mentioned above, *ustadzahs* are the gatekeepers for adolescent health in *dayah*. Teachers as gatekeepers are being acknowledged in playing an important role to support adolescents' access and utilization of health services (WHO/UNAIDS, 2015). Therefore, the *ustadzah* in *dayah* should be trained on how to improve adolescents' access and utilization of health services available for adolescents, inside or outside *dayah*.

Among the prospective changes voiced on health improvement for female adolescents, one prospective change was explicated by the associate participants, including the principal, *ustadzahs*, and the nurse from the nearby health center. They obviously had wider perspective than the female adolescents, and could think of the possibility to make a collaboration between *dayah*, health center, and other stake holders.

In addition, to expand access and varied the form of services for the underserved adolescents, such as adolescents in *dayah*, health care providers should inform the schools about the value of providing health services to adolescents

(WHO/UNAIDS, 2015). In this case, the nurses in the health center are expected to play more active role, as the one who has more resources and knowledgeable on health services for adolescents. Although the *dayah* and the students had negative experience of health service utilization in the nearby health center, the nurse in health center should put more efforts to regain their trust.

WHO/UNAIDS (2015) had set up the eight global standards of quality health services for adolescents, which defines the expected quality level of health service delivery for adolescents globally. Those standards include: adolescents' health literacy, community support, appropriate package of service, provider's competencies, facility characteristics, equity and non-discrimination, data and quality improvement, and adolescent participation. Therefore, it becomes the responsibility of health center, *dayah*, and related stakeholders to ensure the fulfillment of those standard for the better health of adolescents living in *dayah*.

Summary

This study revealed the pattern of power relation structured in *dayah* and how it influenced the health improvement of female adolescents. Religion, education, and social dimension appeared as dominant powers appeared as productive yet oppressive discourse at the same time. This study highlighted the manifestation of power relations in shaping the health conception, the health-facilitating and health-inhibiting conditions, the changes being made, and their voices on prospective changes for health improvement.

Chapter 5

Conclusions and Recommendations

This chapter concludes the findings of the study and elucidates the implications and recommendations for the sake of future contribution of this study findings. The implication was detailed in the relevance to nursing practice, nursing education, and further research.

Conclusions

This critical ethnographic study explores the life experience of Muslim female adolescents on how they practiced, developed, and made changes to improve their health in *dayah*. Prior studies have left the health improvement issues in *dayah* unexplored. Adding up the evidence of *dayah* as an under research area, and female adolescents in *dayah* as the underserved population, this study informed the policy makers in *dayah* and related stakeholders to put more attention on the health needs of the female adolescents in *dayah*.

Previous studies succeeded to bring out the issues of education policy, gender imbalance and power inequality in *dayah*, meanwhile this study reflected that those issues were found to remain existing and effected the health improvement of female adolescents living in *dayah*. Therefore, this study contributed in collating the evidence and knowledge on issues influencing the health improvement of female adolescents who studied in the *dayah*.

In addition, this study exposed patterns of power and domination with a purpose to empower people and transform the political and social realities. The findings

showed that religion, education, and a social dimension of power is embedded in the *dayah* that not only causes constraints, but also involves several productive impacts.

The study findings revealed the meaning of health and the health improvement practices which are influenced by the power relations in the *dayah*. In addition, the changes and prospective changes to furthermore improve the health of female adolescents were also detailed. The four categories are meaning of health, improving health of female adolescents, power relations in *dayah* and health, and changes and prospective changes on health improvement.

1. Meaning of Health

A variety of health conceptions were depicted by the participants, which included: health as a need for a good life; health as a multidimensional composite of body, mind, soul and environment; and health is achieved through faith. This conception of health was considerably shaped by the religion as one of structured power relations in *dayah*. The values that the female adolescents laid on health reflected in the way they performed health practices to improve their health. Besides being aware of positive contribution of health for their lives, the participants associated the meaning of health with multidimensional aspects of complete well-being, and associated the health with their faith as Muslims.

2. Improving Health of Female Adolescents

This study showed the production of distinctive health practices which resulted from the power of religion, education, gender and social dimensions. The specific health practices were: peer support, health practices guided by Islam,

regulation and punishment to force healthy behaviors, and self-adaptation with limited resources and *dayah* culture regarding exercise. Those specific health practices came from health facilitating conditions created by power relations as productive discourse in *dayah*. In other hand, health-inhibiting conditions was also identified as oppressive discourse of power relations. The oppressive discourse appeared as barriers for health improvement which included: stressful living and studying environment, lack of motivation, and limited health resources.

3. Power Relations in *Dayah* and Health

This study explained the power relations embedded in *dayah*, which influenced the way of female adolescents improved their health. Religion, education, gender, and social dimensions were identified as the form of powers which considerably imposed the conception of health and the practices of health improvement among the female adolescents. These power relations were interrelated and could be observed from their manifestations, such as the strict rule and law, leadership and decision making, education structure, administrative hierarchy, financial pressure, and *dayah*'s community participation.

4. Changes and Prospective Changes Voiced by Muslim Female Adolescents on Health Improvement

During the study, some positive changes occurred in *dayah* to initiate further changes. Some prospective changes which were perceived as the solutions for health improvement were voiced by the participants. The prospective changes include rescheduling of additional compulsory activities, female managed health care post,

improved health information resource, training for teachers and peer caregivers, and collaboration with the health center or other stakeholders. Most of the suggested changes can be initiated and implemented by the support of the school level of authority. However, some particular issues related to health services need supports from health center and related stakeholders, such as the local authorities at the sub-district level.

Implications

The study showed that forms of power in religion, education, and social dimensions interacted to construct a distinctive social system, in this case was the *dayah* culture. The findings exposed the forces that prevent female adolescents from making their decision on the matters affecting their lives. The knowledge produced by this study could informed *dayah* and the relevant stakeholders on the issues they should take into account, as well as the strategies they may apply. It also highlighted some recommendations for nursing knowledge and practices, education, and research, as explained below.

Nursing knowledge and practice. The study provided more extensive knowledge on Muslim female adolescents living in *dayah* as one of at risk groups to be addressed by nursing practice. By conducting a critical epistemology, this study identified the manifestations of power relations, differentiate the facts and values, the facts and power, and how they relate each other. In other words, this study brought up the practical knowledge for fostering social action and change.

Beside the practical knowledge, this study could contribute to esthetic, personal, and ethical knowledge in nursing. Esthetic knowledge appeared to be the art

of building relationships to get access to explore this secluded culture of *dayah*. During engaging in a prolonged interaction during participant observation, employing the participatory research methods, such as photovoice, and conducting dialogical data collection, the researcher gained tacit knowledge which contributed to breaking through the barriers in achieving successful rapport with the participants, such as respecting their norms on gender segregation and following the dress code during interacting with the participants.

The findings of this study provided personal knowledge to the researcher while exploring the living experience of female adolescents living in *dayah.* The researcher obtained a more extensive insight on *dayah* culture and the health needs of the ones who living in such culture, as well as the way to deal with the power relations in *dayah* to facilitate them meeting those needs. The insider's or emic perspective of health improvement explicated considerations on how some particular issues should be anticipated to work with this group of adolescents, such as their orientation in preserving the Islamic teaching, the hierarchical flow of power, and the values they put on the religious teachers.

Employing the critical ethnography also brought up ethical knowledge on how the study should be performed carefully in exploring sensitive issues, such as the gender inequality and the subjugation of female adolescent's health need, in a way that not furtherly strengthen the domination of oppressive power in *dayah*. The researcher also acquired the knowledge on not to impose researcher's bias during portraying the insider's or emic perspective by conducting several strategies to maintain the credibility, dependability, confirmability, and transferability of the study findings.

As the ultimate aim of critical ethnography is to generate valuable and practical knowledge for fostering social action and change, this study was expected to set the stage for social action for positive change. Policy reinforcement should be performed to create health-improving *dayah* as schools play a key role in protecting adolescents' health, ensuring they have knowledge, skills, and access to health services. A comprehensive and culturally appropriate program for health improvement should be to developed to address this at risk group.

Nursing education. As this study added up new knowledge on the health improvement of female adolescents living in *dayah*, the curriculum of nursing education should accommodate in translating the finding into nursing practice which could provide the nursing students with skills in addressing various at risk groups among adolescents, including female adolescents living in *dayah*. The curriculum should also include the issues to consider in working with this at risk group.

Nursing research. This study contributed to add up more evidences about *dayah*, which was considered as an under-research setting, especially related to health. The themes emerged in this study could be used as reference in creating a model of interventions for this specific at-risk groups. A curriculum of health improvement which would be compatible to *dayah* culture and the principles of Islamic education is considerably needed to be developed by *dayah* and the relevant stake holders. In addition, studies on various intervention models to improve the health of female adolescents in *dayah* are also important to determine an effective model which works effectively for this at risk group.

References

Abdel-Khalek, A. M. (2007). Religiosity, happiness, health, and psychopathology in a probability sample of Muslim and adolescents. *Mental Health, Religion & Culture, 10*(6), 571-583.

Abdel-Khalek, A. M. (2009). Religiosity, subjective well-being, and depression in Saudi children and adolescents. *Mental Health, Religion & Culture, 12*(8), 803-815.

Abdel-Khalek, A.M. (2014). Happiness, health, and religiosity: Significant associations among Lebanese adolescents. *Mental Health, Religion, & Culture, 17*(1), 30-38.

Abdullah, S., Salleh, A., Mahmud, Z., & Ghani, S. A. (2010). Moral value inventory for Muslim adolescents. *Procedia - Social and Behavioral Sciences, 7*, 106-112. doi:10.1016/j.sbspro.2010.10.016

Abu-Ali, A. (2003). *Ethnic identity and religiosity as predictors of sexual attitudes among Muslim and adolescent girls* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (UMI N0. 3114114).

Adamson, C. (2007). Gendered anxieties: Islam, women's rights, and moral hierarchy in Java. *Anthropological Quarterly, 80*(1), 5-37.

Ahmed, S., Patel, S., & Hashem, H. (2015). *State of American Muslim Youth: Research & recommendations.* Washington: The Family & Youth Institute, and Institute for Social Policy and Understanding.

Alamri, A. A. (2013). Participation of Muslim female students in sporting activities in Australian public high schools: The impact of religion. *Journal of Muslim Minority Affairs, 33*(3), 418-429.

Al-Attas, M. N. (1980). *The concept of education in Islam*. Retrieved from http://www.mef-ca.org/files/attas-text-final.pdf

Al-Iryani, B., Basaleem, H., Al-Sakkaf, K., Kok, G., & Borne, B. V. (2013). Process evaluation of school-based peer education for HIV prevention among Yemeni adolescents. *Journal of Social Aspects of HIV/AIDS, 10*(1), 55-63.

Allen, L. (2008). Young people's 'agency' in sexuality research using visual methods. *Journal of Youth Studies, 11*(6), 565-577.

Al-Mateen, C. S., & Afzal, A. (2004). The Muslim child, adolescent and family. *Child and Adolescent Psychiatric Clinics* of *North America, 13*(1), 183– 200.

Amalik, M. J. (2008). *Pesantren, pendidikan Islam khas Indonesia*. Retrieved from http://www.pewarta-kabarindonesia.blogspot.com/

Asra, H. P. (2010). *Pengaruh pengetahuan dan tidakan hygiene pribadi terhadap kejadian penyakit scabies di pesantren Ar-Raudhatul Hasanah Medan.* Retrieved from http://repository.usu.ac.id/bitstream/123456789/21503 /7/Cover.pdf

Aswat, N. (2013). *Kajian pelaksanaan program pos kesehatan pesantren (poskestren) di Pondok Pesantren Ar-Raudhatul Hasanah Medan provinsi Sumatera Utara*. Retrieved from http://repository.usu.ac.id/handle/123456789/47244

Auda, J. (2010). *Maqasid al-shari'ah as philosophy of Islamic law: A system approach*. Kuala Lumpur: The International Institute of Islamic Thought.

Ayad, A. (2008). *Healing body & soul: Your guide to holistic wellbeing following Islamic teachings*. Riyadh: International Islamic Publishing House.

Baranowski, T., Perry, C. L, & Parcel, G. S. (2002). How individuals, environments, and health behavior interact: Social cognitive theory. In K. Glanz, B. Rimer, &

F. Lewis (Eds.), *Health behavior and health education: Theory, research, practice* (pp. 165-184). San Francisco, CA: John Wiley & Sons.

Barton, T. D. (2008). Understanding practitioner ethnography. *Nurse Researcher, 15*(2), 7-18.

Bell, K., Terzian, M. A., & Kristin, A. M. (2012). *What works for female children and adolescents: Lessons from experimental evaluations of programs and interventions.* Washington, DC: Child Trends.

Berg, G., & Sarvimaki, A. (2003). A holistic-existential approach to health promotion. *Scandinavian Journal of Caring Sciences, 17*, 384-391.

Blackbeard, D., & Lindegger, G. (2007). 'Building a wall around themselves': Exploring adolescent masculinity and abjection with photo-biographical research. *South African Journal of Psychology*, *37*(1), 25-46.

Brockhoff, H. J., Mollema, L., Sonder, G. J. B., Postema, C. A., Binnendjik, R. S, Kohl, R. H. G.,...Hahne, S. J. M. (2010). Mumps outbreak in a highly vaccinated student population, The Netherland, 2004. *Vaccine, 28*, 2932-2936.

Buck, J., & Ryan-Wenger, N. (2003). Early adolescent's definition of health: The development of a new taxonomy. *Journal of Theory Construction & Testing, 7*(2), 50-55.

Carspecken, P. F. (1996). *Critical ethnography in education research*. New York, NY: Routledge.

Castles, L. (1966). Notes on the Islamic school at Gontor. *Indonesia, 1*(1), 30-45.

Castleden, H., & Garvin, T. (2008). Modifying photovoice for community-based participatory indigenous research. *Social Science and Medicine, 66*, 1393-1405.

CDC. (2014). *Sexually transmitted disease surveillance 2013*. Atlanta: U.S. Department of Health and Human Services.

Cheddadi, A. (2000). Ibn Khaldun (A.D. 1332-14-6/A.H. 732-808). *Prospects: The quarterly review of comparative education, 1*, 7-19.

Chen, Y. (2010). Crossing the frontier to inland china. *Chinese Education and Society, 43*(1), 46-57.

Coleman, J. C. (2011). *The nature of adolescence* (4th ed.). London: Routledge.

Connell, R. W. (2002). *Gender*. Cambridge, UK: Polity.

Cook, K. (2005). Using critical ethnography to explore issues in health promotion. *Qualitative Health Research, 15*(1), 129-138.

Coreil, J., Bryant, C. A., & Henderson, J. N. (2001). *Social and behavioral foundation of public health*. Thousand Oaks, CA: Sage.

Creswell, J. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousands Oak, CA: Sage.

Currie, C., Robets, C., Morgan, A., Smith, R., Settertobulte, W., Samdal, O., & Rasmussen, V. (Eds.). (2004). *Health behavior in school-aged children survey (HBSC) study: International report from the 2001/2002 survey*. Copenhagen, Denmark: WHO.

Davlatshoeva, A. (2014). *Understanding health issues among adolescent females in a northeast province of Afghanistan*. Doctoral Dissertations 2014-current. Paper 69. Retrieved from http://scholarworks.umass.edu/dissertations_2

Del Rosso, J. M., & Arlianti, R. (2009). *Investing in school health and nutrition in Indonesia.* Retrieved from http://datatopics.worldbank.org/hnp/files/edstats/IDNwp09c.pdf

Dennis, S., Jr., Gaulocher, S., Carpiano, S., & Brown, D. (2009). Methods in community-based participatory research for health. *Health & Place, 15*, 466–473.

Dooher, J., &Byrt, R. (2005). A critical examination of the concept of empowerment. In J. Cutcliffe, & H. McKenna (Eds.), *The essential concepts of nursing*. Philadelphia: Elsevier.

Doufesh, H., Ibrahim, F., Ismail, N., Ahmad, W. (2014). Effect of Muslim prayer (*salat*) on α electroencephalography and its relationship with autonomic nervous system activity. *The Journal of Alternative and Complementary Medicine, 20*(7), 558-562.

Edberg, M. (2007). *Essentials of health behavior: Social behavioral theory in public health*. Sudbury, MA: Jones and Bartlett.

Edelman, C., &Mandle, C. (2010). Health *promotion: Throughout the life span* (7th ed.). St. Louis, MS: Mosby.

Every Women Every Children. (2015). *Global strategy for women's, children's and adolescent's health (2016-2013): Survive, thrive, transform.* New York, NY: United Nation.

Fadhlullah, A. (1995). *World of our youth*. Montreal, Canada: O.A.I.K. & H.S.

Fadlyana, E., Utja, D., Safitri, R., &Subarja, D. (2002). Indikator kesehatan anak serta fasilitas kesehatan lingkungan santri di pondok pesantren Sukamiskin: Studi kasus di Kecamatan Suka miskin Kabupaten Bandung. *Majalah Kedokteran Bandung, 34*(4). Retrieved from http://www.mkbonline.org/index.php/component/content/index.php?option=com_content&view=article&id=67.

Faisal, A. (2009, July 30). H1N1 outbreak taints image of Islamic boarding schools: Cleric. *The Jakarta Post*. Retrieved from http://www.thejakartapost.com/news/2009/07/30/h1n1-outbreak-taints-image-islamic-boarding-schools-cleric.htm.

Fertman, C., Allensworth, D., & Auld, M. (2010). What are health promotion program? In C. Fertman, & D. Allensworth (Eds.). *Health promotion programs: From theory to practice*. San Francisco, CA: Jossey-Bass.

Foley, D., & Valenzuela, A. (2005). Critical ethnography: The politics of collaboration. In N. Denzin & Y. Lincoln (Eds.). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

French, D. C., Eisenberg, N., Vaughn, J., Purwono, U., & Suryanti, T. A. (2008). Religious involvement and the social competence and adjustment of Indonesian Muslim adolescents. *Developmental Psychology, 44* (2), 597-611.

French, D.C., Christ, S., Lu, T., & Purwono, U. (2014). Trajectories of Indonesian adolescents' religiosity, problem behavior, and friends' religiosity: Covariation and Sequences. *Child Development, 85*(4), 1634-1646.

Gilber, N. (2003). Photo-interviewing for research. *Social Research Update, 40,* 41-43.

Givens, S., & Carpenter, M. (2011). Child and adolescent health. In M. Nies, & M. McEwen (Eds.). *Community/public health nursing: Promoting the health of populations* (pp. 286-313). St. Louis, MS: Saunders.

Glanz, K., Rimer., B. K., &Lewis, F. M. (Eds). (2002). *Health behavior and health education: Theory, research, practice* (3rd ed.). San Francisco, CA: John Wiley & Sons.

Government of Aceh. (2014). *Regulation of Government of Aceh on the principles of Islamic law.* Banda Aceh: Government of Aceh.

Government of Indonesia. (2013). *Act of the Republic of Indonesia number 20 of 2003 on the national education system.* Jakarta: Ministry of National Education.

Government of Indonesia. (2014). *Regulation of Ministry of Religious Affairs on Islamic education number 13 of 2014.* Jakarta: Ministry of Religious Affairs.

Hamjah, S. H., Samuri, M. A., Rasit, R. M., Sham, F. M., Kusrin, Z. M., Ismail, Z., & Bsah, N. K. (2012). Factors relating to premarital pregnancy amongst Muslim adolescents in Malaysia. *Research Journal of Medical Science, 6*(6), 266-271.

Hardcastle, M., Usher, K., & Holmes, C. (2006). Carspecken's five-stage critical qualitative research method: An application to nursing research. *Qualitative Health Research, 16*(1), 151-161.

Hidayat, H. (2009). *Perbedaan penyesuaian diri santri di pondok pesantren tradisional dan modern.* Retrieved from http://*etd.eprints.ums.ac.id/4796/1/ F100040088.pdf*

Hockenberry, M. J., & Wilson, D. (2009). *Wong's essential of pediatric nursing* (8th ed.). St. Louis, MS: Mosby.

Huq, M. E., Rahman, M. R., Shermin, S., Choudhury, K. A., Afrin, S., Afrin, L.,…Uddin, M.N. (2012). Reproductive health problems in adolescent female garment workers of Dhaka City. *Bangladesh Medical Journal, 41*(1), 25-27.

Husin, A. (2014). Leadership and authority: Women leading *dayah* in Aceh. In B.J. Smith, & M. Woodward (Eds.). *Gender and power in Indonesian Islam (pp. 49-65).* New York, NY: Routledge.

Islam, S. M. S., & Johnson, C. A. (2003). Correlates of smoking behavior among Muslim Arab-American adolescents. *Ethnicity & Health, 8*(4): 319-337.

Khan, A. K. M. D. (2013). Health conception among adolescents of a Bangladeshi rural population. *Bangladesh Journal of Medical Science, 12*(1), 30-33.

Kincheloe, J., & McLaren, P. (2005). Rethinking critical theory and qualitative research. In Denzin, N., & Lincoln, Y. (Eds). *The Sage handbook of qualitative research* (pp. 303-342) Thousand Oaks, CA: Sage.

Klima, C. (2001). Women's health care: A new paradigm for the 21st century. *Journal of Midwifery & Women's Health, 46*(5), 285-291.

Laird, D. L., Amer., M. M., Barnett, E. D., Barnes, L. L. (2007). Muslim patients and health disparities in the UK and the US. *Arch Dis Child, 92*, 922-926.

Langford, R., Bonell, C.P., Jones, H.E., Pouliou, T., Murphy, S.M., Waters, E.,…Campbell, R. (2014). The WHO Health Promoting School framework for improving the health and well-being of students and their academic achievement. *Cochrane Database of Systematic Reviews 2014* (4, Art No. CD008958). doi:10.1002/14651858.CD008958.pub2

Latzer, Y., & Tzischinsky, O. (2005). Eating attitudes in a diverse sample of Israeli adolescent females: a comparison study. *Journal of Adolescence, 28*, 317-323.

Lawhead, W. (2000). *The philosophical journey: An interactive approach*. Mountain view, CA: Mayfield.

Lee, B., & Barth, R. P. (2009). Residential education: An emerging resource for improving educational outcomes for youth in foster care? *Children and Youth Service Review, 31*, 155-160.

Leininger, M. M. (1985). *Qualitative research methods in nursing*. Orlando: Grune & Stratton.

Li, T., Liu, Y., Di, B., Wang, M., Shen, J., Zhang, Y., …Zheng, B. (2010). Epidemiological investigation of an aoutbreak of pandemic influenza A (H1N1) 2009 in a boarding school: Serological analysis of 1570 cases. *Journal of Clinical Virology*. doi:10.1016/j.jcv.2010.11.012

Lyn, P. (2006). Islamic veiling: Religious devotion and sexual morality among Minagkabau adolescent girls in West Sumatra, Indonesia. *Asia Insights, 2*, 7-9.

Lynam, M. J., Browne, A. J., Kirkham, S. R., & Anderson, J. M. Re-thingking the complexities of culture: what might we learn from Bourdieu? *Nursing Inquiry, 14*(1), 23-24.

Mariano, C. (2009). Holistic nursing: Scope and standard of practice. In M. Dossey & L. Keegan. *Holistic nursing: A handbook for practice* (5th ed.). Sudbury, MA: Jones and Bartlett.

Mander, M. S. (1987). Bourdieu, the sociology of culture and cultural studies: A critique. *European Journal of Communication, 2*(1): 427-453.

Meo, A. (2010). Picturing students' habitus: The advantages and limitations of photo-elicitation interviewing in a qualitative study in the city of Buenos Aires. *International Journal of Qualitative Methods, 9*(2), 149-171.

Mepham, I. (2001). *A review of NGO adolescent reproductive health program in Indonesia*. Jakarta: USAID

Merikangas, K. R., He, J., Burstein, M., Swanson S. A., Avenevoli, S., Cui, L., …Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study Adolescent

Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(10), 980-989. doi:10.1016/j.jaac.2010.05.017.

Ministry of Communication and Information. (2010). *Pesantren berikan kontribusi besar tuntaskan wajar 9 tahun*. Retrieved from http://www.depkominfo.go.id/berita/bipnewsroom/pesantren-berikan-kontribusi-besar-tuntaskan-wajar-9-tahun

Ministry of Health. (2006). *Pedoman Pembinaan dan Pengembangan Usaha Kesehatan Sekolah (UKS)*. Jakarta: Ministry of Health, Republic of Indonesia.

Ministry of Health. (2009). *Health Profile of Indonesia 2008*. Jakarta: The Center of Data and Information, Ministry of Health, Republic of Indonesia.

Ministry of Health, Indonesia. (2009). *Health Act no. 36/2009*. Retrieved from http://www.depkes.go.id.

Ministry of Health. (2013). *Riset kesehatan dasar 2013*. Jakarta: Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan RI.

Ministry of Health. (2015). *Indonesian health profile 2014*. Jakarta: Ministry of Health, Republic of Indonesia.

Ministry of Religious Affairs. (2010). *Data pendidikan diniyah dan pondok pesantren*. Retrieved from http://www.pondokpesantren.net/

Ministry of Religious Affairs. (2014). *Statistics of Islamic education school year 2013-2014*. Jakarta: Ministry of Religious Affairs, Republic of Indonesia.

Moore, B., & Bruder, K. (2002). *Philosophy: The power of ideas* (5th ed.). Boston, MA: The McGraw-Hill

Morris, J. L., & Rushwan, H. (2015). Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology and Obstetrics, 131*, 40-42.

Nakamura, Y. (2002). Beyond the hijab: Female Muslims and physical activities. *Women in Sport and physical Activity Journal, 11*(2), 21-48.

Nilan, P. (2009). The spirit of education in Indonesian pesantren. *British Journal of Sociology of Education, 30*(2), 219-232.

Nofal, N. (2000). Al-Ghazali (A.D 1058-1111; A.H. 450-505) in UNESCO. (2000). *Prospects: The quarterly review of comparative education, 3*(23), 519-542.

Nurish, A. (2010). women's same-sex relations in Indoesian pesantren. *Gender Technology and Development, 14*(2), 267-277.

Oliffe, J., & Bottorff, J. (2007). Further than the eye can see? photo elicitation and research with men. *Qualitative Health Reseacrh, 17*(6), 850-858.

Omran, A., & Al-Hafez, G. (2002). *Health Education for adolescent girls.* Cairo, Egypt: World Health Organization, Regional Office for the Eastern Mediteranian.

Park, J. M., Han, A. K., Cho, Y. H. (2011). Construct equivalence and latent means analysis of health behaviors between male and female middle school students. *Asian Nursing Research, 5*, 216-221.

Parker, L. (2008). Introduction: Islamic education in Indonesia. *Review of Indonesian and Malaysian Affairs, 42*(1), 1–8.

Patton G. C, Sawyer S. M., Santelli J., Ross, D. A., Afifi, R., Allen, N. B.,…Viner, R. M. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet, 387*, 2423-2478. doi:10.1016/S0140-6736(16)00579-1

Perales, D., Fourney, A., McNelly, B., & Mamary, E. (2010). In Fertman, C., & Allensworth, D. (Eds). *Health promotion programs: From theory to practice*. San Francisco, CA: Jossey-Bass.

Pew Research Center. (2015). *The future of world religions: Population growth projections 2010-2050*. Retrieved from http://www.pewforum.org/2015/04/02/ religious-projections-2010-2050/

Polit, D., & Hungler, B. (1999). *Nursing research: principles and methods* (6th ed.). Philadelphia, PA: Lippincott Wiliams & Wilkins.

Price, V., &Archbold, J. (1995). Development and application of social learning theory. *British Journal of Nursing, 4*(21), 1263-1268.

Purdy, C.H. (2006). Fruity, fun and safe: Creating a youth condom brand in Indonesia. *Reproductive Health Matters, 14*(28), 127-134.

Qaradhawi, Y. (1997). *Introduction to Islam*. Cairo: Islamic.

Qaradhawi, Y. (2005). *Ibadah dalam Islam* [Worships in Islam]. Jakarta: Akbar Media Eka Sarana.

Qaradhawi, Y. (2009). *Fiqih wanita* [*Fiqh* for women] (8th ed.). Bandung: Jabal.

Qureshi, Y.I., & Ghouri, S.A. (2011). Muslim female athletes in sports and dress code: Major obstacle in international competitions. *Journal of Experimental Science, 2*(11), 9-13.

Rahmawati, M. (2009). *Pengaruh pendidikan kesehatan tentang penyakit skabies terhadap perubahan sikap penderita dalam pencegahan penularan penyakit skabies pada santri di pondok pesantren Al-Amin Palur Kabupaten Sukoharjo*. Retrieved from http://etd.eprints.ums.ac.id/4470/1/J210050022.pdf

Ray, M. (1999). *Critical Theory as framework to enhance nursing science.* In E. Polifroni, & M. Welch. (Eds). *Perspective on philosophy of science in nursing: An historical and contemporary anthology*. Philadelphia, PA: Lippincott Williams & Wilkins.

Rayan, S. (2012). Islamic philosophy of education. *International Journal of Humanities and Social Science, 2*(19), 150-156.

Reynolds, H. W., Wong, E., & Tucker, H. (2006). Adolescents' use of maternal and child health services in developing countries. *International Family Planning Perspectives, 32*(1), 6-16.

Riley, G., & Manias, E. (2006). Governance in operating room nursing: nurses' knowledge of individual surgeons. *Social Science & Medicine, 62*, 1541-1551.

Rina, W., Azizah, R., & Indirani, D. (2015). Scabies infection control analysis at Pondok Pesantren (Boarding School) Darussalam Banyuwangi District. *International Journal of Advanced Engineering Research and Science, 2*(7), 73-76.

Roald, A. S. (2001). *Women in Islam: The western experience*. New York, NY: Routledge.

Rosandi, M. E. T., & Sungkar, S. (2014). The knowledge on scabies among students in a pesantren in East Jakarta, before and after health education. *e-Journal Kedokteran Indonesia, 2*(3), 173-178.

Rosso, J. (2009). *Investing in school health and nutrition in Indonesia.* Jakarta: BEC-TF.

Royce, S., Parra-Medina, D., & Messias, D. (2006). Using photovoice to examine and initiate youth empowerment in community-based program: A picture of process and lessons learned. *Californian Journal of Health Promotion, 4*(3), 80-91.

Samdal, O., Nutbearn, D., Wold, B., &Kannas, L. (1998). Achieving health and educational goals through schools: a study of the importance of the school climate and the student's satisfaction with school. *Health Education Research*, *13*(3), 383-397.

Save the children. (2002). *The coming home program: Semi-annual report*. Jakarta: USAID.

Sayeed, S.A., & Prakash, A. (2013). The Islamic prayer (salah/namaaz) and yoga togetherness in mental health. Indian Journal of Psychiatry, 55, S224-S230.

Sciortino, R., Natsir, L.M., Mas'udi, M.F. (1996). Learning from Islami: Asvocacy of reproductive rights in Indonesian pesantren. *Reproductive Health Matters, 8,* 86-96.

Shin, Y.H., & Kang, S.J. (2014). Health behaviors and related demographic factors among Korean adolescents. *Asian Nursing Research*, 8 (2014), 150-157.

Shackleton, N., Jamal, F., Viner, M.R., Disckson, K., Patton., G., & Bonell, C. (2016). School-based interventions going beyond health education to promote adolescent health: Systematic review of reviews. *Journal of Adolescents Health, 58*, 382-396.

Shah, R., & Cardozo, M. L. (2014). Education and social change in post-conflict and post-disaster Aceh, Indonesia. *International Journal of Educational Developemtn, 38*(2014), 2-12.

Situmorang, A. (2003). *Adolescent reproductive health in Indonesia*. Jakarta: USAID.

Sivagurunathan, C., Umadev, R., Rama, R., Gopalakrishan, S. (2015). Adolescent health: Present status and its related programmes in India. *Journal of Clinical and Diagnostic Research, 9*(3), LE01-LE06

Srimulyani, E. (2012). Women from traditional Islamic educational institutions in Indonesia: Negotiating public spaces. Amsterdam University Press.

Srimulyani, E. (2014). Gender in contemporary Acehnese dayah: Moving beyond docile agency? In B. J. Smith, & M. Woodward (Eds.). *Gender and power in Indonesian Islam* (pp. 66-80). New York, NY: Routledge.

Srimulyani, E., & Buang, S. (2014). *Pendidikan Islami* (Islamic education): Reformulating a new curriculum for Muslim schools in Aceh, Indonesia. In S. Buang & G. Chew (Eds). *Muslim education in the 21st century: Asian perspectives*. New York, NY: Routledge.

Svebak, S., Jensen, E. N., & Gotestam, K. G. (2008). Some health effects of implementing school nursing in a Norwegian high school: A controlled study. *Journal of School Nursing, 24*(1), 49-54.

Smith, A. (2008). Boarding school abuse, human right and reparations. *Journal of Religion & Abuse, 8*(2), 5-21.

Smerecnik, C., Schaalma, H., Gerjo, K., Meijer, S., &Poelman, J. (2010). An exploratory study of Muslim adolescents' views on sexuality: Implications for sex education and prevention. *BMC Public Health, 10*(533). Retrieved from http://www.biomedicalcentral.com/147-2458/10/533/prepub.

Spradley, J. (1979). *The ethnographic interview.* Orlando, FL: Holt, Rinehart and Winston.

Steinberg, L. (2011). *Adolescence* (9th ed.). New York, NY: McGraw-Hill.

Stewart-Brown, S. (2006). *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach?* Copenhagen: WHO Regional Office for Europe.

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Swartz, D. (1997). *Culture & power: The sociology of Pierre Bourdieu*. London: University of Chicago Press.

Tolman, D., Impett, E., Tracy, A., &Michael, A. (2006). Looking good, sounding good: Feminity ideology and adolescent girls' mental health. *Psychology of Women Quarterly, 30*, 85-95.

United Nations. (2010). *World youth report: Youth & climate change*. New York, NY: United Nations.

UN Women (2011). *UN Women Annual report 2010-2011*. New York, NY: UN Women.

Utomo, I. D. (2003). *Adolescent reproductive health in Indonesia: Status, policies, programs, and issues.* Jakarta: Policy Project.

Utomo, I.D., & McDonald, P. (2009). Adolescent reproductive health in Indonesia: Contested values and policy inaction. *Studies in Family Planning, 40*(20), 133-146.

'Uwaidah, S. K. M. (2010). *Fiqih wanita: Edisi lengkap* [*Fiqh* for women: Complete edition]. Jakarta: Pustaka Al-Kautsar.

Vandenberg, H., & Hall, W. (2011). Critical ethnography: Extending attention to bias and reinforcement of dominant power relations. *Nurse Researcher, 18*(3), 25-30.

Vandenberg, H. E.R. (2010). Culture theorizing past and present: Trends and challenges. *Nursing Philosophy, 11*(1), 238-249.

Verkuyten, M., & Thijs, J. (2010). Religious group relations among Christian, Muslim and nonreligious early adolescents in the Netherlands. *Journal of Early Adolescence, 30*(1), 27-49.

Viner R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet, 379*, 1641-1652.

Walsh, M. (2002). *Pondok pesantren dan ajaran golongan Islam ekstrim: Studi kasus di pondok pesantern modern putri "Darur Ridwan" Paragharjo, Banyuwangi*. Retrieved from http://www.acicis.murdoch.edu.au/hi/field_topics/mayra.doc

Wanat, S., Whisnant, J., Reicherter, D., Solvason, B., Juul, S., Penrose, B., & Koopman, C. (2010). Coping with the challenges of living in Indonesian residential institutions. *Health Policy*, *26*, 45-50.

Weber, M. (1978). *Economy and society: An outline of interpretive sociology*. Berkeley, CA: University of California.

Wee, H. L., Chua, H. X., & Li, S. C. (2006). Meaning of health-related quality of life among children and adolescents in an Asia country: A focus group approach. *Quality of Life Research, 15,* 821-831.

Welch, M. (1999). Critical theory and feminist critique. In E. Polifroni, & M. Welch (Eds.). *Perspective on philosophy of science in nursing: An historical and contemporary anthology*. Philadelphia, PA: Lippincott Williams & Wilkins.

WHO. (1998). *Health-promoting schools: A healthy setting for living, learning and working.* Geneva: WHO.

WHO. (2007). Global school-based student health survey. *Indonesia 2007 fact sheet*. Retrieved from www.who.int/chp/gshs/GSHS_Country_Report_**Indonesia**_2007.pdf

WHO. (2002). *Adolescent friendly health service: agenda for change*. Oxford, UK: World Health Organization.

WHO. (2009). *Women and health: Today's evidence, tomorrow agenda*. Geneva: WHO.

WHO. (2010). *Child and adolescent health and development: Progress report 2009: Highlight*. Geneva: World Health Organization.

WHO. (2013). *NCD global monitoring framework*. Geneva: WHO. Retrieved from http://www.who.int/nmh/global_monitoring_framework/en/

WHO. (2014). *Health for the world's adolescents. A second chance in the second decade*. Geneva: World Health Organization. Retrieved from http://apps.who.int/adolescent/second-decade/

WHO/UNAIDS. (2015). *Global standards for quality health-care services for adolescents: A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents*. Geneva: World Health Organization.

Williams, R. H., & Vashi. G. (2007). *Hijab* and American Muslim women: Creating the space for autonomous selves. *Sociology of Religion, 68*(2), 269-287.

Yasin, R. F, & Jani, M. S., (2013). Islamic education: The philosophy, aim, and main features. *International Journal of Education and Research, 10*(1), 1-18.

Zubeir, H., Bokhari, A., Marko-Holguin, M., Blomeke, K., Goenke, A., Fogel, J.,…Benjamin, W. (2011). Attitudes toward depression among a sample of Muslim adolescents in the Midwestern United States. *International Journal of Adolescent Medicine & Health, 23*(3), 293-301.

Appendix A

Informed-Consent Form

Research Title:	Health Improvement of Muslim Female Adolescents in Islamic Boarding School in Aceh Province, Indonesia: A Critical Ethnographic Study
Researcher:	Asniar
Address:	Nursing Program, Faculty of Medicine, Syiah Kuala University, Banda Aceh, Indonesia. Phone: +6281316533791. Email: asniar_isfani@yahoo.com
Advisor:	Assoc. Prof. Dr. Urai Hatthakit
Co-Advisor:	Assist. Prof. Dr. Wantanee Wiroonpanich

Dear Participants

I am Asniar, a student of Doctoral Program, Faculty or Nursing, Prince of Songkla University Hatyai, Thailand. I am conducting a research health improvement of female adolescents who live in Islamic Boarding School. You are selected as one of participants to share your experience. The finding of this research is expected to contribute to lead policy enforcement and to develop a health promotion model and curriculum for female adolescents living in Islamic Boarding School.

I would like to ask you to voluntarily complete a demographic form and participate in interviews and observations related to how female adolescents care for themselves and promote their health. The interviews are both individual and group interview, which will take 30-45 minutes for each. The interviews and observations will

be recorded by tape-recorder or video camera with your permission. I will keep the confidentiality of your data and will be used them only for academic purpose. You have a right to withdraw from this research without any consequences. If you agree to participate in this research, please sign your name below.

Agreement for participation in the study

After receiving informed-consent, I understand the purpose of the study and the procedures that I will be involved in. Therefore, I agree to participate in this study.

Participant's name _____

Signature _____

Date _____

For adolescent participants, please provide the signature or your parents or guardian.

Parents' or guardian's name _____

Signature _____

Date _____

Appendix B

Demographic Form

Code of Informant: (filled by researcher)

Instruction: please provide some information about your demographic data by filling in the blank or check the box (✔) as necessary.

1. Age : years old
2. Ethnic :
3. Address :

4. Educational Background:

   ☐ public elementary school ☐ Islamic elementary school

   ☐ public junior high school ☐ Islamic junior high school

5. Staying in current Islamic Boarding School since the level of:

   ☐ junior high school Grade: ☐ 1 ☐ 2 ☐ 3

   ☐ senior high school Grade: ☐ 1 ☐ 2 ☐ 3

6. Is it your first time staying in Islamic Boarding School? ☐ Yes ☐ No
7. Family information:

   - Do you still have alive parents? ☐Ye s ☐ No
   - Do you have brothers/sisters? ☐ Yes ☐ No

     If yes, how many of them? …….. older brothers/sisters that

     ……. younger brothers/sisters

   - Do you get financial support from your parents to study? ☐Yes ☐ No

Appendix C

Photo-voice Guideline and Informed-consent

Instruction for photo-taking

I would like to learn from you about how you care for yourself and promote your health everyday in Islamic Boarding School through the photos that you will take by yourself. Please take the photos of any subjects, persons, or events that relate to how you care for yourself and promote your health in your everyday life in Islamic Boarding School. Please take photos with care, not to bother the class during your study hours. Please ask the permission from your teachers or your friends if you want to take their pictures or whenever they will appear in your pictures. You could tell them that their face will be blurred to be unrecognized in the printed photo. Your confidentiality, as well as your photo subject's confidentiality, will be protected and the photos will be used for academic purpose only. Please give your permission for publication of your pictures by signing your name below. You are free to withdraw your photo to be used in this study anytime without any consequences.

Photo's number :_____(filled by researcher)

Photo:

Instruction: Please check (✔) the box provided below on any type of the use of this photo. You could check more than one option.

Agreement for the use of this photo

I agree to allow this photo to be used in:

- ☐ Individual photo-interview
- ☐ Group photo-interview
- ☐ Papers presented in conferences or scientific meetings
- ☐ Books, posters or leaflets for educational purpose
- ☐ Photo-exhibition for educational purpose
- ☐ Articles of academic journals
- ☐ Research report or thesis

Participant's name : _____

Signature : _____

Date : _____

Appendix D

Photo-Interview Guideline

This photo-interview guideline is designed to discuss about the photos taken by female adolescents in Islamic boarding as a way to explore how they improve their health.

Main question: Could you please tell me about the story of this picture?

Probing questions:

1. What does the picture tell about?
2. What or who is in the picture?
3. Where is the location of the picture?
4. What occasion is in the picture?
5. Why do you take the picture?
6. What do you see in the picture?
7. How do you feel about the picture?
8. What do you feel about taking picture?
9. How the picture is related to your health?
10. What else do you want to share related to the picture?

Appendix E

Focus Group Discussion & In-depth Interview Guideline for Key Participants

This interview guideline is designed to explore how female adolescents improve their health in Islamic Boarding School.

Main question:

How do you usually care for yourself and improve your health in Islamic Boarding School?

Probing questions:

1. What is health for you?
2. With that definition of health for you, what do you do to improve it?
3. What helps you to do it?
4. Who helps you to do it?
5. What kind of barriers that you find?
6. What kind of health problems did you ever have?
7. Do you have any concerns related to your health?
8. As a female student, what do you do about those problems?
9. What do you think the male student does to promote their health?
10. What are Islamic values that you applied to improve your health?
11. Are there any Islamic values that avoid you in improving your health?
12. What are Acehnese cultural values that you applied to improve your health?
13. Are there any Acehnese cultural that avoid you in improve your health?

14. What are the school regulations that facilitate you in improving your health?
15. Are there any school regulations that avoid you in improving your health?
16. How do the religious leaders of the Islamic Boarding School encourage you to do health improvement activities?
17. How do the teachers of the Islamic Boarding School encourage you to do health improvement activities?
18. How does the school and dormitory environment facilitate you to do health improvement activities?
19. How about any support from outside the school that facilitate you to do health improvement activities?
20. Do you have any other concerns related to your life in Islamic Boarding School?

Appendix F

Interview Guideline for Associate Participants

This interview guideline is designed to explore the experience of associate participants related to how female adolescents care for themselves and improve their health in Islamic Boarding School

Main questions:

Please tell me how do female adolescents usually care for themselves and improve their health in this Islamic Boarding School?

Probing questions:

1. How is the life of female adolescents living in this Islamic Boarding School?
2. What do female adolescents usually do to improve their health?
3. How do Islamic values influence those behaviors?
4. How does Acehnese culture influence those behaviors?
5. How does the regulation in Islamic Boarding School influence those behaviors?
6. How do the religious leaders of the Islamic Boarding School influence those behaviors?
7. How does the Qur'an influence those behaviors?
8. How does the Sunna influence those behaviors?
9. How does other Islamic jurisprudence influence those behaviors?
10. How do the teachers of the Islamic Boarding School influence those behaviors?
11. How does the school and dormitory environment influence those behaviors?

12. How about any support from outside the school to improve health of the students
13. How about any policy related to health or health improvement which implemented in the school?
14. What have been done to improve the health of students?
15. What effort that you want to do to improve their health but they still could not be implemented?
16. How do you plan to do it?
17. What kind of support would you like to have to improve the student's health?
18. Are there any local and national health policies that influence the health of female adolescents in IBS? What and how they are implemented?
19. Are there any local and national religious organizations that influence the health of female adolescents in IBS? What and how they engage with female adolescents in IBS?
20. Are there any local and national educational organizations that influence the health of female adolescents in IBS? What and how they engage with female adolescents in IBS?
21. Are there any local, national or international non-governmental organizations (LNGO) that influence the health of female adolescents in IBS? What and how they engage with female adolescents in IBS?
22. What is your expectation in the future related to health improvement for females adolescents in IBS?

Appendix G

Participant Observation Guide

This participant observation guide is designed to record data about the setting and context by observing interactions or places located inside Islamic Boarding School.

Space (describe the physical layout of the place where the observation conducted):

……

……..……

Actors (describe the people involved in the event of investigation)

……

…….

Activities (describe the actions of people involved in the event of investigation)

……

……

Objects (record artifacts such as documents related to adolescent's health behavior)

……

……

An event (a set of related activities conducted by people involved in the event of investigation)

……

……

Time (when the observation was performed, when the activities occurred during those times, effect of time on social situation)

……

……..……

Goal (the expectation of the group in the situation)

……

……

Feelings of each social situation (emotions expressed and observed)

……

……

Additional notes:

……

……

Appendix H

Field Note Form

This form is designed to record the description of events, ethical note, aesthetic note, and researcher's personal note during the interactions with participants in the setting of study.

No. Record:

Date/Time	Description of events	Ethical Note	Aesthetic Note	Personal Note

Appendix I

Data Analysis (Samples)

Low level of inference (coding): healthcare for students

Observational Data:

There was another building utilized as an office for administration of IBS and UKS (School health post). I saw some beds and many equipment and medicines in the cupboard. Some posters of health message were stick on the wall. There was one small room with glass window that looked like a consultation room or examination or intervention room. Two cupboards filled with dressing, medication and medical equipment. While conducting my pilot study in the school before, the health post was not built yet. Ustadzah Z said that the IBS received support for the provision of medical equipment's. Now the health post is managed by an Ustadz, who also was studying in a nearby nursing school. He was not around at the moment. He stayed in the school as the evening teacher (ustadz). The same as Ustadzah Z, he was also the alumni of the IBS.

The diseases that usually treated were fever and toothache. The most severe case that was treated is dyspnea. Yet there are no cases that make students should be referred to the hospital.

The school sometimes asks for help from health center or a health professional (*mantri*) staying nearby to treat the sick student.

(PO1 (L250)

Dialogical Data:

When the students get severely sick, we will contact the parents to bring them back home. If the disease is a common one, M (the *ustadz* that was in charge for health post) will take care of them, otherwise the student will be taken to the nearby health center. M is still studying in school of nursing, so he cannot do much either. Sometimes the students just pretended to be sick, so if we take them to health center, we could confirm if they are really sick. Some of them get scared of being injected, so when we take them to the health center, they will stop pretending to be sick. If during several days the students did not get better, that is our responsibility to find better treatment. We will take them to a *mantri* (the nurse who opened a clinic). (Teacher 3)

Actually it is free to get treatment in the health center, but because of we had a bad experience before, we did not trust them anymore. Once, some children were being sick. So we visited the health center several times. First, no doctor was available, so the nurse treated the student and gave the medicine. Later, when the doctor came and checked the treatment, the doctor said that the nurse gave the wrong medicines. Therefore, we did not trust the service in the health center anymore. The doctor often is not there either. In this *dayah*, when the students get sick, we will go to that *mantri*'s (a nurse who run a medical treatment clinic) private clinic in the afternoon. That is better than visiting the health center. (Teacher 3)

I got disappointed, a bit angry with them. The health center staffs are civil servants, but they acted so proud as if they are better than others. The villagers reported a lot about them. The villagers often seek for medical treatment from the other health centers in other

sub-districts because they were unsatisfied with the health service in our sub-district's health center. (Principal)

This was the first step we made to improve the students' health. Among the student council members, I assigned Nora and Aminah (students) to ask for drugs from *ustadz* M. When the stock is empty, they should ask to refill it. They are in charge of the health division, but they are not being trained. We directly give them responsibility. (Teacher 2)

If after 3 days they didn't get recovered, they still need to rest in bed, we call their parents. That's for sure. Because it's not our responsibility anymore. We hand over the students to their parents after they were being sick for 3 days, because we are afraid that if they keep being here, they will bother the other students. (Teacher 2)

I am in charge for health division for girls. Every morning and afternoon I inspect the bedrooms. After that, if I found someone is sick, I report it to *ustadzah*. The *ustadzah* will ask some medicine from *ustadz*. (FGD5 Nora)

We need an *ustadzah* who take care about student's health. Not only the student organization who take care of it. In *dayah* we cannot independently and directly take action when we need help. The *ustadz* who handles the health post is a male, we cannot directly contact him to seek for healthcare. (FGD 11 Sarah)

I really want to have like a small hospital or clinic inside this school. So anyone who get sick could get helped properly. (FGD 1 Raisa)

High level of inferences (coding)

Foreground meaning (Explicit meaning)	**Background meaning** (Implicit meaning)	**Remote meaning** (hidden/deeply cultural embedded meaning)
Objective: - Separate room for health post was provided, including consultation room and four beds - Donated equipment - Health posters on the wall - Basic medicine is available	-	-
Subjective: - Health center was not being visited anymore - Male ustadzah was in charge for the health post, - No female ustadzah who was responsible for female student's healthcare - Two female students were assigned in health division of student council - Cannot contact ustadz M directly to ask for	Subjective: - Students did not get proper treatment - Ustadz M cannot be contacted directly - *Dayah* did not trust the health center - *Dayah* did not try to collaborate with health center - Hierarchical information flow from student to ustadzah then to ustadz M (time-consuming, no fast response)	Subjective: - Dayah created barriers to provide better health care: • Teachers did not provide access to health center • Gender segregation is applied in communication to access healthcare
Normative-evaluative: - anyone who get sick should get helped properly	Normative-evaluative: - health care in the school is insufficient - health center provided bad service	Normative-evaluative: - *dayah* should also provide female teacher to be in charge for health post

Table continued

Foreground meaning (Explicit meaning)	**Background meaning** (Implicit meaning)	**Remote meaning** (hidden/deeply cultural embedded meaning)
- visiting *mantri* is better than visiting health center		

The data were continuously being analyzed in this manner, by looking at the possible meaning fields (objective, subjective and normative-evaluative). This method of developing codes was performed until saturation was achieved. Later, the normative-evaluative meanings were grouped in a separate table and developed into themes and categories.

Appendix J

Glossary

Al-Quran	The Holy book of Islam
Dayah	A term referring to *pesantren* in Aceh province
Hadith	The secondary source of Islamic jurisprudence which provides details which were not mentioned in *Al-Quran*. It is based upon the sayings and practices of the Prophet Muhammad.
Hijab	A veil for a girl or woman, covering head, neck, and chest.
Kitab	also called kitab kuning; Islamic classical books written in Arabic.
Mengaji	Reciting *Al-Quran* and/or learning *kitab*
Pesantren	An Islamic educational institution which is organized by the community and provides Islamic education on its own or in combination with Islamic junior high school and high school.
Integrated *pesantren*	*Pesantren* which also provide Islamic junior high school and high school education.
Traditional *pesantren*	*Pesantren* which delivers the teachings of classic Islamic books, without introducing science or other conventional or secular knowledge.
Salat	One of five pillars in Islam; prayer performed five times a day
Sharia law	Islamic law covering all aspects of a Muslim's life
Sunnah	Non-compulsory but recommended religious practices
Ustadz / Ustadzah	Male / female religious teacher

VITAE

Name Asniar

Student ID 5310430003

Educational Attainment

Degree	Name of Institution	Year of Graduation
Nurse Specialist in Community Nursing	University of Indonesia	2008
Master in Nursing	University of Indonesia	2007
Bachelor of Nursing	University of Indonesia	2001

Scholarship Awards during Enrolment

2005-2007 ASEA-UNINET (ASEAN European Academic University Network)

2010-2014 Scholarship from the Government of the Province of Aceh

Work-Position and Address

Lecturer, Department of Community Health Nursing, Faculty of Nursing,
Syiah Kuala University, Banda Aceh, Indonesia

List of Publication and Proceeding

Asniar, A., Hatthakit, U., & Wiroonpanich, W. (2011). *Self-photo-voice as a research method to study about female adolescents living in Islamic boarding school in Aceh, Indonesia: A pilot study*. Paper presented at the 8th International Nursing Conference in Seoul, South Korea.

Asniar, A., Hatthakit, U., & Wiroonpanich, W. (2011). Photo-voice as a qualitative research method in nursing and health sciences: A literature review. *Proceeding of the Annual International Conference of Syiah Kuala Univeristy (AIC UNSYIAH), Banda Aceh, Indonesia, 1*(1), 163-171

Asniar, A., Myungsun, Y., Hatthakit, U., & Wiroonpanich, W. (2013). *The experience of Muslim female adolescents living in Islamic Boarding School: Finding a way to improve their health*. Poster presented at International Nursing Conference hosted by The Research Institute of Nursing Science, Seoul National University, Seoul, South Korea.

Asniar, A., Hatthakit, U., & Wiroonpanich, W. (2015). *Meaning of health for Muslim female adolescents living in Islamic boarding school in Aceh Province, Indonesia*. Paper presented at the 6th ICCHNR Conference: Health Promotion Through Lifespan in Seoul, South Korea.

Asniar, A., Hatthakit, U., & Wiroonpanich, W. (in press). Meaning of health and health improvement of Muslim adolescent girls in Muslim schools in Aceh, Indonesia. *Songklanagarind Journal of Nursing.*