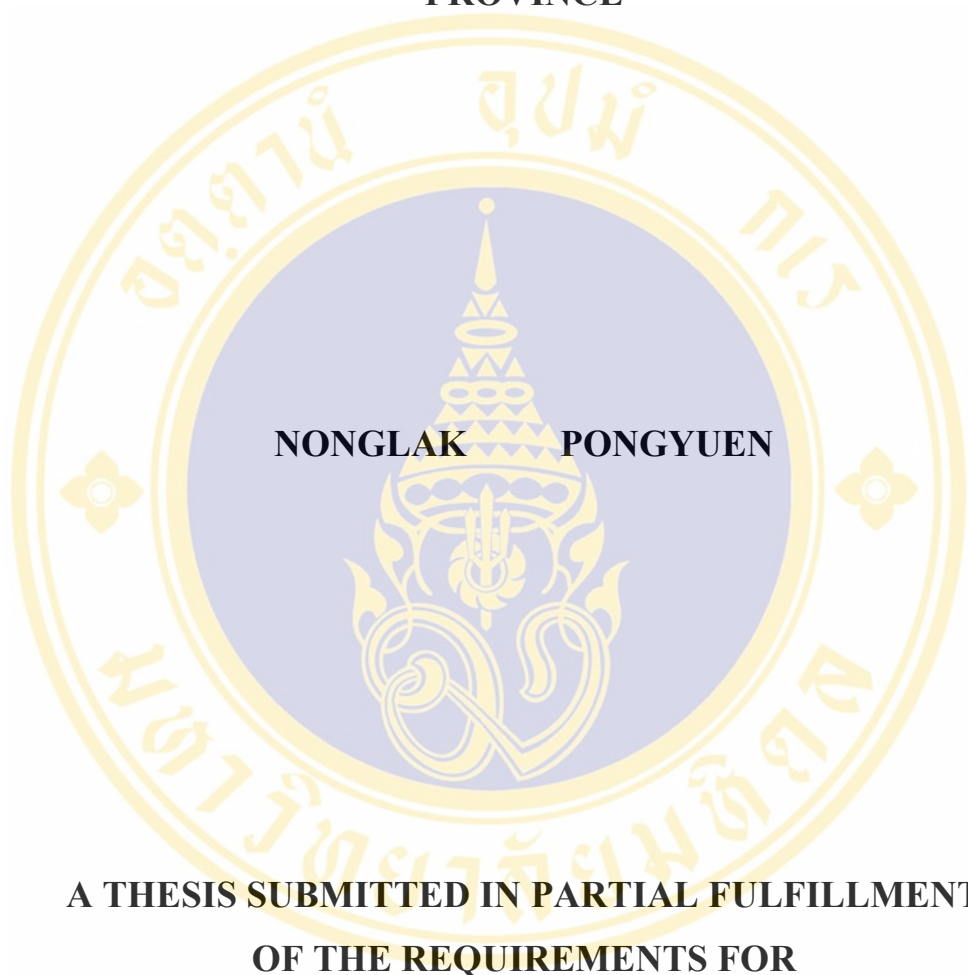


**SEXUAL EXPERIENCES AMONG IN-SCHOOL FEMALE
ADOLESCENTS IN AMPHOE MUANG CHIANG MAI
PROVINCE**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
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ADOLESCENTS IN AMPHOE MUANG CHIANG MAI PROVINCE**



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SEXUAL EXPERIENCES AMONG IN-SCHOOL FEMALE ADOLESCENTS IN AMPHOE MUANG CHIANG MAI PROVINCE

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ABSTRACT

This study uses descriptive exploratory qualitative research methods to study the sexual experiences of in-school female adolescents. Data were collected by in-depth interviews and observations. The sample comprised 20 sexually active 15-18 year-old female adolescents attending school in Amphoe Maung, Chiang Mai Province. Data were analyzed using content analysis.

This study found that most female adolescents studied came from families which were not close-knit and which offered little parental monitoring or support. Their mean age at first sex was 16.75. They perceived that sexual activity is common among their peers. Although, intimacy was the main reason for sexual relationships, a few girls revealed that the desire for material or financial gain was the primary motivation for sexual relationships. The majority of girls had been exposed to risky sexual practices, including failing to protect against unwanted pregnancies and STDs. Although, they had some knowledge of STDs and contraceptive measures, in particular oral contraceptives and condoms, their knowledge was very superficial. They did not acknowledge the potential health risks of intercourse with regular and known partners.

The study also found that 10% of participants had been pregnant and that all of these pregnancies had ended in abortion. Most induced abortions were self-induced. If an abortion was not successful, the girls would usually go to an abortion clinic and were unlikely to seek treatment from health care services because of slow service, negative provider attitudes toward young people and a perceived lack of confidentiality.

The findings from this study suggest that nurses serve an important role in identifying adolescents in need of adolescent- and youth-friendly sexual and reproductive health services; counselling on sexuality, pregnancy, post-abortion issues and family planning; and sex education programmes that are age-appropriate and sensitively imparted.

KEY WORDS: SEXUAL EXPERIENCE / SEXUAL HEALTH/
FEMALE ADOLESCENTS

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ประสบการณ์ทางเพศของนักเรียนหญิงในอำเภอเมือง จังหวัดเชียงใหม่

(SEXUAL EXPERIENCES AMONG IN-SCHOOL FEMALE ADOLESCENTS IN AMPHOE MUANG CHIANG MAI PROVINCE)

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บทคัดย่อ

การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาประสบการณ์ทางเพศของนักเรียนหญิง ใช้ระเบียบวิธีวิจัยเชิงคุณภาพ เก็บข้อมูลโดยการสัมภาษณ์แบบเจาะลึกและการสังเกต กลุ่มตัวอย่างเป็นนักเรียนหญิงที่มีอายุระหว่าง 15-18 ปี กำลังศึกษาในอำเภอเมือง จังหวัดเชียงใหม่ จำนวน 20 ราย

จากการศึกษาพบว่านักเรียนหญิงส่วนใหญ่มาจากครอบครัวที่แตกแยก ขาดความอบอุ่น ปล่อยปละละเลย ส่วนใหญ่เป็นวัยรุ่นหญิงต่างอำเภอที่เข้ามาศึกษาต่อในระดับมัธยมศึกษาตอนปลาย โดยมีการรับรู้ว่าการมีเพศสัมพันธ์เป็นเรื่องที่ปกปิดธรรมดา ปัจจัยหลักที่นำไปสู่การมีความสัมพันธ์ทางเพศคือ ความรัก ความใกล้ชิด สนับสนุน มีวัยรุ่นหญิง 2 คนที่มีความสัมพันธ์ทางเพศเพื่อแลกเปลี่ยนกับสิ่งของและเงินทอง อายุเฉลี่ยของการมีเพศสัมพันธ์ครั้งแรกคือ 16.75 ปี เพศสัมพันธ์ครั้งแรกมักเกิดขึ้นโดยไม่ตั้งใจจาก ความรัก อยากรอง ภาวะจำยอมต่อสถานการณ์ และถูกข่มขืนจากผู้ชาย ส่วนใหญ่ของวัยรุ่นหญิงมีพฤติกรรมเสี่ยงทางเพศ ได้แก่ ล้มเหลวในการป้องกันตนเองจากการตั้งครรภ์และโรคติดต่อทางเพศสัมพันธ์ การขาดความรู้ที่ถูกต้องและไม่ตระหนักถึงภาวะเสี่ยงทางสุขภาพเป็นปัจจัยของพฤติกรรมเสี่ยงทางเพศดังกล่าว ผลที่เกิดขึ้นตามมาคือ ร้อยละ 10 ของวัยรุ่นหญิงเกิดการตั้งครรภ์โดยไม่ตั้งใจ และตัดสินใจจบปัญหาด้วยการทำแท้ง วัยรุ่นหญิงไม่ต้องการเข้าไปรับบริการด้านอนามัยเจริญพันธุ์ในโรงพยาบาล เนื่องจากการบริการที่ล่าช้า ขาดความมั่นใจ และอคติของผู้ให้บริการที่มีต่อวัยรุ่นหญิงที่มีเพศสัมพันธ์ ผลการวิจัยครั้งนี้ผู้วิจัยมีข้อเสนอแนะว่า พยาบาลควรมีบทบาทสำคัญในการจัดบริการด้านอนามัยเจริญพันธุ์ที่สอดคล้องกับความต้องการของวัยรุ่นหญิง จัดบริการการให้คำปรึกษาในเรื่องเพศ และผลักดันให้มีการปรับการเรียนการสอนเรื่องเพศศึกษาให้มีความเหมาะสมและสอดคล้องกับความต้องการและวุฒิภาวะของวัยรุ่นหญิง

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CHAPTER I

INTRODUCTION

Background and significance of the study

The period of adolescence encompasses the transition from childhood to adulthood during the second decade of life. It is one of the most critical periods in an individual's life because during adolescence many key social, economic, biological, and demographic events occur that set the stage for adult life (DiClemente, Hansen & Ponton, 1996: 1; Klima, 1998: 485). The quality of their future lives depends on the extent to which adolescents take advantage of opportunities for personal growth by going to school and being employed while avoiding potentially problematic outcomes of sexual relations, such as early dropout from school, unplanned pregnancy, or adverse health effects. Concerns about the adverse consequences of early childbearing particularly for unmarried women, and the risks of contracting sexually transmitted diseases (STDs) have led to renewed interest in the contraceptive and sexual behavior of adolescents. These concerns, as well as the fact that one out of five people of the Thai population are adolescents at the age of 10 to 19 years old (Department of Health, 2000), therefore, have an enormous impact on future population growth.

Promoting adolescent sexual health- in particular that of female- has become a major issue on the Reproductive Health Policy of Thailand because of female adolescents are normally seen as victims and easy preys of men's sexual exploitation (Sirirasamee, Yoddumnern-Atting & Gray, 2000: 3-4). The age at which a woman first engages in sexual intercourse usually marks the beginning of the period of her exposure to the risk of sexual health problems such as unintended pregnancies, induced abortions, and STDs.

Today more young women are attending school and delaying marriage than ever before. With marriage postponed, they are exposed to the risks of premarital intercourse for longer periods of time, thereby, at greater risk of unintended

pregnancies, induced abortions, and STDs. Although social customs usually discourage sexual relations before marriage, available evidence from surveys suggests that premarital sex is common, and the prevalence of premarital sex appears to have increased over time. A recent survey of Thai people health situation indicates that 18.3-24.0 % of Thai female adolescents have ever had sexual experience, and unwed couple rate among adolescents is 2.9 % (Chuprapawon, 2000; Sethaput, 2000).

Many experts believe that sexual activities among adolescents might not be worried if they have maturely decision making and could protect themselves from pregnancy and STDs (Singh, et al., 2000 cited by The Population Council, Mimeographed). However, developmental factors such as cognitive processes and emotional/psychological growth of adolescents are immature, including the need to belong, the need for intimacy, the desire for passion and curiosity, the need to develop competency, and the need to develop a personal identity. These characteristics lead them have no abstinence, have permissiveness, and finally engage into premarital sexual activity (Neinstein, 1996: 662; May & Mahlmeister, 1994: 200).

The risk of sexual health among female adolescent has risen because in 10 years period ago the first sexual intercourse of Thai men change from prostitute to girlfriend and often be unsafe sex (Ngamprapasom, 2001: abstract). Many studies confirm that the majority of adolescents believe and perceive that it needn't use condoms and protect for safe sex with boy/girl friends (Boonmongkon, et al., 2000: 23; Fakhruddin, K., 2001: 69; Isarabhakdi, P., 2000: vi).

Unsafe sexual behaviors among adolescents initiate to increase of unintended pregnancy. The report of Registration Administration Bureau, Department of Local Administration, Ministry of Interior (1998) indicated that close to 14 % of mothers giving birth in the government hospital are girls under the age of 20. Most of these pregnancies are unplanned. Moreover, the information from Association for the promotion of the status of women (2000) reported that 3.37% of all unintended pregnant clients in 1999 are younger than 18 years old.

Adolescent pregnancy and childbearing are associated with a range of adverse health outcomes, including elevated risks of pregnancy-related and unsafe abortion complications, and maternal death, as well as negative educational and economic consequences because of the physiological and social immaturity of female

adolescents. The health risks associated with childbearing among young women are more pronounced than older women. There are serious health risks for adolescents who have babies. Young adolescents experience a maternal death rate 2.5 times greater than that of mothers aged 20-24. Common medical problems among adolescent mothers include poor weight gain, pregnancy-induced hypertension, anemia, STDs, and cephalopelvic disproportion (The National Campaign to Prevent Teen Pregnancy, 1997). Moreover, future prospects for teenagers decline significantly if they have a baby. They are less likely to complete school and more likely to be single parents. They have to face expulsion from school. Girls who drop out of school as a result of pregnancy rarely return to complete their education. Hence their opportunities for socioeconomic advancement in later life are considerably reduced (The Population Council, Mimeographed).

A means of unwanted pregnancy among female adolescents is induced abortion. For example, a male college student who said “my friend, who has made his partner become pregnancy, does not has to responsibility, his partner must solve by herself because she is too coward to give away. For someone who have little responsibility may conduct his partner to illegal abortion” (Na Nakorn, Mimeographed). In most cases, schoolgirls who become pregnant have to resort to illegal (often unsafe) abortions. The study in female admitting in governmental and private hospitals to treat complications resulting from illegal abortion show that most of subjects (approximately 50%) are younger 20 year-old (Sethapongkul & Boonprasert, 1993; Koetsawang, 1993 cited in Havanon, 1996: 91). According to a recent survey of abortive situation in Thailand in 1999 shows that 30% of abortive patients are younger 20 year-old and 24.7% of them are student (Warakamin & Boonthai, 1999). High morbidity is connected with illegal abortions as most are performed unsafely and by unskilled persons. This is reflected in the increasing number of women who have become infertile after an induced abortion.

In general, all sexually active adolescent women are also increased risk for STDs because of the presence during puberty of ectopy, a biologic cervical immaturity. Further, immune-protective factors of the cervical mucus do not fully develop in adolescent women until 2 to 3 years after menarche. STDs pathogens are more likely to grow in this environment than on the mature cervix of adult women

(Schulenberg, Maggs & Hurrelmann, 1997: 198). Risky sexual behavior in combination with the above developmental factors places adolescent women at great risk for STDs and HIV transmission. According to STDs situation of Thailand reported that AIDS rate in 15-24 year-old female group was 22.13% of all age groups (Chuprapawon, 2000). As a result, although they are usually not fatal, STDs could lead to major pregnancy complications, secondary infertility and severe discomfort. Moreover, STDs have been identified as a predisposing factor in the transmission of HIV.

In an urban community in Chiang Mai province, which is a central province in northern Thailand, has socioeconomic transformation and several educational institutions. It has brought modernization and way of life to this community. Changes in social and economic structures have included the preferential recruitment of young women who have been forced to migrate or commute to urban centers in search of higher education. The growing urbanized popular youth culture could become important factor in the social and sexual lifestyle of adolescents (Boonmongkon et al., 2000: 3). As a result, sex is initiated at a younger age.

The recent study on unwanted pregnancy problem among adolescents in Chiang Mai province in 1999 found that an amount of adolescents have sexual intercourse without pregnancy and STDs prevention. Today unwanted pregnancy problem in Chiang Mai province is very severe. Some schools, students give information that 90% of all of students in a classroom have ever had sexual intercourse. Although abortion rate in Chiang Mai is not yet reported, it could be estimated from information of some clinics, which are abortive clinics, reveal that at 8 a.m., there are unwanted pregnant women waiting for abortion about 10 people. Most of them are female adolescents (Witsarutratar, 2000: Conference paper).

In general, accurate reporting is discouraged by the sensitive nature of issue: the report tends to produce gross underestimates, and underreporting constitutes a major problem. Moreover, owing to the growing HIV epidemic in Thai youth, most research regarding sexual health has focused on male adolescents within the context of STDs and HIV infection rather than female adolescents regarding unwanted pregnancy. As a result, many aspects of adolescent girls' sexual behavior, and why they are having unsafe sex, are still under explored.

The most important obstacle to sexual well being among Thai female adolescents is gender inequality in Thai society. In the European countries where are cited free sex territory found that adolescent pregnancy, abortion, and STDs rates in the Netherlands, France, and Germany are lower than rates in the others. According to the result of Advocates for Youth research in USA found that social openness, convenience, and revelation on sexuality lead adolescents to have access to reproductive health information and service. Moreover, they could understand their sexuality; they have confidence to have satisfactoral sexual activity, and they have practical norm that safe or no sex.

On the contrary, Thai society, which is powerfully held on double standard, provides more liberty about sexuality in male than female. Because male never receives instruction to have sexual responsibilities, they grow up with no attend to use contraception and protect STDs. While, females need contraceptive information and services, they have little chance to access data resource. As social norms expect that females should be virgin and innocent, they should not openly talk and express about sexuality. Although they need information, they could not ask anyone because they fear to be condemned. In particular, female adolescents who engage in premarital sexual intercourse are unacceptable. They are blamed that inappropriate performance, without abstinence, and indulgence. As a result, when female adolescents who enter into premarital sexual intercourse have to experience with sexual health problem, they could not consult anyone, nor could they access into reproductive health services. Most of female adolescents have to seek sexual information and problem solving by themselves that lead to many sexual health problems.

Much of previous research had concentrated on sexual behavior at the level of the individual by quantitative methodology, generally based on the KAP model of sexual behavior, for test hypothesis, while neglecting societal, normative and cultural contexts. Focusing on the individual-level assumes that sexual behavior is the result of rational decision-making based on knowledge. Information gleaned from KAP surveys does not enable developers of intervention programs to consider the contexts in which knowledge is gained and sexuality negotiated, therefore giving only a partial picture of the complex factors shaping sexuality. There are many studies found that only knowledge could not alter or prevent unsafe sexual behaviors. The result found

that although most of teenagers had better of knowledge that condom was high efficiency to protect pregnancy and STDs, the practice was still inconsistent (Kanatho, 1998: 110; Koniak-Griffin & Brecht, 1995 cited by Taylor-Seehafer & Rew, 2000: 19; Keller et al., 1996:125; Fakhruddin, K., 2001: IV; Isarabhakdi, P., 2000: vii). According to the studies about contraceptive acceptance among adolescents found that adolescents who had sexual experience accepted contraception only in idea but declined to practice (Chaiyapak, 1987: 68-70; Bebena, P.R., 1998: 45; Isarabhakdi, P., 2000: 96). In reality, sexual behavior is too complex a phenomenon to be conceptualized in terms of decontextualised and quantifiable individual behaviors. The use of quantitative methods provides answers limited to whether rather than promoting an understanding of why. In addition, quantitative methods do not allow researcher to consider the processes but rather limit them to the final outcome. Moreover, most sexuality research have focused on male adolescents rather than female adolescents, so the context of research concerned safe sex from the infection aspect rather than safe sex regarding unwanted pregnancy and other reproductive health (Havanon, 2000: 88).

The objectives provided by Healthy People 2010 (2002) target disparities relating to improving reproductive health through family planning and promoting responsible sexual behavior. To enable adolescents with good sexual health and live happily in society, nurse, as a key health professional, is an important person to encourage female adolescents to increase their safer sex behaviors and have better sexual health. From all of the above, this study was undertaken to listen to the voices of girls in order to develop an intervention program relevant to their lives.

Statement of the problem

What are sexual experiences among in-school female adolescents in Amphoe Muang Chiang Mai Province?

Purpose of the study

General Purpose

To gain knowledge and understanding of sexual experiences among in-school female adolescents in Amphoe Muang Chiang Mai Province.

Specific Purpose

1. To gain understanding of sexual meaning and sexual behaviors among in-school female adolescents.
2. To explore perceptions of in-school female adolescents relating to safe and unsafe sexual behaviors.
3. To identify risky sexual behavior among in-school female adolescents.
4. To identify patterns of reproductive health services appropriated for in-school female adolescents.

Scope of the study

This study focus on studying heterosexual experience, sexual health, and factors influencing safe/unsafe sexual behavior among female adolescents between the ages of 15 and 18, who attending school within Amphoe Muang, Chiang Mai Province.

Expected outcomes and benefits

1. The study could be used as a guideline for nursing performance by considering the research result, and the concerns of personal factors and environment context to promote female adolescents to have an appropriate way to increase their safer sex behaviors and have better sexual health.
2. The results of this study will be useful for other health professionals who working with adolescents (e.g. policy-makers, social workers, doctor, community leaders, etc.) to serve as a resource in the development and implementation of programs designed to prevent adolescent pregnancy, STDs contacting, including AIDS that are efficacious and appropriate with requirement of female adolescents.
3. The results of this study could be used as the profile for continuous research regarding sexuality among female adolescents.

CHAPTER II

LITERATURE REVIEW

This study aims to understand sexual experiences affecting sexual health among female adolescents. The relevant literatures are reviewed in this chapter as follows:

- Concept and theories concerning adolescent,
- Concept and theories concerning sexuality,
- Literature related sexual experience among female adolescents.

1. Concept and theories concerning adolescent

Adolescence is derived from a Latin word “Adolescere”, meaning grow into maturity. The World Health Organization defines the adolescence in 3 distinct characteristics (Jensen & Bobak, 1985: 1150) namely:

1. Physical development starting from change of the reproductive organs to complete maturity.
2. Psychological development starting from the childhood to adulthood.
3. Social and economic changes especially from family-dependent to the self-dependent by seeking employment of one's own.

It is difficult to set a definite age of adolescence since the development of human body is a continuing process with no distinct interruption. However, the average age of adolescence extends from 13 to 21 years for girls and 14 to 21 years for boys (Hurrocks, 1995: 2). The ending of adolescence is less clear and may extend well beyond the legal age of 21 years (Felice, in Levine, et al.,Eds., 1992: 65).

Adolescence is characterized by the onset of the physical changes of puberty and by the psychosocial development of the ego, which helps the individual achieve a sense of self (Bobak, Loweermilk, Jensen, & Ferry, 1995: 723). Adolescence has been

described as a critical developmental period in the life cycle. With major changes occurring in biological, cognitive, psychological, social and environmental processes, exploratory behavior and experimentation with a wide range of behaviors is essential for normal adolescent development (DiClemente, Hansen & Ponton, 1996: 1; Klima, 1998: 485).

The period of adolescence could be classified into three different phases of development: early (13 to 15 years), middle (15 to 18 years), and late (18 to 21 years). These age ranges are arbitrary and approximate and can overlap or vary within different cultures (Levine, et al., 1992: 65).

Adolescents' psychosocial development occurs in an asynchronous style and creates an abundance of self-concerns. With that in mind, three phases of adolescent psychosocial development have been articulated by Neinstein (1996: 40-45) and serve as a practical guide for the nurse. These phases are described with the understanding that adolescents are not a homogeneous group and have individual responses to the demands and choices presented to them. Further integral to the psychosocial development is adolescent sexual preference development.

Erikson (1950, 1968 cited in Berk, 2001: 390) termed the maturational crisis of adolescence the need to resolve the issue of *identity versus identity confusion*. During this fifth stage of psychosocial development Erikson believed that adolescents must successfully develop a clear concept of their identity. They must also begin to consider what role they will eventually take in our society.

This decision-making process is shaped by both parental and peers group expectations. Identity is also influenced by the cultural values of his the adolescent's peer group world. Peer group values may be the most powerful motivator.

Psychosexual developmental stages

The psychosexual developmental stages of adolescence occur along a time continuum which is divided into three stages: early, middle, and late adolescence.

Early adolescence

Early adolescence is characterized by concern about physical changes. Ambivalence regarding independence versus protection from parents and from other

adults in authority is also common. Early adolescence is also characterized by egocentricity, the belief that the needs of the individual exist before those of anyone else.

Finally, during this early stage adolescents need to begin a dramatic separation from their family of origin and develop a unique, independent sense of identity. Some developmental theorists have defined this period of time as the second separation from parents.

During this time, adolescents also begin to challenge not only their own beliefs but most of their parents' beliefs as well. Therefore this can be a time torn with strife. There is frequent unease and conflict between adolescents and their parents as separation is negotiated. No longer is the child's world a safe haven, and no longer are the parents the unchallenged authorities. The adolescent frequently perceives even trivial issues as catastrophic.

Middle adolescence

The most significant concern at this stage is the need for peer approval. Frequently, there is a desire to separate from old friends and create a set of new peer group friends who share the same values and attitudes. Choosing new friends may sometimes be confusing because adolescents may still be struggling with their own emerging values.

Peer group behavior also strongly encourages or discourages sexual activity. Like younger adolescents, adolescents who have sexual intercourse at this age frequently do so to prove themselves and/or to feel loved and accepted. Rarely during this developmental stage are concerns regarding commitment, preferences about sexual pleasuring, or even contraception discussed prior to sexual intercourse. Teenagers are not typically comfortable discussing sexuality with anyone, especially their parents.

Late adolescence

It is assumed that at this stage of life the teenager had become more cognitively mature, and for the majority of teenagers this may well be true. The development of healthy intimacy and the need for and experience of long-term

relationships may occur. The presence of a strong moral and value system should have also developed. Further exploration regarding sexual identity and orientation may still be occurring.

These characteristics lead them have no abstinence, have permissiveness, and finally engage into premarital sexual activity (Neinstein, 1996: 662; May & Mahlmeister, 1994: 200). Moreover, today more young women are attending school and delaying marriage than ever before. With marriage postponed, they are exposed to the risks of premarital intercourse for longer periods of time, thereby, at greater risk of unintended pregnancies, induced abortions, and STDs.

2. Concept and theories concerning sexuality

The term 'sexuality' refers to sexual behavior, attitudes and preferences. Zeidenstein & Moore (1996:1) refer to sexuality as 'a social construction of a biological drive', incorporating elements of biology, gender and power relations.

Sexuality is an integrated, unique expression of self that includes physiological and psychological processes inherent in sexual development that encompasses a view of self as a female and presentation of self as a woman, sexual desire, sexual response, and sexual orientation (Bobak, et al. 1995: 725; Zawid, 1994: 4). Furthermore, sexuality is a basic part of a woman's life and an important aspect of her health throughout her life. Few women are alive for whom sex has not been important at some time in their lives. Through her sexuality a woman expresses her identity and her need for emotional and physical closeness with others. Women express their sexuality differently at different times-alone, with one partner, or with many-and no two women express sexuality in exactly the same way. Expressed positively, sexuality can bring much pleasure, but sexuality also has the potential to cause great pain. Sexuality is not limited by age, attractiveness, partner availability or participation, or sexual orientation.

In support of this, Sexuality is defined by WHO as a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors,

practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. (WHO, 2000)

Understanding sexuality among female adolescents has to consider to sexual activity that not only safe from STDs and AIDS but also sexual rights and sexual pleasure.

Sexual health is defined by WHO (2002) as a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health,

the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections.

Components of sexuality

The unique human quality that is sexuality has several dimensions, including sexual desire, sexual identity, and presentation of self. Sexuality includes more than heterosexual intercourse and involves a wide range of behaviors, including fantasy, self-stimulation, noncoital pleasuring, erotic stimuli other than touch, communication about needs and desires, and the ability to define what is wanted and pleasurable in a relationship.

Dixon-Mueller (1993: 273) stated that sexuality has different meanings for different people in different contexts. Sexual behavior consists of actions that are empirically observable: what people do sexually with others or with themselves, how they present themselves sexually, how they talk and act. In contrast, sexuality is a more comprehensive concept that encompasses the physical capacity for sexual arousal and pleasure as well as personalized and shared social meanings attached both to sexual behavior and the formation of sexual and gender identities. Dixon-Mueller identified four dimensions of sexuality that are relevant to sexual and reproductive health. (See figure 1)

Sexual partnerships

The first element of the sexuality addresses the number of each person's sexual partners, current and past; the timing and duration of sexual partnerships throughout the person's lifetime; the identity of partners (socioeconomic characteristics, relationship); the conditions of choice under which each partner is selected or imposed; and the rate and conditions of change of partners.

Sexual acts

The second element of the sexuality encompasses the nature, frequency, and conditions of choice of specific sexual practices in which individuals and couples engage. Focusing on reproduction, the conventional demographic literature makes the

simplistic assumption that sex consists of voluntary heterosexual intercourse with vaginal penetration and ejaculation.

Sexual meanings

The social construction of sexuality refers to the process by which sexual thoughts, behaviors, and conditions are interpreted and ascribed cultural meaning. This third element incorporates collective and individual beliefs about the nature of the body; about what is considered erotic or offensive; and about what and with whom it is appropriate or inappropriate for men and women (according to their age and other characteristics) to do or to talk about sexually.

Sexual drives and enjoyment

This element includes women's and men's knowledge of the body's sexual and reproductive capacities and the ability to obtain physical and emotional pleasure from fantasy, sexual encounters, or self-stimulation.

3. Literature related sexual experience among female adolescents

As adolescents develop a capacity for sexual intimacy, sexual curiosity and experimentation are common. Today adolescents are more sexually active than ever before and at an earlier age. Adolescents often face peer pressure to be sexually active; and additional motivation for sexual activity for girls may be a desire for sexual intimacy rather than a wish for the physical act of intercourse. Risks associated with early sexual activity are increased risk for contracting sexually transmitted infections, including human immunodeficiency virus, and unintended pregnancies.

Attitude towards premarital sexual intercourse

Recently, western value about free sex rapidly spread into Thai society (Khamkayan, 2000: 3). As a result, Thai female and male in various ages begin to have attitude and value about premarital sexual intercourse that it is normal and not suffer to their life style. A survey of ABC-KSC Internet Poll Research Center (Mimeographed) revealed that majority of male adolescents have attitude agreeing to premarital sex with their girlfriends/lovers. According to pilot study of

Poosanasuwansri (1997: 5-6) has found that most of adolescents had attitude to premarital sexual intercourse that it was preparation for male and female before marriage.

Experience of premarital sexual intercourse

The modern tradition about premarital sexual intercourse is increasingly accepted among adolescents. This tradition causes adolescent early enters into first sexual intercourse. The findings of research found that both male and female adolescents had early first sexual intercourse at 15-17 years of age by average (Durex Global Sex Survey, 1999; Serintawatana & Komphayak, 1999; Chuprapawon, 2000; Sethaput, 2000). In female adolescents, the study has revealed that 50 per cent of urban female adolescent had experience of premarital sexual intercourse (Chuprapawon, 2000). The most of female college students in rural began to have first sexual intercourse on the average 17 year-old while the most of female college students in Bangkok began to have first sexual intercourse on the average 15 year-old (Maungsom, 2000: 29). According to the study about sexual behavior among single female youth in belonged to out-school educational center in Audornthanee found that 21% of female students had ever had sexual experience (Siriwattanakan, 1998: abstract).

Moreover, in 10 years period ago Thai men turning to have first sex with girlfriend or casual sexual partner more than commercial sex workers (Boonmongkon et al., 2000: 23; ABAC-KSC Internet Technology and Training Institute, Mimeographed; Ngamprapasom, 2001: abstract).

Experience of having several partners

The tradition of having several partners is still spreading among adolescents. The recent survey found that 34% of global adolescents having more than one sexual partner at the same time; Thai adolescents had the most unfaithful statistic, which was 52%, in the world (Durex Global Sex Survey, 1999). The study of Pimpawan Boonmongkon (1998: 54-55) found that sexual behavior patterns among adolescents were multiple partners on short duration. According to the study about sexual behavior among single female youth in belonged to out-school educational center in

Audornthanee found that most of female students having sexual experience had 1-2 partners (Siriwattanakan, 1998: abstract).

Contraceptive practice

The study of Amara Soonthorndhada (1996: abstract) about safer sex behavior among 15 sexually active female adolescents found that there were only 6 cases used contraception and 9 cases did not use any contraception. In non-use contraception cases resulted from they lacked knowledge about contraceptive method and feared side effects of contraceptive use. According to the study about sexual behavior and contraceptive use among female adolescents of Niramon Maungsom (2000: 119-121) found that an amount of in-school and out-school female adolescents did not use any modern contraception. When they missed their menstrual period, they drank a menstruation regulation drug to release their menstruation. Female adolescents who did not use any contraception would negotiate their partners to use condom and withdrawal method. In particular, withdrawal method was widespread method among adolescents because male did not use condom and female did not use any contraception. Moreover, the study of Boonmongkon, et al. (2000: 26) confirmed these risky sexual behaviors. They found that some girls did not choose to use any contraceptive method and some chose to use other methods such as the withdrawal method.

Prevention of sexually transmitted diseases (STDs)

The studies about sexual behavior among female adolescents found that they had sexual behavior patterns that increased the risk of contacting to STDs, including AIDS. These studies confirmed that sexual intercourse among adolescents was often non-use condom especially with their lovers. There were only 4 % of female adolescents who worked in factory used condom with their boyfriends (The Population council, 1995: VI). According, the study of Boonmongkol, et al. (2000: 28) found that the majority of male adolescents had sex with their girlfriends without using condom. Similarly, the study of Niramon Maungsom (2000: 179) found that female adolescents had chance to contact STDs because of their risky sexual

behaviors. These could be arranged in order of frequency that were non-use and inconsistent use of condoms.

Factors affecting premarital sexual intercourse among female adolescents

Today, it is relatively clear about factors relating premarital sexual intercourse. Many studies describe various related factors that induce sexual intercourse among adolescents. For example, Orapan Thongthang (1993 cited by Diloksambandh, 1996: 26) indicates that early or unintended sexual intercourse among adolescents resulted from immature emotion more than moral reasoning. Although female adolescents may know what right and wrong are, they are pressured from 3 influencing factors: biological, psychological, and sociological factors. According to Manop Kanato (1998:107-111) mentioning 4 factors affecting sexual intercourse among adolescents: personality, identity, social network, and situation factors. From literature review, I consider to 2 major factors affecting sexual intercourse among adolescents, which are individual and environmental factors.

Individual factors include developmental and personal factors. Developmental factors such as biologic changes, cognitive processes, and emotional/psychological growth play a significant role in early sexual intercourse among adolescent. Biological changes of adolescent result from sex hormone. As a result, it induces adolescents to have natural sex drive and interest opposite sex. Early pubertal development is associated with an increased likelihood for early sexual debut and early experimentation with sexual behavior. Of note, age at menarche has decreased this century; it has been identified as a factor related to early initiation of sexual intercourse (Schulenberg, Maggs & Hurrelmann, 1997: 198).

Cognitive processes has changed, Dixon-Mueller's sexuality concept stated that sexual meanings are perceptive process on sexuality. Sexual behaviors and factors are contributed or assigned by social norms, and interpreted by various culture of each region (Vance, 1991 cited in Dixon-Mueller, 1993). Sexual meaning is personal belief about their own biological and erotic such as attitude about sexual intercourse is expression of masculinity and femininity; include how they perceive the meaning of sexual activity. Sexual meanings may be more complicated in intended sexual intercourse or sexual intercourse without love.

Emotional growth processes include psychological motivations which are basic characteristics of adolescents are curious, pleasurable, impatient, and conspicuous; moreover, they want to learn or try a new thing. The consequent of these is adolescents have basic instinct to experiment new thing or copy traditional performance especially sex curious which lead to require to try sexual intercourse and finally enter into sexual intercourse (Suporn, 1993:276). The study of Tungkulboriboon et al. (1999: 42) found that sexual behavior of collage and high school students in Khonkaen province resulted from poppy love and closeness that conducted adolescents made decision to engage in sexual intercourse without awareness of the consequent.

However, only personal factors could not describe all of origin of sexual intercourse among female adolescents, so we have to consider environment contexts that surround, induce, and persuade female adolescents engage in sexual intercourse.

Social network especially peers that have more influence to thinking and acting of adolescents because they will often copy tradition and norm of peers. Peers influences have 2 dimensions that are informational and normative influences. Informational influence means peers have duty like data resource about performance guide, attitude, and consequences of actions for members. Normative influence means peers have attempted to pressure members to performance as group norm. There are 2 associated process of peers influence include social comparison and conformity especially adolescent norm about sexual intercourse.

Recently, western value about free sex rapidly spread into Thai society (Khamkayan, 2000: 3). As a result, Thai female and male in various ages begin to have attitude and value about premarital sexual intercourse that it is normal and not suffer to their life style, so they tend to enter into sexual intercourse as group norm. According to pilot study of Poosanasuwansri (1997: 5-6) found that most of adolescents had attitude to premarital sexual intercourse that it was good to prepare for male and female before marriage and male adolescents agreed with premarital sexual intercourse of peers. Including, the study of Nuchanat (1988: abstract) found that sexual intercourse of closed friend statistically associated with sexual experience of adolescents. Moreover, the study of Dusex (1987: 287 cited in Diloksamandh, 1995: 27) indicated that informational acquirement from friends would often make female

adolescents received incorrect knowledge and wrongly attitude such as decrease virgin value, sexual relationship indicate to autonomy and modernizes. These attitudes led to careless behaviors, sexual contact, and lately engaged into sexual intercourse.

Additionally, environment that surrounds adolescence in recent conducts they engage into situations that reinforce to sexual intercourse. There are many risky situations that led female adolescents to do risk behavior and easily enter into sexual intercourse in the end. These situations are alcohol and/or drugs consumption and intimacy. Alcohol and/or drugs consumption make adolescence unconscious, uncontrolled, and soon engage in unintended sexual intercourse. Intimate situations such as stay with boyfriend in private place, alone going out with boyfriend, and having party without supervision by adult induce adolescents have chance to intimate together, and engage into unintended sexual intercourse from their uncontrolled sexual desire. Some female adolescents may be forced by their partners and friends to have sex. The first sexual experience is often happened at the home of partner. The study of Poosanasuwansri (1997: 5) confirmed that first premarital sexual intercourse of female adolescents was unexpected. It resulted from date with boyfriend at amusing or entertaining place and drink.

Although existed studies have describe relatively clear regarding factors affecting premarital sexual intercourse but these results are summarize both male and female adolescents. Only few studies emphasizing to female adolescents. Despite the fact that, male and female adolescents are different both in cognition issue and expectation from social norms.

Sexual meanings of female adolescents may be difference from majority social norms. Adolescents may perceive that sexual intercourse is intimate relationship, love, trust, admiration, and seeking sexual experience (Diloksambandh, 1995: 136; Khamkhayan, 2000: abstract; Muangsom, 2000: 98). Moreover, they may perceive that sex was sexual drive response, biological and psychic pleasure, enjoyment, improvement their sexual ability, preparation before enter into marriage and binding by love (Wasikasin & Earmpradit, 1994: 27).

Generally, most of female adolescents perceive that sexual relationship is unconditioned love. When they love they will be trust and accordance because they

perceive that having sex with their lovers is expression of true love. If they are stimulated sexual emotion, they are willing to have sex, so love is often associated with sexual drive (Nyanzi, et al., 2001). According to the pilot study by focus group discussion with female students found that they had attitude that love was sacrifice both body and mind for their lover, and they agree with lost of virgin to prove their true love. While some of them perceived that sexual relationship was exchange, they might enter into sexual intercourse for things, money, and even for change with longer relationship with their partner (Poosanasuwansri, 1997: 5-6).

Factors affecting safe or unsafe sexual behaviors among female adolescents

The concept of personal factors affecting sexual behaviors

Personal factors of female adolescents such as cognitive processes, and emotional/psychological growth play a significant role in decision-making on use of contraception and condoms. These factors are the ability to reason abstractly, to foresee consequences of actions, and to understand the social context of behaviors. An adolescent's degree of cognitive maturity may place limits on her ability to plan for sexual relationships, clearly articulate personal values, negotiate with a partner, and obtain contraception and condoms. Personal factors that contribute to safer sex behavior or risky sexual behavior in female adolescents include sexual knowledge, perceived self-efficacy, perceived self-esteem, perceived risk opportunity to STDs and unintended pregnancy, attitude about contraceptive and condom use and communication skills.

Sexual knowledge

Knowledge about safe sex behaviors among female adolescents contributes understanding and participation to enter into that behavior. Generally, how people will participate and perform into any healthy behaviors is up to how much knowledge and understanding they have. According to Becker, et al. (1974: 29-30) stated if people do not have knowledge about that disease, they will not seek for self-care, prevention, or healthy examination because they lack healthy attraction. As researches found that sex education made adolescents increase knowledge about sexuality, have positive attitude about sexuality and contraceptive and condom use, and intend to use contraception in

the future (Visser&Van, 1994 cited in Shuaytong, et al., 1998: 331). Similarly, the outcome evaluation of providing sex education for male and female adolescents showed that although it could not be decreased sexual intercourse but it could be delayed onset of first sexual intercourse, and encouraged to safer sex. These results led to decrease intended pregnancy rate and contacting STDs rate (The Annie E. Casey Foundation, 2000). Especially in Thailand many researches tend to study about linkage of the knowledge and contraceptive use. These include condom and knowledge of reproductive health, STDs and AIDS (Soonthaorndhada. (1996: abstract; Pattaravanich, 1996: 26; Limsumphan, 1997: 161,163; Pinyapong, 2001: conference proceeding). The results of finding showed that adolescents and young adult have limited knowledge about reproductive health, STDs and AIDS. Many adolescents get incredible amounts of misinformation from friends and the media. They are very misinformed about safer sex and what puts them at risk for pregnancy and STDs, including AIDS. They tend to discount a lot of risky behaviors.

Self-esteem

Self-esteem's basic concept mentions that everybody even need love, admiration, and acknowledgement from the others. Self-esteem is very advantage to the development of cognition, emotion, and practice. People with high level of self-esteem will perceive on self-worth, self-respect, and self-love. Moreover, people will meet true happiness if they get acknowledgement, admiration, and worth from the others (Amattayakul, 1991: 18-21). Self-esteem is important to the development of a healthy sense of one's sexuality and may effect safer sex practices especially female adolescents who have to face many risky stimulators which lead to sexual problems such as unintended pregnancy, contacting of STDs. Female adolescents with higher levels of self-esteem may be better able to resist pressures to engage in risky sexual behavior than those with lower self-esteem. They are not afraid to ask any guy to use protection because they feel they are worth too much to be risking their life over some guy who's too childish to take precautions (Yawn ,1993 :40 ; Felton, 1996 : 227 ; Gillmore et al., 1992 cited by Taylor-Seehafer & Rew , 2000 : 20; K. Choi, et al., 2000). Self-esteem and self-worth also may play a mediating role in use of social support and helping resources by female adolescent. Contrary, female adolescents with

self-worthlessness may be lost self-confidence led to pointless life process, worthless performance (i.e. sexual promiscuity), and lately contacting of STDs or AIDS (Diloksambandh, 1995).

Perceived self-efficacy to enter into safe sex behaviors

Self-efficacy is one of the most important aspect in behavior-specific cognition that contributes to health promoting behavior (Pender, 1996 : 65). Perceived self-efficacy influences the decision of persons to change their behaviors. This is claimed by Pender as the judgement of individual ability and leads to practicing activities, regardless of whether the individual has the skill in practicing activities. Similar to Bandura's social cognitive theory (Bandura, 1997: 11) who stated that it is a judgement of one's capability to accomplish a certain level of performance. A person who has the perceived self-efficacy will be determined to perform that activity. Conversely, a person with low perceived self-efficacy would sure not be determined to perform that activity (Bandura, 1997: 20). It is the linkage between knowledge and action because knowledge alone can not guarantee an individual's behavioral changing. Sieving and colleagues (1997) found self-efficacy for condom use the strongest predictor of change in sexual risk behavior for female adolescents. Perceived self-efficacy in female adolescents is major factor led to condom and contraceptive use decision-making and negotiation with partner (Beitz, 1998:29; Taylor-Seehafer & Rew, 2000:19). In Thailand, the study of Pudsadee Tiumtud (1992: 113) found that factor that could be classified safer sex behaviors was perception in self-efficacy. According to researches found that perceived self-efficacy in protection risky sexual behaviors from STDs influenced the intention of persons to change their risky sexual behaviors (Chirakulpatana, 1993: 61; Diloksambandh, 1995: 134).

Perceived risk opportunity to STDs and unintended pregnancy

Becker's health belief concept (Becker, 1974) stated that it is the belief that directly effect to performance according to healthy advice both healthiness and illness. People who perceive susceptibility to disease will be determined to perform preventable activity. Female adolescents who have perceived susceptibility to STDs, AIDS, and pregnancy seem to increase safer sex practice. Contrary, female

adolescents who have perceived that their sexual behaviors insusceptibility to STDs, AIDS, and pregnancy seem to increase unsafe sex practice (DiClemente, 1990; Cerwonka, et al., 2000; Hutchinson, 1999: 65; Parsons, et al., 2000). In Thailand, the studies about perceived risk opportunity to STDs and unintended pregnancy in adolescents found that most of adolescents perceived that diseases were yet far away from them even though they still performed risky sexual behaviors. Although, they had knowledge and understanding how contracting of STDs or AIDS but denied to do that because they believed that diseases could not be contacted to them and they might not be in risky group (Kanoengsaksem, 1993: abstract; Seangkrachang, 1995: 89; Kanato, 1998: 110). According to the study about factors relate to risky sexual behavior among adolescents of Boonmongkon, et al. (1998: 55) indicated that the cause of non-use condom was lack of perceived risk opportunity to AIDS of partners. Moreover, the study of Pattaravanich (1998: 62) by in-depth interview a sexually active teen who doesn't use any contraceptives found that reason of having unsafe sex was she believed that she could not be gotten pregnant from withdrawal ejection of her partner.

Attitude about contraceptive and condom use

Attitude about contraceptive and condom use is one of factors that influenced to sexual behavior because attitude is personal belief and feeling for anything that results from learning and experience. It stimulates person to practice or tends to response to stimulator in any way (Ajzen, 1988: 117). Adolescents who have positive attitude to condom use appear to promote their consistent use (Catania, et al, 1992). Murphy (1998) found that having a positive attitude about condom correlated with their consistent use. Additionally, having a positive attitude of partner about safer sex practice seems to decrease high-risk sexual behavior. Contrary, adolescents who have negative attitude to condom use tend to deny condom use. Studies of Ford & Kittisuksathit (1996: 28) and Fakhruddin (2001: 69) about attitude to condom and contraceptive use among adolescents found that male adolescents thought to use condom with prostitute but did not use condom with their girlfriends. Contraceptive use was responsibility of female. While general female adolescents were afraid to seek information about birth control and thought that condom was symbol of bad women.

These made female adolescents afraid to ask their partners or boyfriends to use condom because they might be condemned that “bad women”. According to the results of studies about condom use among adolescents found that major reason why they did not use condom was they had negative attitude about condom use. They thought that condom use was not appropriate for loving relationship because it indicated to mistrust and lost of closeness together. Moreover, they thought that condom use made them lose the feeling during sex (Boonmongkon, et al., 1998: 55; Katianurug, 1992: 62).

Communication skill

Communication practices are also an important behavioral factor in the reduction of risky sexual behavior. Inability to negotiate with a partner is and impediment to the adoption of safer sex practices. Female adolescents who are able to talk with their partner about aspects of STDs risk before having intercourse or without having intercourse, are significantly less likely to engage in high-risk sexual behavior (Diiorio, et al., 2000 ; Siering et al., 1997 cited by Taylor-Seehafer & Rew ,2000 : 20). In Thailand, gender role directly effects to ability to communicate with partner. Thai women are expected from social to be passive so they are not comfortable enough to talk about sex and contraceptive and condom use with their partner .The study of Umaporn Pattaravanich (1995: VIII) found that female adolescents tended to negotiate to have sex with partners but negotiation to use condom were relatively little that led to increase of having sex without condom use. According to the study about reason of inconsistent use of condoms and other barrier contraception among Thai adolescents is loss of communication with partner about pregnancy, STDs, and AIDS risk (Boonmongkon, 1998: 55).

Much of previous research has concentrated on the phenomenon of sexual behavior at the level of the individual, the dominance of survey approaches, and generally based on the KAP model of sexual behavior. Therefore giving only a partial picture of the complex factors shaping safe or unsafe sexual behaviors. Focusing on the individual-level assumes that sexual behavior is the result of rational decision-making based on knowledge. Surprisingly, there are the amounts of adolescents who know about contraception, but still do not use any during sexual activity. This result

showed that only knowledge might not be sufficient to alter or prevent unsafe sex behaviors. Adolescents and young adults with high levels of knowledge about STDs (AIDS in particular) continue to practice unsafe sex. Many researches indicates that there was little connection between knowledge of HIV/AIDS and self-protective sexual behavior (Bebena, 1998: 11-12; Beitz, 1998 :29; Keller, 1996 : 125 ; Koniak-Griffin & Brecht,1995 cited by Taylor-Seehafer&Rew, 2000: 19; Sriboonruong: abstract). However, it is one of the links in the chain of events that results in behavior change. Adolescents as a group appear to be inconsistent in effectively processing risk information into behavioral modification of their sexual activities.

Many researchers who attempted to describe the phenomenon of safer sex behavior found that only personal factors affected decision-making of female adolescents to have safer sex were insufficiency to describe all of the phenomenon of sexual behavior. In reality, sexuality is too complex a phenomenon to be conceptualised in terms of decontextualised and quantifiable individual behavior because some female adolescents may be engaged into sexual intercourse without preparation, reasoning in decision-making, and negotiation about pregnancy and STDs prevention. By the same token, they use feeling associated with sexual behavior more than reason. Rarely has research targeted the broader context of sexual behavior that are societal, normative, and cultural context. Moreover, in many studies, researchers develop a conceptual framework, and then analyze qualitative data according to the categories in the framework, rather than deriving the categories inductively from the data.

Parker, et al. (1991: 77-78) stated that understanding on sexuality involve contracting of STDs or not had to make sense to personal practice rather than to measure the frequency of sexual intercourse. It should be also considered social, cultural, economical, and political factors, which associated with sexual experience. These factors assisted to better understand to the phenomena of problem about sexual experience. Thus, this study attempts to understand sexual behaviors affecting reproductive health in holistic view both in the individual-level and broader contexts that effect to sexual behavior among female adolescents.

Socio-cultural context

Cultural norms in regard to gender roles are important in shaping sexual patterns. In general, “gender” refers to the expectations and norms shared within a society about appropriate male and female behavior, characteristics, and roles. Each society may differently regulate gender role of male and female. Attitude, belief, and practice of people in each society associate with gender role perception constructed from culture of each society. Social inequalities between the sexes serve as one of the most important bases for power differentials in the sexual lives of women and men. The effects of gender power on the sexuality of women and men are reflected in the control of women’s sexuality.

In Thai society, Cultural norms based on gender inequality in sexual relations expect that women have to be inexperienced and naïve in sexual matters, and to see themselves as passive receptacles of men’s sexual passions, while males are nurtured to have higher status and sexual power than females. A double standard based on the assumption that males have a greater desire and need more sexual activity than females do causes most women to internalize their passive and non-initiative taking role. “Good” women should suppress their sexual feelings and reactions, not display sexual pleasure or sexual desire, so they won’t be accused of being like a prostitute who has sexual skills (Fongkaew, 1996: 5; Yoddumnern-Atting, 2001: 16). These clearly reflect to sexual performance, negotiable power, responsibility and non-responsibility to the consequence of sexual act, use and non-use contraception, and protection themselves and their partners from STDs (Gray & Punpuing, 1999 cited in Yoddumnern-Atting, 2001: 11).

According to the studies found that society expected female should not reveal their sexual feeling, sexual activities, include sexual desire. Thus, It was very hard for female to talk for safer sexual intercourse. In addition, female were inappropriate to commence in condom use mention that indicated mistrust (Boonmongkon, et al., 1998: 55; Pattaravanitch, 1995: 3-4; Taylor-Seehafer & Rew, 2000: 18). Moreover, female may think about condom use that it is male task and shame for female to have knowledge and ability about condom use (Diloksamandh, 1995: 8).

Cultural norms are also important obstacle of female adolescents to access reproductive health services because they are afraid their premarital sexual intercourse

will be found out if they receive services and they may receive stigma as “bad female” from society. Moreover, the attitude of reproductive health providers will often evaluate females who have reproductive health problems as promiscuous women and they often think that these problems could not occur with good women. Above-mentioned causes effect to female adolescents who have exist less power to make self decision increase pressure to access correct information and reproductive health services. Lack of access and lack of information put them at risk for pregnancy and STDs, including AIDS.

Gender based power in sexual relationship

The context of relationship with partner should be also considered to gender-based power in sexual relationships. Under patriarchy social construction, male have much power in decision-making. Male are leaders of female in several dimensions, especially in sexual dimension. These result from gender role that is regulated by society. In general, “gender” refers to the expectations and norms shared within a society about appropriate male and female behavior, characteristics, and roles. In addition, gender role effects to male expression of power over female. Gender-based power inequities generally incorporate the belief that men should control women's sexuality. Gender-based power in sexual relationships is frequently unbalanced and those women usually have less power than men. Furthermore, these imbalances operate in the context of a nearly universal sexual double standard that gives men greater sexual freedom and rights of sexual self-determination than women enjoy (Blance, 2001: 190). Particularly in patriarchy society, without an equalization of power in their relationships with male partners, female adolescents are powerless to sexual negotiation. For example, in case of unintended and unsafe sexual intercourse, most of female are fear to say no with their partners and they have difficulty asking partners to use a condom (Taylor-Seehafer & Rew, 2000 : 18). In case of female who are brave to negotiate but this may not be success if lack of participation of male, include this may be cause of unsteady relationship.

Women's economic dependence on men reinforces their vulnerability to disease by increasing the likelihood that they will exchange sex for money or favors. Young women who have few alternatives for economic survival are likely to fear

abandonment and, therefore, will hesitate to leave a risky relationship. This situation will reduce their ability to negotiate condom use with their partners (Blanc, 2001: 199).

Sexual relationship

Generally, in recently society has 2 characteristics of sexual partnership are casual sexual partnership and continuous sexual partnership. According to the study about Thai adolescent sexuality and reproductive health found that sexual partnership for male adolescents could be divided into who types: short term relation and long term relation. For the short-term sexual relation, boys would have sex with girls for 1-2 times and then they quit the relationship. For the long-term sexual relationship, boys felt emotionally attached to the girls and many times planned to get married with girls. The duration of this type of relationship was more than six months (Boonmongkon, et al., 2000: 22). The result of this studies pointed that female adolescents who have stable, continuous, or long sexual partnership may have unsafe or unprotect sexual behaviors because they trust their partners and believe that their partners are safe from STDs. These reasons put them neglect to have safe sex. However, casual sexual partnership may be also obstacle to condom use especially in case of partners who were power in decision-making while they have sex, they may force to unprotect sexual behavior (Crosby, 2000; Kordoutis, et al., 2000; Narring, Wydler& Michaud, 2000).

Social network

Peers are one of the most critical of environmental forces that influence to health risky behavior of adolescents. Adolescents generally select their peers from common sociocultural and behavioral groups. Whereas peers are considered to have positive value with regard to adolescent socialization. Peers influence the likelihood of sexual experimentation and involvement with other problem behaviors. The study about condom use behavior among African-American youth found that peer's norm to condom use was good predictor to condom use (Jemmott & Jemmott, 1991). While female adolescents who were in peers who have sex without condom use tended to increase having unsafe sex as 3 times (Walter, et al., 1992).

Furthermore, peers may also influence to substance and alcohol abusive behaviors because of these behaviors are accepted among adolescents as one of social behaviors. Risky sexual behavior is more likely to occur when adolescents use alcohol and/or drugs. Especially, male adolescents will often use drugs and alcohol as method to seduce female adolescents for having sex. Recently, the prevalence rate for use of alcohol or drugs with sex has increased in female adolescents. Effects of drugs and alcohol let female adolescents lack of self control, lack of contemplation, and soon enter into unsafe sex, for example, having sex with multiple partners and neglect to use condom or any birth control (Brown, et al., 2000; Dolezal, 2000). Contrary, there are researchers mention that the substance by itself does not lead to safer or unsafe sex (Lauchli, et al., 1996; Prince & Bernard, 1998). These indicate that association between drugs or alcohol consumption and unsafe sex is yet very complex.

Sexual health among female adolescents

The recent studies in Thailand show that both male and female adolescents have sexual activity patterns. They have early first sexual intercourse at 15-17 years of age by average (Durex Global Sex Survey, 1999; Serintawatana & Komphayak, 1999; Chuprapawon, 2000; Sethaput, 2000). Moreover, with increasing awareness of HIV/AIDS in Thailand, most of boys turn to have first and regular sexual experience with girlfriends or normal girls instead of going to commercial sex workers (Boonmongkon et al., 2000: 23; ABAC-KSC Internet Technology and Training Institute, Mimeographed; Ngamprapasom, 2001: abstract). However, most of them ignore to use condom with their lovers and friends due to the belief that their partners are not risky. The condom is used with the prostituted women or partners in temporary sexual relationship (Thanapun et, al., 1993: abstract; Pinyapong, 2001: conference proceeding).

Changes in the sexual behavior of teenagers could have a significant impact on levels of adolescent pregnancy and transmission of STDs. For male, the use of condoms is viewed as only necessary for preventing STDs or HIV while the use of condom among female is necessary not only HIV/STDs prevention but also pregnant prevention. In addition, there exist no state-provided services and information on sexual health for female adolescents, in particular, and unmarried female adolescents,

in general. As a result, female adolescents ignored to use condom from their partners increase the risk of sexual health problems as follows:

Unwanted pregnancy

Consistent with the fact that, adolescents have more premarital sexual intercourse while there are not yet directly contraceptive services for them. As a result, it has possibility that they will more experience with unintended pregnancy. The report of Office of the Thai National Commission on Youth's affairs (1990: 83) indicates that 21.4% of 16-18 year-old female adolescents have ever been unintended pregnancy. Moreover, the information from Association for the promotion of the status of women (2000) reports that 3.37% of all unintended pregnancies in 1999 are younger than 18 years old.

Unsafe abortion

The mostly consequence of unwanted pregnancy among female adolescents is unsafe abortion. The study in female admitting in governmental and private hospitals to treat complications resulting from illegal abortion show that most of subjects (approximately 50%) are younger 20 year-old (Sethapongkul & Boonprasert, 1993; Koetsawang, 1993 cited in Havanon, 1996: 91). According to in 1999, a recent survey of abortive situation in Thailand shows that 30% of abortive patients are younger 20 year-old and 24.7% of them are student (Warakamin & Boonthai, 1999). Moreover, the study about Thai adolescents' sexual and reproductive health problems has found that some adolescents choose to abort the baby because their baby's father refuse to be responsible for marriage and they do not want to quit school or do not want their parents to know about their pregnancy. Quite a number of girls go for abortions at the private illegal clinics operated by Non-M.D (Boonmongkon, et al., 2000: 26; Pinyapong, 2001: conference proceeding).

From these situations, many girls are at risk of sepsis and death from unsafe abortion. High morbidity is connected with illegal abortions as most are performed unsafely and by unskilled persons. This is reflected in the increasing number of women who have become infertile after an induced abortion.

Serious consequences for the teen mother and child

In male adolescents not avoiding this problem, the most serious suffering that may be occurred is despair or despondency of their family and change of their future plan. On the contrary, female adolescents facing this problem, they have serious consequences for the teen mother and the child in general.

Teen pregnancy is bad for the mother in many dimensions. First, there are serious health risks for adolescents who have babies. Young adolescents (particularly those under age 15) experience a maternal death rate 2.5-3 times greater than that of mothers aged 20-24 (The National Campaign to Prevent Teen Pregnancy, 1997). Common medical problems among adolescent mothers include poor weight gain, preterm deliveries, pregnancy-induced hypertension, anemia, sexually transmitted diseases (STDs), and cephalopelvic disproportion (The National Campaign to Prevent Teen Pregnancy, 1997; Bobak, Lowdermilk & Jensen, 1995: 730; May & Mahlmeister, 1994: 202; Neinstein, 1996: 663; Sable & Wilkinson, 1998: 155-165). Second, they have difficulty fulfilling the important risk of parenting. Finally, future prospects for teenagers decline significantly if they have a baby. Teen mothers are less likely to complete school and more likely to be single parents. They may be lost educational and occupational opportunities. As a result, they are at high risk of poverty in adulthood. Some of them may move to other place for avoiding stigma from their relations and neighbors. Moreover, the most severity of some female adolescents not solving this problem is suicide (The Population Council, 1999: Mimeographed).

Teen pregnancy is bad for the child. Children born to teen mothers suffer from higher rates of low birth weight and related health problems. The proportion of babies with low birth weights born to teens is 28 percent higher than the proportion for mothers age 20-24.8 Low birth weight raises the probabilities of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, and cerebral palsy. In addition, low birth weight doubles the chances that a child will later be diagnosed as having dyslexia, hyperactivity, or another disability. Children of teens often have insufficient health care. Despite having more health problems than the children of older mothers, the children of teen mothers receive less medical care and treatment. Moreover, Children of teen mothers often receive inadequate parenting because their mothers — and often their fathers as well — are typically too young to

master the demanding job of being a parent and often fall victim to abuse and neglect (The National Campaign to Prevent Teen Pregnancy, 1997).

Sexually transmitted diseases (STDs)

The tradition of having several partners is still spreading among adolescents. This sexual behavior induces to the risk of contacting STDs and AIDS as the study regarding sexual behavior among single female youth in belonged to out-school educational center in Audornthanee has found that 21% of female students have ever had sexual experience. Most of them have 1-2 partners and 25.5% of them had ever been STDs (Siriwattanakan, 1998: abstract). Similarly, the study of Niramom Maungsom (2000: 179) found that female adolescents had chance to contact STDs because of their risky sexual behaviors. These could be arranged in order of frequency that were non-use and inconsistent use of condoms, to be rape by their partners, and having multiple partners.

Generally, all sexually active female adolescents are increased risk for STDs because of the presence during puberty of ectopy, a biologic cervical immaturity. Further, immune-protective factors of the cervical mucus do not fully develop in adolescent women until 2 to 3 years after menarche. STDs pathogens are more likely to grow in this environment than on the mature cervix of adult women. Risky sexual behavior in combination with the above developmental factors places adolescent women at great risk for STDs and HIV transmission (Cowan & Mindel, 1993 cited in Taylor-Seehafer & Rew, 2000: 16). According to STDs situation of Thailand reported that AIDS rate in 15-24 year-old female group was 22.13% of all age groups (Chuprapawon, 2000). As a result, although they are usually not fatal, STDs could lead to major pregnancy complications, secondary infertility and severe discomfort. Moreover, STDs have been identified as a predisposing factor in the transmission of HIV.

Female adolescents' sexuality in urban Northern Thai

Chiang Mai is principal province in North region of Thailand. This setting is central part of several developments both in education, public health, and

modernization. Moreover, it has modification of society, culture, and other environmental context that influence to life style of female adolescents.

Changes in social and economic structures have included the preferential recruitment of women, particularly young women who have completed the compulsory education of sixth grades have been forced to migrate or commute to urban centers in search of higher education. Young girls who went to study in the city on a daily basis, however, were even more liberated in engaging in premarital sex. The study of Fongkaew (1996: Conference proceeding) has reported that some young girls who study in the city institutions-including secondary and tertiary level are promiscuous because they are fascinated by the city lights and influenced by peer.

It is not uncommon today to find teenaged couples on motorcycles passing along the roads in the town. Moreover, most households own motorcycles and / or cars which provide adolescents more freedom to wander. In recent decades, lessening of maternal ancestral spirits has contributed to the emergence of multiple sexual patterns, or sexual and social liberation.

The pattern of sexual relations has changed from one in which they occurred as part of a process of marriage to one in which sex has become an aspect of individual pleasure and gratification. Sexual behavior has become more promiscuous. Premarital sexual relations have become the new norm of the community (Fongkaew, 1996: Conference proceeding). Similarly, the research in Chiang Mai province by Srisuda Phoka (1998: abstract) regarding sexual behavior of male students grades 10-12 attending four public schools in Muang District indicated that majority of them had first sexual intercourse at 15-17 years of age and had first sex with lovers or casual sexual partner. Other research concerning risk sexual behavior of Mathayom Suksa 5 students in Chiang Mai province (Intha, 1999: abstract) found that almost 5% of female students had ever had sexual intercourse. This study also found that a large majority of respondents, 75%, did not use any contraception. Their reasons included they were unprepared, unintended, and unexpected to have sex; they thought that only one time it did not matter; they chose to use withdrawal method and natural/safe period method. Moreover, concerning self-prevention to contact STDs found that only 25% of them use condom every time, 23.5% use only some time, and 51.5% never use condom. Their reasons regarding non-use condom were they were convinced that

their partners were safe from AIDS; they were uncomfortable or dare not to buy and carry condom.

Regarding commercial sex in Chiang Mai province, the study by Balzer & Sriensri (1996: conference proceeding) regarding the going-out lifestyle of the *wairoon cai taek* found that an amount of female adolescents made money by sleeping with men (the sale of sex) because they need money to by food and clothes, basically to pay the daily and monthly expenses.

Female adolescents' sexual health in Chiang Mai Province

In Chiang Mai province, adolescent girls' sexual activity is on the rise, and their unwanted pregnancies and illegal abortions constitute a major threat to their sexual and reproductive health. The study on unwanted pregnancy problem among adolescents in Chiang Mai province in 1999 found that an amount of adolescents have sexual intercourse without pregnancy and STDs prevention (Witsarutratara, 2000: Conference paper). According to the study of Fongkaew (1996: Conference proceeding) has reported that some of young girls who study in the city institutions-including secondary and tertiary level had to have abortions while they were in school. Some of them have to quit school of their unintended pregnancy. Furthermore, the study of Jeerapun Intha (1999), which collected data about risk behavior of Mathayom Suksa 5 students in Chiang Mai Province, found that almost 1 in 8 of sexually active female adolescents had ever had unwanted pregnancy and induced abortion are sought by them. Although abortion rate in Chiang Mai is not yet reported, it could be estimated from information of some clinics, which are abortive clinics, indicate that at 8 a.m., there are unwanted pregnant women wait for abortion about 10 people and most of them are female adolescents (Witsarutratara, 2000: Conference paper).

Owing to the growing HIV epidemic in Thai youth, most research regarding sexual health has focused on male adolescents within the context of STDs and HIV infection rather than female adolescents regarding unwanted pregnancy. Despite the fact that, sexual health problems happened in female adolescents include not only STDs and HIV/AIDS but also unwanted pregnancy. Since irresponsibleness of males

to protect their own partners, female adolescents have to face up to many sexual health problems both STDs, and HIV/AIDS, unwanted pregnancy, and serious consequences of unwanted pregnancy, such as, unsafe abortion, RTI (Reproductive tract infection), and serious consequences for the teen mother and child.

Recent years have seen growing recognition of the sexual health needs faced by young adults, particularly those who are unmarried. Globally, as the age of marriage rises, adolescents are more likely to experience pre-marital sexual activity, despite the fact that there are often strong taboos on such behavior. Sexually active adolescents, especially unmarried female, are also neglected. Many receive no reproductive health services until pregnancy or delivery, yet may be at risk of infection from their partners.

In general, accurate reporting is discouraged by the sensitive nature of issue: the report tends to produce gross underestimates, and underreporting constitutes a major problem. As a result, many aspects of adolescent girls' sexual behavior, and why they are having unsafe sex, are still under explored. Thus, it is essential that the researcher increase insight within a broader interest in sexual health including not only STDs and HIV/AIDS but also unwanted pregnancy among female adolescents.

Because of concern within STDs and AIDS domain, most of studies relating to sexual behavior has solely focused on safe sex from the infection aspect rather than broad safe sex, include unwanted pregnancy, the ability of female adolescents to prevent themselves from unintended pregnancy, the ability to make decision to access sexual intercourse by their own pleasure, and accessibility to efficient reproductive services.

Literary review indicated that sexual behaviors affecting sexual health among female adolescents especially pregnancy and STDs were safe and unsafe sexual behaviors. Safe sex behaviors were any sexual activity that no risk of contracting diseases and pregnancy such as sexual intercourse with no STDs and AIDS partners, consistent use of condoms, and other efficiency contraception (Vipaweealakul, 1997: 6-7). Unsafe sexual behaviors or risky sexual behaviors could be defined as any sexual activity that increased the risk of contracting AIDS or other STDs or becoming pregnant. These included early sexual debut, unprotected sexual activity, inconsistent

use of condoms, high-risk partners (e.g., injection drug users, survival sex [sex in exchange for money, drugs, food, or shelter]) or sex with a partner who had other partners or more than one partner at a time (Aral, 1994; IOM, 1997 cited by Taylor-Seehafer & Rew, 2000: 16).

Another area of limited research is female adolescent who experience forced or coerced sex, commercial sex, and lack of accessibility to efficient sexual and reproductive services.

Sexual coercion

Adolescents who do not control the circumstances of their sexual activity, such as victims of sexual coercion and abuse, are at risk of STDs and unwanted pregnancy. Sexual coercion, the act of forcing other individuals through violence, threats, or deception to engage in sexual behavior against their will, can result in psychological trauma, unwanted pregnancy, and STDs (Thongkrajai et al., 1999: 2). Few reports have shown that the first sex of Thai female adolescents is mostly unexpected and often a result of date rape and rape by relatives or strangers (Thongthang, 1993 cited by Diloksambandh, 1996: 26). According to the study of Boonmongkon, et al. (2000: 23) found that the first sex for the girl was usually unwanted but she was convinced by the boy to have sex with him. The later sexual intercourse was mostly voluntary and many times of having sex could happen for fear of upsetting their boyfriends although they did not want to. Violence against women within sexual relationships is a neglected area in public health despite the fact that, in partially defining women's capacity to protect themselves against STDs, pregnancy and unwanted sexual intercourse, it directly affects female sexual health.

Commercial or consumer sex

Commercial or consumer sex is female adolescents who use their body to modify to commodity for example sex in exchange for money, goods, and other as agreement (Balzer & Srionsri, 1996: Conference proceeding). It is one of patterns of sexual service hidden in female students. As female adolescents need to increase monetary status, they engaged into sexual intercourse especially with older partner (Okpani & Okpani, 2000). Commercial sex results from social construction that has

economical development as materialism. Under the construction of these economic system leads to new value as materialism what produces new pattern of sexual relationship, commercial or consumer sex, in female adolescents. Moreover, with increasing awareness of HIV/AIDS, men are now increasingly blamed for luring younger, 'safer' girls who are hopefully too young to be infected by HIV into sexual relations by promising them some degree of financial security. In recently, the study of Soonthornthada (1996:2-3) found that some female adolescents both schooling and out-schooling who lived in dormitory entered into sexual intercourse with male who had high economic and society status. Their reasons were these males could give money, things, and economic support for her. Other research by Limsamphan (1997: 168) found that economic reason was a factor forcing female adolescents to exchange their virginity for financial supports.

Female adolescents' contraceptive choice and satisfaction with method

Sexually active female adolescents would usually use the contraceptive pill taken after sex to protect them from pregnancy. They tended not to use condoms because their male partners did not like to use them because they interfered with sexual pleasure. Buying contraceptive pills and regularly taking contraceptive pills caused girls to publicize their sexual activities. So the girls' partners usually bought postcoital contraceptive pills (Boonmongkon, et al., 2000: 24).

Female adolescents' accessibility to reproductive health services

In the existing studies found that many adolescents chose self-treatment first by buying drugs from drug store because low cost and convenient. If the symptom persisted or became more severe, they would go to the private clinics and hospitals more than the government health centers. No female adolescents wanted to go to the V.D. clinic because of health care services was complicated and stigmatizes adolescents who came to use the service for their sexual health problems (Limsamphan, 1997; Kritsanaseranee, 2000: abstract; Boonmongkon, et al., 2000: 28-32).

From all above-mentioned data, it shows that sexual behavior among female adolescents is relatively complicated because person will perform whatever depends upon many factors. Much of the existing research has been directed to documenting young people's patterns of sexual and contraceptive behaviors, knowledge of reproductive health risks and means of avoiding them, attitudes toward contraceptive and condom use. These factors are, however, only a small subset of those that influence adolescent risk-taking and health-seeking behaviors.

The research in last decades have found that there are young people engaged in premarital and unsafe sex more than in the past; for example, early first sexual intercourse, having more than one sexual partner, unsafe sexual intercourse, and commercial sex. Yet, a review of sexual experiences literature reveals that much of the existing researches typically adopt narrow definitions of sexual experience. Much of researches had concentrated on sexual behavior at the level of the individual by quantitative methodology. Surveys of adolescents generally inquire about their age at first intercourse, number of partners, and contraceptive use, therefore giving only a partial picture of the sexuality. Few authors have focused on adolescent sexuality. This study aims to understand sexual experience among female adolescents which is not only sexual attitudes and behavior but refers to a broader view of sexuality.

This study attempts to understand in wider view of sexual experiences not only in STDs or HIV domain but also the ability of female adolescents to prevent themselves from unintended pregnancy, the ability to make decision to access sexual intercourse by their own need, and accessibility to efficient reproductive services. Moreover, key informant who could greatest informs this phenomenon is a sexually active female adolescent.

From the literature review mentioned above, the theoretical base that the researcher study can be illustrated in Figure I.

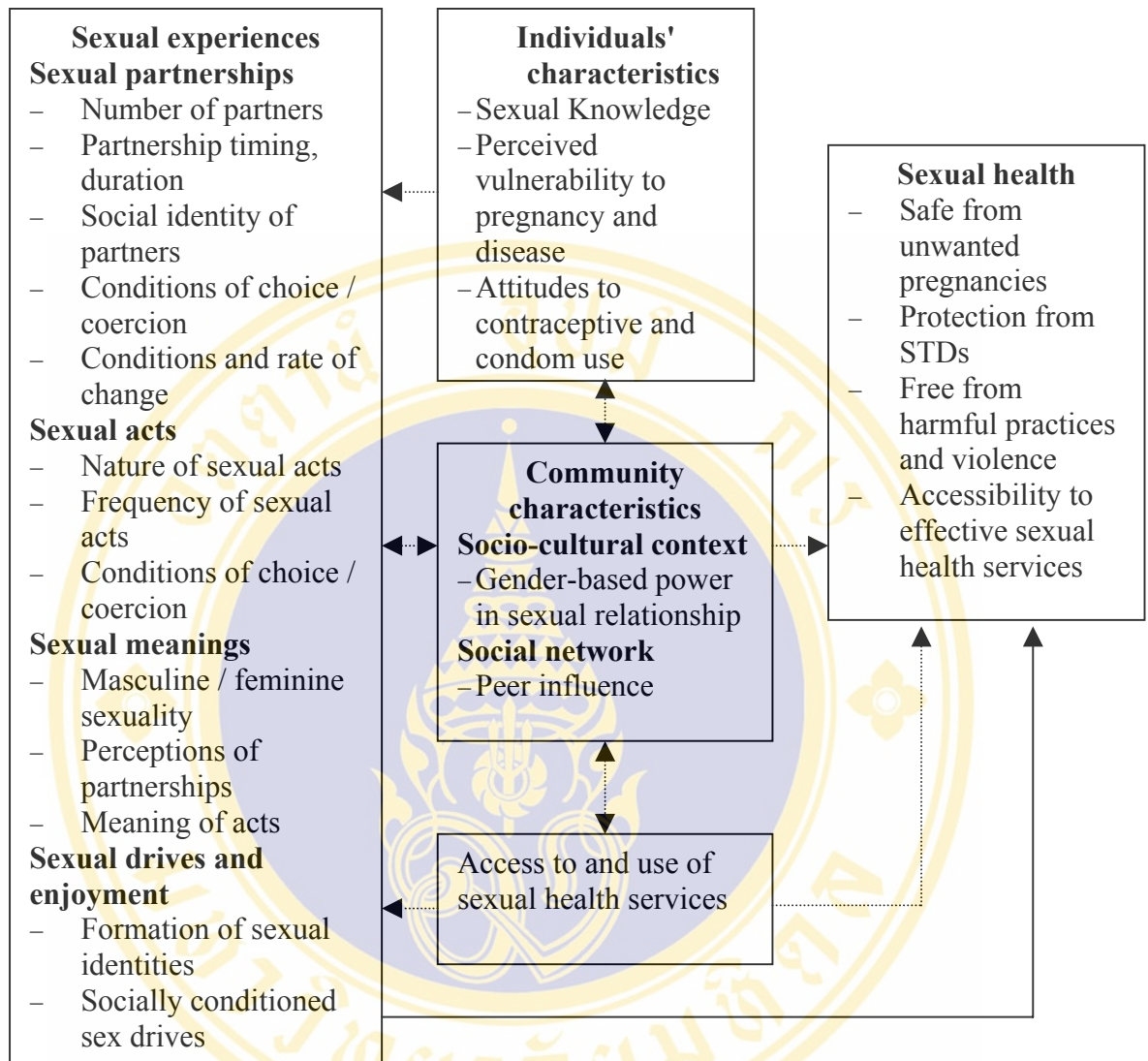


Figure I: Theoretical base (Modified from Dixon-Mueller, 1993: 271)

CHAPTER III

METHODOLOGY

Research design

This study was descriptive exploratory qualitative research method to insight sexual experience among in-school female adolescents in Amphoe Muang Chiang Mai Province.

Setting

The study was purposely conducted in Amphoe Muang, Chiang Mai Province. This setting was central part of several developments both education, public health, and modernization. Moreover, it had modification of society, culture, and other environmental context that influence to life style of female adolescents. However, it had existence of gender-based power between male and female so this setting was appropriate to study.

The participant

The target population studied and sample consisted of female adolescents between 15 and 18 years old, who attending school within Amphoe Muang, Chiang Mai Province. The samples were drawn based on snowball technique (Field & Morse, 1994: 95) and purposive sampling technique including: those who had had experiences of sexual intercourse; those who were introduced by their social network and were willing to be interviewed or participate in the study as well as those whose rapport among the researcher had been established. The first participant was introduced by a nurse who knew sexually active female teen for providing the first contact. Then the first informant had introduced the researcher to other informed persons. The researcher would conduct target population until attain factual and complete data as research objectives. To attain in actual fact and accurate data, researcher basic assigns

20 samples. The demographic characteristics of the participants were presented in Chapter 4.

Data collection methods

In this study, data collection methods included in-depth interviews and observations. The interview guide (see detail in Appendix) was used primarily as guideline for questioning, as it contains open-ended questions. This was a written list of questions or topics that need to be covered during the interview. However, the exact order and wording of the questions might be flexible from respondent to respondent. The interviewer might still follow leads and new topics that arise in the course of the interview, but the interview guide was a set of clear instructions concerning the main questions to be asked or topics to be probed.

Participant observation was conducted at discotheque (two times), shopping malls for walking around, doing some shopping, and/or eating food (twenty times), and recreational park (two times).

Furthermore, the credibility of qualitative inquiry is especially dependent on the credibility of the researcher because the researcher is the instrument of data collection and the center of the analysis process. In order to attempt to increase the credibility in this study, the researcher developed knowledge and expertise to conduct the study by taking in the qualitative research course offered for Medical and Health Social Sciences Programme, Faculty of Social Sciences and Humanities, Mahidol University. I engaged learner in this course over a period of 16 weeks, the artificial constraint of the given semester time. The learner simultaneously designed, conceptualized, and conducted a ministudy. Within the study, the learner might practice exercises in and out of class focusing on in-depth interviews, observation, the role of research, and analysis of data which were helpful for developing my understanding and skills to produce a rich qualitative study.

Data collection

The researcher collected the data after receiving permission from the Faculty of Graduate studies, Mahidol University. All participants were provided sufficient information about the purpose, reason for the study, the method used, and risks and

benefits of their participation in the study. They were made to understand that they would be free to withdraw from the study at any time they wanted to, without disadvantage. In addition, the participants were assured of the privacy and confidentiality of their information and of their relationship to the study. They were provided an opportunity to ask any questions they might have before their consent or refusal to participate was ascertained.

Before the initial interview, the participants were asked to sign a written consent form to be interviewed and audio tape recorded during the interviews. Most of participants prefer to have verbal consent based on personal rapport and trust.

The in-depth interviews were arranged in natural settings as much as possible. For the female students, most of the interviews were conducted during a weekend or after school. Each participant was interviewed individually in the privacy of her own setting. All participants appeared to be relaxed, comfortable, and willing to talk about their experience. The interviews were conducted in the local language.

Tape recordings of interviews were made only with the respondent's explicit consent and were destroyed at completion of the study. In order to maintain confidentiality a system of pseudonyms was used. A pseudonym was assigned to each participant and used in all written records of the study including interview transcripts and field notes. Only the researcher had access to the list which associated pseudonyms with informants' real names. The audio tapes were listened to only by the researcher. If participant was inconvenient to audio tape recording, researcher would take field notes while interview.

Through in-depth interviews, I sought deeper understanding of informants' sexual experiences. The success of the interviews depended on my ability to establish rapport, mutual respect and trust with them. Particularly due to the sensitive natures of the subject matter, whatever insights I gained were heavily dependent on the quality of the relationships that I was able to develop with informants. Usually, interviews were conducted entirely in the local Thai dialect. The research would initiate a conversation with each participant with a general statement. Then the researcher began with individual information and followed by in-depth interview using guideline questions to focus the discussion; but allowed to probe participants, to follow leads and notes as many quotations, details and case stories as possible.

The length of the interviews varied from 60-90-minute, depending on the participants' responses. The interviews were conducted by the researcher using probes to elicit information about the teen's perspectives related to the sexual experiences affecting sexual health. After each time of interview finished, the researcher still kept continuous relationship with participants to confirm reliability of data and to ask for more data in the future. There were 3-4 interview sessions per each girl.

The researcher collected all data from interview by recording data by detailed as in-depth interview guideline. The data from audio tape recording was transcribed as word by word within the day conducted interview. The data from fieldnotes was recorded after finish interview by suddenly. To gain the most rightful and protected confusion in some issues, all data was conducted to analyze, verify, compare, and summarize data of each participant at the beginning as purpose of the study. If these data was not clear or need more information, researcher would interview in the next time to acquire complete and clear data until could answer the research questions.

When the interviews with that informant completed, the informant was asked to introduce or refer the researcher to another person to interview. Data were collected until no new information is obtained.

Protection of human subjects

The data collection procedure in this study certainly compassed the protection of human subjects. The researcher explained the purposes and the method of this study for the subjects and asked for their permission to collect data and use an informed consent form to ensure that the subjects had volunteered. Written informed consent and verbal consent from participants were obtained. The participants were assured that all of the responses would remain confidential, their identity would not be revealed, there were no known risks in participation. Tape recording was transcribed verbatim and, on completion of the study, the tape was erased. Furthermore, the participants had the right to withdraw from this study at any time, even after they started to answer the questions, and this would also not affect their status in any way.

Validity and Reliability

The assessment of in-depth interview guideline was initially submitted for inspection their validities of contents and language by thesis supervisory committee. Suggestions from thesis supervisory committee were incorporated in the revision of the in-depth interview guideline. Then the revised in-depth interview guideline was initially tried out with 2 female adolescents having qualities that similar to the samples. Finally, the researcher had incorporated in the final revision of in-depth interview guideline. To increase validity and reliability of data, the researcher used methods as follows:

1. The establishment and development of the mutually satisfying relationship between the research and the informants. The rapport relationship would lead informants to have willingness and trust to reveal their real feelings and experiences.
2. In-depth interview into informal and natural atmosphere, it was two-way communication which informants could give in-depth notions and data.
3. Selection key informants who were members of the social or cultural group in the research context; who provided information and assistance with the interpretation of the setting.
4. Because of the researcher, too, inhabited Chiang Mai and could speak in the local Thai dialect, which were helpful to profound understanding the context and valid interpretation the information.

Data Analysis

Analysis began with the first available transcript. Each taped interview was transcribed and analyzed line by line to understand and to interpret the female teens' words. Interviews were compared with each other to confirm/disconfirm emerging themes. This process continued until consistency and representativeness of concepts validated the established themes, which began to occur during the 18th interview. After completing two more interviews, new information ceased to emerge. An expert in qualitative methodology was consulted on a regular basis throughout the data collection and analyses to validate the process and establish the credibility of the findings.

CHAPTER IV

FINDINGS

"If you're pregnant while you're teenager who is studying, you can't tell anyone because they'll tell someone else. It is more difficult to tell your parents because they would blame you. So you don't tell anyone you do the abortion yourself and it's like I was never pregnant." *Noo*, 17 years old girl, said.

This is just one voice of many sexually active girls who have to experience to the risks of unprotected sexual intercourse. Although "sexuality is complex" but the complexity begins to unfold as we listen in nonjudgmental ways to what people have to say about their own sexual realities.

This study aims to gain understanding of sexual experiences among in-school female adolescents in Amphoe Muang Chiang Mai Province. The findings from the data analysis will be illustrated as follow:

Part 1: Background characteristics

Part 2: Sexual experiences among in-school female adolescents

Part 1: Background characteristics

Table 1. Number and percentage among female adolescents categorized by age, educational level, income sufficiency, family characteristic, and living arrangement. (n=20)

Characteristic	Number
Age (years)	
15	2
16	6
17	7
18	5
Educational level	
- Senior high school	7
- Primary vocation certification	13
Income sufficiency	
Adequate with no savings	20
Family characteristic	
Nuclear family	16
Extended family	4
Living arrangement	
Living with family	4
Living alone/with close friend at dormitories	11
Living with partners	5

Research informants consisted of 20 in-school female adolescents. All of them were native to Chaing Mai. Four girls were within Amphoe Maung and sixteen girls were recruited from peri-urban villages of Chiang Mai into the urban. On average, informants were 16.75 years old. All girls were currently attending some school within Amphoe Muang of Chiang Mai Province, with 35% attending in senior high schools and 65% primary vocation certification. All identified themselves as having adequate income, which were supported from their parents and/or their partners.

1.1 From low cohesion and poor parental monitoring and support

In the overall girls, sixteen girls were from a small nuclear families consisted of parents and their children, only four girls were from extended family included the nuclear family and other people related by blood such as grandparents, aunts, and cousins.

More than half of participants, thirteen girls, were from two biological parents' family; seven girls were from a nature parent and a step parent family; and two girls were from single mother family.

Interestingly, majority of the girls (16) were in a family characterized by low cohesion, with poor parental monitoring and support. Only four girls had lived in the familial environment with comfortable and agreeable relationship.

The majority of girls had lived in the familial environment with fragile relationship and scarcity of love. They lived in the environment that filled with problems like quarrels, divorce, and new families. These made them emotional stress and lack of affection. As a result, they confided personal problems with their parents. A common thread that was heard through the interviews was the fact that her relationship with her mother and/or father was strained and, in a few situations, close to being severed.

Ann, 16 year-old girl who was from biological father and stepmother family, told details of strained relationship within her family that "My biological parents divorced when I was still young. I and *Nan* (her older sister) lived with dad while *Odd* (her younger brother) lived with mom. My dad had remarried with *Mae Sang* (her stepmother's pseudonym) and moved into her house. *Mae Sang* didn't have her own child so she loved me so much. Previously, we didn't have any problem until one day she had known regarding unfaithfulness of my father. This event made her furiously. My father was expelled to go away from her house but he didn't leave. After that she neglected to pay attention to my dad and me."

Bee, 18 year-old girl, told details of strained relationship within her family that "I love my mom but I didn't like what she did. My biological parents had divorced and my mom had new partner, who was about 50 year-old man and had married. My mom told me that he was our financial resource. He often visited to my mom in afternoon. Because of I didn't want to meet him, I had to spend time after school by wandering with my friends or going out to my friend's dormitory."

Meaw, 16 years old girl, were from her nature father and stepmother family. She told me that "My parents divorced when I was 14. After their separation, I had to live with dad whilst my younger sister lived with mom. After my dad had remarried, we had moved to be with stepmother who lived in extended family included her children, one son and one daughter, and grandparents. I didn't like the stressful atmosphere of the house. They made me felt alone. They had no interest in me. They never asked my joy and sorrow. I thought they didn't love and want me. I preferred being with my friends who love me and want me rather than being with my new family".

Poi, 17 year-old girl, was from single mother family. Her parents had divorced when she was young because her dad had a son with minor wife. She told me that "my dad wanted to divorce with my mom for remarriage with his minor wife who was younger and more beautiful than my mom. After their separation, he had to support both my school fee and daily expenses. However, my mom had to work outside the house to earn money for the family. I feel that I and my mom are rejected. We aren't worth enough to be with. If he doesn't want me, I don't have to care him. I care only my mom's feeling.

This finding showed that the majority of them were living in the familial environment with fragile relationship and scarcity of love. Such critical situations forced most of the girls to seek affection and attention from out-of- home.

1.2 Independence at an early age and extensive free time

For this study, only four girls reported living with their parents. Two girls revealed that they had a low amount of autonomy which allowed them to have a going out life style. They usually stayed at home after school. They always had to get their parents' permission for going out (*pai thiaw*). Sometimes they had to tell lies to their parents that they went out for tutoring, sporting or trips were arranged with a peer group when in actual fact that they were dating their boyfriend. In the other hand, two girls revealed that their parents had to work full-time. These provided greater freedom from parental monitoring.

More than half of girls, eleven girls, reported living on their own or with their close friends at dormitories. All of them were from suburban districts such as Amphoe Mae Rim, Mae Teang and Chiang Dao. Education opportunity was the main motives for rural to urban migration. Because of the distance from their home to school was relatively far away, so they decided to move into dormitories in the city. After that girls and their parents would look for a dorm. Decision to choose any dorm depended on approbation of their parents. Some of girls shared a dorm with a friend from the same village. When they first moved in, most of them felt unfamiliar and dislike life style in dorm. Particularly, girls who living alone described they felt as lonesome and homesick.

For a while, when they began to make new friends and to know a lot of places in town, they began to join with their peer to take a walk in shopping mall or to be joyful at one dorm of their friends. As **Lek** said:

“I think staying at dormitory is also a chance for adventure and fun, a time for new experiences and independence”.

Soon afterwards, some of them transferred to a new dorm such as from female dorm to apartment. Some of them shared a dorm with their intimate friends. It

was also found that they feel less lonesome and homesick than before. The main reason in which the girls visited to their parents was financial support.

Most of girls who stayed at the dormitories owned motorcycles to facilitate their journey, involving going out and around (*pai thiaw*).

This finding showed that girls who living alone/with close friend at dormitories had a high amount of autonomy which allowed them to have a going out life style. Living apart from the parent seemed to be the clearest way to gain the independence adolescents crave. As some girls said,

“Before, if I wanted to go out I had to be allowed from my parent. Now I have the freedom to go to anywhere and with anyone as I please without permission”. (*Mon*)

“It's nice to be free of my parents. It's convenient in many ways. It makes me feel like an adult”. (*Noo*)

However, financial support forced them back into being dependent on their parents.

Female adolescents' life styles

Life style of each adolescent girl appeared to be varied depended on individual personality traits, peer, freedom from the family control, and money. Particularly, girls moved from suburban into the cities were suddenly independent of their parents and responsible for themselves economically; they were setting up their own living quarters, planning their activities without interference. It was a new and exciting world.

Adolescent girls liked to go out and did activities as a group even when they went out. The groups of them ranged in size from 3 to 5 people. Most of the groups usually had members who were all female. They might stay in the same dormitories or study in the same classroom. Being with friends in a group encouraged each other to do activities together. Adolescents who belong to the same group typically had similar habits and activities. For example, they tended to enjoy going out or hanging around

and talking to each other because they gave the same habits or shared the same interests or liked to talk about similar topics.

Each group did similar activities: some groups liked to go to the public park; some groups liked to go to the shopping mall; some groups liked to go to discotheque. For example:

Uom, 18 years old girl, who came from Hang Dong District revealed that after finishing M3, she came to town with the intention of studying. She moves into a dormitory and shared expense with a friend from the same village. When she first moved in, she only went out with her friend once in a while such as Huai Teing Thao reservior and discotheque. Afterward, she went out to discotheque at least 2 times per week. The reasons she gave for going out were to have fun, to be drunk (*moa*), to celebrate, and to persuade boys. She and her friends were regular customer at a discotheque on Chang Klan Street. "I like this discotheque because DJ and the band are the best. They play my favorite song. It makes me extremely enjoyable. Moreover, I know the waiters, they give me good service. Sometimes I get a bottle of whiskey for nothing." Another discotheque where she went once in a while was a discotheque on Chiang Mai Land Street. This discotheque often had promotion for lady, namely "lady night". Lucky lady would get a bottle of whiskey. Sometimes, there was dancing competition in which the ladies would show dancing by rubbing their body with stainless pillar. The winner would receive a reward such as money, a bottle of whiskey, or refrain from fee.

Because I wanted to understand life style of the girls, when *Uom* invited me to go to discotheque I said "yes" immediately.

A Night on the Town

About 10.00 P.M., a discotheque where located on *Chang Klan street* was already crowded with young people when we arrived. *Uom* and her friends were regular customer of this discotheque. They recognized a lot of people. When I asked *Uom* and her friends about their identification card (ID card) because they were younger than 18 years old, they answered that "don't worry this place will screen ID card only once in a while but if they do I know the waiters." As good as she said this discotheque did not screen ID card.

A waiter conducted us to a small table without any chair to sit in front of the stage. *Uom* told me that it was usual on holiday. A waiter hurries to take our order. *Uom* ordered a bottle of whiskey, 2 mixers of soda, ice cubes, and popcorn. In the discotheque, I observed that most of people both male and female usually drank alcoholic beverages. When the band on the stage started to play one of the most popular songs of the moment, most of young people mirthfully joined to sing and dance with the singer.

I observed a group of three girls were dancing around their table beside my table. They were certainly not older than 18 years old. There was a man aged about 30 years old walked to their table and talked with them. *Uom* told me that these girls were "*cha-nee*". She described that it meant girls who seduced men to engage in sex. Apart from going to discotheque to have fun by dancing or talking to their friends, and listening to modern music, these girls went to discotheque for making money by sleeping with men.

When I looked around, I also found that most of the couples were free to behave any way they liked such as held hands, hug or kiss each other.

It was almost 2:30 A.M., the official closing time at the discotheque. I found that one girl who was called "*cha-nee*" went out with a man who just knew in the discotheque.

1.3 Some contradictions regarding the gender role as perceived by girls

In this study, there were some contradictions regarding the gender role as perceived by girls. They perceived that they were equal to men while at the same time

they were controlled by Thai cultural values that good women must be proper and should preserve her body.

Most of girls accepted traditional gender roles and believed that it was up to them to set limits on sexual activity. There was no expectation for boys to limit themselves in any way.

The gender role, pointed out by the girls, could be categorized into: women have the same opportunities as men; households should be headed by men; and men had much freedom.

Women have the same opportunities as men

Generally, the most of girls perceived that nowadays, men and women were equal in ability and achievement as men. Both men and women were equal in educational opportunity and occupational opportunity. Women had rights to do everything for themselves and could be also chosen to be leader. Some women could do the same hard work as men. As **Nok** said:

“I think women can be able to do whatever men can do. Women can have higher education as much as they can.”

Some girls revealed that in their families both their mother and father had to help to earn income for the family. As **Nee** said:

“Women can go out to work and do the same hard work as men. As my mom, she had to help to earn income for the family by seeking jobs outside the house.”

Regarding sex issue, majority of girls perceived that they had as much freedom of sexual choice as boys. Girls felt they had an entitlement to initiate for courting boys and have numerous boyfriends at the same time for discriminating.

Households should be headed by men

There were a few girls perceived that men should still be leaders in some circumstances and need to be more responsible than women. Regarding responsibility in the family, most of girls still viewed that men should be head of family as women should be housewife. As some girls said:

“Men should be the leaders because they are stronger than women. Men can do more kinds of tasks than women.” *(Bee)*

“I think men should be the leader of the family because they can make the decision better than women. As my family, my father works outside the house to earn money for the family while my mom do the housework.” *(Jane)*

Men had much freedom

Some girls described that there were social inequalities between both sexes. They felt that they were highly restricted by their parents and felt that they did not have much freedom. They perceived that men had much freedom to roam, to play sport, and to entertain themselves while women had to stay at home after school, perform their domestic chores which included cooking, cleaning, and washing, and always had to get their parents' permission for going out. As *Noo* said:

“For the boys, they can go out wherever they want to. Their parents don't concern about them. But for me, if I want to go out, I have to be allowed by my mom. If I eluded to go out, I am scolded by my mom.”

Good women should be inexperienced and naïve in sexual matters

Some girls viewed that men had much freedom to have relationship with opposite sex, and becoming sexually experienced, while girls were warned to take extreme caution in maintaining their chastity in order to avoid public gossip and

criticism. They revealed that good women in their society should be inexperienced and naïve in sexual matters. As some girls said:

“For girls who roam around like boys and allow boys to touch them, they were labeled as bad girls who were very easy to seduce.” (*Nid*)

“Nobody condemned boys who had numerous sexual experience while condemning girls who did the same. Particularly, for girls who becoming pregnant, they were extremely blamed. Nobody viewed that it was also boys' faultiness.” (*Mint*)

"More sexually active girls were disparaged by the other, as lecherous girl or slut girl." (*Ann*)

Part 2: Sexual experiences among in-school female adolescents

Analysis of the content revealed six major themes in the sexual experiences among in-school female adolescents: meaning of sex, sexual partnerships, sexual activities, perception of safe/unsafe sexual behaviors, risky sexual behavior, and access to reproductive health.

1. Meanings of sex

Girls would allude to intercourse with word, such as losing the body (*Sia Teuw*), finishing (*Saet*), sleeping (*Norn*), wanting each other (*Uao*), and meddling or becoming involved (*Yoong*).

To investigate girls' meaning toward sex, the researcher asked participants to respond to statements reflecting beliefs and values regarding this topic. This study found that their answers were varied from "sex was love" to "sex was barter" which depended upon sexual experiences of each girl. The analysis revealed four categories:

Sex as love and intimacy

Some girls in this study, particularly girls who were willing to have sex, stated affection for their partner as the reason they had sexual intercourse. According to the participants,

"He told me he loved me and wanted me more, it made me felt good. There's no reason why we shouldn't have sex." (*Faa*)

"I liked him and we were very intimate." (*Nid*)

Sex as a biological event and physical pleasure and new experience

Some girls revealed that love and sex was not the same thing. As *Nam* said:

"For me, love is an emotion or a feeling while sex is a biological event. It isn't always intimate. I have sex with my boyfriend because I want to know how sex is."

Another girl said: "Sex was a way to act like a grown-up." (*Mon*)

Interestingly, some girls viewed that sex did not limit only men and women but also women and women or men and men.

Sex was barter

Two girls in this study who had sexual relationship with a man identified as sugar daddy (*Paa*) explained that they received money from him in exchange for sex. Sex made them had material and money.

Aye, 17 year-old, had a sexual relationship with a 60 year-old, married partner. She said: "*Paa* is my financial resource. He gave me 5,000 baht and a motorcycle for the first time of sex and 1,000 to 2,000 baht for the subsequent sexual intercourse". She disclosed that "I had no sexual pleasure at all from the sexual activity and

wanted to get it over with as quickly as possible, but he was my major source of income so I tried my best to make him give me more money." In spite of the fact that she had no intention of continuing the relationship if she did not receive money from her partner.

Interestingly, a girl, who detailed her mom was minor wife of married 50 year-old man, also viewed that sex as financial gain.

Bee, 18 year-old girl, said: "My mom had new partner, who was about 50 year-old man and had married. My mom told me that he was our financial resource. Although I don't like such behavior, but I can not refuse that it is a method to earn money."

Sex as disgusting, and reluctant

Some girls, particularly who was forced to have sexual intercourse, viewed sex as the worst thing.

Yam, 15 years old, was forced to have first sexual intercourse from a boy who she did not love. She viewed that sex was disgusting and reluctant. However, she agreed if sex was happened from intimacy or love.

Yim, 17 years old, was unwilling to have sex with her boyfriend. She was forced to have sex while their dating. She said, "I feel bad to have sex with him. It is very disgusting."

When the researcher asked female students how they perceived about premarital sex. The analysis revealed two categories:

Premarital sex was common among their peers

They generally agreed that sexual activity was common among their peers. It was a natural follow on in the relationship. Some girls remarked that their peers first had sex with males in their own age-group. As some girls said:

"It is normal for a person like me to have sex." (*Mo*)

"Everyone does it so don't be old-fashioned." (*Noo*)

Permissiveness with affection is acceptable

Some girls revealed that although an adult viewed their premarital sexual intercourse was inappropriate but they viewed that having sexual intercourse with boys who they love was not bad. It was clear that girls now firmly believed that premarital sex with affection was acceptable.

Nid, 17 years old girl, engaged in first sexual intercourse at 14 years old with her boyfriend who she loved. She said, "I did not regret with this situation because I liked him and we were very intimate."

2. Sexual partnership

Relationships were probed through questions exploring the girl's concepts of relationships. Their actual relationships-how they began and why they were attracted to their partners. For each partner they had had sexual activity with, when sexual activity occurred. The study focused on girl's relationships with men (it was targeted at heterosexual girls).

The analysis was specified in subthemes: intimacy sexual relationship-boyfriend ("*phan*") and commercial sexual relationship-sugar daddy ("*paa*"). The first type of sexual relationship was usually based on emotion and feeling while the second type was usually based on financial support. Moreover, they revealed that relationships with men identified as the first received more social acceptance and recognition than relationships with the second.

2.1 Intimacy sexual relationship-- boyfriend (“Phan”)

Boyfriend was someone girls considered having a love relationship with and regular contact. Girls revealed that having a close relationship (**Phan**, literally "being a lover", usually without sexual relations) was common. Boyfriends tended to be sexual partnership in the next time. Most of girls accepted some various degree of intimate relationship including touching, and holding hands or hugging. However, they revealed that they would permit only boyfriends they liked or loved to hold hands, hug, and kiss. Particularly, they would have sex with only boyfriends they loved. This finding showed that intimacy could be a powerful aphrodisiac.

Because of majority of girls perceived that they had as much freedom of sexual choice as boys, so they had an entitlement to initiate for courting boys and have numerous boyfriends at the same time for discriminating. Seventeen girls revealed that they started to look for boyfriends and thought to have boyfriends when they enrolled on senior high level whilst a few had ever had 2-3 boyfriends before.

The reason participants gave for relationship (which might or might not involve sex) were peer pressure, to love and to be loved, to enhance self-esteem, and to have fun.

Peer pressure

Peer group behavior strongly encouraged sexual partnership. Friends informed each other about who was interested in whom. Most of girls disclosed that being in the group of girls who were more likely to have boyfriends, they would encourage each other to do the same. As **Yim**, 17 year-old girl, said:

“Most of my friends had boyfriend, some of them had 2-3 boyfriends at the same time; and some of them had only one boyfriend. For girl who did not have boyfriend was called from peers as “**cheiy**” (unfashionable).”

To love and to be loved

Some girls, particularly who living at dormitories felt very lonesome to be alone so they need someone to love and attend them. When they had boyfriends it made them felt secure to have someone to love and to be loved. As **Nang** said:

“It is nice when someone who loves you treats you special.”

To enhance self-esteem

Some of girls viewed having boyfriend as showing justifiable self-respect. As **Jum** said:

“If I had no boyfriend and was not interested from males, I would feel like worthless and loss of confidence.”

To have fun

Some of girls remarked that going out with their boyfriends made her very happy and fun. As **Lek** said:

"Actually my boyfriend makes me happy and I go out with him every day."

Qualities of their boyfriends

Their boyfriends might be boys who studied in the same school or other school through introducing by their friends. Majority of girls' boyfriends was just the same age with girls while the other was some years older than girls. Interestingly, because of most of them were enrolling on school so they were, financially, still dependent on their family

The main quality that most of girls gave for selecting a male to be boyfriend (which might or might not involve sex) was physical attraction. They reported that it seemed to be a stronger factor for them because physical attractiveness tended to create the first appeal. As **Yim** said:

"I have 2-3 boys who pay attention to me but I choose **Tom** to be my boyfriend because he is the most attractive. The other girls are crazy over him."

Other qualities they gave were personality such as sense of humor, compatible interests, and fun to be with. Furthermore, some of girls indicated that males' socioeconomic status was also an important factor because it indicated males' ability to provide financial support or inducements to female partners.

However, some of girls revealed that their boyfriends, particularly who were attending in vocational school had disproportionately more problems with academics and behavior, such as flee from schooling for going out (**pai thiaw**) and looking for fun, drink liquor, smoke cigarettes, and use of illicit drugs. Some of girls accepted that they had known these problems since they began relationship. Because of they thought they could change boyfriends' behavior so they still continued their relationship with boyfriends. While the other had known after their sexual relationship but they did not care because it did not be problem to their relationship. However, some girls had to stop their relationship because their boyfriends were arrested.

Aye, 17 year-old, said: "Tom, my boyfriend, didn't intend to be educated. He always absented school to join with his friends. The teacher reported this behavior to his parent but he didn't care. He told me that the most trouble was just only studying in the same level again. The other reason he gave me was his parent followed his heart" (**tam jai**).

Yam revealed the details that "I don't know much about my boyfriend's behavior regarding substance abuse. I only know that he have a lot of friends who often come to his dormitory until one day the police penetrated for searching his room and found many of "**ya baa**" (amphetamine) hidden in a nook of the door. It was my

fortunate that didn't go to his room; otherwise I had to be arrested with him. Because of this event, our relationship had ended."

2.2 Commercial sexual relationship--sugar daddy ("Paa")

Sugar daddy was someone girls received money from him in exchange for sex. For this study, two girls had this relationship. One started relationship with a man identified as *Paa* after broken her first sexual partner for a month. Another one had one boyfriend and sugar daddy at the same time. Two participants explained that the desire for material and financial gain was the primary motivation for this relationship.

Aye, 17 year-old, had a relationship with a 40 year-old, married partner. She mentioned that he had fallen in love with her. "He comes to me to escape frustrations from home. He gave me 5,000 baht and a motorcycle for the first time of sex and 1,000 to 2,000 baht for the subsequent sexual intercourse". She disclosed that "I had no sexual pleasure at all from the sexual activity and wanted to get it over with as quickly as possible, but he was my major source of income so I tried my best to make him give me more money". In spite of the fact that she had no intention of continuing the relationship if she did not receive money from her partner.

Interestingly, without an equalization of power in their relationships with their daddy sugar, they reported that it was difficult to refuse sex when money and gifts are offered.

From first impressions to sexual intercourse

Sexual intercourse for girls was handled mainly through dating relationship. Dating was an opportunity for opposite-sex interaction. A boy and girl can be alone at almost anytime in almost anyplace. The feeling of anonymity and distance from social control was increased.

Most of girls revealed that dating was a way to raise their status within the peer group. Friends tend to inform each other about who is interested in whom. They had known their current partner for some time before going out with them. Some had known for 1-2 months before going out. Usually the period of dating each other was about 2-6 months prior to becoming sexual intercourse. Interestingly, one girl had met her partner only recently before engaging sexual intercourse.

Participants started dating at roughly the age and had been dating for about 0.5-1.0 year at the time of enrolment in the study. Girls revealed that dating was mostly considered fun. First of all, they seemed to be more group activity, going out to movie, shopping mall, and the public park with other couples or with friends. Generally, friends tended to inform each other about who was interested in whom. Going out as a group happened about two to three times. After that, the later dating involved boy and girl couples alone. They went out to the movies or restaurants or visited places that allowed privacy for them to be by themselves such as the public park. As they saw each other more frequently, it became increasingly difficult to avoid sexual intimacy.

When they were alone together the boy usually started to urge the girl to have sex with him. All of girls revealed that it was due to male desire and manipulation rather than a female expressing her own innate sexual desire. These behaviors could be ranged from touching, embracing, kissing, and then move on fondling and petting, and subsequently engage in sexual intercourse.

Number and duration of relationships with sexual partners

Three relationship categories were obtained from this study: cohabitation relationship, serial monogamous relationship and nonmonogamous sexual relationship.

Cohabitation relationship

Five girls in this study had sexual lifestyle as cohabitation-that was, live together without marriage. However, living together was not a true commitment. It was only a commitment that said, "I can leave anytime I wish."

All of them decided to live with their partners after their first sexual intercourse. Almost all, four girls, moved to live with their partners' families and another one moved to live at her boyfriend's dormitory. They had sexual lifestyle as cohabitation-that was, live together without marriage.

Girls who moved to live with their partners' families revealed that they were unwillingly permitted from their parents. Main reasons that motivated girls to stay with their partners' families were their sexual relations were disclosed and their parents wanted male's families to take responsibility.

Ann, 15 years old and the youngest daughter of the family, decided to move to partners' house. The reason she gave was her parents penetrated her sexual relation and the boredom of the house. "I had sexual intercourse with *Tom* for 2 months but my parents didn't know. Until one day I was boring with the lessons so I skipped school and went to *Tom's* house. My teacher notified my absence to my parents. They wrung the truth from my friends where I went. Then they pursued to *Tom's* house and tugged me to return home. At home, my mom condemned me that "*mai rak dee*" (disreputable person) and entrust worthy person. She intended to hit me with a broom. I was very angry so I disputed that "you are not my nature mother, if you hit me I fight." She screamed and collapsed. Soon afterwards, we separated from each other (no converse, no look at each other). I didn't want to stay here, and I better got a move on. A few days later, *Tom's* parents came to my house to ask for betrothal because they fear that my father would notify the police to arrest their son.

Nan, *Ann's* older sister, was about 17 years old. She gave same reasons as *Ann*. "After my younger sister left, my stepmother tried to concentrate on my behavior. When she knew my sexual relation, I was also expelled from house to stay with my boyfriend."

When I asked the girls what the parents of their boyfriends responded to them, all of them told that they were permitted from the parents of their boyfriends to stay in their homes (willy-nilly). In particular, the parents of their boyfriends might be responsible either school fee or expenses of the girls or both. The main reason that parents of their boyfriends permitted girls to stay at their house was they wanted the girls to restrain their son from multiple risk behaviors including running away, smoking cigarettes, alcohol consumption, and drug abuse. .

Fern was a girl stayed at partners' dormitory, the reasons that motivated her to live with her boyfriend at dormitory were "I don't like being alone and need someone to give my love to" and "to save money." However, she kept it secret from her parent. The main reason she gave was "I don't know how our family will react to our living together. They probably won't support our relationship."

Serial monogamous relationship

This sexual lifestyle was an established pattern of having one monogamous relationship followed by another. The majority of the girls (15 girls) were in an ongoing relationship with the male with whom they first had sexual intercourse. While three girls revealed having had two sexual partners since sexual debut and concealed to new partners about their past sexual experiences.

However, many of girls revealed that monogamous relationships did not last forever. They did not limit their sexual behavior with only one or two partner. If their current sexual relationship broke up they could enter into another relationship. As *Jane* said,

"Although he was my first sexual partner in my life but he was not the last one. Because of I was still young so I had more chance to encounter a better one."

Interestingly, most of girls revealed that they did not have to disclose to new partners about their past sexual experiences. As *Kaew* said,

"Why I have to tell if my new partner doesn't ask about my past sexual experience. However, if he doubts or wants to know I don't have to confess."

This finding showed that many of girls tended to have sexual life-styles of what was commonly called serial monogamy relationship. They broke up and eventually entered into another monogamous relationship and had to disguise their past sexual experiences to new partners.

The duration of the relationship varied from about 4-5 months to more than one year for the long-term sexual relationship. Most of girls reveal that it depended on working out of relationship and how they felt to the boys. If they felt emotionally attached to the boys, relationship was more than one year. However, most of the girls never intended to marry their partner. For example, I then asked to what extent she envisaged a long-term tie with her partner. Her reply was:

Jane: "Do you mean are we going to get married? The answer is no."

Kaew: "I don't know about that; that's a long time from now. But we won't date anybody else as long as we're together."

Nonmonogamous sexual relationship

Two girls had been a nonmonogamous heterosexual relationship. This sexual lifestyle was an established pattern of having multiple partners at the same time. One girl had sexual relationships with two boyfriends at the same time. The other one had sexual relationships with her boyfriend and sugar daddy at the same time.

Poi, 17 year-old girl, had sexual relationships with her boyfriend and sugar daddy at the same time. She said: "I have sex with my boyfriend because I like him but I need to have sex with *Paa* because my school fees. I was willing to have sex with my boyfriend but I had to let sex happen with *Paa*."

3. Sexual activities

The analysis was specified in subthemes: early sexual debut, ambivalent feeling toward sexual intercourse, and traditional gender roles limited the negotiation of sex

Early sexual debut

This study found that the mean age at first sexual intercourse for female students was around 16.4 years. The lowest age at first sexual intercourse for girls was 14 years. To no one's surprise, seventeen of their first sexual partners were their boyfriends, especially with their first boyfriend. Interestingly, three girls revealed that their first intercourse experience occurred with "a friend" whom they had met only recently. However, "a friend" whom they first had sexual intercourse became to be their boyfriends later.

Although all of them had first intercourse with their first boyfriend but only five girls in this study reported they were willing to have sex the first time whilst a substantial number (15 girls) reported it was not planned.

The reasons given were: They were in love; they were curious and wanted to experiment; and they were under pressure from those they were dating.

They were in love

Five girls in this study cited affection for their partner as the reason they first had intercourse. They would give whatever the boy wanted, would make the boy feel good.

Faa, one sixteen-year-old interviewee, remarked, "He told me he loved me and wanted me more, it made me felt good about self so I was willing to take a chance. There's no reason why we shouldn't have sex."

Although they stated they were willing to have sex the first time but if sex occurred it was due to male desire and manipulation rather than a female expressing her own innate sexual desire.

They were curious and wanted to experiment

Curiosity was found to be the reason of having first sex. Ten girls revealed that it was the accident that could happen because of the environment that aroused the sexual desire. Sexual activity between girls and their partners occurred rapidly in a variety of situations in order for people to express their sexual desire. For example: Atmosphere was conducive or private such as "everyone was out at a family reunion so we were alone." Or being home alone with boyfriends and having sex (progression from kissing to petting, to sexual intercourse). They were persuaded to go to private and anonymous places, such as their boyfriend's home while parents were out.

Mint, one 16-year-old girl, explained how she "happened" to have sex, "It was just like I was at his house one day. His parents weren't there and it just happened."

Moreover, drinking made girls unconscious, uncontrolled, and soon engage in unintended sexual intercourse.

Maew, one 18 year-old, revealed the effect of alcohol to have sex, "I don't know how it happened, we drank too much and to be drunk. He took me to my room and it just happened by unconscious."

This study also found that if girls believed that most of her friends were having sex, there could be intense pressure-internally as well as externally-to conform. Many teenage girls also felt pressured to engage in sex. As some girls said:

"I had sex at 17 in my senior year...So many of my girlfriends would talk about doing it with and for their boyfriends, and would ask me about my experience. I was so ashamed for never having done anything throughout my entire life...I was pressured by myself, him, and all my friends to do it, so I did. For no other reason than curiosity, I went through pain...." (***Mint***)

"I had my first sexual relationships at 14....I realize now that my reason for these relationships was to be accepted, wanted, have a boyfriend and pleasing him to keep him." (*Kai*)

The girls agreed with statements that intercourse happened on the spur of the moment, that people of their age seem to do it and that it was a natural follow on in the relationship.

Duang, seventeen-year-old interviewee, described, "I accepted I wanted to experiment sex because I had ever seen and read regarding sex in the magazine books. Moreover I had ever heard from my friends how sex made them fun. Thus, when my boyfriend started to urge to have sex, I didn't stop him."

They were under pressure from those they were dating

Five sexually active females report that their sexual debut was a result of force or pressure from their partner and occurred during a date.

Yam, 15 year-old girl, said, "It (her boyfriend) deceived me to go to his home. His parent wasn't there so it forced me to have sex. I extremely attempted to resist his threat but didn't succeed. Finally, I had to unwillingly concede to have sex. I'm not sure it was rape or not because he was my boyfriend."

However, although the first sexual intercourse was often unexpected for girls, the later sexual intercourse was mostly voluntary.

At the time of interview, fourteen girls reported that they were either still in their first relationship; five girls said that they had moved onto a second or subsequent partner within a month; only one girl reported that the relationship did not continue after the first episode of intercourse.

Most of girls revealed that they had regular intercourse, one to two times a week. Unless girls staying with their parents, they revealed that they did not have

regular sexual intercourse with their partner. They said about 2 to 3 times a month. Their sex depended on opportunity to avoid from their parental control. Their sexual encounters were carried out in secrecy often after school. According to most girls, as both they and their partner were afraid of being discovered, the intercourse took place in a great hurry.

Ambivalent feeling toward sexual intercourse

Female adolescents had to experience a range of feelings after their sexual debut. Although first intercourse could be pleasurable and exciting, but most of girls disclosed that they frequently had feelings of shame, guilt, and anxiety when coping their emerging sexual intercourse.

Am had sex for the first time when she was 16 with her boyfriend. She said, "I want to show my guy how much I love him". Although the actual physical experience was good, but she revealed that she felt bad emotionally afterward.

Mon said, "My first sexual experience was when I was 15. Everyone else was 'doing it' so I figured I should too. When it was over I cried. I wish I would have waited. Maybe not till I was married, but until I was more mature".

Nok said, "I feared of parent's finding out because for my family this matter was shameful."

Nid said, "I feared of my boyfriend's desertion and getting pregnancy."

Feelings toward subsequent sexual intercourse

Female adolescents had to experience a range of feelings toward their sexual intercourse such as boredom, voluntary but didn't want, exciting, fun, and fun. For example:

"It was very good. It made me happy, fun and relaxes." *Joy* said.

"Sometime I was very tired after school. When my boyfriend persuaded me to have sex, although I didn't want but I had to do for pleasing him." *Nam* said.

Traditional gender roles limited the negotiation of sex

This study revealed that ambivalent social attitudes toward sexuality had resulted in girls receiving conflicting messages. Sexual expression and experimentation were viewed as acceptable activities for male adolescents, yet unacceptable for females.

When girls and boys entered into relationships, most of girls disclosed that they had decision and bargaining power as well as boys. They could make decisions regarding their choice of sexual partners. As *Bee* said,

"Nowadays girls could initiate to courting boys and could have numerous boyfriends at the same time to discriminate."

Once they became lovers, some girls revealed that they had less of such power since boys were the ones who initiated the situations to meet and physical contact, and insisted for sexual relations, which proceeded "little by little."

Once they became sexual partners, over half of girls in this study said that power was shared equally in their relationship. They are involved in making decisions about sexual behavior, including condom use. As *Nee* said,

"If I was unwilling to have sex, I did not have to always respond his sexual desire. I could negotiate for refusing."

However, some girls disclosed that they were not encouraged or given the support to negotiate with their partners the timing and nature of sexual activity, to protect themselves from unwanted pregnancy and disease, and least of all to acknowledge their own sexual desire. This finding revealed that one manifestation of

traditional gender roles was the acceptance of male power and control in their relationships. As some girls said:

"Girls who initiated for having sex were viewed as lecherous girl." (*Maew*)

"Many times I had to unwillingly have sex. Although I told him that I didn't have sexual desire but he was disinterested and forced me to have sex at last." (*Mo*)

"I never declined to have sex with him. He always gave me money. So if he wanted, I had to respond." (*Poi*)

"Girls were often intimidated by the guys and didn't want to try and forced them to do anything." (*Aye*)

For girls who did not want to have sex, the ways they did to refuse their partners as follows: some girls they told their partner that

Nid: "I didn't have sexual desire."

Noe: "I was much tired and wanted to sleep."

However, their refusing did not always achieve. It depended on partners' sexual desire. Furthermore, for some girls they thought that pleasing their partner when having sex was more important than pleasing them. They feared that they would be beaten or their partners would leave them if they refused to have sex.

4. Perceived safe and unsafe sexual behaviors

Most of the girls perceived that pregnancy and sexually transmitted diseases could be happened if they had unsafe sexual behaviors. However, this finding revealed that most of girls seemed less concerned with protecting themselves from STDs than from pregnancies.

Just using the pill without using a barrier method was "safe sex."

Most of the girls still believed that the most important ways to reduce their risk were just using birth control (the pill) without using a barrier method was "safe sex." As *Pin* said:

"I have not become pregnant because I use the pill regularly. So I think I have safe sex, at least safe from pregnancy."

Only one partner was "safe sex"

Most of the girls thought that they didn't worry about getting sexually transmitted infections if neither partner ever had sex with anyone else. They believed that intercourse between two people who have known each other for long time was safe. As *Nid* said:

"If I have sex only with my boyfriend and he also have sex with me, I think I safe."

In addition, they revealed that having multiple partners and engaging in sex with unknown partners were high-risk behaviors.

Unsafe sexual behavior was unprotected sexual activity

Most of the girls perceived that unprotected sexual activity was unsafe sexual behavior, including, non-use any contraceptive and condom. However, they would screen potential partners visibly for risk of infection, rather than suspend sexual interaction or use condoms for disease protection. As *Pim* said:

"If I have sex without any protection, I am performing unsafe sexual behavior because I have chance of becoming pregnant."

5. Sexual risk-taking behavior

Sexual risk-taking behavior was specified in subthemes: fail to protect against unwanted pregnancies and STDs.

Fail to protect against unwanted pregnancies and STDs

The use of contraceptives at sexual debut was infrequent

Most of girls had had first sexual intercourse in an "at-risk" situation either because they were not using any method of contraception or because the methods they were using were inadequate. Very few teenagers reported using contraception at first intercourse. However, the most often used contraceptive methods for first intercourse depended on male decision making. Three girls revealed that their boyfriends bought Postinor® from drug store for the girls to take. They stated that their partners did not know much about this method so it was female responsibilities to seek more detail. Only one girl stated that her partner used condom the first time. However, she revealed that it made her pain, discomfort and skin irritation.

The reasons they gave regarding non-use contraceptive could be summarized as follow:

Unexpected and unprepared

Because the first intercourse was usually not planned, ten girls in this study revealed that they were not using any method of contraception the first time. Moreover, they could not tell anyone so they had to leave this situation to fate.

It was male responsibilities

The other reason they gave was that they thought it was male responsibilities to prepare any method of contraception. Six girls revealed that withdrawal was method that their boyfriend used to protect pregnancy. They also believed that they could not get pregnant if a man pulls his penis out of vagina before he "comes."

Slow to adopt contraception and typically irregular in its use

During the first few times of sexual intercourse, some couples did not use contraception of any kind from the beginning; some girls used any contraceptive within a month after first intercourse. These group of girls using any contraceptive method, some girls still used contraceptive method as same as the first time of sex; some girls used varied methods, which depended on a situation at that time such as if withdrawal method was failed boys had to buy Postinor® for girls.

Most of girls revealed that during the first few times of sex, decision making to use contraceptive method depended on their boyfriends. Usually after the sexual relationship became steady, some of girls would take responsibility for using oral contraceptive pills method because they believed that it was the women's role and sureness. However, few of girls I interviewed had never used any contraception.

With respect to pregnancy and contraceptive decisions, girls overwhelming reported that the decision is either a joint one or theirs alone. This finding may in part reflect the types of contraception that are most often used by girls (e.g., birth control pills), because these methods do not require the participation of the male partner. In addition, the responsibility for pregnancy prevention is most often placed on girls.

The most prevalent method of birth control was withdrawn, followed by oral contraceptive pills (OCPs), and the emergency contraception (Postinor®). The least popular method was the condom. However, most of girls stated that they did not have to choose only one method. It depended on a situation at that time. Generally, they wanted methods that were easy to use, reliable, and free of side effects.

Withdrawal (coitus interruptus)

Most of girls accepted to use this method. They described that it was the method that the male withdraws his penis just before reaching orgasm and ejaculates outside girls' vagina.

The reasons they gave were that it was easier than other methods. They did not have to buy and take the pills every day. In addition, friends gave some girls information about this method. As *Noi* said:

"My friend told me that if a man withdraws his penis just before he ejaculates, it won't keep the woman from getting pregnant."

However, girls revealed that sometime their partners were not sure about their ejaculate. If this situation happened their boyfriends would buy Postinor® for girls.

Oral contraceptive pills (OCPs)

This method remained a popular choice among female adolescents, particularly the girls who stayed with their partners. Nine girls had tried oral contraceptives. In two cases, *Ann* and *Nan*, her mother had advised to use this method while the other had advised to use by their peer or female relatives.

However, some had stopped using them because of side effects. For example:

Yan had "gained 3 kgs" while on the pill; "I felt that I was getting fatty. It made me very ugly, so I decided to stop the use."

Another said; "I used the pill only 2 months, then, I stopped the use because I was getting headache and nausea while on it. (*Mai*)"

Many said that a major disadvantage of the pills was that they had to be taken every day. Sometimes they kept forgetting to take them and were confused about the directions of what to do for "missed pills." Moreover, buying contraceptive pills and regularly taking contraceptive pills caused girls to publicize their sexual activities.

Emergency Contraception Pills

This method was used with increasing frequency by girls, particularly the girls who stayed with their parents that did not have regular sexual intercourse. Prostinor[®] and Madonna[®] were the postcoital contraceptive pills which was very popular. The main reason they gave for using this method was that it did not have to be taken every day and it could be easily buy at the drug store. The other reason was their partners failed on withdrawal method.

However, there were several factors seem to limit their use, including the fact that buying contraceptive pills caused girls to publicize their sexual activities so the girls' partners usually bought postcoital contraceptive pills. Moreover, few of them did not know that the drug could not be used regularly or more than 4 pills per month.

Injectable contraceptive

Only one girl in this study was induced from her grandmother to use this method. However, she told me that she did not want to use this method once again because it caused amenorrhoea. She believed that menstruation was essential for bodily cleanliness her body. Amenorrhoea was like having bad blood remained in her body. It made her exhaust and discomfort.

Moreover, she had shown that nurses in sub-district health center provide little information, method choice or discussion of side effects.

Male condom

Half of sexually experienced girls had ever used a condom. However, they did not regularly use. They stated that it was male responsibilities to use it so it was not appropriate for girls to ask them to use it. Most of girls thought that they had only one partner so they did not have to use it. The other reasons given by their partners were that 'condoms delayed the activity'. Moreover, girls indicated that condoms were also less likely to be used if girls and/or their partners were "high" from alcohol prior to sex.

In summary, large numbers of sexually active girls failed to protect themselves against unwanted pregnancies and STDs. Although some girls revealed that they used any contraceptive method, but contraceptive use was typically irregular. The analysis revealed three reasons why girls failed to protect themselves against unwanted pregnancies and STDs: lack of accurate information; too cognitively immature to take seriously the possibility of serious long-term consequences; and inability to negotiate with partners.

Lack of accurate information

Lack of accurate information for many female adolescents led to misperceptions. Teenage girls' predominant sources of sexuality information were from the peers, and teachers. In addition, they described newspapers, magazines, and posters as the most common sources of sexual activity, contraceptive and STDs information, followed closely by radio, television, film, and internet. Some girls reported they also learned about HIV/AIDS from adult family members. Although

some girls, particularly who attending in the vocational schools reported that they were taught about contraceptive method and HIV/AIDS from competent health staff who was invited to teach at their schools but they thought it was not enough.

In this study, all the girls knew of several types of contraceptive measures, in particular, oral contraceptives and condom. However, their knowledge was very superficial. For example, they did not know what to do for missed pills or they could not identify any of the specific steps associated with correct condom use. In addition, most of girls thought that girl did not have to know how to use condom because it was male responsibility.

Regarding transmission of STDs, almost all had some knowledge about STDs, although there was disagreement about the medical parallels to local names and about the symptoms and causes of the STDs. Gonorrhea and AIDS were identified as STDs in almost all of girls, and syphilis was mentioned in many of them. They knew that sexual intercourse and blood were means of transmitting HIV/AIDS and STDs. Most of girls had more knowledge about HIV/AIDS than about other STDs.

Peers are a major source of information on sexuality

All girls revealed that it might be reluctant to ask family members for sexual and reproductive information for fear of being perceived to be sexually active. Because they found talking about sex with parents and adult family members was uncomfortable or impossible, peers often constitute the reference group for transmitting information about sexual activity and birth control.

Most of girls revealed that sex education was no such specific courses in schools. It was only one topic, which taught into hygienic courses. They described teaching contraceptive method in school that it was very tedious, inappropriate and could not apply for adolescents, for example, male/female sterilization and intrauterine device (IUD).

In absence of traditional sources of information, young people turn to their peers for information concerning issues relating to sex. As a result teens had to seek information from other resource, particularly their friends that are often given a great deal of misinformation about contraception, as *Nok* said:

"My friend told me that if a man withdraws his penis just before he ejaculates, it won't keep the woman from getting pregnant."

Most of girls revealed that in their peer group they had got much information about sexual experiences of their friends such as each of steps and position of sexual intercourse, contraceptive use, and management with sexual health problem such as taking a menstruation regulation drug, and abortive clinic.

Too cognitively immature to take seriously the possibility

The findings found two categories regarding perceived personal risk for an unplanned and unprotected sexual encounter: there was no chance of their becoming pregnant and infected; and aware of the possibility but not very concerned.

There was no chance of their becoming pregnant and infected

In approximately half of the girls, they overlooked the possibility of becoming pregnant. Moreover, some girls thought of the possibility of having an abortion if they did get pregnant.

Almost all of the girls said that there was no chance of their becoming infected or that they didn't know whether or not they were personally vulnerable, indicating that they didn't connect their own behavior with STDs/HIV risk messages. Attitudes include,

Noo : "I don't think it could happen to me because I had sex only between two and four times per month."

Nid : "I had not become pregnant with my previous partner. Therefore, it won't happen to me with this one."

Dang : "As I have sex with clean or disease-free man, there is no chance to disease."

Aware of the possibility but not very concerned

Most of the girls, though, were aware that they could get pregnant. They perceived their possibility of becoming pregnant through non-use any contraception.

However, some thought they were too young to conceive. Another few argued that they had not become pregnant with their previous partner. Therefore, it did not occur to them that they would get pregnant with this one. Moreover, some girls stated that it was not a major worry because they thought the possibility of having an abortion if they did get pregnant. As *Bee* said:

“If it happens it happens.”

Regarding perceived risk of STDs, most of girls were also aware of the possibility of contracting a sexually transmitted disease (STD) but they were not very concerned. Although they thought condom was the best method of pregnant and AIDS prevention but it needn't for their relationship. Negative attitude towards condoms was the main reason.

Condom is the best but it needn't

Trust was given as the dominant reason for not using condoms but was never based on discussion about sexual histories. Some girls perceived that they would not contract STDs and AIDS from their regular sexual partner. They perceived that STDs would be happened for persons who have had numerous sexual partners.

Some girls perceived risk of their partners in the encounter. Individuals having sex with a boyfriend might feel that their partner was "safer". They tended to screen potential partners visibly for risk of infection. The other thought that it was solely their partners' responsibility to protect themselves from catching diseases.

This finding showed that majority of girls tended to screen potential partners visibly for risk of infection, rather than suspended sexual interaction or used condoms for disease protection. As some girls said,

"I think that my boyfriend who fears to contract AID should know how to protect himself if he sleeps with another girl."

(Nim)

"As I have sex with clean or disease-free man, there is no need to use condoms." *(Pim)*

Condoms are only for prostitutes

There was a strong belief among adolescent girls that condoms were only for prostitutes. Some girls felt that a partner's wish to use a condom suggested that they were not clean. Some indicated that they would make use of condoms to prevent pregnancy with regular partners but that condom use was most important for preventing getting a disease in casual relationships. Trust was given as the dominant reason for not using condoms but was never based on a negative STDs or HIV test or discussion about sexual histories. Furthermore, girls tended to internalise the frequently negative attitudes their peers express about condoms. These included attaching negative attributes to the contraceptive value of condoms and the notion that condoms are only necessary for those already infected with STDs or HIV.

Moreover, this finding also found that girls perceived condom use to be a man's prerogative, no girls mentioned asking her boyfriend to use a condom. Others said whether or not they used a condom depended on who they were with and "how much I trust them."

The finding revealed that most of girls considered only the risk of unwanted pregnancy but ignored the risk of STDs. Although most of girls knew that condom was only method, which protects against STDs but they continue to view the use of condoms as only necessary among those already infected with STDs or HIV. They tended to trust that they would not contract STDs or HIV from their sexual partner. As some girls said:

"I never use condoms. I think that my boyfriend who fears to contact AID should know how to protect himself if he sleeps with another girl." (*Pang*)

"We never use a condom because he tell me that I am the first of him. So we don't need to use it." (*Nan*)

Inability to negotiate with partners

Girls who felt little control over their sexual behavior were more likely to engage in risky sexual activity and to fail to use condoms consistently.

The girls sought affection and attention elsewhere, often becoming emotionally dependent on boyfriends and afraid of losing them by resisting their importuning for a sexual relationship. Particularly, girls needed a sexual relationship with older males to help with school fees and other expenses. They had little leverage with which to say "no" to unwanted sex or to oppose male partners who argue that no risk was involved in having sexual relations.

Mai, 18 years old, said, "Once, I asked my boyfriend to put a condom on but he said 'no,' and told me never to question any of his decisions. He told me not to worry about getting pregnant. I really liked him a lot and I trusted him."

Poi, 17 year-old girl who had sexual relationship with sugar daddy, said: "I have to please him. Although I am not willing but if he want I have to say 'yes'. Decision making to use or non-use condom has to depend on him. If he doesn't want to use it, I don't have leverage to say 'no'."

This finding revealed that where the imbalance in power reduces the female voice in the negotiation of sex. In instances such as these the chances that girls were able to insist on condoms were very small.

Overlook the consequences of engaging in risky behaviors

Of course, such unsafe sex placed them at risk of experiencing two serious consequences: sexually transmitted diseases and teenage pregnancy. Girls often dismiss these very real dangers with: "It can't happen to me." But it could.

Aye was one of many sexually active teens who had intercourse without protection. "I thought that it seemed like everyone was

already doing it”, says Aye, 17. But despite knowing how to get and use a barrier method (condom) and hormonal method (the Pill) of contraception, Aye had intercourse without using any. She put herself at risk for sexually transmitted diseases (STDs) and unwanted pregnancy but she didn't worry about the risks. Aye was unsafe and lucky.

Ever involved in a pregnancy

For this study, sexual health problem which girls had to experience was unwanted pregnancy and unsafe abortion. No unintended pregnancies would occur if all girls who wish to avoid pregnancy were to use effective contraception perfectly. But not all such girls practice contraception. As a result, five girls interviewed had been pregnant and all had terminated their pregnancies with induced abortion.

Of the five girls, two girls revealed that they were not using any method of contraception, two girls revealed that withdrawal was method that their boyfriend used to protect pregnancy, and one girl reveal that she took OCPs but she often forgot to take pill. All of them did not think that it could happen to them. As some girl said:

"I had been having sex since I was 16. I always believed that I couldn't get pregnant because my partner told me that he withdrew. When I found out I was two months pregnant. I was completely shocked." (*Noo*)

"I often missed pills and had not become pregnant. Therefore, I did not think that it would occur." (*Noi*)

"I never though it could happen to me. I was kind of naïve. I mean I knew I could get pregnant but I never used my head. I was like a dingy little girl". (*Nid*)

When the girls missed their menstrual period, four girls consulted their female friends and/or boyfriends while only a girl consulted their adult relatives who

they trusted. All of them were recommended for getting a pregnancy test from the drug store or private clinic.

Not surprise, three girls elected to purchase a home pregnancy testing because it was privacy and inexpensive. They did not want to wait for calling at the clinic. For two girls, they elected to observe their menstruation for 1-2 months to be certain of her pregnancy status. Then one girl took traditional drug believed to help propel the blood (*yaa khab lued*) after 2 months of amenorrhea with no pregnancy test. The other one began to seek information to solve the problem from her friend and adult relative.

The decision to terminate pregnancy

Once pregnancy became a reality, all girls revealed the feeling of shock, angry, and out of control gave way to realization. All pregnant girls felt isolated and suffered stress as they had no one to turn to for help.

Negative consequences of becoming pregnant girls concerned, including school expulsion, parental disapproval and punishment (parents' refusal to send adolescent girls back to school). Therefore, they had to hide their pregnant from the other, particularly their parents. The following emotional reactions were reported by the five pregnant student girls about their pregnancies were disappointed, depressed, frustrated and felt guilty.

The reasons cited for these emotional experiences about their pregnancies as follows: they perceived that pregnancy for girls particularly who attending school brought shame to both her and her family; they might be condemned from the other as bad girls; and denied their responsibilities or suggested abortions by male partners.

All girls in this study had terminated their pregnancies. The major reasons given for why they seek termination of pregnancy were: the need not to interfere with schooling; not being old enough to get married; too fear to inform their family of their sexual activity; not planning to marry the partner; being jilted by a partner.

Bee, 18 year-old girl, was pregnant after a few months engaging in sex with her boyfriend. She did not realize that she was pregnant even knowing that mens had not come for tow months. Once pregnancy became a reality she revealed the feeling of shock. She

said, “My mom expects that I will have bright future. She always thinks that I am a good daughter. She doesn’t know about my sexual experience. If she knows about my pregnancy, it makes her sorry to disappoint in my bad behavior. Moreover, pregnant students are labeled as "bad girl". Inducing an abortion is a way to solving such problem.”

After girls decided to terminate their pregnancies. All girls consulted their friends and boyfriends for seeking abortive information. They were recommended many methods such as a menstruation regulation drug, "beating it out" by folk midwife, the so-call "abortion" pills, and abortion clinic. Information about abortion services was readily available through friends or friends of friends.

The girls in this study had had several self-induced abortions using. Most induced abortions were self-induced. If it did not succeed, they went to abortion clinic. According to the participants,

Kaew had her first sexual relationship with her boyfriend at 16 without protection because it was unplanned. She bought a pregnancy test at drug store and discovered she was pregnancy. She and her boyfriend discussed the situation and sought advice from their friends about the so-called "abortion" pills and clinics. The pill failed to work and the boyfriend coughed up Bt 4,500 for the abortion at private clinic.

Noi, 17 year old who becoming pregnant from missed pills, said, “I am still in school and unable to care for a child. I have only two choices: terminate the pregnancy and return to school, or keep the baby and leave. For me, one of the top things in my life right now is school.” She bought a menstruation regulation drug called "**Ya sa tree**" (medicine to release menstruation) from the drug store. She drank for 2 bottles but it failed. Then boyfriend took her to

private abortion clinic. Her boyfriend paid Bt 3,000 for the abortion.

Kaew and *Noi* revealed more detail about their abortion with vacuum suction that they stayed at clinic only 2-3 hours after abortion. They could return to their normal activities the next day. However, bleeding might last about two weeks. They felt like menstrual cramps.

Men's role in advising/paying the induced abortion

All the pregnant girls had informed their partner of their pregnancy and had discussed the choice of abortion with their partners. Two of the partners had advised the girls where to go for the abortion and had also paid for the procedure. Two girls had been advised by a girlfriend and had provided the money themselves. The remaining girl had received advice and financial assistance from her female relatives.

Noi, 17 year old who becoming pregnant from missed pills, said: "When my partner knew about my pregnant, he was very angry. He reviled me that I was stupid to forget to take pill. He thought that It was really up to me to protect myself. For me, I didn't agree with him because he had sex with me, too. I didn't see why birth control must always be my responsibility. It wasn't only my fault that I forgot."

"He didn't help me pay for my abortion. I borrowed the money from my friends. He didn't take me to the abortion clinic either, instead a girlfriend drove me." (*Noo*)

6. Accessibility to reproductive health services

This study highlights some of the barriers that girls faced in many places when seeking such services, barriers that serve to inhibit their wider use. Moreover, female adolescents' access to education and information on sexual matters, including

contraception had been seriously neglected, largely because of fear of encouraging any 'immoral' or unrestrained sexual behavior.

Adolescent girls are not expected to be sexually active

In this study, it was found that availability of sexual health services was particularly problematic for girls. No girl utilized the government health services for received services, including contraception and pregnancy test. Girls stated that they could not dare to access to reproductive services in the hospital because they were assumed from the other that they were not sexually active. They revealed that fear of disclosure prevented many girls from seeking appropriate and timely care for a variety of sexual and reproductive health needs. In some girls, a major reason for unprotected sexual activity was fear of disclosure while seeking contraceptives. As **Nam** explained:

"I wouldn't want to walk into health service and buy the pill. It would be too easy for someone to see me."

Moreover, most of girls viewed that the negative attitudes of health staff at the local clinics prevented them from accessing. They thought that staff gossiped about the reasons for their visits.

"I won't go to a government clinic," **Yo** explained. "I didn't want to be asked by health staff 'What are you doing with pills? Do you have sexual intercourse?"

Some girls revealed that adults in the community preferred warning them off sex through punishment and gossip rather than encouraging them to use contraceptives when having sex.

Mai said, "The problem was that they just beat you for having sex. Others will just condemn you and spread the rumors around that you misbehave. They don't give you any advice."

As a result, the worst thing of no access to health service was that all of girls used self-treatment and bought medication from drug store. Most girls noted the economic advantage of self-treatment with medication from a chemist. As *Nam* said:

“It is cheaper. You buy as your money can afford.”

Reproductive health services needed for girls

Some girls revealed that they need information and caring advice from professionals, including doctors and nurses, on birth control, sexually transmitted disease, reproductive tract infections, and safe abortion.

Sexual education in school should be adjusted

Girls also suggested that sexual education in school should be adjusted according to the student needs. They said school sex education was further limited by the fact that it was typically provided during the late stages of high school, a time when most adolescents had already begun sexual experimentation. Moreover, most of girls revealed that sex education was no such specific courses in schools. It was only one topic, which taught into hygienic courses. They described teaching contraceptive method in school that it was very tedious, inappropriate and could not apply for adolescents, for example, male/female sterilization and intrauterine device (IUD). The topics they wanted to learn about, included feelings about the other sex, birth control, pregnancy, abortion, and how to decide about sex.

Some girls thought that doctors and nurses gave the most "valid" information. They felt that teaching or individual counseling by these professionals was the best way to provide sex education. Some girls viewed that counseling clinic in school by doctor or nurse or health personnel would be most suitable.

Reproductive services specifically for adolescents

They also suggested that more teenagers might attend reproductive clinics if they could attend these services specifically for adolescents. Most girl in this study revealed that they preferred to go to the health center where the health staff paid

attention and was friendly to them, having privacy, good quality of care in terms of having time for the patients to ask questions regarding their health problems, and low cost. Moreover, they suggested that there should be adolescent health clinics for adolescents to use the service.

Respectful, caring, and supportive relationships with health staff

Most of girls in this study wanted relationships with health staff that were respectful, caring, and supportive. They wanted to be given educational information, but did not want health care providers to assume that they did not have knowledge. They wanted a health staff to provide education to guide the adolescent's choices. Female adolescent also needed nonjudgmental health teaching that includes accurate information about sexual health. Contraception, sexual transmitted diseases, and AIDS, communication skills, and general health care are all topics that need to be discussed. They needed the opportunity to discuss issues related to sexuality. They need a friendly, unbiased ear.

CHAPTER V

DISCUSSION

This study aims to gain understanding of sexual experiences among in-school female adolescents in Amphoe Muang Chiang Mai Province. This chapter discusses the findings of sexual experiences among in-school female adolescents. Included in the discussion are six major themes in the sexual experiences.

Sexual experiences among in-school female adolescents

Six major themes in the sexual experiences were discussed as follow: meanings of sex, sexual partnerships, sexual activities, perception of safe/unsafe sexual behaviors, risky sexual behavior, and access to reproductive health.

1. Meanings of sex

This study found that their answers were varied from "sex was love" to "sex was barter" which depended upon sexual experiences of each girl. Girls, who were willing to have sex, stated affection for their partner as the reason they had sexual intercourse. They viewed sex as love and intimacy. Some girls revealed that love and sex was not the same thing. They viewed sex as a biological event, physical pleasure, and new experience, which were not limited only heterosexual intercourse but also, homosexual intercourse. Girls, who were forced to have sexual intercourse, viewed sex as disgusting, and reluctant. The remaining girls explained that sex was barter. They received money from their daddy sugar in exchange for sex.

This finding showed that sexual meanings of female adolescents might be difference from their sexual experiences. According to many researchers, adolescents may perceive that sexual intercourse is intimate relationship, love, trust, admiration, and seeking sexual experience (Diloksambandh, 1995: 136; Khamkhayan, 2000: abstract; Muangsom, 2000: 98). Moreover, they may perceive that sex was sexual drive response, biological and psychic pleasure, enjoyment, improvement their sexual

ability, preparation before enter into marriage and binding by love (Wasikasin & Earmpradit, 1994: 27).

This finding differs with Dixon-Mueller (1993: 273) who stated that the social construction of sexuality refers to the process by which sexual thoughts, behaviors, and conditions are interpreted and ascribed cultural meaning. These may be due to girls in this study are sexually active girls, so they viewed sexual meanings from their sexual experience more than from majority social norms.

Perception toward premarital sex

They generally agreed that sexual activity was common among their peers. It was a natural follow on in the relationship. Although some girls revealed that premarital sexual intercourse was inappropriate but they viewed that having sexual intercourse with boys who they love was not bad. It was clear that girls now firmly believed that premarital sex with affection was acceptable. This finding showed that nowadays, western value about free sex rapidly spread into Thai society (Khamkayan, 2000: 3). As a result, Thai female begin to have attitude and value about premarital sexual intercourse that it is normal and not suffer to their life style. According to pilot study of Poosanasuwansri (1997: 5-6) has found that most of adolescents had attitude to premarital sexual intercourse that it was preparation for male and female before marriage.

It is clear that peers have more influence to thinking and acting of adolescents because they will often copy tradition and norm of peers. There is so much peer pressure to deciding whether you should become sexually active. They thought "Everybody's doing it." Peers' sexual experience influences the girls' view on sexual relation in the way that premarital sex is normal practice. Because of female adolescents in this study were the middle teenage period (age 15-18 years), so the most significant concern at this stage is the need for peer approval. Frequently, there is a desire to separate from old friends and create a set of new peer group friends who share the same values and attitudes (Erikson, 1950,1968 cited in Berk, 2001: 390). This is consistent with Nuchanat's study (1988: abstract) found that sexual intercourse of closed friend statistically associated with sexual experience of adolescents. Moreover, the study of Dusex (1987: 287 cited in Diloksamandh, 1995:

27) indicated that informational acquirement from friends would often make female adolescents received incorrect knowledge and wrongly attitude such as decrease virgin value, sexual relationship indicate to autonomy and modernizes. These attitudes led to careless behaviors, sexual contact, and lately engaged into sexual intercourse.

2. Sexual relationship

In this study, a second type of relationship was mentioned by a couple of girls: intimacy sexual relationship-boyfriend (“*phan*”) and commercial sexual relationship-sugar daddy (“*paa*”). The first type of sexual relationship was usually based on emotion and feeling while the second type was usually based on financial support.

2.1 Intimacy sexual relationship-boyfriend (“*phan*”)

The reason participants gave for this relationship (which might or might not involve sex) were peer pressure, to love and to be loved, to enhance self-esteem, and to have fun.

Peer group behavior strongly encouraged sexual partnership. Friends informed each other about who was interested in whom. Most of girls disclosed that being in the group of girls who were more likely to have boyfriends, they would encourage each other to do the same. These may be due to girls in this study were the middle teenage period (age 15-18 years), so the most significant concern at this stage is the need for peer approval. Frequently, there is a desire to separate from old friends and create a set of new peer group friends who share the same values and attitudes (Erikson, 1950,1968 cited in Berk, 2001: 390).

Because the family characteristics nowadays, unlike those in the past, were a small nuclear families, divorce and remarriage families, and single mother families. Family relationships had changed. They had to live in the environment that filled with problems like quarrels, divorce, and new families. They seemed to have difficulty accepting their new stepparents’ overtures. As a result, they had to live in an ambiguous situation, which may foster emotional detachment. Although they like freedom and dependence but they also want to be loved and cared by people around them especially their parents (Subcommittee on Family Affairs, 2000: 136). Girls

want someone to confide in, someone who can offer emotional support and understanding. Such critical situations in the families forced most of the girls to seek affection and attention from out-of-home and pushed them to relate with boys and end up with sexual relation.

Nowadays, education opportunity was the main motives for rural to urban migration. Many girls had to move in dormitories. These might provide greater freedom from parental supervision, which allowed them to have a going out life style. They found many more opportunities to meet one another. Modern youth meet at parties, make dates via the telephone, and go off alone to spend time together on the town. Chiang Mai society was not only more permissive than in the past but also actually encourages early contact between the sexes.

Because girls had education opportunity than the past, so it was the main motives for more self-confident and intellectually creative than the past. They can make independent choices probable. Therefore, majority of girls perceived there was gender equality between men and women. These caused them to have high autonomy at the younger age, and therefore offered more opportunities for meeting eligible members of the opposite sex and developing intimate relations.

2.2 Commercial sexual relationship-sugar daddy (“paa”)

Two participants explained that the desire for material and financial gain was the primary motivation for this relationship.

It is one of patterns of sexual service hidden in female students. Commercial or consumer sex is female adolescents who use their body to modify to commodity for example sex in exchange for money, goods, and other as agreement (Balzer & Srionsri, 1996: Conference proceeding). As female adolescents need to increase monetary status, they engaged into sexual intercourse especially with older partner (Okpani & Okpani, 2000: 40-47). Commercial sex results from social construction that has economical development as materialism. Under the construction of these economic system leads to new value as materialism what produces new pattern of sexual relationship, commercial or consumer sex, in female adolescents.

This is consistent with Balzer & Srionsri's study (1996: conference proceeding) regarding the going-out lifestyle of the *wairoon cai taek* found that an

amount of female adolescents made money by sleeping with men (the sale of sex) because they need money to buy food and clothes, basically to pay the daily and monthly expenses. This is similar to many studies' findings that economic reason was a factor forcing female adolescents to exchange sex for financial supports (Soonthornthada, 1996:2-3; Limsamphan, 1997: 168).

3. Sexual activities

The analysis was specified in subthemes: early sexual debut, ambivalent feeling toward sexual intercourse, and traditional gender roles limited the negotiation of sex.

Early sexual debut

This study found that the mean age at first sexual intercourse for female students was around 16.4 years. The lowest age at first sexual intercourse for girls was 14 years. To no one's surprise, seventeen of their first sexual partners were their boyfriends, especially with their first boyfriend.

This finding is similar to what reported in other studies that female adolescents had early first sexual intercourse at 15-17 years of age by average (Durex Global Sex Survey, 1999; Serintawatana & Komphayak, 1999; abstract; Chuprapawon, 2000; Sethaput, 2000). The most of female college students in Bangkok began to have first sexual intercourse on the average 15 year-old (Maungsom, 2000: 29).

The reasons given were: they were in love; they were curious and wanted to experiment; and they were under pressure from those they were dating.

As adolescents develop a capacity for sexual intimacy, sexual curiosity and experimentation are common. Today adolescents are more sexually active than ever before and at an earlier age. Adolescents often face peer pressure to be sexually active; and additional motivation for sexual activity for girls may be a desire for sexual intimacy rather than a wish for the physical act of intercourse (Masters, Johnson, & Kolodney, 1995; Zwelling, 1997).

Emotional growth processes include psychological motivations which are basic characteristics of adolescents are curious, pleasurable, impatient, and

conspicuous; moreover, they want to learn or try a new thing. The consequent of these is adolescents have basic instinct to experiment new thing or copy traditional performance especially sex curious which lead to require to experiment and finally enter into sexual intercourse (Suporn, 1993:276).

There was some recognizable pattern to traditional dating. Female adolescent dating was controlled by the youth themselves and involves relative freedom for the young man and woman to be alone together. This intensified the pressure for the pair to move toward premarital intercourse as a means of handling their sexual drives. Thus, although some girls perceived that it was not appropriate to engage in sexual relationship but curiosity, sexual desire and the atmosphere lead to unplanned sexual relation.

Ambivalent feeling toward sexual intercourse

Female adolescents had to experience a range of feelings after their sexual debut. Although first intercourse could be pleasurable and exciting, but most of girls disclosed that they frequently had feelings of shame, guilt, and anxiety when coping their emerging sexual intercourse.

These may be due to girls, nowadays, had education opportunity than the past, so it was the main motives for more self-confident and intellectually creative than the past. They can make independent choices probable. They feel that they have an entitlement to engage in sexual activity, including sexual intercourse, at whatever age seems appropriate to them. On the contrary, Thai society, which is powerfully held on double standard, provides more liberty and authority in male than female. It is patriarchy society, which gender-based power in sexual relationships is frequently unbalanced and those women usually have less power than men (Blance, 2001: 190). A double standard based on the assumption that males have a greater desire and need more sexual activity than females do cause most women to internalize their passive and non-initiative taking role. “Good” women should suppress their sexual feelings and reactions, not display sexual pleasure or sexual desire, so they won’t be accused of being like a prostitute who has sexual skills (Fongkaew, 1996: 5; Yoddumnern-Atting, 2001: 16).

Traditional gender roles limited the negotiation of sex

In this study, there were some contradictions regarding the gender role as perceived by girls. They perceived that they were equal to men while at the same time they were controlled by Thai cultural values that good women must be proper and should preserve her body. Most of girls accepted traditional gender roles and believed that it was up to them to set limits on sexual activity. There was no expectation for boys to limit themselves in any way.

Social inequalities between the sexes serve as one of the most important bases for power differentials in the sexual lives of women and men. The effects of gender power on the sexuality of women and men are reflected in the control of women's sexuality.

Under patriarchy social construction, male have much power in decision-making. Male are leaders of female in several dimensions, especially in sexual dimension. Gender-based power inequities generally incorporate the belief that men should control women's sexuality. Women usually have less power than men. These imbalances operate in the context of a nearly universal sexual double standard that gives men greater sexual freedom and rights of sexual self-determination than women enjoy (Blance, 2001: 190). Without an equalization of power in their relationships with male partners, female adolescents are powerless to sexual negotiation. For example, most of female did not dare to say no with their partners (Taylor-Seehafer & Rew, 2000: 18). Moreover, girls' economic dependence on men, this situation will reduce their ability to negotiate with their partners (Blanc, 2001: 199).

4. Perceived safe and unsafe behaviors

Safe sexual behaviors as perceived by girls were just using birth control (the pill) without using a barrier method and sexual intercourse between two people who have known each other for long time. While unsafe sexual behaviors were having multiple partners, engaging in sex with unknown partners, and unprotected sexual activity, including, non-use any contraceptive and condom.

This finding is similar to what reported in other studies that safe sex behaviors were any sexual activity that no risk of contracting diseases and pregnancy such as sexual intercourse with no STDs and AIDS partners, consistent use of

condoms, and other efficiency contraception (Vipaweealakul, 1997: 6-7). Unsafe sexual behaviors or risky sexual behaviors could be defined as any sexual activity that increased the risk of contracting AIDS or other STDs or becoming pregnant. These included early sexual debut, unprotected sexual activity, inconsistent use of condoms, high-risk partners (e.g., injection drug users, survival sex [sex in exchange for money, drugs, food, or shelter]) or sex with a partner who had other partners or more than one partner at a time (Aral, 1994; IOM, 1997 cited by Taylor-Seehafer & Rew, 2000: 16).

However, this finding revealed that most of girls seemed less concerned with protecting themselves from STDs than from pregnancies.

5. Sexual risk-taking behavior

Sexual risk-taking behavior among participants was failing to protect against unwanted pregnancies and STDs. Most of girls had had first sexual intercourse in an "at-risk" situation either because they were not using any method of contraception or because the methods they were using were inadequate. Very few teenagers reported using contraception at first intercourse. Although some girls revealed that they used any contraceptive method in subsequent sexual intercourse, but contraceptive use was typically irregular.

This was consistent with Amara Soonthornhada's study (1996: abstract) about safer sex behavior among 15 sexually active female adolescents found that there were only 6 cases used contraception and 9 cases did not use any contraception. Moreover, the study of Boonmongkon, et al. (2000: 26) confirmed these risky sexual behaviors. They found that some girls did not choose to use any contraceptive method and some chose to use other methods such as the withdrawal method.

The analysis revealed three reasons why girls failed to protect themselves against unwanted pregnancies and STDs: lack of accurate information; too cognitively immature to take seriously the possibility of serious long-term consequences; and inability to negotiate with partners.

Lack of accurate information

This study reiterates the fact that information on sexuality, conception, pregnancy, contraception, and disease is rarely imparted by teachers or health

professionals. Moreover, parents are frequently not the primary source of information. Ranking high as main sources of information are friends and the media. This can have disastrous consequences.

This finding is similar to many studies' findings that adolescents and young adult have limited knowledge about reproductive health, STDs and AIDS. Many adolescents get incredible amounts of misinformation from friends and the media. They are very misinformed about safer sex and what puts them at risk for pregnancy and STDs, including AIDS. They tend to discount a lot of risky behaviors (Soonthaorndhada. (1996: abstract; Pattaravanich, 1996: 26; Limsumphan, 1997: 161,163; Pinyapong, 2001: conference proceeding).

Knowledge about safe sex behaviors among female adolescents contributes understanding and participation to enter into that behavior. Generally, how people will participate and perform into any healthy behaviors is up to how much knowledge and understanding they have. According to Becker, et al. (1974: 29-30) stated if people do not have knowledge about that disease, they will not seek for self-care, prevention, or healthy examination because they lack healthy attraction.

Too cognitively immature to take seriously the possibility

The findings found two categories regarding perceived personal risk for an unplanned and unprotected sexual encounter: there was no chance of their becoming pregnant and infected; and aware of the possibility but not very concerned.

One barrier to STDs prevention pertains to the nature of normal adolescent development. Adolescents are sexual experimenters and risk-takers, not because they necessarily seek danger, but rather because they are learning about their sexuality for the first time. In addition, girls think concretely and can not fully comprehend the consequences of their actions. Another barrier to prevention is related to the diseases themselves. Many STDs are asymptomatic or have a prolonged latency period, making it even more difficult for girls to understand the potential dangers of unsafe sexual activity.

As a result, most of adolescents perceived that diseases were yet far away from them even though they still performed risky sexual behaviors. Although, they had knowledge and understanding how contacting of STDs or AIDS but denied to do

that because they believed that diseases could not be contacted to them and they might not be in risky group (Kanoengsakasem, 1993: abstract; Seangkrachang, 1995: 89; Kanato, 1998: 110).

Moreover, they did not acknowledge the potential health risks of intercourse with a regular known partner. Familiarity with a sexual partner is accompanied by a perception of decreased risk. This is similar to many studies' findings that sexual intercourse among adolescents was often non-use condom especially with their lovers. (The Population council, 1995: VI).

People who perceive susceptibility to disease will be determined to perform preventable activity. Contrary, female adolescents who have perceived that their sexual behaviors insusceptibility to STDs, AIDS, and pregnancy seem to increase unsafe sex practice (DiClemente, 1990; Cerwonka, et al., 2000; Hutchinson, 1999: 65; Parsons, et al., 2000).

Attitude about contraceptive and condom use is one of factors that influenced to sexual behavior because attitude is personal belief and feeling for anything that results from learning and experience. It stimulates person to practice or tends to response to stimulator in any way (Ajzen, 1988: 117).

This study found that major reason why girls did not use condom was they had negative attitude about condom use. While general female adolescents thought that condom was symbol of bad women. These made female adolescents afraid to ask their partners or boyfriends to use condom because they might be condemned that "bad women". They thought that condom use was not appropriate for loving relationship because it indicated to mistrust and lost of closeness together (Boonmongkon, et al., 1998: 55; Katinurak, 1992: 62).

Inability to negotiate with partners

Gender roles were salient to the extent that girls were expected to learn how to resist pressures to have sex, or, failing that, how to manage contraceptive protection.

The sexuality of girls had highlighted imbalances in gender power that prevent them from negotiating safe sexual encounters. Social constructions of

masculinity that promote the idea of men 'needing' sex further constrain women's negotiation potential by limiting opportunities for women to either refuse sex or negotiate safe sex. Most girls engaged in sexual risk-taking because they perceived this behavior to be consistent with social norm. Because social norms might define a "good woman" as one who was ignorant about sex and passive sexually. Girls were more likely to report that their partners expected them to be obedient and submissive and to engage in coitus. In addition, girls believed that boys had a "natural right" to make more demands in sexual relationships.

In Thailand, gender role directly effects to ability to communicate with partner. Thai women are expected from social to be passive so they are not comfortable enough to talk about sex and contraceptive and condom use with their partner. The study of Umaporn Pattaravanich (1995: VIII) found that female adolescents tended to negotiate to have sex with partners but negotiation to use condom were relatively little that led to increase of having sex without condom use. According to the study about reason of inconsistent use of condoms and other barrier contraception among Thai adolescents is loss of communication with partner about pregnancy, STDs, and AIDS risk (Boonmongkon, 1998: 55).

Overlook the consequences of engaging in risky behaviors

For this study, sexual health problem which girls had to experience was unwanted pregnancy and unsafe abortion. No unintended pregnancies would occur if all girls who wish to avoid pregnancy were to use effective contraception perfectly. But not all such girls practice contraception. As a result, five girls interviewed had been pregnant and all had terminated their pregnancies with induced abortion.

Pregnancy was a sensitive issue for girls. Those who faced such a problem normally decided either to keep the baby and leave school or terminate the pregnancy and return to school. Despite the fact that there were often strong taboos on pre-marital sexual activity, sexually active girls were also neglected. Girls suffering from unwanted pregnancy might be ashamed to seek care. They often faced difficult decisions when pregnancy was unplanned. There was a lot to think about. The socialization process produced girls who were more submissive and less able to hold responsibility than men, yet were expected to be responsible for the consequences of

their sexuality. These included unwanted pregnancies leading to problems such as forced cessation of education of girls, and alienation from their families. As a result girls who becoming pregnant had to self-induced abortion or illegal abortion.

This is similar to the study of Jeerapun Intha (1999), which collected data about risk behavior of Mathayom Suksa 5 students in Chiang Mai Province, found that almost 1 in 8 of sexually active female adolescents had ever had unwanted pregnancy and induced abortion are sought by them.

6. Accessibility to reproductive health services

Relatively few girls were currently using contraceptives. It reflected the significant barriers of contraceptive use that many girls faced. Family planning programs found providing contraceptives to the unmarried, especially unmarried adolescents, almost impossible. As a result, sexually active girls usually had no access to contraceptives, so pharmacies and department stores were the preferred sources of contraceptive supplies. This is similar to the case study of students and factory workers in Bangkok, Thailand (Soonthorndhada, 1996: abstract), reports that pharmacies and department stores were the preferred sources of contraceptive supplies, because of the privacy and anonymity these sources enabled.

Cultural norms are also important obstacle of female adolescents to access reproductive health services because they are afraid their premarital sexual intercourse will be found out if they receive services and they may receive stigma as “bad female” from society. Moreover, the attitude of reproductive health providers will often evaluate females who have reproductive health problems as promiscuous women and they often think that these problems could not occur with good women. As a result, female adolescents who have exist less power to make self decision increase pressure to access correct information and reproductive health services. Lack of access and lack of information put them at risk for pregnancy and STDs, including AIDS.

Even where no legal restrictions existed to providing sexual counseling and reproductive services to unmarried adolescents, social sanctions against premarital childbearing might be reflected in providers’ negative attitudes or refusal to supply contraceptives to young people upon request.

CHAPTER VI

CONCLUSION

Summary of the study

This study was an exploratory and descriptive research design and employed qualitative method to insight sexual experiences among in-school female adolescents. Data was collected through in-depth interview and observation techniques. The sample was comprised of 20 sexual actively 15-18 year-old female adolescents, who attending school within Amphoe Maung of Chiang Mai Province. Data were analyzed using the content analysis

Most female adolescents studied are in middle adolescence coming from small nuclear families consisted of parents and their children. They were in a family characterized by low cohesion, with poor parental monitoring and support. These made them emotional stress and lack of affection. Education opportunity was the main motives for rural to urban migration. Most of girls had independence at an early age. There were some contradictions regarding the gender role as perceived by girls. They perceived that they were equal to men while at the same time they were controlled by Thai cultural values that good women must be proper and should preserve her body.

Meanings of sex as perceived by girls were varied from "sex was love" to "sex was barter" which depended upon sexual experiences of each girl. Most of girls perceived that sexual activity was common among their peers.

They revealed that although intimacy is the main reason for sexual relationships, two girls revealed that the desire for material or financial gain is the primary motivation for sexual relationships. Their mean age at first sex was 16.75. The reasons given were: They were in love; they were curious and wanted to experiment; and they were under pressure from those they were dating.

The majority of girls had been exposed to risky sexual practices, including failing to use condoms. They had some knowledge contraceptive measures and STDs,

in particular, oral contraceptives and condom, but their knowledge was very superficial. Many denied using efficient contraception. Moreover, they did not acknowledge the potential health risks of intercourse with regular, known partners were high-risk behaviors.

Although sexual experimentation might be normative for adolescents, these experiences could result negative consequences for girls. Interestingly, five girls in this study had ever been pregnant; all of these pregnancies ended in abortion. Most of them induced abortions were self-induced. If it did not succeed, they went to abortion clinic; they were unlikely to seek treatment from health care services because of slow service, negative provider attitudes toward young people and a perceived lack of confidentiality.

To reduce the incidence of unprotected premarital sexual activity, adults need to understand adolescent reproductive decision-making. Clearly, the social environment plays an important role in affecting adolescent behaviors. The social environment for adolescents includes their friends, sexual partners and family members, as well as their community, school and other institutions that work with youth.

Findings from this study stress the global need for: adolescent- and youth-friendly sexual and reproductive health services; counselling on sexuality, pregnancy, post-abortion issues and family planning; and sex education programmes that are age-appropriate and sensitively imparted.

Suggestions and Recommendations

Recommendation for nursing practices

1. The findings of the present study revealed that female adolescents require more knowledge about reproduction, contraception, emergency contraception, terminate of pregnancy services, and "safe sex" in order to attain the freedom of making their own choices base on factual information. Based on this finding, the following recommendations are made:
 - 1.1 Peer group counseling: Because female adolescents are not typically comfortable discussing sexuality with anyone, especially their parents

so useful intervention for this concern include peer group counseling by slightly older person of the same sex.

1.2 Sex education

- Adolescent girls need knowledge and skills to perform a given behavior; thus, interventions need to promote mastery learning through skills training. So they should be informed and knowledgeable by nonjudgmental health teaching that includes accurate information about sexual health. Contraception, sexual transmitted diseases, and AIDS, communication skills, and general health care are all topics that need to be discussed. Schools need to incorporate a curriculum on sex education that, in addition to including facts, stresses concepts of sexual responsibility and sexual decision making. For example: Teaching skills for handling sexual situations through creative discussion and role-playing techniques, which permit girls to confront sexual situations similar to those they will encounter in everyday life. Moreover, involving young people in program development and implementation is one way to increase program effectiveness.
- Provide information through media acceptable to youth such as radio, television, and film.
- Improving parents' knowledge and their ability to communicate with their children about sexual and reproductive health.
- Promoting a healthy degree of attachment between adolescents and their families, exploring family of origin issues, and referring for more intensive services when needed.

2. The findings of the present study revealed that it is very difficult for female adolescents to obtain health care for sexual concerns and problems. They are unlikely to seek treatment from health care services because of high cost, slow service, and negative provider attitudes toward young people and a perceived lack of confidentiality. Based on this finding, following recommendations are made:

- 2.1 Establishing youth-friendly services, which serve adolescents, is essential. Such services usually emphasize low-cost or free treatment and staff trained to treat young people sensitively.
- 2.2 Training providers in sensitivity, confidentiality and other special needs of young people might increase attendance of youths at hospitals and clinics. Nurses and other health professionals need to be aware of the underlying dynamics of the young adolescent. All too frequently these adolescents fall under our care because they are pregnant or need birth control information. We need to not only address the physical components of their care but also consider the underlying dynamics of why these teens are choosing to be sexual at such an early age. It is within the scope of our nursing practice to address developmental issues, to offer counseling, and to present psychoeducational programming.
- 2.3 Other useful interventions include providing privacy when discussing sexuality with female adolescents and trying to provide a nonjudgmental atmosphere.

Recommendations for Future Research

1. Develop a new model of sexual health clinic for adolescents based on adolescent's perspectives and needs.
2. This study was specific to the female adolescents who were attending formal education in school. Further study is needed to investigate other female adolescents who were not studying in school or who have low-income family.
3. This study focused on sexual experiences affecting sexual health among female adolescents only. There should be a further study with various age groups should be considered to extend base of knowledge.

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ภาคผนวก
คำชี้แจงและการพิทักษ์สิทธิของผู้เข้าร่วมการวิจัย

ดิฉัน นางสาวนงลักษณ์ พงษ์เย็น นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต สาขาการพยาบาลมารดาและทารกแรกเกิด คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล กำลังทำวิจัยเรื่อง พฤติกรรมทางเพศที่มีผลกระทบต่อสุขภาพทางเพศของวัยรุ่นหญิง เนื่องจากคุณเป็นบุคคลสำคัญอย่างยิ่งในการให้ข้อมูลครั้งนี้ ดิฉันจึงใคร่ขอความร่วมมือจากคุณในการให้สัมภาษณ์ โดยมีจำนวนครั้งในการสัมภาษณ์อย่างน้อย 3 ครั้ง ซึ่งจะใช้เวลาในการสัมภาษณ์แต่ละครั้งประมาณ 45-60 นาที ขณะสัมภาษณ์ดิฉันขออนุญาตในการบันทึกเทป ข้อมูลที่ได้จากคุณจะเป็นประโยชน์ต่อส่วนรวมอย่างยิ่ง เพราะผลที่ได้จะนำไปใช้ในการวางแผนให้การพยาบาลและส่งเสริมสุขภาพทางเพศของวัยรุ่นหญิงเพื่อให้มีคุณภาพชีวิตที่ดีต่อไป

การเข้าร่วมการวิจัยจะเป็นไปตามความสมัครใจของคุณ ไม่ว่าคุณจะเข้าร่วมการวิจัยหรือไม่ก็ตาม จะไม่มีผลกระทบต่อคุณแต่อย่างใด หากคุณยินดีเข้าร่วมการวิจัยและภายหลังเกิดเปลี่ยนใจ คุณมีสิทธิ์จะถอนตัวได้โดยไม่มีข้อแม้ใดๆ และข้อมูลที่ได้จากคุณทั้งหมดจะถือเป็นความลับ ในการนำเสนอผลการศึกษาก็จะเป็นการนำเสนอในภาพรวม จะไม่มีการเปิดเผยชื่อจริงของคุณ และจะไม่มีผลกระทบต่อคุณและสถาบันการศึกษาของคุณแต่อย่างใด ในระหว่างเข้าร่วมการวิจัย ถ้ามีข้อสงสัยใดๆ ดิฉันยินดีตอบข้อสงสัยของคุณตลอดเวลา และขอขอบคุณที่กรุณาให้ความร่วมมือ

นงลักษณ์ พงษ์เย็น

ผู้วิจัย

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สำหรับผู้เข้าร่วมการวิจัย

ดิฉันได้รับทราบรายละเอียดของการวิจัยดังได้อธิบายไว้ข้างต้น มีความเข้าใจและยินดีเข้าร่วมในการวิจัยครั้งนี้

ลายมือชื่อ.....

(.....)

วันที่.....เดือน.....พ.ศ.....

แนวทางการสัมภาษณ์เจาะลึก

ส่วนที่ 1 ข้อมูลทั่วไป

- อายุเท่าไร
- ขณะนี้เรียนอยู่ชั้นอะไร ผลการเรียนเป็นอย่างไร
- ขณะนี้พักอยู่ไหน พักอยู่กับใคร
- สมาชิกในครอบครัวมีใครบ้าง ความสัมพันธ์ของสมาชิกในครอบครัวเป็นอย่างไร
- ค่าใช้จ่ายประจำวันได้มาจากไหน ได้เดือนละเท่าไร พอใช้หรือไม่ ถ้ามีปัญหาเดือดร้อนเรื่องเงิน น้องทำอย่างไร

ส่วนที่ 2 ประสบการณ์ทางเพศ

ประเด็นที่ 1 คู่สัมพันธ์ทางเพศ

- มีแฟนคนแรกตั้งแต่เมื่อไร
- รู้จักกันได้อย่างไร
- อะไรทำให้น้องเลือกที่จะคบกับเขาแบบแฟน
- เขาอายุเท่าไร มีนิสัยเป็นอย่างไร ฐานะทางบ้านเป็นอย่างไร
- กับแฟนแต่ละคนมีความสัมพันธ์กันถึงขั้นไหน
- ใช้เวลานานเท่าไรกว่าจะมีความสัมพันธ์ทางเพศกัน
- อะไรเป็นสาเหตุที่ทำให้น้องตัดสินใจที่จะมีความสัมพันธ์ทางเพศกับแฟน

ประเด็นที่ 2 พฤติกรรมทางเพศ

- มีเพศสัมพันธ์ครั้งแรกกับใคร
- เพศสัมพันธ์ครั้งแรกเกิดขึ้นตั้งแต่เมื่อไร เกิดขึ้นได้อย่างไร
- ตอนที่มิเพศสัมพันธ์ครั้งแรก มีการคุมกำเนิดด้วยวิธีใด และป้องกันโรคติดต่อทางเพศสัมพันธ์ อย่างไร ถ้าไม่ได้ป้องกัน เป็นเพราะอะไร
- น้องรู้สึกอย่างไรกับเหตุการณ์ครั้งนั้น
- เพศสัมพันธ์ในครั้งต่อไป เกิดขึ้นได้อย่างไร
- มิเพศสัมพันธ์กันบ่อยแค่ไหน น้องเต็มใจทุกครั้งหรือไม่ ถ้าไม่เต็มใจเกิดจากอะไร มีวิธีการปฏิเสธอย่างไร ผลเป็นอย่างไร

- คุณกานิดาวิธีใด ใครเป็นคนเลือกที่จะใช้วิธีนี้ หามาได้อย่างไร ใครเป็นคนหามาให้ เพราะอะไรถึงเลือกใช้วิธีนี้
- น้องเชื่อมั่นในวิธีการคุมกำเนิดที่ใช้อยู่มากน้อยแค่ไหน เพราะเหตุใด ใช้แล้วเป็นอย่างไร มีปัญหาหลังจากการใช้หรือไม่ อย่างไร แก้ไขอย่างไร
- ในกรณีที่ไม่ได้ป้องกัน เพราะอะไร
- มีการป้องกันโรคติดต่อทางเพศสัมพันธ์อย่างไร ป้องกันทุกครั้งหรือไม่

ประเด็นที่ 3 การให้ความหมายทางเพศ

- บทบาทของผู้ชายและผู้หญิงโดยทั่วไป ในความคิดของน้องเป็นอย่างไร มีความเหมือนหรือแตกต่างกันอย่างไร
- ในเรื่องของเพศสัมพันธ์ น้องคิดว่าบทบาทของผู้ชายและผู้หญิง เป็นอย่างไร มีความเหมือนหรือแตกต่างกันอย่างไร
- น้องคิดอย่างไรกับการที่ผู้ชายจะมีเพศสัมพันธ์ก่อนแต่งงาน
- น้องคิดอย่างไรกับการที่ผู้หญิงจะมีเพศสัมพันธ์ก่อนแต่งงาน
- น้องคิดว่าพฤติกรรมการมีเพศสัมพันธ์ของน้อง มีความปลอดภัยหรือไม่ปลอดภัย เพราะเหตุใด น้องใช้อะไรเป็นเกณฑ์ในการตัดสินใจว่ามีความปลอดภัยหรือไม่ปลอดภัย

ประเด็นที่ 4 แรงขับทางเพศ และความพึงพอใจทางเพศ

- ทุกครั้งที่มีเพศสัมพันธ์กัน น้องเต็มใจหรือไม่
- ถ้าน้องไม่เต็มใจหรือไม่พร้อมที่จะมีเพศสัมพันธ์กับแฟน น้องทำอะไร ผลเป็นอย่างไร
- น้องเคยปฏิเสธที่จะมีเพศสัมพันธ์กับแฟนหรือไม่ น้องพูด หรือให้เหตุผลกับแฟนว่าอย่างไร แฟนของน้องยินยอมหรือไม่ เขาให้เหตุผลอย่างไร

ส่วนที่ 3 เจาะใจด้านคุณลักษณะส่วนบุคคลที่ทำให้วัยรุ่นหญิงตัดสินใจที่จะมีเพศสัมพันธ์ที่ปลอดภัย / ไม่ปลอดภัย

ประเด็นที่ 1 ความรู้และทัศนคติต่อการคุมกำเนิดและการใช้ถุงยางอนามัย

- น้องรู้จักวิธีการคุมกำเนิดวิธีใด อะไรบ้าง
- น้องได้ข้อมูลเกี่ยวกับการคุมกำเนิดมาจากไหน ใครเป็นคนแนะนำ
- แต่ละวิธีที่น้องรู้จัก มีวิธีการใช้อย่างไร ผลข้างเคียงของแต่ละวิธีมีอะไรบ้าง
- น้องรู้จักโรคที่ติดต่อทางเพศสัมพันธ์หรือไม่ อะไรบ้าง ได้ข้อมูลมาจากไหน

- นื่องรู้สึกอย่างไร ถ้าแฟนใช้ถุงยางอนามัยเวลามีเพศสัมพันธ์กับนื่อง

ประเด็นที่ 2 การรับรู้โอกาสเสี่ยงต่อการตั้งครรภ์ และการเกิดโรคติดต่อทางเพศสัมพันธ์

- ปัญหาอะไรบ้าง ที่นื่องคิดว่าจะเกิดขึ้นได้ จากการมีเพศสัมพันธ์
- ปัญหาที่นื่องกลัวมากที่สุดคืออะไร เพราะเหตุใด และปัญหาที่กลัวรองลงมาคืออะไร เพราะเหตุใด
- นื่องคิดว่าตนเองเสี่ยงที่จะเกิดการตั้งครรภ์ และโรคติดต่อทางเพศสัมพันธ์หรือไม่ มีความเสี่ยงมากน้อยเพียงใด เพราะเหตุใด
- นื่องคิดว่า แฟนของนื่องมีความเสี่ยงต่อการเป็นโรคติดต่อทางเพศสัมพันธ์มากน้อยเพียงใด เพราะเหตุใด
- นื่องใช้อะไรเป็นเกณฑ์ ในการตัดสินใจว่าแฟนของนื่องเสี่ยงหรือไม่เสี่ยงต่อการเป็นโรคติดต่อทางเพศสัมพันธ์
- ในกรณีที่นื่องคิดว่าแฟนมีความเสี่ยงต่อการเป็นโรคติดต่อทางเพศสัมพันธ์ นื่องยังมีเพศสัมพันธ์กับเขาหรือไม่ เพราะเหตุใด

ประเด็นที่ 3 ทักษะในการต่อรอง

- ถ้านื่องไม่เต็มใจหรือไม่พร้อมที่จะมีเพศสัมพันธ์กับแฟน นื่องทำอะไร ผลเป็นอย่างไร
- นื่องเคยขอร้องให้แฟนใช้ถุงยางอนามัยหรือไม่ เพราะเหตุใด ผลเป็นอย่างไร
- นื่องเคยปฏิเสธที่จะมีเพศสัมพันธ์กับแฟนหรือไม่ นื่องพูด หรือให้เหตุผลกับแฟนว่าอย่างไร แฟนของนื่องยินยอมหรือไม่ เขาให้เหตุผลอย่างไร

ส่วนที่ 4 เจื่อนใจทางสังคมที่มีอิทธิพลต่อมีเพศสัมพันธ์ที่ปลอดภัย / ไม่ปลอดภัย ของวัยรุ่นหญิง

ประเด็นที่ 1 ความสัมพันธ์เชิงอำนาจระหว่างชายหญิง ในบริบทของความสัมพันธ์ทางเพศ

- นื่องกล้าที่จะปฏิเสธการมีเพศสัมพันธ์กับแฟนหรือไม่ เพราะเหตุใด
- ใครเป็นคนตัดสินใจ ในการเลือกใช้ชีวิตคุมกำเนิด เพราะเหตุใด
- นื่องกล้าที่จะขอร้องให้แฟนใช้ถุงยางอนามัยหรือไม่ เพราะเหตุใด

ประเด็นที่ 3 เครือข่ายทางสังคม

- กลุ่มเพื่อนเกี่ยวกับการมีเพศสัมพันธ์ก่อนแต่งงานเป็นอย่างไร

- ภายในกลุ่มเพื่อนได้เคยมีการพูดคุยแลกเปลี่ยนประสบการณ์การมีเพศสัมพันธ์หรือไม่ อย่างไร
- ภายในกลุ่มเพื่อนได้มีการพูดคุยเกี่ยวกับวิธีการป้องกันตนเองเพื่อป้องกันการตั้งครรภ์ และการติดเชื้อโรคติดต่อทางเพศสัมพันธ์หรือไม่ อย่างไร

ส่วนที่ 5 สุขภาพทางเพศของวัยรุ่นหญิง

- น้องเคยมีปัญหาอะไรบ้างที่เกิดจากการมีเพศสัมพันธ์
- น้องคิดว่าปัญหานั้นเกิดขึ้นได้อย่างไร
- น้องแก้ปัญหาที่เกิดขึ้นอย่างไร ขอคำแนะนำจากใคร ใช้บริการที่ไหน มีปัญหาจากการเข้าไปใช้บริการหรือไม่
- น้องมีปัญหาในการคุมกำเนิดหรือไม่ เป็นอย่างไร ช่วยเล่าให้ฟังหน่อย
- น้องมีปัญหาในการป้องกันโรคติดต่อทางเพศสัมพันธ์หรือไม่ เป็นอย่างไร ช่วยเล่าให้ฟังหน่อย
- น้องมีความรู้สึกรับรู้เกี่ยวกับการเข้าไปใช้บริการเกี่ยวกับปัญหาสุขภาพทางเพศ

ส่วนที่ 6 แหล่งบริการด้านอนามัยเจริญพันธุ์ที่วัยรุ่นหญิงต้องการ

- น้องสะดวกใจที่จะไปรับบริการด้านอนามัยเจริญพันธุ์ จากแหล่งบริการในรูปแบบใด เพราะเหตุใด
- น้องต้องการให้มีบริการด้านอนามัยเจริญพันธุ์อะไรสำหรับวัยรุ่นหญิง รูปแบบใด ดังที่ไหนบ้าง ใครควรเป็นผู้ให้บริการ ผู้ให้บริการควรมีลักษณะหรือคุณสมบัติอย่างไร

BIOGRAPHY

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