‘They call me a bad girl’: a feminist analysis of agentic behaviour in pregnant adolescents in Thailand

By

Supiya Wirifai

Thesis

Submitted to Flinders University

for the degree of Doctor of Philosophy

Doctor of Philosophy

College of Nursing and Health Sciences

27th March 2019

Contents

SUMMARY

Background Adolescent pregnancy in Thailand has been associated with educational and financial disadvantages, and unfavourable health outcomes for mothers and infants. Pregnant adolescents have been shown to demonstrate little or no control in their decision-making regarding pregnancy, practicing healthy behaviours, preparation for parenting and future employment. This study sought to explore the role of agency in adolescents' ability to exercise influence over events that affect their lives in a range of social and cultural contexts.

Design Within a critical framework, this ethnographic study was conducted in an antenatal clinic and 15 villages in Mahasarakham Province, Thailand. Data was collected over a 6 month period from 15 pregnant adolescents and 15 caregivers. Methods of data collection included semi-structured interviews, photo elicited interview, and participant observation.

Findings Four themes emerged from thematic analysis including social stigma, support and support systems, cultural heritage, and self-care. Feminist theoretical analysis of these themes identified that gender inequity, fear, and spirituality were key factors in shaping the agency of pregnant adolescents in Thailand.

Conclusion Gender inequity predominantly impeded agentic behaviour. Some adolescents however resisted the prevailing social forces of inequity, thereby acting agentically. Fear was a pervasive force that impeded agentic behaviour. Spirituality presented as a paradox where it both enabled and impeded agency. Agency and the sociocultural factors that shape adolescent behaviour must be essential considerations for the care and wellbeing of pregnant adolescents in Thailand.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed.....

Date.....27/03/2019.....

ACKNOWLEGEMENT

This thesis would not have been successful without the assistance of my supervisor team, Associate Professor Julian Grant and Dr Lana Zannettino. They provided constant support and worked tirelessly to assist me in reaching my PhD milestones and the standards of Flinders University. They provided dedicated effort and knowledge to guide me in developing the quality of my thesis. They also offered critical suggestions on my work that helped me to enhance my abilities to analyse information and integrate various sources of knowledge to develop my thesis. At every meeting, they provided a supportive environment and offered opportunities to share knowledge and experiences. I understand it is difficult to supervise a student who had English as a second language. Their patience, understanding, and encouragement improved my confidence to communicate and to enhance my academic writing. I would like to thank them deeply for all the support. It was a privilege to have them as supervisors.

Second, I would like to deeply thank the Royal Thai government for providing financial support in the form of a scholarship to enable me to study for a doctoral degree. I also would like to acknowledge the support from the Office of Educational Affairs, the Royal Thai Embassy in Canberra and their staff. They were quite caring and supported me throughout the time of my study in Australia. I would like to gratefully thank the Praboromarajchanok Institute of Health Workforce Development and Srimahasarakham Nursing College who provided this great opportunity for higher degree study. I gained knowledge in doing research in the area of nursing and experienced a very different culture.

I would like to deeply thank the 15 pregnant adolescents and 15 caregivers who participated in this study and shared their experiences, perspectives, and beliefs with me. Without the assistance of nurses, doctors, and the administrative staff of the prenatal clinic, Mahasarakham Hospital, Mahasarakham Province, my project would not have been successful. I would like to acknowledge Mrs. Arunee Srisuying, who was involved with the safety protocol by accompanying me on my visits to the participant's residences. I really appreciate her friendship. Without their valuable support it would not be possible to conduct this study.

My sincere thanks also go to Dr Robert Muller who engaged in the professional editing of this thesis. His work edited my grammar,but did not change the content of the thesis. I learned how to write academic work from him.

Last but not the least, the unconditional love of my family members: Sommai Wirifai, Patharawadee Wirifai, Thetiya Wirifai, Issac and Newton who supported me spiritually as sources of strength in writing this thesis and in my life in general. This thesis is dedicated to my father and my mother who are worked hard all their lives and provided support to help to make a better life for my family members.

Finally, thank you for my PhD friends who shared their knowledge and experience and supported me emotionally throughout my PhD journey. Without the support of the staff in School of Nursing and Midwifery, it would not be have been possible to complete this study. The great experiences I had at Flinders University forever engraved on my memory.

Supiya Wirifai

27th March 2019

LIST OF ABBREVIATIONS

WHO	World Health Organisation
GDP	Gross Domestic Product
UNICEF	The United Nations Children's Fund
UNFPA	United Nations Population Fund

CHAPTER 1 BACKGROUND

Introduction

Adolescent pregnancy is a significant public health problem affecting 21 million girls in developing nations (Darroch, Woog, Bankole, & Ashford, 2016). In Thailand, adolescent pregnancy has been steadily increasing since the start of the 21st century (UNICEF, 2015). The rate of adolescent pregnancy in Thailand is highest for those aged 15-19 years, and represents 15 per cent of all pregnancies (UNFPA, 2013). In addition, the rate of adolescent pregnancies in Thailand (42.5 per 1000) is higher than in neighbouring countries such as Japan, South Korea, China, and Singapore where the rate ranges from 2 to 6 per 1,000 (UNFPA, 2013). As a result, the high prevalence of adolescent pregnancy in Thailand is a major concern.

This phenomenon is of concern because adolescent pregnancy has been associated with negative socioeconomic and health consequences for both the woman and her baby. For example, young pregnant women often have poor socioeconomic status due to leaving school early (Grant & Hallman, 2008; James, Van Rooyen, & Juanita Strümpher, 2012), and subsequently, have difficulty in finding paid employment (Gennari, 2013). They also face social stigma which makes engagement in teen activities difficult and reduces their chances of future marriage relationships (Muangpin, Tiansawad, Kantaruksa, Yimyam, & Vonderheid, 2010).

In relation to health consequences, adolescent pregnancy has been associated with an increased risk of physical and psychological complications, and adverse infant outcomes. The most common complications for pregnant adolescents include anemia (Rojsutapong, 2011), pre-term delivery (Mukhopadhyay, Chaudhuri, & Paul, 2010; Thato, et al., 2007), and pregnancy-induced hypertension (Klein & Adelman, 2008; Shah, Prajapati, & Sheneeshkumar, 2012). In addition, some adolescent pregnancies have been related to psychological problems such as depression and suicide (Coelho et al., 2013; Humayun, Haider, Imran, Iqbal, & Humayun, 2013; Tzilos, Zlotnick, Raker, Kuo, & Phipps, 2012). Additionally, babies born to adolescents are more likely to be born prematurely, have a low birth weight (Abu-Heija, Ali, & Al-Dakheil, 2002; Areemit et al., 2012; Kongnyuy et al., 2008; Mukhopadhyay et al., 2010; Thato et al., 2007; Watcharaserance, Pinchantra, & Piyaman, 2006), and have long-term educational problems (Gueorguieva et al., 2001; Morinis, Carson, & Quigley, 2013).

Such a constraining sociocultural and health context may make it difficult for pregnant adolescents to exercise agency in managing their own and their unborn child's health and wellbeing. Here, agency, refers to the ability of pregnant adolescents to make choices independently and then to transform these choices into desired outcomes (Begum & Sen, 2005; Klugman et al., 2014). Agency is the key to understanding how pregnant adolescents shape their own lives, actions, and emotions,

and how they can influence society though interaction and presentation. Prior studies suggest that young pregnant women experience little or no control in decision-making in relation to their pregnancy (Atuyambe, et al., 2009; Olsson & Wijewardena, 2010; Ralph, Gould, Baker, & Foster, 2014), their practice of healthy behaviours (Harley & Eskenazi, 2006), and in preparation for parenting and future employment (Pungbangkadee, Parisunyakul, Kantaruksa, Sripichyakarn, & Kools, 2008). There is a lack of knowledge of how pregnant adolescents in Thailand exercise their agency in caring for themselves and their unborn babies. This is important to explore given the increasing rates of adolescent pregnancy in Thailand. Therefore, the challenges faced by pregnant adolescents may influence to what extent they are able to act independently or to freely make decisions about controlling their own lives.

Defining adolescence and adolescent pregnancy

Adolescence is understood as a period of transition from the dependence of childhood to the independence of adulthood (UNICEF, 2012). The term “adolescent” is often used interchangeably with other terms, especially when translated into Thai, such as “young people”, “teen”, “teenager”, and “youth” (Sriyasak, 2016). Definitions of the “adolescent” period may be presented differently by a range of organisations and in a range of societies because of social, cultural, legal, and economic conditions (AlBuhairan, Areemit, Harrison, & Kaufman, 2012).

These definitions are usually based on chronology. The United Nations, for example, proposes that adolescence is a period which is separate from both childhood and adulthood and ranges from 10-19 years of age (United Nations., 2009). Similar descriptions are provided by the World Health Organisation in which adolescence is defined as the developmental period ranging from 10-19 years, young people ranging from 10-24 years, and youth ranging from 15-24 years (Blum & Nelson-Mmari, 2004; World Health Organisation, 2015). In addition, Sawyer et al. (2018) suggested extending the adolescent age range from 10-19 years to 10-24 years to facilitate extended investments across a limited range of settings. This is based on a study that shows that the pattern of biological growth and role transition have changed over time.

The term “adolescent pregnancy” used in everyday speech, refers to a young woman who becomes pregnant under 20 years of age, before reaching legal adulthood (UNICEF, 2008). The World Health Organisation (2015) also defines adolescent pregnancy as pregnancy in a woman aged 10-19 years where the baby is also born during this time. In Thailand, the Ministry of Public Health follows the World Health Organisation age definition of 10-19 years (Bureau of Reproductive Health, 2016; Bunyarit Sukrat, 2014).

The prevalence of adolescent pregnancy in Thailand

Adolescent pregnancy is problematic in many countries. Adolescent pregnancies make up 10% of all births worldwide and this equates to 14 million births per year, of which 6 million are from Southeast Asia (World Health Organisation, 2016). Due to data limitations on the prevalence of adolescent pregnancy in Thailand, the birth rate in adolescent mothers is used instead of the rate of adolescent pregnancy. Thailand ranks second highest in Southeast Asia for adolescent birth rates (Fernquest, 2013).

The concern in Thailand is that 16 per cent of births are to adolescent mothers and this trend is increasing (UNFPA, 2013). From 2003 to 2016, the proportion of births for adolescent girls aged 10-19 years rose from 12.9 to 14.2 per cent respectively (Bureau of Reproductive Health, 2016). In the same period, the birth rate was highest among adolescents aged 15-19 years (UNICEF, 2015). For this group, the birth rate rose from 3.92% in 2003 to 4.25% in 2015 (Boonrit Sukrat & Eamkong, 2015).

The distribution of adolescent birth rates varies across different regions in Thailand. These regions include Bangkok, the Central Region, the Northern Region, the Northeastern Region, and the Southern Region (World Vision, 2010). In 2013, the birth rate among adolescents aged 10-19 years in the Northeastern Region increased rapidly in comparison to other regions (UNICEF, 2015). Birth rates in the Northeastern Region among pregnant adolescents aged 10-14 years and 15-19 years were 3 and 3.5 per cent respectively (Tippawan & Suchonwanich, 2014). The above data indicates that there has been an alarming increase in adolescent pregnancies. The increasing prevalence of adolescent pregnancy in Thailand is concerning because the research indicates that both mothers and babies have poorer outcomes.

The challenges faced by pregnant adolescents

Adolescents who decide to keep their babies confront many challenges that have an impact on their capacity to make their choices about their own lives. The most challenging issues for pregnant adolescents include the health impacts for the young women and their babies and the subsequent educational and economic impacts.

Health impacts related to pregnant adolescents and their babies

Pregnancy in adolescence is associated with increased morbidity and mortality for both mother and infant. The WHO has identified that the second cause of death for 15-19 year olds worldwide is the complications associated with pregnancy (World Health Organisation, 2015). The adverse health outcome for adolescents who are pregnant present a major challenge for both the adolescent and their babies because these influenced control over getting healthy pregnancy and unborn babies.

These issues can be summarised into three topics including the physiological, psychological, and infant impacts.

Physical impacts

Adolescent pregnancy has been associated with an increased risk of medical complications (Kovavisarach, Chairaj, Tosang, Asavapiriyanont, & Chotigeat, 2010). Many studies from Thailand and other countries, report a high incidence of pre-term delivery (Areemit et al., 2012; Thaithae & Thato, 2011), and anemia in adolescent pregnancy (Banerjee et al., 2009; Mukhopadhyay et al., 2010; Rojsutapong, 2011; Thato et al., 2007). Additional reported health issues include induced hypertension, sexually transmitted disease (Galvez-Myles & Myles, 2005; Shah et al., 2012), urinary tract infections, antepartum hemorrhage, and asthma (Klis, Westenberg, Chan, Dekker, & Keane, 2002).

Some studies have looked at age in relation to adverse consequences (Ganchimeg et al., 2014; Khashan, Baker, & Kenny, 2010; Shah et al., 2012; Watcharaseranee, Pinchantra, & Piyaman, 2006). A Thai study carried out at Chonbubri Hospital from 2000-2005 found that, compared to mothers aged 20-24 years, adolescent mothers aged 13-20 years had a higher risk of pre-term delivery, anemia, and severe neonatal complications (Watcharaseranee et al., 2006). Another study indicated that adolescents aged 13-16 years had the highest risk of low birth weight of the infant than any other age group (Prasitlumkum, 2009).

In relation to delivery and postpartum consequences, adolescent mothers had a considerably higher rate of prolonged labour, perineal tears, episiotomy during delivery, and postpartum hemorrhage (Kongnyuy et al., 2008; Shah et al., 2012). In addition, some studies have shown that the risk of cesarean section was lessened due to the high incidence of low birth weight babies (Fleming et al., 2013; Gupta, Kiran, & Bhal, 2008; Thato et al., 2007). Other studies have shown the opposite, with a number of Thai studies demonstrating an increase in cesarean section or forced extraction in pregnant adolescents during delivery (Kovavisarach et al., 2010; Thaithae & Thato, 2011; Yadav et al., 2008). The rates of cesarean section and operative vaginal delivery (forceps and vacuum extraction) reached 12.1 and 15.6 per cent respectively in a study of pregnant adolescents aged less than 15 years carried out in Chulalongkorn Hospital, Thailand (Suebnukarn & Phupong, 2005). Consistent with a study in Rajavithi Hospital, a Thai study showed that the cause of the high incidence of adolescent cesarean delivery was due to an unhealthy fetus, particularly in relation to low birth weight (Kovavisarach et al., 2010). These studies propose that in Thailand, as in other countries, pregnant adolescents have a greater risk of exposure to medical complications and disease.

Psychological impacts

Adolescents face a number of psychological health conditions related to pregnancy and being a new mother. During adolescence, young people face challenges in developing their identity, autonomy, and independence from their parents (Lerner & Steinberg, 2009). Pregnancy in adolescence is argued to inhibit the growth of individual identity and to interfere with the task of adolescent development through peer relationships, schooling, dating, and career choices (Grady & Bloom, 2004). In addition, adolescents who are pregnant must work to integrate their life role and their maternal role, which may lead to role conflict (Birkeland, Thompson, & Phares, 2005). For example, a study of the perceptions of conflict in early motherhood among pregnant Thai adolescents identified four perceived conflicts between needs as a mother and the needs of being an adolescent. These were perceived as a conflict between focusing on the child and the self, taking care of the child and desiring to go to school and work, conflict between maternal image and self-image, and independence with family and independence from family (Pungbangkadee et al., 2008). Bah (2016) suggested that such conflict may lead to psychological problems such as anxiety and depression.

Depression is also a high prevalence psychological problem in pregnant adolescents (Uthaipaisanwong et al., 2015). Compared to older adolescents, adolescents who become pregnant between the ages of 11 and 13 years have a higher prevalence of depressive symptoms (Nkansah-Amankra, 2018). Figueiredo et al (2006) specifically found the prevalence of depression to be high in the third trimester of pregnancy and in the 2-3 month postpartum phase in adolescents. Coelho et al (2013) investigated the association between depression and socio-demographic characteristics, obstetrics history, and psychosocial variables in pregnant adolescents. The study found that academic failure and unemployment for pregnant adolescents were linked with major depression disorders. Low emotional support from the partner was another risk factor for depression in a study of adolescent pregnancy in Portugal (Figueiredo et al., 2006).

In a study in Thailand carried out in Chulalongkorn Memorial Hospital, 46 per cent of pregnant adolescents were found to have prenatal depression (Uthaipaisanwong et al., 2015). In exploring the factors that contribute to depression in Thai adolescent mothers compared with western mothers, Srisaeng (2003) found that self-esteem and stressful life events were major factors in adolescent Thai mothers compared to western adolescent mothers. A cohort study of depression in Thai women using the Edinburgh Postnatal Depression Scale indicated that religion, the perception of having pregnancy complications, and negative attitudes towards adolescent pregnancy were related to depression (Limlomwongse & Liabsuetrakul, 2006). Domestic violence was also identified as being predictive of depressive symptoms in pregnant Thai adolescents (Jantacumma, Powwattana, Lagampan, & Chansatitporn, 2018).

In terms of consequences, symptoms of depression may limit health-seeking behaviours and affect pregnant adolescents in their attempts to improve maternal-infant health outcomes (Stewart, 2011). Studies from Thailand and other countries have indicated that depression is associated with poorer pregnancy outcomes (Gavin, Chae, Mustillo, & Kiefe, 2009; Grote et al., 2010; Nkansah-Amankra, 2018). For example, Nkansah-Amankra (2018) found that high levels of depressive symptoms in pregnant adolescents aged 15-19 years resulted in higher rates of low birth weight babies, which can lead to perinatal morbidity and long-term adverse consequences. Likewise, a meta-analysis of 20 studies of antenatal depression and risk of infant outcomes showed that depressive symptoms were associated with a 1.4 to 2.9 times higher risk of low birth weight in undeveloped countries, and a 1.2 times higher risk on average in the USA (Grote et al., 2010). Furthermore, depression was related with deteriorating maternal health and an increased risk of pre-term birth, intra uterine growth restriction, and suicide attempts (Orr, Blazer, James, & Reiter, 2007; Uthaipaisanwong et al., 2015).

Pregnant women who have suffered intense psychiatric disorders are at risk of attempting suicide (Orr et al., 2007). Suicidal behaviours during pregnancy, particularly suicidal ideation and suicide attempts, have been reported at rates ranging from 2.7 to 14 per cent (Gavin et al., 2009; Pinheiro et al., 2012), with a frequency of more than double the average in teenagers who had a previous history of abortion (Pinheiro et al., 2012). Additional risk factors for suicidal behaviour in pregnant adolescents include psychiatric disorders as well as major depressive disorder (Bridge, Goldstein, & Brent, 2006). In addition, many studies have indicated that a range of social and interpersonal factors are related to adolescent suicidality, including age, being unmarried, unemployment, intimate partner violence, low social support (King & Merchant, 2008), and family and peer relationships (Connor & Rueter, 2006). A Thai study also showed that being disappointed and unwanted, by their partner in their first serious relationship was a risk factor for suicide, as was becoming pregnant and having their partner not accept the pregnancy (Sukhawaha, Arunpongpaisal, & Rungreangkulkij, 2016).

The information presented above indicates that maternal role conflicts, and psychological problems and their consequences shape adolescents' ability to deal with these challenges. As a result, agency is an important factor in describing how pregnant adolescents face psychological problems, including the factors that impede and facilitate their agency.

Infant impacts

Adolescent pregnancy brings with it high levels of perinatal risk. Babies born to adolescents have a high incidence of low birth weight (Kongnyuy et al., 2008; Mukhopadhyay et al., 2010; Thato et al., 2007; Watcharaseranee et al., 2006), and pre-term birth (Areemit et al., 2012; Tippawan & Suchonwanich, 2014). An analysis of Thailand's 2004-2013 birth statistics found that mothers aged 10-14 years were twice as likely to have low birth weight infants than mothers aged 20-29 years

(UNICEF, 2015). A number of Thai studies have also shown that along with biological immaturity, a poor socioeconomic environment (Watcharaseranee et al., 2006), being unmarried, experiencing malnutrition (Prasitlumkum, 2009), and avoiding antenatal care (Chirayus & Chandeying, 2012; Pattanapisalsak, 2011) were considered as significant factors in giving birth to low birth weight babies.

Low birth weight and prematurity are significant as they increase the probability of adverse medical consequences for the baby, such as pulmonary hypertension, cerebral palsy, mental retardation, and psychological underdevelopment related to decreased gestational age (Areemit et al., 2012; Moster, Lie, & Markestad, 2008). In addition, infants who were born with low birth weight and prematurity had an almost two times greater rate of admission to the neonatal intensive care unit in Thailand (Thaithae & Thato, 2011) and higher still-birth rates and deaths of infants within 48 hours in severe cases (Mukhopadhyay et al., 2010).

Furthermore, infants who were born to adolescent mothers were more likely to have educational disabilities and education difficulties throughout their life (Aarnoudse-Moens, Weisglas-Kuperus, van Goudoever, & Oosterlaan, 2009; Gueorguieva et al., 2001; Morinis et al., 2013; Shaw, Lawlor, & Najman, 2006). For example, Aarnoudse-Moens et al. (2009) found that poor academic achievement, attention problems, anxiety and depression, and poor executive function were associated with very low pre-term birth (≤ 33 weeks), and low birth weight (≤ 1500 g) infants. Morinis et al. (2013) studied the cognitive development at age 5 years among children born to mothers aged less than 18 years. The study indicated that children had low non-verbal and spatial abilities and were delayed in their language development. Therefore, such adverse consequences for infants are a major challenge for pregnant adolescents in maintaining the health of the unborn child.

Educational and economic impacts

Adolescent pregnancy is associated with educational and economic deprivation. These consequences of adolescent pregnancy are profound for the adolescent themselves, their babies, and for wider society. These issues are described briefly in this section in relation to educational and economic impacts.

Adolescent pregnancy results in lower levels of educational success. Some studies have found that pregnant adolescents are often excluded from education for many reasons including a range of social factors and the attitudes of instructors (Eloundou-Enyegue, 2004; Mpanza & Nzima, 2010; Smith, Jones, & Hall, 2001). Eloundou-Enyegue (2004) studied the issues associated with schooling for pregnant adolescents in Cameroon, and found that school attendance was challenging due to social divisions such as class and gender that led to them leaving school on purpose because they did not feel welcome. Smith et al (2001) focused on the attitudes of educators to adolescent pregnancy in Georgia and found that the instructors felt uncomfortable when pregnant adolescents

studied in their classes believing that these students should leave school. Likewise, some educators in a study in South Africa were not willing to permit pregnant adolescents to attend their classes (Mpanza & Nzima, 2010). They also commented that pregnant adolescents lost much time in their learning because they needed to attend prenatal clinics, and often had minor discomforts which would result in absences from school. These issues made it difficult for pregnant adolescents to attend school and complete their studies.

In Thailand, pregnant adolescents generally either leave school, or move to another school, as Thai culture does not approve of pregnant students attending school (Neamsakul, 2008). For example, two studies indicated that Thai culture continued to emphasize the importance of virginity among young women, along with discouraging interest in sexual relations outside of marriage (Thato, Jenkins, & Dusitsin, 2008; Vuttanont, Greenhalgh, Griffin, & Boynton, 2006). Social stigma was therefore a major reason for pregnant adolescents leaving school (Oh & Van Der Stouwe, 2008). In addition, pregnancy may have a negative impact on the school's reputation; hence, if pregnant students do not leave of their own volition, the school would force them to stop attending (UNFPA, 2013).

Incomplete education can have a wide range of negative impacts on pregnant Thai adolescents and their babies by limiting their educational achievements and economic stability. Poor educational performance and a lack of skills makes it difficult to find a job, and this often leads to long-term unemployment or jobs that are poorly paid and insecure (Neamsakul, 2008); hence, pregnant adolescents often rely on financial support from their families (Clarke, 2005; Sriyasak, 2016). Insufficient income to cover living expenses for pregnant adolescents creates an economic burden for their families and also adds to their own personal economic strain (Pungbangkadee et al., 2008). Poor economic capacity also leads to pregnant adolescents being unable to access adequate nutrition, both during pregnancy and after delivery (Atuyambe, et al., 2005). Furthermore, a study of financial burden on the timing of prenatal care initiation indicated that without money in hand, pregnant adolescents initiated prenatal care attendance quite late in their pregnancy (Gross, Alba, Glass, Schellenberg, & Obrist, 2012). Furthermore, poor educational achievement is associated with poorer knowledge of self-care behaviours and less awareness of the importance of being pregnant (Narukhutrpichai, Khrutmuang, & Chattrapiban, 2016; Panthumas, Kittipichai, Pitikultang, & Chamroonsawadi, 2012). Hence, the impacts of leaving school early for pregnant adolescents have far-reaching educational and economic consequences which push them into poverty and reduce their capacity for self-care.

Being a pregnant adolescent in Thailand

One of the main intentions of this study is to explore the sense of agency of pregnant Thai adolescents so that this issue can be understood within the contexts that challenge pregnant

adolescents to actually exercise their agency. This section provides an overview of the sociocultural context of Thailand to enable an interpretation of the sociological impact of pregnant adolescents to exercise choice. It begins with a brief geographical overview, followed by reflections on the Thai family structure and a range of aspects of Thai society and culture, which will then be followed by a review of religious considerations.

Geographical profile of Thailand

Geographical information about Thailand provides a context for understanding pregnant adolescents and their environmental interaction. The following section will provide basic geographical information about Thailand, and will also look specifically at Mahasarakham province, which is located in the Northeastern Region where there is a high birthrate for adolescents.

Thailand is located in Southeast Asia and covers an area of 510,890 square kilometres with a population of 69 million (Woldometers, 2018). Thai society has become an increasingly industrial society with an upper-middle income economy since 1980 (World Bank, 2016). Thailand has recorded intermediate economic development with a Gross Domestic Product (GDP) per head of $USD9,187 (Skirbekk et al., 2015). The country is divided into six geographical regions including the Central region, the Northern Region, the Northeastern Region, the West, the East, and the Southern Region. The official language is Thai for speaking and writing. The main religion practiced by Thais is Buddhism (World Vision, 2010).

Mahasarakham Province is a small province in the Northeastern Region of Thailand. This province is a significant education centre for the region, earning the nick-name “Taksila”, which means ancient learning centre of India. The area of the province is about 5,267.55 square kilometers with a population of 963,484. The province is divided into 13 districts, 133 sub-districts, and 1,944 villages. The average family salary per month is 21,640 Baht ($AUD866) (Mahasarakham Province, 2014). The health care sector of Mahasarakham Province is governed by the Ministry of Public Health. It includes one provincial hospital, 10 district hospitals, 174 primary health care centres, four community health centres, and one university hospital. The ratio of doctors per patient is 1:3,345, while the ratio of nurses per patient is 1:609 (Mahasarakham Provincial Public Health Office, 2018). Mahasarakham Province lies within the region with higher birth rates among adolescents aged 10-19 years (UNICEF, 2015). From 2010 to 2013, the birth rate among pregnant adolescents aged 15-19 years in Mahasarakham Province increased from 35.2 to 35.5 per 1,000 females (Bureau of Reproductive Health, 2016).

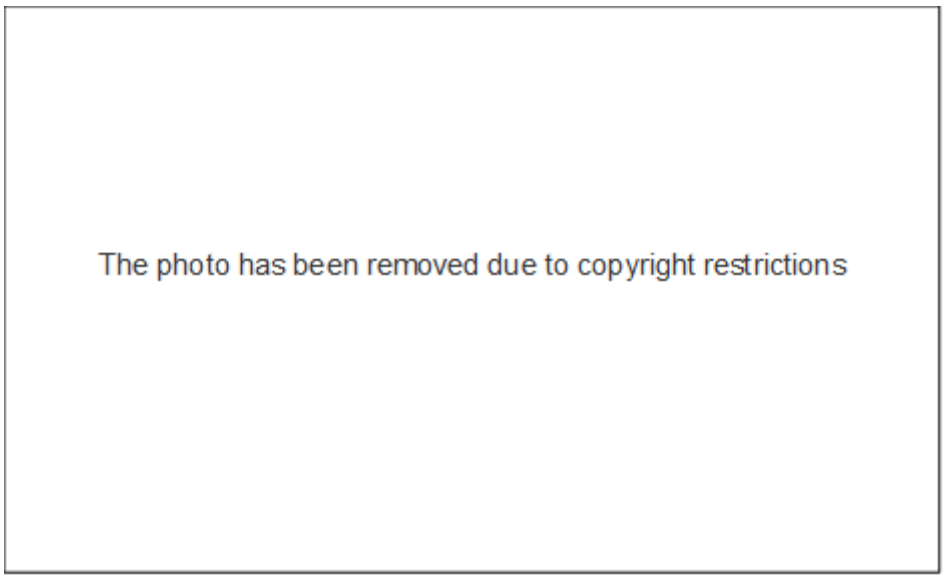


Figure 1 Map of study area, Mahasarakham Province, Thailand
Retrieved from http://www.websanom.com/accommodation_maha_sarakham.php

Thai social culture, norms, and religion

Thailand is a highly conservative Buddhist country in which people strongly follow the cultural traditions (Skirbekk et al., 2015). Premarital sex and adolescent pregnancy are considered to go against Thai cultural norms (Sridawruang, Crozier, & Pfeil, 2010), as virginity is considered to be virtuous in Thai females (Thianthai, 2004) and is preserved until the wedding day (Ounjit, 2011). Loss of female virginity through pregnancy out of marriage is characterised as "being ruined" and a sign of being a bad girl (Muangpin et al., 2010). These views are attributed to the woman being unable to control her sexual desires by engaging in sexual activity at an early age (Muangpin et al., 2010; Sridawruang et al., 2010).

Teenagers who do not follow these customs are criticised and their families lose the respect of the community (Neamsakul, 2008; Sridawruang et al., 2010). A Thai study of pregnant adolescents' attitudes, conducted by the United Nations Fund for Population Activities, indicated that many adolescents also believe that pregnancy in adolescence is inappropriate because the girls are not ready to take care of their children, and they claim that pregnancy is shameful and unacceptable in Thai society (UNFPA, 2013). Sridawruang et al. (2010) also identified that adolescents experienced community gossip and criticism of their behaviours. Another Thai study found that pregnant adolescents faced gossip from neighbours about their parents' lack of supervision (Sa-ngiamsak, 2016).

Adolescents themselves reported that their loss of virginity, and being pregnant outside of marriage resulted in them feeling unworthy to continue the matrilineal line (Muangpin et al., 2010). They also reported feeling worthless when they became pregnant outside of marriage (Punsuwun, Sungwan, Monsang, & Chaiban, 2014). The fear of social stigma, a lack of support, and an imbalance between

the perceived responsibilities of the sexes have also been reported as negative experiences for pregnant adolescents (Sridawruang et al., 2010). Other attitudes are that pregnancy ruins girls' future (UNFPA, 2013) because they leave school early, isolates them from their friends, means that they are unable to engage in teen activities, ruins relationships, decreases job opportunities, and results in financial problems (Fengxue, Isaranurug, Nanthamongkolchai, & Wongsawass, 2003; Prasertwit, Reznik, & Halpern-Felsher, 2010).

Buddhism is the predominant religion of Thailand and has a powerful effect on cultural traditions (Skirbekk et al., 2015). Traditional Buddhist doctrine situates females as being inferior to males. If a woman wishes to become a monk and attain enlightenment, she must gain lots of merit, and pray to be reborn as a male in the next life (Sa-ngiamsak, 2016). In addition, females are also portrayed as being 'supporters' for Buddhism, who provide routine support for monks and the temple. Women are also unable to have contact with monks in both direct and indirect ways, and are unable to enter a pagoda due to karma (Pipat, 2007; Xu, Kerley, & Sirisunyaluck, 2011).

Adhering to this social norm means that girls who became pregnant are not valued in society and therefore may not have a wedding ceremony or receive a bride price. In Thai culture, having a wedding ceremony and receiving a bride price is the public expression of social respectability (Neamsakul, 2008). It also demonstrates that the male has the earning capacity to support their family and shows wealth, prestige, and generosity of the groom (Laiphrakpam & Aroonsrimorakot, 2017; Muangpin et al., 2010). Traditions around the wedding ceremony vary across Thailand. This study took place in the Northeast region, where people rigorously follow tradition and firmly adhere to Northeast religious beliefs. Parents and elders in families are gatekeepers of arranged marriages. In the arranged marriage, the wedding ritual starts with the groom's parents making a marriage proposal, on their son's behalf, with the bride's parents (Pomsema, Yodmalee, & Lao-Akka, 2015). They then organise the ceremony date and time, and invite guests from their communities (Pomsema et al., 2015). On the wedding day, the groom and his family parade to the bride's home, with the bride price and give it to bride's parents in front of the guests. The bride price usually comprises money, gold, ornaments for the bride's family. The amount of bride price depends on several factors such as social status, parents' wealth, bride's education, age, and beauty (Laiphrakpam & Aroonsrimorakot, 2017). A religious rite named 'Baisri Sukwan' follows. This ritual is conducted by a 'Morstra' who gives a blessed chant to the groom and the bride. After that, the parents and the guests tie the couple's wrists with cotton strings and bless the groom and the bride (Pomsema et al., 2015).

Pregnant adolescents are stigmatised when they do not have a wedding ceremony and do not receive an honourable bride price (Muangpin et al., 2010). This is consistent with traditional wedding norms related to dowries among Hmong women in USA, where the dowry was a symbol of respect for women among members of their culture (Soung, 2015). This raises questions around how Thai

social cultural norms shape pregnant adolescent's status in society and their capacity to function with respectability.

Thai family structure

In the Thai family structure, Buddhism plays an important role because religion shapes cultural traditions and values that dictate the family hierarchy and roles (McHale, Dinh, & Rao, 2014). In this structure, the husband presents as the head of the family, while the wife usually shows respect for her husband. Thai family norms encourage the wife to be selfless, nurturing, devoted to her husband, and prepared to make sacrifices for her family (Xu et al., 2011). The wife has also been taught to accept without question, and this results in her having no power over her own life and no control over sexual health and decision-making (Klunklin & Greenwood, 2005). Clearly, women's status in Thai culture is secondary to that of men.

The family structure is also based on traditional kinship structures (Quah, 2008). The Thai family structure is wider than merely the parents and the children, with the family being based on kin comprising of those who are related principally, but not absolutely, through blood ties on the maternal side. The types of kinship are referred to as members of the family who live in the same house and share many aspects of daily activities and roles, which may include parents and children, grandparents, aunts and uncles, siblings, close neighbours, and friends (Jiumpanyarach, 2011). In the rural areas, the Thai family structure is characterised by an extended family with a bilateral kinship system (Yeung, Desai, & Jones, 2017). This means that several generations of a Thai family often live together under the same roof. Young people in Thailand generally live with their parents until they are married, and some couples live with their families until they have children (Embassy of the Kingdom of Thailand, 2007).

The matrilineal kinship system is also part of the Thai family structure (Dommaraju & Tan, 2014). This means that females have free choice to select their own partner, and the couple move into the home of the wife's parents (Lim, 2011). Dommaraju and Tan (2014) have argued that there is a high proportion of married women in Thailand who often move back into their mother's house, or invite their mothers and/or grandmothers to live with them to take care of their babies. In addition, a Thai daughter inherits the majority of the family property and family land, as well as responsibility for the care of the parents in their old age (Lim, 2011). Males must show respect to their future wife and her family by paying a bride-price as a way of paying for access to the inheritance he receives through marriage (Laiphrakpam & Aroonsrimorakot, 2017). In this way, the Thai family structure is a strong matrilineal form of kinship, with mothers and daughters maintaining a continuous relationship.

In addition, patriarchy is a characteristic of the traditional Southeast Asian family structure, particularly in Thailand (McHale et al., 2014). This results in males having authority over other family members (Chirawatkul, Rungreangkulkij, Sawanchareon, & Watananukooliat, 2012). Patriarchal and

patrilineal family structures determine roles and authority in adherence with religious cultural traditions and values. For example, the father possesses more power than other family members, while the husband enjoys more privileges than the wife. Within the Thai household, the oldest man is normally the patriarch of the family. Family members also comply with the oldest living male and have to obey and act in accordance with his decisions (Chirawatkul et al., 2012; Embassy of the Kingdom of Thailand, 2007).

The aforementioned points indicate that the Thai family structure involves a rigid and strong relationship between parents and their children; however, the patriarchal system in the family may negate the ability of pregnant adolescents to exercise agency in their own lives.

Contraceptive availability in Thailand

The wide availability of contraception in Thailand, however the challenges to adolescents accessing contraception were parallel to those in accessing reproductive health services. Thai adolescents described contraceptives as easy to access, especially since forms of contraception like condoms and pills can be accessed at convenience stores, pharmacies, and vending machines (Unicef, 2015) In addition, some adolescents could access free condoms from primary care units in urban areas, from nursing units at schools, at school exhibitions and during any health promotion events for youth, e.g. drug prevention, stop adolescent pregnancy, stop violence on women and girls (Sananee et al., 2017).

Conversely, many Thai studies found that the barriers to adolescents accessing contraception (Tangcharoensathien et al., 2015, Unicef, 2015, Sananee et al., 2017). A study of Unicef (2015) reveled that stigma against contraception and adolescent sexuality emerges as a key barrier to accessing contraception. Sansanee (2017) also found that eight factors influencing on decisions about contraceptive 1) fear of negative consequences of pregnancy on parents; 2) fear of physical and socio-economic difficulties to self; 3) fear of being unable to fulfil cultural expectations as the first female child in the family; 4) fear of HIV/AIDS; 5) fear of contraceptive pill side effects; 6) female negotiation skills ; 7) seniority of females in a relationship; and 8) complicated factors associated with cohabitation circumstances, in conjunction with male preferences and an allergy to hormone pills. The other barriers were the provision of accessible and supportive family planning services for youth, including universal health coverage for emergency contraception and access to safe abortion (Tangcharoensathien et al., 2015).

The aforementioned indicated the availability of contraception appears widespread in Thailand, interpersonal and social-cultural factors found as barriers in ability of adolescents to access contraceptions.

Reasons for conducting the research

In this section, I will briefly discuss the influence of her personal background and experiences in taking a position in relation to this study, as well as her inspiration for conducting this study on the agency of pregnant adolescents.

I am a woman who was born in a sub-district of Mahasarakham Province in the Northeastern Region of Thailand. I live with my extended family which includes my mother, two sisters, my brother-in-law, and two nephews. My family and I embrace Buddhism, and in terms of education, I finished primary and secondary school in my hometown. Adolescent pregnancy brings back memories of past events. In my family, I was taught to keep my virginity until after I was married, while the boys were not taught the same principle. As a result, pregnancy would cause embarrassment for family members, while the parents would be blamed by people in the community. At school, the curriculum did not provide any education on sexuality and pregnancy, except for the health education class which only included information about the human reproductive system. Therefore, knowledge of sexuality and pregnancy was gained through television, novels, or text books. The storylines in the movies and on television programs prompted the Thai public to believe that adolescent pregnancy had a high prevalence and that more pregnant adolescents were seeking abortions; for example, in a movie based on a true story named “The Unborn Child 2002”. This movie tells the story of a girl who had an unwanted pregnancy and decided to have an abortion at an illegal clinic because her partner did not take any responsibility. Consequently, she faced complications and felt guilty about having an abortion. The end of the story showed a scene involving numerous pregnant adolescents having had abortions and keeping their unborn baby’s bodies in a temple morgue. This raised the awareness of people in Thai society about the consequences of adolescent pregnancy.

After finishing high school, I continued my undergraduate and postgraduate studies in Thailand. I gained knowledge about how to assess problems and provide nursing care for pregnant women according to both theory and practice. During my placement in a hospital, I found that pregnancy in adolescents was associated with adverse health consequences for both mother and baby. I also wrote a Master’s degree thesis on the issue of premature labour pain. The study indicated that pregnant adolescents were at high risk of premature labour pain and that their babies were often born with low birth weight. After I graduated, I worked as a nursing instructor at a Nursing College in Mahasarakham Province. Here, I experienced taking care of pregnant adolescents in the antenatal clinic, the delivery room, the postpartum ward, and in the community. I found that pregnant adolescents not only faced health problems, but they also faced socioeconomic issues; for example, girls who became pregnant were criticised by people in their community and by their school contacts which resulted in them avoiding meeting people and to leave school early. In addition, I witnessed the rate of pregnant adolescents increase in Thailand, but with only a small number of them applying for health care services and asking for assistance. Hence, pregnant adolescents faced many

challenges in their lives, and as a result, had to live with the adverse consequences. This raised questions in my mind about how pregnant adolescents deal with the challenges in their lives, and how they exercise their ability to make their own decisions in facing life challenges.

My experiences and the limitations of my knowledge about how pregnant adolescents exercise agency in their lives inspired me to conduct this study. This study seeks to understand pregnant adolescents' agency in a range of social and cultural contexts in order to address a gap in existing knowledge.

Statement of research problems

Pregnancy is a great challenge faced by adolescents. In Thailand, pregnant adolescents are more likely to confront adverse consequences. Adolescent pregnancy exposes young women to physiological, psychological, and neonatal risks, and economic deprivation. They have a high risk of dying during childbirth and of being socially excluded by society, particularly at school. Exclusion from school results in limited educational achievements and economic instability for pregnant adolescents. Other challenges are exacerbated by the Thai sociocultural context, including the patriarchal system and religion which provide privilege and power for males over females in society.

These challenges shape adolescents' ability to make their own choices when pregnant. To support pregnant adolescents, it would be helpful to understand how they exercise agency in maintaining their own health and wellbeing and that of their unborn babies. According to Ortner (2006), agency is the ability of an individual to influence events and maintain some control over their life. Ortner (2006) described two fields of meaning in relation to agency: agency for projects and agency for power. Agency for projects is about intentionality and the pursuit of projects that are always culturally constituted. Intentionality as a concept includes a range of states, both cognitive and emotional, and at various levels of consciousness. Agency for power is about power and acting within relationships of social injustice, asymmetry, and force, although in relation to power asymmetry, subordinate agents always have some capacity to influence events, indicating that all power relations are unstable. Agency is never merely one or the other, and has two faces as project or as power which blend into one another. As well, all individuals have agency. Agency cannot be equated with either free will or resistance; it is always socially embedded and shaped within different power regimes (Ortner, 2006). Agents are constantly engaging with their context, and through their actions, social formations of power are produced and reproduced (Ortner, 2006). In this study, I intend to employ Ortner's work on agency to explore how pregnant adolescents act independently, or make their own decisions, when faced with challenges in their lives, and to investigate the factors that impede and enable agency. Therefore, this study is significant because it will explore how agency is enacted by pregnant adolescents and how it is shaped by the personal, interpersonal, cultural, familial, and societal aspects of pregnant adolescents' lives. This new knowledge can shape how society and

health professionals support adolescents to improve health outcomes for themselves and their unborn babies.

The aims of the study

The aims of this study are to explore how adolescents in Thailand exercise influence over their lives when they are pregnant, or in other words, how they exercise agency in caring for themselves and their unborn babies. The objectives are as follows:

1. Explore how pregnant adolescents exercise their agency
2. Explore interpersonal factors that shape the capacity of pregnant adolescents to exercise their agency
3. Investigate the social and environmental factors that shape the capacity of pregnant adolescents to exercise their agency

Research questions

The research questions of the study are:

1. How do pregnant adolescents exercise their agency?
2. What are interpersonal factors that shape the capacity of pregnant adolescents to exercise their agency?
3. What are social and environmental factors that shape the capacity of pregnant adolescents to exercise their agency?

Thesis outline

The thesis comprise seven chapters as follows:

Above, Chapter One has provided a background to pregnancy issues related to the study. It began with an overview of definitions of adolescent pregnancy and the prevalence of adolescent pregnancy in Thailand. The next section presented the challenges faced by pregnant adolescents in relation to health impacts and educational and economic impacts. Next, the challenges faced by pregnant adolescents in the Thai sociocultural context were discussed, including the geographic profile of Thailand, Thai socio-cultural norms, religion, and family structure. The substantive part of the chapter concluded with a statement of the research problems and the aims of the study.

Chapter Two explores the existing literature relevant to the agency of pregnant adolescents. A thematic literature review was undertaken to determine the current level of knowledge of agency in pregnant adolescents. The method of review is detailed followed by a presentation of the five main themes. These include decision-making about pregnancy, ability to practice health behaviours,

ability to access health care services, ability to develop the maternal role, and ability to confront social stigma. The last part of the chapter discusses the gaps in the literature on how pregnant adolescents exercise their agency over events that affect their lives in a range of social and cultural contexts.

Chapter Three discusses the philosophical assumptions and the design strategies underpinning the research study. Ontology and epistemology are considered, and critical theory is identified as the framework for this study, while ethnography is presented as the research design. The next section details the research methods, including the data collection method, the research setting, participant selection, and ethics considerations. Following this is a section on entering the field in Thailand to collect the data. Trustworthiness is considered in this section to ensure the rigour of study. The final part of the chapter describes the two-stage data analysis process, including a thematic analysis followed by a theoretical critique using a feminist lens.

Chapters Four and Five present thematic insights into the relevant parts of the lives of the participating pregnant adolescents and their caregivers, detailing the factors that shape their agentic behaviours. These experiences are presented in four main themes including social stigma, support and support systems, cultural heritage, and self-care.

Chapter Six presents three core analytical concepts that will be synthesized by overlaying a critical feminist lens across the initial themes. These concepts of gender inequity, fear, and spirituality are discussed in relation to pregnant adolescent capacity to act agentically.

Chapter Seven summarises the key findings of this study and follows with a discussion of the research limitations. The final section provides a number of recommendations for policy, education, nursing practices, and further research.

CHAPTER 2 LITERATURE REVIEW

Introduction

This chapter presents a literature review on pregnant adolescents' agency to identify relevant information, to outline the existing knowledge in the field, and to identify any gaps in the research, thereby providing a rationale for this study. The chapter is divided into three sections. The first section describes the review process including the search strategy, critical appraisal, and data synthesis. The next section presents five main themes identified from the literature including decision-making in pregnancy, practicing health behaviours, accessing health care services, maternal role development, and social stigma. In the last section, a discussion of the knowledge gaps in the literature will be presented and the research problems identified.

Methods

The literature to review was extensive; hence, a systematic approach was required to organise the large amounts of literature exploring pregnant adolescents' agency and the factors that influence their agency. The purpose of this review was to determine the level of current knowledge surrounding agency in pregnant adolescents. A thematic literature review of research articles was undertaken to achieve this aim (Thomas & Harden, 2008). The following summarises the search strategy, critical appraisal, and data synthesis.

The first step was the search strategy. The literature searched covered five major databases including ProQuest, Scopus, PubMed, ScienceDirect, and Google Scholar. Highly sensitive topic-based search strategies were designed for each database with the help of the subject librarian. I then refined the search terms or keywords related to "agency". For this study, agency was defined as the ability to make one's own choices and to maintain some control over one's life (Ortner, 2006); hence, I identified keywords that had the same meaning as agency, including "agency", "ability", "capacity", and "decision-making", to broaden the results. In addition, adolescent pregnancy, young pregnant women, and teenage pregnancy were used as the search terms in relation to pregnant adolescents. Furthermore, the inclusion criteria were restricted according to study type, language, and publication date. I included any qualitative study published in the English language between 2008 and 2018 inclusive. Qualitative articles were selected for review as it has been argued that they provide in-depth information that is specific to a particular context, time, and group of participants. Overall 2,702 articles were identified through searching the databases. I then added all of the retrieved articles from each search into Endnote and 1,233 articles were recorded after duplicates were removed. The articles were then screened by reading the titles and abstracts and skimming the results in those abstracts that did not show more information. In total, 1,217 articles were excluded after screening, as they did not meet the inclusion criteria of the study, were not about

pregnant adolescents, were quantitative in design, or were conference abstracts. A total of 16 articles were assessed for eligibility. A flow diagram of the above process is presented in Appendix (see Appendix A).

The critical appraisal was the next step. I applied the critical appraisal skills program (CASP) checklist to assess the rigour of the 16 articles. Each article was assessed according to the 10 questions in the checklist including if there was a clear statement of the aims of the research, whether the qualitative methodology was appropriate, if the research design was appropriate to address the aims of the research, whether the recruitment strategy was appropriate for the aims of the research, if the data was collected in a way that addressed the research issue, if the relationship between the researcher and the participants had been adequately considered, whether ethical issues had been taken into consideration, if the data analysis was sufficiently rigorous, if there was a clear statement of the findings, and if the research was valuable, all of which were answered with a "Yes", a "No", or a "Can't tell" (Critical Appraisal Skills Programme, 2018). The CASP assessment identified nine articles which met all the criteria of the appraisal checklist. However, seven articles did not meet the criterion of reporting of ethics considerations. Five studies provided only a limited discussion of the issues raised by the study, and a limited description of their explanations to the participants for the reader to be able to assess whether ethical standards had been maintained. In addition, two studies had not reported on ethics considerations at all. Despite these weaknesses being identified in seven articles, they were still included due to the scarcity of other articles that fitted the criteria. After appraisal, all 16 articles met the criteria of the appraisal checklist. A summary of the critical appraisal is shown in Appendix B (see Appendix B).

In the last step, a thematic analysis was undertaken following Braun and Clarke's (2012) approach. The NVivo 11 software program assisted with organising the data. The articles were coded line by line, after which the themes were identified by noting the overlaps between the codes. The codes were then sorted into themes and sub-themes.

Results

It was important to obtain articles from a range of locations in order to identify any cultural or geographical variations. Of the 16 articles that met the inclusion criteria, four were studies conducted in the United Kingdom, two in Mexico, two in South Africa, and one each in Vietnam, Jamaica, Uganda, Hong Kong, Bangladesh, the USA, Ghana, and Thailand. Five main themes relating to pregnant adolescents' agency emerged from the analysis including decision-making in pregnancy, practicing health behaviours, accessing health care services, maternal role development, and social stigma. These five themes and their associated sub-themes are presented in Figure 2 and are described in the following sections.

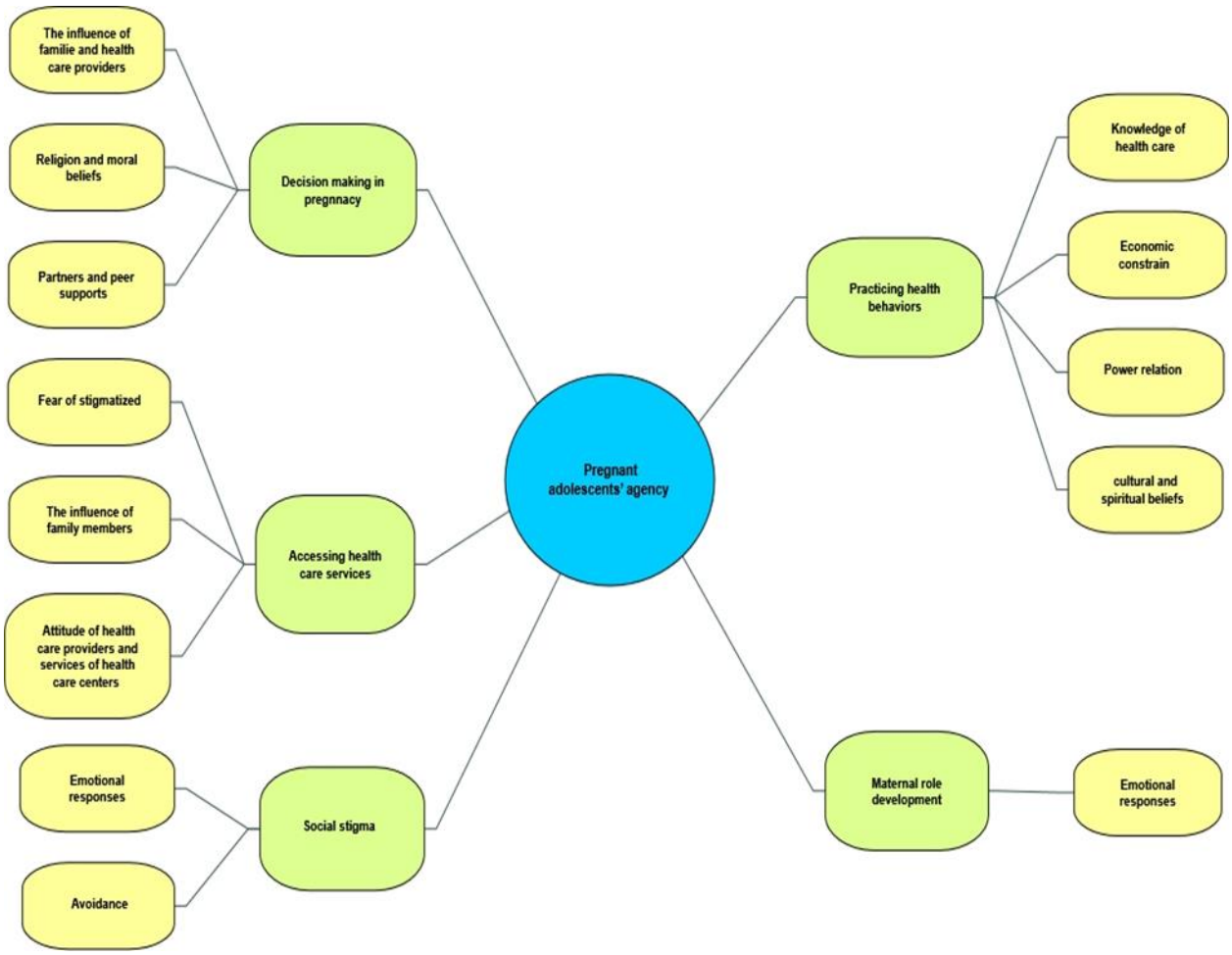


Figure 2 The main themes and sub-themes of pregnant adolescents' agency

Decision-making in pregnancy

When adolescents find out they are pregnant, they face a difficult situation in making their own decisions on their pregnancy (Tatum, Rueda, Bain, Clyde, & Carino, 2012). Six of the articles under review identified decision-making in relation to pregnancy as the main theme. There were also three sub-themes which identified a number of important factors influencing decision-making in pregnancy, including the influence of families and health care providers (Mantovani & Thomas, 2014a; Sa-ngiamsak, 2016; Tatum et al., 2012; Wilson-Mitchell, Bennett, & Stennett, 2014), religion and moral beliefs (Hoggart, 2012; Loke & Lam, 2014; Mantovani & Thomas, 2014a; Sa-ngiamsak, 2016), and partner and peer support (Loke & Lam, 2014; Tatum et al., 2012).

There was a strong influence of family members on pregnant adolescents' ability to make decisions about their pregnancy. The ability to make decisions was demonstrated in four studies undertaken in Vietnam, Jamaica, Mexico City, and Thailand (Klingberg-Allvin, Binh, Johansson, & Berggren, 2008; Sa-ngiamsak, 2016; Tatum et al., 2012; Wilson-Mitchell et al., 2014). These studies indicated that pregnant adolescents' decisions on their pregnancy were influenced by family members, especially parents, the baby's father, and the baby's father's family. Five studies asserted that pregnant adolescents' decisions were subordinated within their family and in health care services as

a result of their inability to make their own decisions (Atuyambe et al., 2009; Klingberg-Allvin et al., 2008; Mantovani & Thomas, 2014a; Sa-ngiamsak, 2016; Shahabuddin et al., 2017).

For example, Klingberg-Allvin et al. (2008) described decision-making about pregnancy by pregnant Vietnamese adolescents as "being in the hands of others". Some pregnant adolescents explained that they were being subordinated to the husband's extended family and were striving to please their husband. These reasons were related to the pregnant adolescents' inability to make their own decisions on their pregnancy. Similarly, pressure from the baby's father and his family influenced decision-making in pregnant Thai adolescents. Pregnant adolescents were pressured to terminate the pregnancy because the fathers avoided taking responsibility and had no income to look after a family. When the termination process was unsuccessful, the decision to keep the baby was also influenced by the babies' fathers (Sa-ngiamsak, 2016).

In addition, health care providers influenced pregnant adolescents' ability to make decisions about their pregnancy. A study on black minority ethnic groups in London indicated that pregnant adolescents aged 16-19 years were in a disempowered position when interacting with professionals, which made decision-making more difficult (Mantovani & Thomas, 2014b). The interactive process in which health professionals provide personal advice often provoked anguish in an already vulnerable person and seemed to overlook the possibility that having an abortion could be a positive solution for some pregnant adolescents. In one example from the study, a nurse proceeded to book an abortion without consulting the pregnant adolescent on the grounds of her young age and on the assumption that she would be leaving school (Mantovani & Thomas, 2014b).

Four studies demonstrated that strong religious and moral beliefs influenced pregnant adolescents' decision to continue their pregnancy (Hoggart, 2012; Loke & Lam, 2014; Mantovani & Thomas, 2014a; Sa-ngiamsak, 2016). A moral framework was also used to frame decision-making on whether to continue with the pregnancy of adolescents in England. The study found a relationship between moralistic constructions and feelings of regret following an abortion that led pregnant adolescents to decide to keep their babies (Hoggart, 2012). Similarly, Mantovani and Thomas (2014a) indicated that pregnant African and British adolescents in the United Kingdom decided to keep their babies and rejected having an abortion by evoking the moral values imposed by their culture or by religious norms. In Thailand, pregnant adolescents also held strong religious beliefs to the effect that abortion is a sin and would bring bad karma. This belief influenced pregnant adolescents' decisions to not have an abortion (Sa-ngiamsak, 2016). Pregnant Chinese adolescents in Hong Kong also respected the sanctity of life and that a fetus has a right to live; hence, they decided to continue with their pregnancy (Loke & Lam, 2014).

Partners and peers were reported to influence decisions to continue with the pregnancy. This was supported by three studies (Loke & Lam, 2014; Mantovani & Thomas, 2014a; Tatum et al., 2012).

Peers and friends assisted some pregnant adolescents to overcome feelings of doubt that limited their decision-making and provided emotional support by exploring options and helping pregnant adolescents to determine how they wanted to proceed (Tatum et al., 2012). Partners provided similar emotional support as peers and, in addition, provided financial support and offered commitment to assist with raising the baby (Loke & Lam, 2014; Mantovani & Thomas, 2014a).

Practicing health behaviours

The ability to practice health behaviours in pregnant adolescents is associated with many factors including health knowledge (Haddrill, Jones, Mitchell, & Anumba, 2014), economic constraints (Atuyambe et al., 2009; Klingberg-Allvin et al., 2008; Sa-ngiamsak, 2016), and cultural and spiritual beliefs (Atuyambe et al., 2009; Shahabuddin et al., 2017).

Health knowledge contributes to pregnant adolescents' ability to practice health behaviours (Haddrill et al., 2014; Shahabuddin et al., 2017). A study conducted in South Yorkshire in the United Kingdom found that a lack of reproductive knowledge resulted in a misdiagnosis of their pregnancy symptoms and delayed attendance at a prenatal clinic (Haddrill et al., 2014). Likewise, some pregnant adolescents in Bangladesh had only limited knowledge of maternal health care such as prenatal care, hospital delivery, and postnatal care. As a result, they did not attend antenatal care unless they experienced complications (Shahabuddin et al., 2017).

Recent studies have also shown that economic constraints affect pregnant adolescents' ability to practice health behaviours. Atuyambe (2009) found that pregnant adolescents in Uganda were unable to access enough appropriate food. Studies in Vietnam and Uganda also found that economic constraints limited pregnant adolescents' ability to access treatment, cover medical expenses, and purchase supplies (Atuyambe et al., 2009; Klingberg-Allvin et al., 2008). For example, they could not afford to buy maternal clothes to accommodate their expanding bodies and were afraid of looking funny in very tight dresses. This led to them avoiding attending prenatal services (Atuyambe et al., 2009). Moreover, financial difficulties led some Thai families to force pregnant adolescents to continue working throughout their pregnancy, even when this posed a risk to their safety or that of their baby (Sa-ngiamsak, 2016).

Strong cultural and spiritual beliefs surrounding pregnant adolescents influence the practice of health behaviours. A study in Bangladesh demonstrated that cultural and spiritual beliefs influenced pregnant adolescents to follow traditional and spiritual healers because they believed that health problems were caused by the acts of evil spirits (Shahabuddin et al., 2017). Atuyambe (2009) indicated that older people in Ugandan families, such as the grandmother and the older women, tended to refer to their own experiences of pregnancy in relation to traditional medicine. In addition, some pregnant adolescents chose to give birth at home so that traditional rituals related to the placenta could be performed. If they gave birth in hospital, the placenta would be discarded as

medical waste. In this study, some pregnant adolescents differentiated when they wanted to use traditional medicine rather than western medicine; however, they did adhere to traditional herbal medicines to alleviate pregnancy complications and to promote a safe birth (Atuyambe et al., 2009).

Accessing health care

Accessing health care services is important for pregnant adolescents to improve pregnancy outcomes and maternal and fetal mortality and morbidity rates (Haddrill et al., 2014). Five of the studies under review identified that accessing health care services was a challenge for pregnant adolescents. Some pregnant adolescents reported that they avoided and delayed accessing health care services (Atuyambe et al., 2009; Haddrill et al., 2014; Owusu-Addo, Owusu-Addo, & Morhe, 2016; Shahabuddin et al., 2017). There were three factors influencing pregnant adolescents' ability to access health care services that were identified as sub-themes under this theme. These include fear of stigmatization (Haddrill et al., 2014; Klingberg-Allvin et al., 2008; Owusu-Addo et al., 2016), the attitudes of health care providers and providers of services in health care centres (Atuyambe et al., 2009; Klingberg-Allvin et al., 2008; Owusu-Addo et al., 2016; Shahabuddin et al., 2017), and the influence of family members (Atuyambe et al., 2009; Shahabuddin et al., 2017).

Fear of being stigmatized was expressed in three studies (Haddrill et al., 2014; Klingberg-Allvin et al., 2008; Owusu-Addo et al., 2016). In the United Kingdom, for example, pregnant adolescents avoided attending antenatal clinics as they were afraid of the social consequences of pregnancy such as negative judgements from their family, the baby's father, and their peers, or being forced to terminate the pregnancy by social services (Haddrill et al., 2014). In a study in Ghana, Owusu-Addo et al (2016) also found that pregnant adolescents were afraid of the reactions of their family. They thought that their parents and other relatives might suggest terminating the pregnancy when they were found to be pregnant; therefore, they delayed attending a prenatal clinic in the early stages of their pregnancy until such a time that they could no longer hide being pregnant. Two further studies identified that fear of being treated differently by health care services resulted in adolescents not attending an antenatal clinic (Klingberg-Allvin et al., 2008; Owusu-Addo et al., 2016). Klingberg-Allvin et al. (2008) found that pregnant Vietnamese adolescents were afraid that people would laugh at them because of their young age, and therefore, they delayed their first visit to a prenatal clinic. Likewise, Owusu-Addo et al. (2016) indicated that fear of being treated differently and of not receiving good services resulted in their lack of attendance at a prenatal clinic. They also expected to be treated as individuals rather than as older pregnant women.

Three studies identified that family members influenced pregnant adolescents' ability to choose health care services (Atuyambe et al., 2009; Shahabuddin et al., 2017; Tatum et al., 2012). Atuyambe (2009) demonstrated that male partners in Uganda held absolute control over pregnant adolescents in decision-making on seeking and attending health services. In a study in Bangladesh, some partners did not allow pregnant adolescents to attend health care services as this meant that

they would need to take time off work, thus resulting in reducing the family income; hence, pregnant adolescents chose delivery at home to reduce expenses (Shahabuddin et al., 2017). Parents also played an important role in decision-making. For pregnant adolescents who continued with their pregnancy, the overwhelming majority of parents selected the hospital or doctor for antenatal care without the adolescent's participation in the decision (Tatum et al., 2012).

The attitudes of health care providers also influenced pregnant adolescent's decisions to access health care services. It has been shown that the negative attitudes of health care providers limits the ability of pregnant teenagers to access health care services (Owusu-Addo et al., 2016). In Uganda, pregnant adolescents indicated that health care providers in public health facilities were rude, abusive, and threatening, and that they did not maintain confidentiality. Being discouraged from attending public health services, these pregnant adolescents often resorted to traditional herbalists or simply stayed at home (Atuyambe et al., 2009). In a study in Vietnam, pregnant adolescents who had encountered the uncaring attitudes of health care providers were made to feel vulnerable and exposed. Therefore, they delayed attending a prenatal clinic (Klingberg-Allvin et al., 2008).

Two studies reported that pregnant adolescents were not confident about the competence of health care providers, which led to them to avoid public health services (Klingberg-Allvin et al., 2008; Shahabuddin et al., 2017). A study in Vietnam found that pregnant adolescents reported that their inquiries were met with being told that "everything is normal." This made them doubt the competence of the health professionals and to lose trust in their medical judgement, which resulted in reducing their contact with health care services (Klingberg-Allvin et al., 2008). Finally, a study in Bangladesh demonstrated that poor transportation, low quality of services, and the limited opening hours of health centers limited pregnant adolescents' access to health care services (Shahabuddin et al., 2017).

Maternal role development

Maternal role development was reported as a challenging task for pregnant adolescents in three studies. The development of the new role led to pregnant adolescents experiencing a range of emotions that were reported in three studies in the USA, Ghana, and Thailand. Some pregnant adolescents expressed a range of negative feelings including feeling shocked and frightened when they received the initial pregnancy diagnosis and recalled struggling to process their thoughts and feelings (Owusu-Addo et al., 2016; Sa-ngiamsak, 2016; Sadler, Novick, & Meadows-Oliver, 2016). On the other hand, some pregnant Thai adolescents reported positive feelings towards their new role, including feelings of happiness and joy at being pregnant (Sa-ngiamsak, 2016). Klingberg-Allvin et al. (2008) indicated that a strong sense of ambivalence toward pregnancy was described in both positive and negative terms by pregnant Vietnamese adolescents. This ambivalence created feelings of happiness and pride alongside feelings of being too young to become a mother. These feelings of happiness and pride were associated with the positive feelings of the extended families

and husbands about the pregnancy, their pride in being able to conceive, their pride in becoming a mature person, and in their happiness in pleasing their family (Klingberg-Allvin et al., 2008). On the other hand, their feeling of being too young to become a mother was described, and they also conveyed feelings of sadness, hurt, and regret for getting pregnant so young and a lack of confidence in their forthcoming motherhood (Klingberg-Allvin et al., 2008). A study in the USA demonstrated that the changing identities of pregnant adolescents in terms of their physical appearance, lifestyle changes, and the shifts in their roles, influenced their ability to develop the maternal role. For example, some pregnant adolescents changed from being self-centered to being more child-focused which enhanced their sense of maturity (Sadler et al., 2016).

Social stigma

Stigmatisation towards adolescent pregnancy exacerbated challenges to restrict pregnant adolescents' capacity to exercise their agency to access education, and to defend themselves against the experience of stigma. The stigma of being pregnant as an adolescent was experienced in a range of contexts, particularly within the family, at school, and in the community. When adolescents revealed their pregnancy, they often experienced blame, gossip, pressure, and responsibility (Sa-ngiamsak, 2016). Psychological responses to social stigma were identified in three studies. In a study of unmarried adolescent mothers in rural Thailand, it was found that some pregnant adolescents reported feelings of guilt for not being able to fulfil their duty as a good daughter, and they thought that they had failed to meet their families' expectations because traditional Thai culture expected girls to be married before becoming pregnant and, in addition, the family expected girls to have completed a high standard of education (Sa-ngiamsak, 2016). Atuyambe et al., (2009) found that strong feelings of shame and embarrassment were reported by some pregnant adolescents in Uganda. In addition, feelings of regret about becoming pregnant were identified. Pregnant adolescents in South Africa also indicated that being a mother while at school was a "mistake", and that their pregnancy had disappointed their parents (Singh & Hamid, 2016).

Avoidance was a common response by pregnant adolescents in confronting social stigma. This was supported in studies by Atuyambe (2009) and Sa-ngiamsak (2016). Both studies reported that some pregnant adolescents in Uganda and Thailand attempted to conceal their pregnancy by avoiding public appearances and wearing loose clothing. The main reason for hiding their pregnancy was to avoid public criticism (Atuyambe et al., 2009; Sa-ngiamsak, 2016). Sa-ngiamsak (2016) also found that some pregnant adolescents had left school early to avoid conflict with their school and the negative reactions of other students. This was explained in terms of being against school regulations. However, Singh and Hamid (2016) mentioned that although there is continued disapproval of young pregnant women in school, teenage mothers were experiencing an overall decrease in stigmatising and moralising attitudes. Increased support from parents and teachers, and a policy that allowed pregnant learners and teenage mothers to return to school had contributed to reducing the stigma.

Discussion

This review has sought to improve the understanding of how pregnant adolescents' exercise agency and to explore the factors that shape pregnant adolescents' capacity to act agentically. Evidence from 16 qualitative studies of pregnant adolescents and adolescent mothers were examined, with five main themes being identified including decision-making in pregnancy, practicing health behaviours, accessing health care services, maternal role development, and social stigma.

The studies under review indicated that pregnant adolescents were not positioned to make their own decisions, and thereby, to maintain some control over their lives. The influence of the family, health care providers, peers, and spiritual beliefs were the main factors preventing pregnant adolescents from acting independently when they faced challenges in their lives. These challenges related particularly to decision-making about their pregnancy, and their ability to access health care services and to confront social stigma. These challenges also had a negative influence for pregnant adolescents in maintaining a healthy pregnancy, the health of the unborn baby, and to access suitable health care services. The review did not explore how exercising agency in pregnant adolescents actually takes place. The findings from the qualitative research for this study will provide greater insight into this important area.

The findings of the review also highlighted the context within which pregnant adolescents navigate their lives, including the influence of parents, partners, parents-in-law, peers, and religion and spiritual beliefs, which all exert varying levels of influence on decision-making in relation to pregnancy, the ability to practice health behaviours and confront social stigma, and to access health care services. Therefore, exploring the environment within which the pregnant adolescent interacts can provide an understanding of the factors that shape pregnant adolescents' agency.

The factors mentioned above were the main issues associated with the agency of pregnant adolescents within the studies under review. Nevertheless, there were other important factors that were identified, including economic constraints, lack of knowledge of health care, fear of being stigmatized, and the attitudes of health care providers and from service providers in the health care centres. These factors negatively affected pregnant adolescents' agency because the adolescents had only a limited ability to maintain control over their own lives. However, the findings of the review showed only the negative factors influencing pregnant adolescents' agency. The positive factors will be explored in the findings and discussion as factors that shape adolescents' agency.

In conclusion, this review shows that there is a lack of insight into how pregnant adolescents exercise their agency over events that affect their lives in a range of social and cultural contexts. In addition, the specific factors that enable or impede the agentic behavior of pregnant adolescents in Thailand has not been fully captured. This represents a significant gap for further exploration in order to gain a comprehensive understanding of the agency of pregnant adolescents.

Summary

Current knowledge of pregnant adolescents' capacity to exercise agency and the factors that shape their capacity have been identified in this review. The findings identified five main themes related to the agency of pregnant adolescents. They reported an inability to make decisions about their pregnancy. The influence of the family and health care providers, religion and moral beliefs, and partner and peer support that contributed to the decision-making process were also explored in this review. Consequently, the factors that influenced the practice of health behaviours were reviewed as negative effects on pregnant adolescents' agency, including the lack of knowledge of health care, economic constraints, the influence of family members, and cultural and spiritual beliefs. Pregnant adolescents also reported an inability to access health care services. In addition, the fear of stigmatization, low levels of personal authority, and the attitude of health care providers and of service providers in health care centres were identified as factors that lessened pregnant adolescents' agency. The ability to develop the maternal role and to confront social stigma were reviewed as approaches associated with pregnant adolescents' agency. Through the review, gaps in the knowledge have been identified. In response, the exploration of how pregnant adolescents' agency is exercised, the identification of current and potential interpersonal factors that shape their agency, and an investigation of the social and environmental factors that shape agency in pregnant adolescents in the Thai context have been proposed as research problems. The following chapter will present the methodology and methods used to collect and analyse the data in order to explore these research problems.

CHAPTER 3 METHODOLOGY AND METHODS

Introduction

This chapter demonstrates how qualitative inquiry as a research paradigm is used to achieve the research aims of exploring how pregnant adolescents exercise agency and to investigate the factors that shape their capacity to behave agentically. Critical social theory is presented as the initial framework of the inquiry, while ethnography is presented as the data collection approach. As this study was undertaken in the Northeast of Thailand where there is a diversity of cultural backgrounds, detailed attention has been given to the social context and the process of entering the field. The strengths and weaknesses of the approach and the ethical concerns when working with such a vulnerable group are discussed. The study approach will be discussed, reflecting a strong commitment to providing participants with opportunities to provide their viewpoint on how they exercise agency, and what the factors are that shape agentic behaviours in their particular context.

Ontological and epistemological considerations

This section provides an overview of the ontological and epistemological considerations relevant to the qualitative study of pregnant adolescents in Thailand. These assumptions inform me about, and provide an understanding of, social research and the development of a research methodology and methods that fit the research question.

Ontological and epistemological assumptions are important elements of the philosophy of knowledge and reality that underpin decisions in qualitative studies (Lewis, 2015). Ontological issues relate particularly to the nature of reality and its characteristics (Creswell & Poth, 2017). This study has been guided by historical realism in which reality is shaped by social, cultural, economic, political, and gender-based factors (Scotland, 2012). Realities are also socially constructed entities that are under constant internal influence (Cohen, Manion, & Morrison, 2007). In this study, it is argued that being pregnant and an adolescent constitutes the participants' reality. In addition, the exercise of agency by pregnant adolescents is a construction that is shaped by cultural, political, historical, and economic value systems. Ritchie (2013) emphasised the importance of gathering a range of participants' viewpoints to interpret, and to acknowledge that this will provide different types of understandings and multiple viewpoints, but that this does not negate the existence of an external reality. I recognises that diverse viewpoints add richness to the understanding of how adolescents who are pregnant exercise agency and that multiple realies can coexist.

Epistemology relates to the theory of knowledge; how knowledge is obtained, who has access to particular knowledges, and how knowledge is assessed as credible (Creswell & Poth, 2017). Epistemology is subjectivist, based on real-world phenomena, and linked with societal ideology;

therefore, knowledge is both socially constructed and influenced by power relations from within society (Scotland, 2012). Cohen et al. (2007) emphasized that what counts, or is accepted, as knowledge is imposed by the social and positional power of the advocates of that knowledge. This study explores the exercise of agency by pregnant adolescents and how this agency is shaped by the patterns of social relationships and power relations within society. Therefore, a critical paradigm is appropriate for this study to enable an examination of the participants' experiences from their own perspective as well as the role of social context in their lives.

Methodological and Theoretical considerations

Critical social theory frames this study, enabling an exploration of the construction of knowledge for an emancipating and liberating purpose. I have used a range of feminist considerations, under the umbrella of critical social theory, as the final critical lens for the data synthesis. This approach is in response to the themes that emerged from the data in relation to gender inequality and power relations which affected pregnant adolescents' capacity to exercise their agency. This section begins with broad information about how critical theory has been employed in this study, followed by a discussion about the relevance of feminist theory in providing a critical perspective on the agency of pregnant adolescents.

Critical theory

Critical theory is a type of social theory oriented toward evaluating and changing society as a whole (Fuchs, 2015). A basic principle of critical theory is the promotion of human enlightenment and emancipation by offering alternative possibilities which emancipate those once excluded and silenced (Ogbor, 2001). Critical social theory is concerned in particular with issues of power and justice and the ways in which the economy, race, class, gender, ideology, critique, education, religion, social organisations, and cultural dynamics interact to construct the social system (Zou & Trueba, 2002). Critical theorists undertake the scientific study of social institutions and their transformation through interpreting the meanings of social life and the historical problems of domination, alienation, and social struggles (Lincoln & Guba, 2003). The following section describes the main constructs of critical theory that have been employed as a framework for this study.

The challenges faced by pregnant adolescents are shaped within a cultural context. Culture is a collective term for all human values, practices, customs, and artefacts, and this often appears to contradict nature, which is seen as being outside of, and preceding, human influence (Fuery & Mansfield, 2000). Culture is important for understanding power and domination. As a result, culture is viewed as a domain of struggle in which the production and transmission of knowledge is always a contested process (Kincheloe & McLaren, 2002). Dominant and subordinate cultures deploy different systems of meaning based on the forms of knowledge produced within the cultural domain (Kincheloe & McLaren, 2002). In addition, in the modern world, the realm of culture, particularly mass

media, plays an increasingly important role in critical research on power and domination. As a result, this has changed the ways in which culture operates (Kincheloe & McLaren, 2003). From this point of view, critical theory assists in exposing situations of domination associated with the cultural context of pregnant adolescents.

In any cultural context, ideological systems are argued to integrate people into social networks of oppression and subordination (Stoddart, 2007). The term 'ideology' has been broadly understood as referring to systems of ideas and beliefs which are socially shared by members of a collectivity of social actors (Haralambos & Holborn, 2008). Thompson (2013) proposed two general types of ideology including a neutral conception of ideology that involves the attempt, explicit, or implicit, to strip the concept of its negative sense and to coopt it into a corpus of descriptive content. This conception of ideology can be regarded as a system of thought, a system of belief, or as symbolic and pertaining to social action or political practice. Thompson's second type is a more critical conception of ideology. This is where meaning serves, in particular circumstances, to establish and sustain relations of domination (Foshaugen, 2004; Thompson, 2013). In this view, ideology can be defined generally as a person's worldview, and that there are various and competing ideologies operating within society at any given time, some more dominant than others. In this study, ideology plays a role in how pregnant adolescents view how they exercise agency to keep themselves well and healthy during pregnancy. A study of ideology in pregnant adolescents considers the ways in which meaning is constructed and conveyed by symbolic forms of various kinds, and the social context within which symbolic forms are employed and deployed. Furthermore, the concept of ideology can bring an analysis of ideology into the domain of methodological issues. The analysis is concerned with the characteristics of action and interaction, forms of power and domination, the nature of the social structure, social change, the structures of symbolic forms, and the roles played within social life. Hence, in the context of cultural examination, it was essential that this research should explore, with pregnant adolescents, the ideologies that shape their world.

In addition, hegemony represents an important reinterpretation of the concept of ideology (Kincheloe & McLaren, 2003). Hegemony demonstrates the distinction between coercion and consent to operate social power (Howson & Smith, 2008; Stoddart, 2007), and refers to the ability of a dominant class or culture to exercise social and political control, and to legitimate that control though influencing the consciousness of people to accept its worldview (Lincoln & Guba, 2003). Here, coercion refers to the capacity for violence, which it can use against those who refuse to participate in capitalist relations of production. On the other hand, hegemonic power operates to convince individuals and social classes to contribute to the social values and norms of a fundamentally exploitative system. Yilmaz (2010) has argued that two kinds of power are required by hegemony, relational and structural power. Relational power is the strength to persuade and coerce other actors either as individuals or in groups. Structural power is the essential capacity to realise the desired rules, norms, and operations in the international system. Hegemony generates or maintains critical

regulations to cooperate in the future and reduces unreliability, while other states focus on their own interests. Therefore, for me, the concept of hegemony and how it operates in the context of adolescent pregnancy is of considerable importance.

The aforementioned critical theory framework can help to explain the particularity of aspects of social domination that affect pregnant adolescents' agency. I understand that such particularity cannot be explained away by abstract theories of cultural systems that exalt the fixed virtues of cultural rootedness over the uncertainty of cultural struggle. Concepts within feminist theory, particularly those of gender inequity and power relations, assist in explaining the profound impacts on society that influence pregnant adolescents' agency. Hence, feminist theory has been employed as a critical lens through which to make sense of the findings.

Feminist theory

Feminist theories are located under the critical social theory umbrella, and provide perspectives for understanding human behaviour within the social environment by reflecting on women and the issues that women face in society (Germov & Poole, 2006). Regarding the constructs of critical theory, culture and hegemony are viewed through the lens of feminist theory in order to provide an understanding of the sites of gender issues and power relations in society. Hence, a feminist approach provides a critical perspective on the agency of pregnant adolescents, as will be described below.

Feminism is an ideology that addresses gender issues in the social, economic, and cultural fields (Lay & Daley, 2007). This approach aims to bring about change in society in order to provide gender equity and to prevent discrimination based on gender (Kaur, 2016). Feminism is a broad social and intellectual movement that addresses many issues through a range of academic disciplines. These dominant feminist traditions include liberal, radical, Marxist, and post-modern approaches. All of these types of feminism share certain concerns about women, but also diverge in ways that have affected feminist thought (Germov & Poole, 2006). Despite the diversity of approaches, feminist perspectives all highlight the importance of gender inequality and power relations.

Radical feminism takes the position that patriarchy is at the root of gender inequality and the social domination of women by men (Lorber, 2001; Thompson, 2001). Patriarchy is a system of social structures and practices in which women are dominated and oppressed by men (Gneezy, Leonard, & List, 2009), and this term is mainly used to describe the power relationship between men and women (Sultana, 2012). Tong (2007) indicated that radical feminism is divided into two streams of thought, radical libertarian feminists and radical cultural feminists.

Radical libertarian feminists tend to explore what they regard as the satisfaction of any kind of consensual sex, seeking to free women from the belief that good sex can only be experienced in a

committed, long-term love relationship, and that sex for sex's sake is somehow bad or immoral (Tong, 2007). This view assists women avoid what they view as the burden of human reproduction, recommending that natural reproduction be replaced by technological reproduction. Radical cultural feminists aim to explore male power and privilege as the root cause of male sexual violence against women (DeKeseredy, 2011; Dutton, 2010). Radical feminists have noted that heterosexual sex is usually more hazardous than pleasurable for women. They claim that male sexual violence is justified from compulsory institution of heterosexual sex (Tong, 2007). From this viewpoint, heterosexuality is about men control over women's sexuality, and this presents as targeted physical violence against women, and how women are depicted as sex objects in the mass media and as pieces of meat in pornography, which are expressions of patriarchal conceptions of men's rights to use women sexually (Lorber, 2001). From the radical cultural feminist point of view, this approach assists women to discover sex as being separate from men's demands created through the unconstrained feeding of men's sexual appetites, which should result in people being able to nurture each other's sexual needs, and to embrace each other as equals (Tong, 2007). In addition, radical feminism's critique of the heterosexual nature of mothering produced a schism among feminists, offending many who were in heterosexual relationships or who did not want to have children. Radical feminism's praise of women's emotionality and nurturing capabilities and its condemnation of men's violent sexuality and aggression has been seen as essentialist (Lorber, 2001).

Power relations between men and women are also argued to be embedded within social structures, whereby men view themselves as superior to, and having rights and control over, women (Tong, 2007). Radical feminists assert that the concept of power is a relation of patriarchy, and they regard the integration of patriarchal norms as a natural consequence of the pervasive power dynamics of gender domination (Munro, 2003). The feminist critique of power relations has been influenced by the work of Foucault. Although radical feminism focuses on issues of power and sexuality, the work of Foucault appears to resist the radical feminist emphasis on grand-scale theories of domination and gender-based oppression (Dore, 2009).

Foucault proposed that power relations are contained within other relations (Dore, 2009). His work shares feminist concerns over the political significance of power and sexuality (Munro, 2003). He views power in much the same way as radical feminists, and gives historical descriptions of the different forms of power that operate in the world, including centralising repressive forms of power such as those that exist and operate at the micro-level of society (Hewitt, 2004). Foucault proposed a model of three basic ways in which power operates, as power which is exercised, power which is productive, and power as coming from the bottom-up (McNay, 2013). Foucault substituted a relational model of power as being exercised, by focusing on the power relations themselves and giving an account of how subjects are created through power relations. Foucault also focused on the productive nature of power by presenting force as evidence of a lack of power and giving accounts of institutional and cultural practices that have produced individuals. Finally, the analysis

of power from the bottom-up attempts to show how power relations at the micro-level of society make possible certain global effects of domination, such as class power and patriarchy.

In feminist theory, patriarchal structures in society are viewed in terms of domination and subordination as they relate to gender, identifying that everyone has the right to be free from discrimination and oppression. Hence, a feminist lens has challenged me to investigate and understand gender inequality in more complex and contested ways and to offer a useful theoretical perspective to address how pregnant adolescents exercise their agency within a patriarchal social system. In particular, gender equality is considered in relation to issues of domestic violence in relation to agency in pregnant adolescents. In addition, feminists have argued that the mechanisms of power in gender domination at the micro-level of society have become part of the dominant networks of power relations. This offers a theoretical perspective for this study to explore the impact of power relations of gender domination in exercising pregnant adolescents' agency, and of the power relations that shape agency in pregnant adolescents.

Research designs

Ethnography was determined as the guiding research design to capture the fullness of the experiences of the pregnant adolescents in the study. The term "ethnography" broadly refers to the study of people and culture (Brewer, 2000). Fetterman (2010) indicated that from an ethnographic perspective, culture can be divided into two areas of focus including materialist and ideational perspectives. From the materialist perspective, culture focuses on behaviours. In other words, culture is the summation of behavioural patterns, traditions, and lifestyles. The ideational perspective defines culture as a cognitive approach that comprises ideas, beliefs, and knowledge (Fetterman, 2010). Both ways of exploring cultural behavior and cultural knowledge can be used in ethnographic studies to describe cultures and sub-cultures (Richards & Morse, 2007). The use of ethnography in this study enables me to explore cultural information to identify rich, holistic insights about the meaning that pregnant adolescents ascribe to their ability to act agentically.

Three primary characteristics of ethnographic design are significant for this study,including the capacity to gather thick description (Reeves, Kuper, & Hodges, 2008), the capacity to offer both etic and emic perspectives (Fetterman, 2010), and the embedded opportunity for reflexivity (Anney, 2014).

Thick description refers to the collection of detailed descriptions made possible by me being embedded in the field of research, enabling deep engagement with, and reflection upon, patterns of cultural and social relationships (Geertz, 2000; Reeves et al., 2008). The gathering of thick description also enables identification of meaningful structures of practice, including shared and sometimes contradictory meanings (Ponterotto, 2006). In this study, I have gathered, described, and interpreted meaning based on the behaviours and reflections of pregnant adolescents in the specific

contexts in which the social action took place. In the field, I faced differing visions of reality based on different participants' interpretations of each situation. Nevertheless, I presented these different interpretations and incorporated them into the analysis.

Etic and emic perspectives were considered deeply within the ethnographic design to maintain cultural distinctions. The etic perspective reflects the researcher's point of view (Madden, 2010). This approach avoids altering the culture that the researcher is studying by direct interaction (Fetterman, 2010). The emic perspective manifests the participant's point of view (Madden, 2010). This perspective includes more detailed and culturally rich information because the researcher places herself within the culture of the intended research in which they observe comprehensive details of the practices and beliefs of that society (Hoare, Buetow, Mills, & Francis, 2013). I grounded both emic and etic perspectives into this study by positioning herself as a group insider to examine behaviours and their meanings in relation to how pregnant adolescents exercise agency. I also considered herself as an outsider in investigating the behaviours of pregnant adolescents by taking an external view of the culture, language, meaning associations, and real-world events surrounding these adolescents.

Reflexivity is another important characteristic of ethnographic design. This is a technique which involves reflecting on the ways in which the researcher carries out and understands how the process of conducting the research shapes its outcomes (Hardy, Phillips, & Clegg, 2001). Reflexivity also allows the researcher to identify biases and define notions, and to recognize influences on the data and on the interpretation. This means that the researcher must be aware that her actions and decisions will influence the process and interpretation of the study (Horsburgh, 2003). In this study, I reflected on her own perspectives and experiences in relation to pregnant adolescents' agency in the outline of her reasons for conducting the research in Chapter One. My experience as a nursing instructor and my personal perspectives about pregnant adolescents' agency had challenged and assisted me in becoming aware of the biases that I had experienced in relation to pregnant adolescents from a range of social and cultural contexts and her own view of adolescent pregnancy. Managing her own assumptions during the collection of the data, I ensured that the interview questions were semi-structured, thereby encouraging the participants to talk from their own perspectives, and giving them the opportunity to modify, clarify, and add more information. In addition, in relation to reflexivity in the ethnographic observation for this study, I used a critical lens to carry out the observations by ensuring that her field notes consisted of interpretations of these interactions. These could assist me to gain an awareness of the participants' own assumptions, locations, and feelings (Tan & Ko, 2004). Consequently, I checked my own assumptions which were confirmed by the participants. During the data analysis process, the supervisors constantly asked me to reflect on her assumptions.

In addition, personal characteristics, particularly role, gender, and age, have an influence on the power difference between the researcher and the participants during the interview process, and in observation (Mauthner & Doucet, 2003). In this study, the position of I was as a student who assisted with creating a rapport with the pregnant adolescents and their caregivers. In addition, I realised that the participants often wanted advice from me. As a result, the participants knew that I was a nursing instructor. I proposed that the participants discuss their issues after the interview. I realized that my main role was as a researcher rather than that of a nurse; therefore, I had to monitor my own position while collecting the data to create a balance of the power relations between me and the participants. Additionally, the gender of me had an influence on the interviews with, and observation of, the participants especially the pregnant adolescents and the female caregivers. The female participants tended to be more comfortable discussing issues with me than the male participants (male caregivers). The female researcher limited the responses of the male participants when discussing sensitive issues regarding adolescent pregnancy. In doing so, I was following the strategies of Gailey and Prohaska (2011) in order to reduce the gendered effects on the quality of the data by allowing the participants to have some control over the interview and encouraging them to ask questions at the end. In addition, age was associated with the ways in which the participants reacted to the researcher and what they were permitted to do (Marshall, Fraser, & Baker, 2010). My age was approximately 20 years older than the pregnant adolescents and 5-10 years older than the caregivers; hence, I considered the types of relationships that had been established between me and the participants to reduce the age gap.

I found that it was important and beneficial to go through the process of reflexivity in order to raise her awareness and to have a better understanding of the position of me. As a result, in this study, reflexivity facilitated me to mitigate the power issues with the participants and helped me to understand the social context of adolescent pregnancy in Thailand.

Data collection methods

I employed three stages of data collection, including semi-structured interviews, participant-observation, and photo-elicited interviews. These methods provided a detailed and rich database for investigation, analysis, and reporting. In addition, they enabled me to collect data in a realistic or naturalistic setting in which pregnant adolescents act naturally, focusing on both their verbal and non-verbal behaviours. The methods are discussed further below.

Semi-structured interviews

The semi-structured interview is a widely used interviewing format for qualitative research that can occur either with an individual or in a group (DiCicco-Bloom & Crabtree, 2006). In this study, semi-structured interviews enabled me to probe beneath the surface of superficial responses to obtain meaning that the adolescents assigned to objects, people, and events reflecting the complexity of

their attitudes, behaviours, values, beliefs, and experiences (Teijlingen, 2014). According to Keller and Conradin (2018), semi-structured interviews enable participants to independently express their views and encourage two-way communication and in-depth discussions of sensitive issues.

In this study, semi-structured interviews involved face-to-face interaction between me and the participant. The interviews also involved me eliciting information from an interview guide. The guide enabled a systematic exploration of the issues with the participants, and assisted in keeping the interview flowing according to the desired line of action (DiCicco-Bloom & Crabtree, 2006). While being flexible in delivery, the interview guide also included key questions for the interview consisting of a series of open-ended questions organised around how pregnant adolescents exercise their agency, and the interpersonal, social, and environmental factors that shape the capacity of pregnant adolescents to exercise their agency. The information in the interview guide was divided into two groups, one for the pregnant adolescents and one for their caregivers (see Appendices C and D). The questions were deliberately open-ended, such as “Can you tell me about your experiences of being pregnant?” Various prompts were used such as “Can you tell me more about that?” and “Can you tell me more about how this happened?”

I began the interview with simple topics before moving onto those that were more complex to elicit fruitful information from the participants on specific topics which enabled me to tap into greater depths of self-expression by the participants (DiCicco-Bloom & Crabtree, 2006). The questions in the semi-structured interviews were flexible, enabling modifications in the ordering, content, and structure of the questions in order to privilege the participants’ voices. In addition, the question wording could be changed to be suitable for the participants, while the question probes were used to explore personal perspectives, allowing for, and capturing, multiple meanings and interpretations of specific cultural practices (Liamputtong, 2013). All the interviews were audio-recorded enabling me to engage without distraction, and effectively capturing long verbatim conversations with me and maintaining a natural conversational flow.

Participant observation

As a method of data collection, participant observation sits under the umbrella of ethnographic methods (DiCicco-Bloom & Crabtree, 2006). Participant observation is the systematic observation of events, behaviours and artefacts in fieldwork using the five senses and providing a written account of existing situations (Kawulich, 2005). This method requires the researcher take part in the daily activities, rituals, interactions, and events of groups of people (DeWalt & DeWalt, 2011). Social interaction is central to participant observation in two significant ways, exploring phenomena that emerge in interaction between people in a given context, and generating knowledge through personal interaction between the researcher and the people who make up the social context under investigation (Moen & Middelthon, 2015). Participant observation is useful for this study because it enables the researcher to identify non-verbal expressions, to contextualise the participants’ lived

experiences and interactions, and to determine how the participants communicate with each other. In addition, the observation method affords access to otherwise unrepresented aspects of culture, enabling richly detailed descriptions of behaviours, intentions, situations, and events as understood by the participants (Kawulich, 2005).

In this study, I drew on Patton's five dimensions of variation in approaches to observation (Patton, 2015). Firstly, the role of the observer in this study is as a partial observer. I was part of the group for the duration of the participants' activities while they attended the antenatal clinic and engaged in routine activities in their private residence or in the community, whereas I was an observer to the interactions between the participants and the health care providers and other people. Secondly, I ensured that her role and actions as an observer was made very clear to the staff in the antenatal clinics and the adolescent participants and caregivers. Thirdly, portrayal of purpose is another dimension of the observation method within a range of variation from full explanation of real purpose to false, or concealment of, explanations; thus, in this study, I introduced the aim of the study, a description of her role, and the purpose of the observation to each individual participant. In addition, I gave the participants the opportunity to express their feelings and concerns about the observation. Fourthly, the focus of observations ranges from a narrow to a broad focus; thus, I incorporated a broad focus to describe a more holistic view of the exercise of agency by pregnant adolescents and all its elements. Lastly, the duration of the observation was six months in the antenatal clinic at Mahasarakham hospital and in the villages around Mahasarakham Province. Fetterman (2010) argued that a lengthy residence advantages the ethnographer by allowing for the comprehension of basic beliefs, fears, hopes, and expectations of the participants being studied. It was anticipated that each participant was observed on approximately two separate occasions for a period of approximately 1 to 2 hours, or for as long as the participant was comfortable, in order to learn the language and observe patterns of behaviour over time. The observation also used field notes to capture data.

Field notes

Recording of field notes is an important procedure to capture data from participant observations and interviews (DeWalt & DeWalt, 2011). In ethnography, field notes are where initial patterns emerge, and researchers rely extensively on them to provide insight about what qualities may define the members of a given group. The researcher also depends on their field notes to discover connections, to work toward preliminary understandings, to develop interpretations, and eventually, to reach conclusions (Hoey, 2014). The contents of field notes always acknowledge when and where the recording has been made and what it consists of (Nurani, 2008). In addition, Sunstein (2012) introduced four major elements of field notes: jotting brief words or phrases down while involved in the fieldwork, descriptions of everything the researcher can remember, analysis of what the researcher has learnt in the setting in relation to the research questions, and the personal reflections of the researcher. These aspects of field notes are written in different ways by each researcher.

In this study, I employed field notes to capture data from the participant observations. The field notes were recorded to confirm that what I was observing was accurate and worthwhile. During the observation, the date, time, place of observation, the physical context, the people involved, and non-verbal communications were also recorded. However, some notes were written after the observation because it was inconvenient to take notes openly on some occasions because the participants would feel uncomfortable; hence, I relied on memory when the situation was not appropriate for me to take notes. The documents below illustrate the field notes taken during the observations.

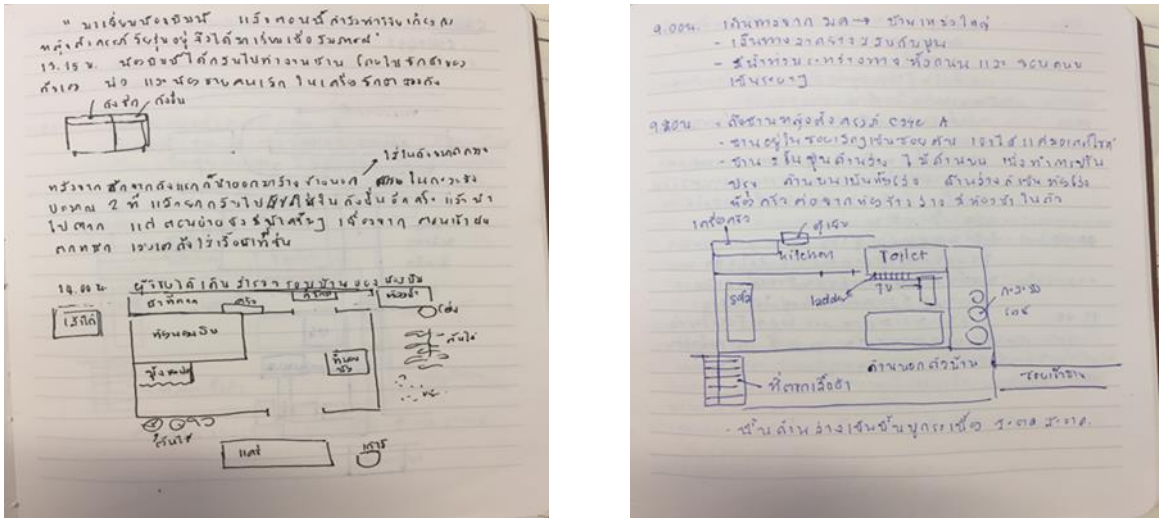


Figure 3 Field notes to capture data from observations.

Photo-elicited interviews

Photo-elicited interviews are an ethnographic tool where photos are used to reflect on the meaning of objects, people and social activities (Langhout, 2014). Photo elicitation was initially defined by American Anthropologist, John Collier, in 1957 when he used photos in the research process to engage the participants in his study of Navajo Native Americans (Copeland, 2011). Wagner expanded this practice in people in community to explicitly stimulate participants' responses during interview (Harper, 2002). These landmark studies laid the groundwork for employing photos in the research process to explore history, culture, and the experiences of people in society (Hurworth, 2003).

A number of studies propose that photo elicitation is advantageous for qualitative researchers. As a tool it enables the researcher to gain rich narratives of participant experiences (Sibeoni et al., 2017). Photo-elicitation interviews also appear to offer a way of gaining insight into participants' viewpoints by asking the photographer for their interpretation of the visual image and, in the process, gaining access to their construct of self (Croghan, Griffin, Hunter, & Phoenix, 2008). In addition, Epstein et al (2006) highlighted that this method is an "ice breaker activity" to create a comfortable space for discussion and to talk about specific issues and unforeseen dimensions during the interview. Harper (2002) also argued that the idea behind ice breaking is that the photos may lead the participants to

a new view of their social existence, and as a bridge between worlds that are culturally distinct.

Researchers have identified that photos could stimulate participant memories and reflections (Clark-Ibáñez, 2004; Reszel, Peterson, & Moreau, 2014). Photos also facilitate communication in the interview process by creating a comfortable environment for discussion and providing opportunities for participants to take the lead during interviews (Epstein et al., 2006). In reflecting on photo's that the participants themselves took, Meo identified that conversations flowed readily (Meo, 2010). For this study photo elicitation facilitated participants' engagement in the interviews and resulted in the collection of rich data.

Photo elicited interviews have been used in a wide range of studies with adolescents to explore perspectives, beliefs, and attitudes (Noone et al., 2014; Reszel et al., 2014; Richardson & Nuru-Jeter, 2012), empower adolescents (Boucher, 2018; Meo, 2010; Noone et al., 2014), investigate health behaviours (Clark & Anderson, 2014; Lee et al., 2017; Reszel et al., 2014), and promote community development (Hergenrather, Rhodes, Cowan, Bardhoshi, & Pula, 2009). For example, Noone et al. (2014) used photo elicitation to study Latino adolescents' concerns about adolescent pregnancy. They asked the participants to take photos of images that showed their perspectives of being pregnant in their communities. The benefits of using this tool were that it provided an opportunity for participants to engage with their community and to produce insights about their own challenges. In another example, Reszel et al. (2014) used the photo elicitation technique to investigate the experiences of pregnant adolescents and adolescent mothers about health expectations and behavioural changes during pregnancy. The participants used photos to describe their experiences of practicing health behaviours and changes during pregnancy. These studies show the benefits of using photo elicitation to gather data in qualitative studies and its suitability for this study.

This study employed photo-elicited interviews as a core method of data collection. Taking photos gave participants a tangible opportunity to engage actively in this study. I asked the participants to select the photos they most wanted to talk about in the interview about places, people, and things from which they drew strength. Each adolescent participant selected 3-4 photos to talk about. The participants were invited to tell the researcher about each photo, what was represented, and why they had taken it. The interview was audio-recorded to assist with analysis. Taking photos gave participants a tangible opportunity to engage actively in this study. The researcher depended on this engagement for the production of photos to prompt conversations about participant perspectives, contexts, and meanings. I depended on this engagement for the production of photos to prompt conversations about participant perspectives, contexts, and meanings. Epstein (2006) argued that by taking their own photos, participants were empowered to make decisions about what photos to show and discuss during interviews. Furthermore, the photos were used as a conduit during the interview, facilitating verbal exchanges and expression of experiences. The participants were invited

to tell me about each photo, what was represented, and why they had taken it. The interview was audio-recorded to assist with analysis.

In the figure below, I provide a summarised diagram to assist with an understanding of the entire process of data collection from the pregnant adolescents and their caregivers.

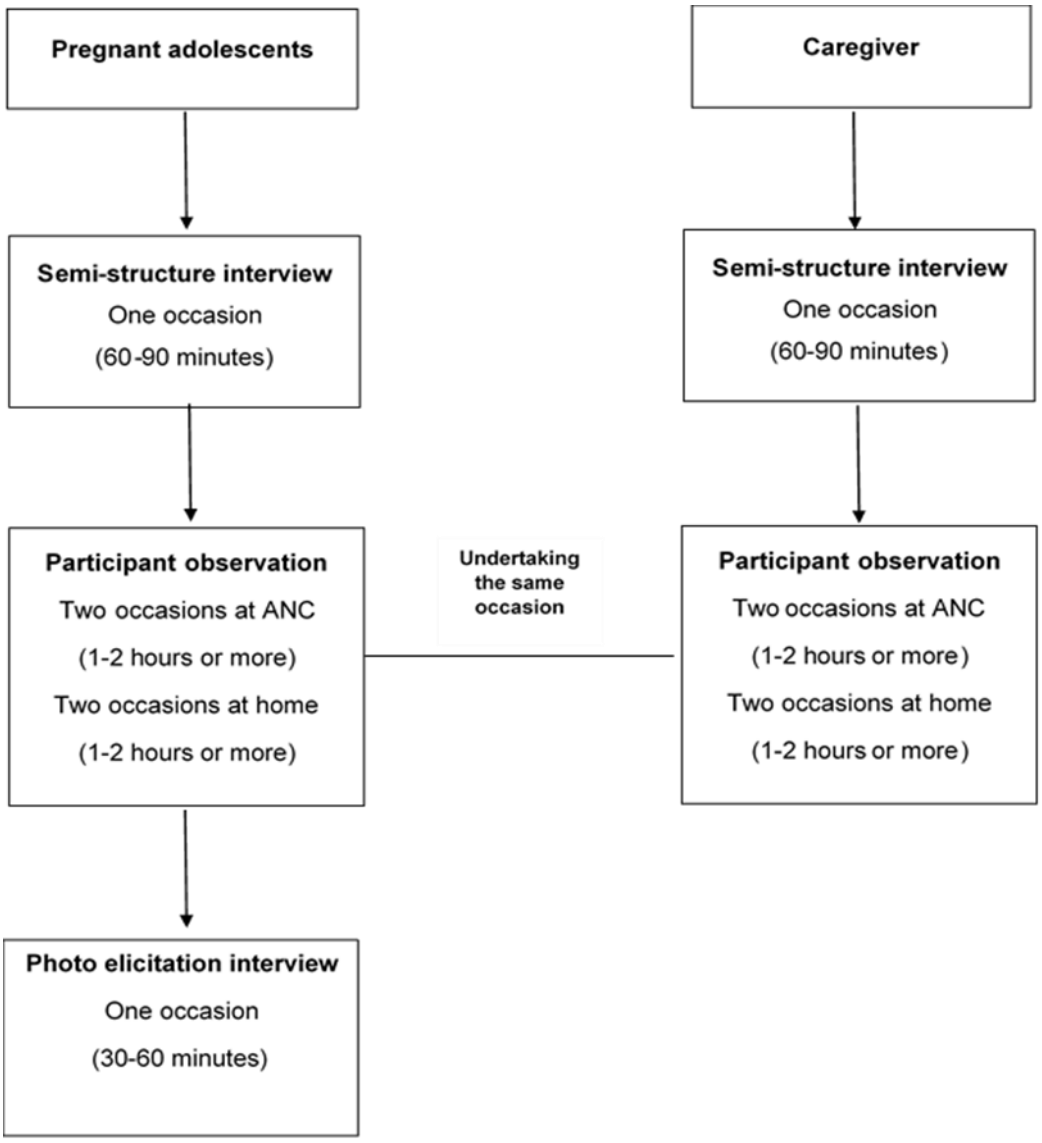


Figure 4 An overview of the data collection process

Research settings

As presented in Chapter 1, Mahasarakham Province is the setting in this study. The reasons for choosing Mahasarakham Province were (i) this province lies within the region with higher birth rates among adolescents aged 10-19 years (UNICEF, 2015); (ii) working in an area where I understand the local culture and dialect. As I has been working as a nursing instructor at Srimahasarakham Nursing College over 18 years that meant I had already established professional networks with the agencies that assisted with collecting data.

The study took place in a range of venues, including the antenatal clinic at Mahasarakham hospital, and the family homes of the young female participants. These family homes were located across 15 villages in Mahasarakham Province, which is located in the Northeastern Region of Thailand, and is bordered by Khon Kaen, Kalasin, Roi-et, and Surin Province. The province is between 130 to 230 metres above sea level and is 470 kilometres from the capital city Bangkok. The province covers an area of 5,267.55 square kilometres (Mahasarakham Province, 2014). The population of the province is 963,484 with 472,972 males and 490,512 females. Of this population, there are 38,531 females between 15-19 years of age, and 37,706 are 15-19 year old males (Mahasarakham Provincial Public Health Office, 2018). Most of the population are Buddhist and the main occupation in this area is farming.

The antenatal clinic at Mahasarakham hospital is where the young women see their doctors and nurses. Mahasarakham hospital is a general hospital under the supervision of the Ministry of Public Health. It provides 472 inpatient beds and a 24 hour service covering all of Mahasasakham Province. The antenatal clinic is an outpatient clinic run by the obstetrics and gynecology department. This clinic provides daily services from 8.00 am to 4.00 pm from Monday to Friday, except on Thailand's official holidays. One doctor, three registered nurses, and one officer provides health care services. In 2014-2015, an average of 25 pregnant adolescents aged between 15-19 years attended the prenatal clinic every month (Mahasarakham Hospital, 2015).

There is a well-established transport system in the city with links enabling people to access other provinces by car and bus. The nearest airport and train station are in the neighbouring province of Khon Kaen, about 70 kilometres away. However, public transport is limited in the villages, which means that young people have difficulty accessing the city. In this study, the participants' residences were in small villages approximately 10 to 30 kilometres from the city hospital. All the participants had limited transport options. I used her own car to access the participants' villages. Figure 5 illustrates the environment around some of the participants' villages.


Figure 5 The environment around the participants' villages

Selection of participants

Purposive sampling was used in the selection of the research participants for this study, to enable selection of those who could provide unique and rich information of value to the study (Palinkas et al., 2015). The sample size was determined by data saturation (Etikan, Musa, & Alkassim, 2016). Data saturation means the collection of qualitative data to the point where further data collection becomes redundant (O'Reilly & Parker, 2013). To ensure data saturation, I took field notes during the interviews and summarised the major viewpoints of the participant after each interview, in order to understand the amount and variability of the information provided by the participants. This practice was to ensure the depth and breadth of information was obtained to achieve sample adequacy which is regarded as a mean of data saturation for qualitative research (O'Reilly & Parker, 2013). Therefore, 15 adolescents and 15 caregivers in total were interviewed, until there was no new information arising from the last few interviews. The pregnant adolescents and their caregivers were recruited according to the following inclusion criteria:

The inclusion criteria used for selecting the participants were:

- Pregnant adolescents aged between 15 and 19 years (inclusive) who have decided to continue their pregnancy.
- Pregnant adolescents who attended the antenatal clinic at Mahasarakham hospital.
- Participants in any trimester of their pregnancy.
- Caregivers such as parents, a partner, a friend, or a neighbour who attended the antenatal clinic to support the pregnant adolescent.

The exclusion criteria used for selecting the participants were:

- Pregnant adolescents who presented with psychological and/or cognitive difficulties that were unable to engage in interviews.

- Pregnant adolescents who were not interested in taking part in the study.
- Caregivers who were unwilling to be participants in the study.

In this study, there were 20 pregnant adolescents and 20 caregivers who met the inclusion criteria. However, two pregnant adolescents and two caregivers withdrew from the study because they moved out of the area. In addition, three pregnant adolescents gave birth to their babies prior to the completion of the data collection phase. A total of 15 pregnant adolescents and 15 caregivers completed the study. Below, I has provided a table describing the characteristics of the participants.

Table 1 Demographic characteristics of the pregnant participants

Participant	**Age**	**Gestational age**	**Marital status**	**Education**	**Occupation**	**Adolescent lives with**	**Religion**	**Relationship with caregiver**
Pha	16	32	Single with partner contact	Grade 9	none	Partner's parents	Buddhist	Mother- in-law
Kung	19	28	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother
Nam	17	21	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother
Tik	17	15	Single with partner contact	Grade 9	none	Father	Buddhist	Father
Nok	18	17	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother
Fang	17	30	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother
Noi	15	23	Single with partner contact	Grade 8	student	Mother	Buddhist	Mother
Tim	17	33	Single with partner contact	Vocational school	none	Partner' s parents	Buddhist	Partner
Jeab	16	34	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother
Klang	17	29	Single without partner contact	Grade 9	none	Parents	Buddhist	Mother
Sand	17	28	Single without partner contact	Grade 9	none	Parents	Buddhist	Mother
Nim	19	26	Single with partner contact	Vocational school	student	Parents	Buddhist	Mother
Kit	15	28	Single without partner contact	Grade 9	none	Mother	Buddhist	Mother
Top	19	26	Single with partner contact	Grade 9	none	Parents	Buddhist	Mother

Participant	Age	Gestational age	Marital status	Education	Occupation	Adolescent lives with	Religion	Relationship with caregiver
Ann	17	20	Single with partner contact	Vocational school	Student	Mother	Buddhist	Mother

The adolescent participants ranged in age from 15 to 19 years inclusive, with the majority aged 17 years. Most of the participants were in their first trimester (0-28 weeks), and most were single with partner contact and lived with their parents. Most of the participants had graduated at Grade 9 and were unemployed. All the participants were Buddhist. Finally, most of the participants identified their mothers as their caregivers.

Table 2 Demographic characteristics of the caregivers

Participant	Age	Marital status	Education	Occupation	Religion
Pha's mother-in-law	44	Married	Grade 6	Employee	Buddhist
Kung's mother	46	Married	Grade 6	Employee	Buddhist
Nam's mother	47	Married	Grade 6	Business	Buddhist
Tik's mother	45	Married	Grade 6	Employee	Buddhist
Nok's mother	44	Married	Grade 9	Employee	Buddhist
Fang's mother	39	Married	Grade 12	Employee	Buddhist
Noi's mother	56	Widow	Grade 6	None	Buddhist
Tim's partner	17	Married	Grade 9	Self-employed	Buddhist
Jeab' father	41	Divorced	Grade 12	Employee	Buddhist
Klang' mother	46	Married	Grade 9	Employee	Buddhist
Sand's mother	52	Married	Grade 9	Employee	Buddhist
Nim' s mother	51	Married	Grade 9	Employee	Buddhist

Participant	Age	Marital status	Education	Occupation	Religion
Kit's mother	46	Divorced	Grade 6	Employee	Buddhist
Top's mother	42	Married	Grade 6	Housewife	Buddhist
Ann's mother	37	Divorced	Grade 9	Employee	Buddhist

The caregivers ranged in age from 17 to 56 years. Most of the caregiver were married. Most of the participants had graduated at Grade 6 and were employed. All the caregivers were Buddhist.

Ethical considerations

This study was approved by the Flinders University Social and Behavioural Research Ethics Committee (Project No. 6900) (see Appendix E) and the Ethics Committee of Mahasarakham Hospital, Thailand (Project No.0032.201/3956) (see Appendix F). As the study focused on pregnant adolescents who were in a vulnerable group, the methods of this study tended to have sensitive ethical issues resulting in the asking of sensitive questions, issues of ethical principles, and parents' consent being requiring. The ethical considerations in this study were based on the National Statement on Ethical Conduct in Human Research guidelines (2007), including issues of merit and integrity, justice, beneficence, parental consent, and the best interests of the child.

Participation was voluntary. I provided an introductory letter and an information sheet to inform the potential participants about the research objectives, research design, participant selection, duration, risks, advantages, and data analysis (see Appendices G and H). All introductory letters and information sheets were translated from English into Thai. I took time to clarify the information and the potential participants were able to ask questions at any time. Some participants requested that I read the introductory letter and information sheet to them. Additional time was also offered so that potential participants could discuss their participation with family members and friends before finalising their decision.

Once the participants decided to become involved in the study, consent was sought from the pregnant adolescents and their caregivers (see Appendix I). For the pregnant participants who were under aged 18, the permission of the parents or guardians was required (see Appendix J). I explained the aims and processes of the study, asked the participants if they had any inquiries, and then explained the instructions for using the camera before the data gathering started. Finally, I also gave the participants' the opportunity to end their participation at any time throughout the study without explanation.

Confidentiality and anonymity were also explained to the potential participants. Pseudonyms were used throughout the research process to ensure that the participants remained anonymous. Each participant was assigned a pseudonym by me, so they are not identifiable in any of the written accounts that were transcribed. I was only the person to transcribe all the data from the audio-recorder. All recorded interviews, transcriptions, observation notes, and photos were stored on a password-protected laptop, and in a secure filing cabinet at Flinders University.

Participants all signed an informed consent form allowing me to use their photos in the study and dissemination (see Appendix J).The consent form was included information about the photovoice (aims, procedures, risks, advantages, and participants' rights and tasks), as well as the choices and options participants had regarding (i) which photos could be credited to them in the final research paper or for which photos they wanted to remain anonymous and (ii) which photos could be share and disseminate the images in research's background analysis, thesis materials, and academic articles and presentations. and which photos needed to be treated confidentially. Ownership of the photos always remained with the research participants to prevent the use of photographs for commercial use and ensuring the appropriate use of images.

Consideration was given to the potential sensitivities of working with pregnant adolescents. Opportunities to refuse to answer sensitive questions were reinforced at the beginning of each interview and throughout the interview process. I offered to switch off the audio-recorder whenever the participants requested, which actually happened at no stage throughout the interviews. When the participants appeared to experience emotional distress, the interview was stopped and the incident was reported to the head nurse of the antenatal clinic. If the participants required counselling, I provided contact details to access these services. In this study, two caregivers cried during the interviews. I took a break of approximately 20 minutes and offered to cancel the interview. However, the participants said that they felt better and the interviews were continued.

Entering the field

After the ethics application was approved by the Flinders University Social and Behavioural Research Ethics Committee and the Ethics Committee of Mahasarakharm hospital, I met with the head of the Obstetrics and Gynecology department at the hospital to explain the study, answer any questions, and address concerns. Subsequently, I met with the head nurse of the antenatal clinic and her team to describe the method of study and to ask for support to undertake the research. The nurses identified potential participants who met the selection criteria, and how they and other staff could support the study, after which I organised times for the interviews and the observation.

The administrative officer who worked at the antenatal clinic gave the introductory letter to the potential participants who fit the eligible criteria. If the potential participants were interested in participating, they were asked to contact me directly at the antenatal clinic or by telephone. I then

gave the potential participants an information sheet and a consent form and asked them to contact me after they had made a decision to participate.

Once the participants had consented to be involved in the study, I organised an appointment with the participants at a convenient time for the interviews, observations, and photo elicitation interviews. I also provided an in-country phone number for direct contact if the participants wanted to change the meeting schedules.

All the participants were initially interviewed on one occasion for a duration of approximately 60-90 minutes, or more if the participants requested more time (see Table 3). At the first semi-structured interview, the participants were asked about their experiences of being pregnant, the challenges in their lives, their decision-making, and the factors that shaped their experience of pregnancy. During the interview, the participants were asked to nominate their significant other to be interviewed. Once identified and consent received, the caregivers were asked about their experiences of taking care of and supporting the pregnant adolescent, and the factors that shape the adolescents' decision-making. The interviews initially took place in a private room at the prenatal clinic; however, if the participants felt uncomfortable because of the crowded and noisy nature of the clinic, I changed the interview place to the participant's residence or a venue of their choice.

The data gathered from participant observation provided contextual information from which to interpret the participant interviews. Each pregnant adolescent participant was observed on approximately two separate occasions for a period of approximately one to two hours, as long as the participant was comfortable (see Table 3). In the prenatal clinic, the participants were observed while participating in activities such as assessments, screening, health care education classes, examinations, and counseling sessions. The participants were also observed in their private residence or in a self-determined community context while participating in everyday activities. I also observed the caregiver who undertook these activities with the pregnant adolescent. The data were recorded as field notes. A period of approximately one month separated observations in the prenatal clinic from those in the participants' residences. During the observations, the description of the physical context, the people involved, and non-verbal communications were recorded.

A photo-elicited interview with the pregnant adolescent participants was the last phase of the data collection. I gave a digital Sony camera to the participants and explained how to use it. The participants were asked to take photos of a range of objects, places, and/ or people that shaped their ability to influence their lives and to care for themselves and their baby. Subsequently, in the interview, the participants were asked about the meaning and importance of the captured images. The photos were discussed on one occasion for a duration of approximately 30 to 60 minutes in a safe venue of the participants' choosing.

Both the interviews and the observations in the participants' residences provided challenges in the Thai context, particularly in relation to me being a stranger in the villages when visiting the participants. With the permission of the participants, I spent time with the family members, such as the grandparents, cousins, friends, and neighbours on one to two occasions to develop a rapport and answer any questions about the research process before interviewing and observing. All the participants were enthusiastic for me to meet their family members and friends. At times, the interviews and the participant observations were postponed when the participants changed their plans, did not attend prenatal clinic appointments, or when I was unable to get to the villages because of heavy rain. The following table presents the details of the data collection to understand the entire process of collecting data in both pregnant adolescents and their caregivers.

Table 3: Summary of occasions and hours used to collect data in pregnant adolescents and their caregivers (Pregnant adolescents = 15, Caregivers = 15)

Participants	**Semi-structured interview**		**Photo-elicited interview**		**Participant observation**	
	Occasions	**Duration**	**Occasions**	**Duration**	**Occasions**	**Duration**
Pregnant adolescents (N=15)	1 each	(Range of 35 – 80 mins) Total 17 hrs, 30 mins	1 each	(Range of 20 – 36 mins)	2 each	(Range of 2 – 4 hours) Total 150 hours
Caregivers (N=15)	1 each	(Range of 30 – 60 mins) 6 hrs, 30mins	-	-		
Total	30 interviews	24 hours	15 interviews	7 hours	60 occasions of observation	150 hours

The table demonstrates the total number of interviews and occasions of participant observation for the study. The pregnant adolescents and their caregivers were interviewed on 3 occasions accounting for a total of 24 hours. The pregnant adolescents were photo-elicited interviewed on 15

occasions accounting for 7 hours. In addition, both pregnant adolescents and their caregivers were observed at the same time on 60 occasions accounting for 150 hours.

Trustworthiness

In qualitative research, I needs to consider issues of establishing rigour. In this study, the concepts of credibility, dependability, transferability, and confirmability, as developed by Lincoln and Guba (Anney, 2014), have been adopted to explain the overarching concept of trustworthiness.

Credibility is an important criterion in assessing the internal validity of a research study (Shenton, 2004). The main strategy used to ensure the credibility of the ethnography was prolonged engagement in the field. Prolonged engagement assisted the researcher to gain insight into the context of the study, which minimised the distortions of information that can arise due to the limited presence of the researcher in the field (Onwuegbuzie & Leech, 2007). In this study, I was engaged in participant observation over a period of six months in the prenatal clinic and in the participants' residences, which allowed me to check her and the participants' perspectives, and which also allowed the participants to become familiar with me, thereby enhancing rapport between I and the participants.

Trustworthiness also included transferability in relation to external validity (Shenton, 2004). Transferability refers to when research findings are applied to other contexts with other respondents (Graneheim & Lundman, 2004). Purposive sampling was employed in this study to select the participants based on the specific purpose of being able to answer the research questions (Etikan et al., 2016). I also recorded the details of the participants carefully and described the inclusion and exclusion criteria for participant selection. Therefore, purposive sampling helped me to refer to the study findings that could predict and explain similar situations. Trustworthiness is demonstrated through me detailing the entire research process, the data collection and data analysis strategies, and the context of the study (Anney, 2014) for public scrutiny. In this study, the data collection methods and the characteristics of the setting are explained so that other researchers could replicate this study under similar conditions in other settings.

In addition, dependability was included to assess reliability (Anney, 2014). This involved the core issue of research being consistent across time, researcher, and analysis technique. Dependability is established through using an audit trail, a code-recode strategy, and peer examination (Anney, 2014). To check dependability in this study, the audit trail was concerned with detailing the inquiry process to validate the data, whereby I accounted for all her decisions and activities to show how the data were collected, recorded, and analysed. Every aspect of the inquiry process has been clearly presented in previous sections of this thesis. In addition, the research involved a code-recode strategy of the data throughout the data analysis process. I coded relevant data in a systematic way throughout the entire data set, categorising relevant data into each code. Before completing the

coding stage, I double-checked each part of the data with their given codes to ensure consistency of interpretation and rigour. Moreover, the use of my supervisors to check the research plan and implementation was another way of ensuring dependability. This process contributed to a deep reflexive analysis which assisted in identifying hidden meanings in the data (Anney, 2014).

The last standard was confirmability, which refers to the measure of objectivity used in assessing outcomes, and how well the research findings are supported by the data when confirmed by other people (Shenton, 2004). Confirmability is based on the perspective that the integrity of the findings lied in the researcher adequately tying together the data, the analytical processes, and the findings in such a way that the reader is able to confirm the adequacy of the findings (Morrow, 2005). The audit strategy is the main technique used to enhance confirmability, and includes using an external auditor throughout the research process along with a detailed outline of the product, data, findings, interpretations, and recommendations for understanding exactly how and why decisions were made (Onwuegbuzie & Leech, 2007). In this study, I provided raw data that was incorporated into the audit trail, particularly field notes and audio recordings to ensure that the data supported my analysis and interpretation of the results.

Transcription and translation

Interviews being conducted in one language and findings presented in another has a direct impact on the trustworthiness of research and its reporting (Chen & Boore, 2010). In this study, all the interviews were transcribed and translated, with the interviews being conducted in Thai and the research findings presented in English. Therefore, language is an important issue to be considered in terms of transcription, the translator, and translation and back-translation. These issues are considered further below.

All the interviews were transcibed after the fieldwork had been completed. Transcription is an important first step in the data analysis process, as it assists me to become familiar with the data and focuses attention on what is actually there rather than what is expected, which facilitates the recognition and connection of ideas that emerge during the analysis (Bailey, 2008). In this study I transcribed the interviews verbatim into Thai. All the words and emotional expressions from the participants, including their laughter, pauses, sighs, and stutters were kept because they indicated how the participants felt about what they were saying at the time (Liamputtong, 2013). All the interview transcriptions were read and re-read, while the audio-recordings of the interviews were listened to on two or more occasions so that I could become immersed in, and intimately familiar with, the data. Notes were used to assist me in the analysis process as memory aids and triggers for the analysis.

Translation is required when there are language differences in research; hence, a translator plays an important role in bringing the second language as close as possible in meaning to the original

language through translation (Wu, 2006). In addition, the linguistic competence of the translator and the translator's knowledge of the people being researched can affect the quality of the translation (Chen & Boore, 2010). In this study, the chosen translator had impressive linguistic credentials. He had been working as an English language lecturer at a Physical Education Institute for approximately 22 years and graduated with a PhD in English and Language Arts at Mahasarakharm University. His research area involves working with adolescent students, which enabled him to understand the target group of this study.

All the Thai transcripts and field notes were initially translated into English by me. Four approaches were used in the translation process to ensure the relevance of the content including being aware of similarity of meaning, conceptual equivalence, comparable methods of data collection, and consistency of the translated terms (Regmi, Naidoo, & Pilkington, 2010). The professional translator, mentioned in the previous paragraph, then translated these transcripts and field notes in order to evaluate the accuracy of my translation. The two versions of the translations were then compared to validate the translation and enhance the trustworthiness of the study. An evaluation of equivalence of language and conceptual meaning was undertaken by the two research supervisors. They considered the meanings in the two versions to validate the translation of the general content. They found that both versions were similar with only minor differences in synonyms that did not influence the overall meaning. A further degree of rigour was applied through back-translation to achieve sematic equivalence (Chen & Boore, 2010). The professional translator was asked to back-translate additional translations undertaken by me from English to Thai to compare language validity in both the Thai and English languages. This resulted in similar versions, again with only minor differences that did not have an impact on meaning.

Data analysis

For the data analysis, all the interviews and field notes were used in their transcribed and translated form. These data were analysed in two stages, first through a thematic analysis, and then through a critical analysis. The thematic analysis enabled the identification of themes by regrouping text fragments according to similarity and overlap. This data was grouped according to each participant as well as comparatively between participants. This enabled the production of understandings related to how pregnant adolescents exercise their agency in a range of social and cultural contexts.

Thematic analysis

Following the work of Braun and Clark (2012), thematic analysis was initially used to analyse the content of the participants' data. This involved undertaking six stages of familiarisation with the data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and producing an initial summary report.

The NVivo 11 software program also assisted me to code and organise the data. The data were read line-by-line, and when I had become sufficiently familiar with the data, it was coded by word, sentence, or paragraph (Saldaña, 2015). Preliminary codes were identified where the features of the data appeared to be meaningful. My supervisors were involved during this stage to verify and support the refinement of the naming codes. After collation, 1,180 codes emerged from the interview data. The following is an example of the initial codes that were generated from the analysis of the interviews with the pregnant adolescents.

Table 4: Example of coded transcript

Transcript	**Initial codes**
Kit: I didn't want to have a child because it was not appropriate time. My partner told his mom that I got pregnant. His mom said that *"Why do you have a child at this time? And you have to get abortion*". I retorted her that *"you love your son, it is a human, it wasn't a dog, and why did you take me to get abortion?".* I admitted to my mistake, but I didn't want to destroy one life.	Not wanting to have a child Not appropriate time to have a baby Mother-in-law does not accept pregnancy Dealing with forced abortion Concern about unborn baby Admitting "mistake"

As the preliminary codes were developed, I started to shape the codes into themes. At this stage, I reviewed the coded data to identify any similarity or overlap between the codes, after which she sorted the codes into potential themes. As an example of the process, I identified codes on social stigma in pregnant adolescents. I then constructed a single theme by using all the codes related to the social stigma faced by pregnant adolescents, such as the attitudes of people in the community towards adolescent pregnancy, responses to social stigma, the ability to confront stigma, and support from family members. In addition, a mind-map was used to consider the relationship between the potential themes that worked together to form an overall picture of the data. After this, the potential themes were reviewed by checking them against the collated extract and exploring the themes that were associated with the data. In this stage of the process, the potential themes were refined, which sometimes involved them being combined, discarded, or relocated.

In the next stage, the themes were defined and named to identify the essence of what each theme was about and to determine the aspects of the data that each theme captured (Braun & Clarke, 2012). I determined that each theme answered the research questions and that there was no overlap between themes. In addition, I identified a number of sub-themes within each main theme to provide a structure, particularly for the more complex themes, and to demonstrate the hierarchy of meaning

within the data. Clear definitions and the names of each theme were generated including social stigma, support and support systems, cultural heritage, and self-care.

In the final stage, the analysis provided a concise story of the data through the themes. All the themes are presented in Chapters Four and Five, and quotes have been extracted from the data to capture the essence of the point that I was demonstrating at each point.

Theoretical analysis

All four main themes that emerged from the thematic analysis underwent secondary critical analysis through the feminist lens to explore the specific factors that shape the capacity of pregnant adolescents to exercise agency. The main strategy used to achieve this was codeweaving for the second coding cycle to bring meaning, structure, and order to the data, following Saldana's (2015) approach, as described below.

Codeweaving is the integration of key code words and phrases into narrative form to see how the puzzle pieces fit together. This was undertaken in three stages following Saldana's (2015) approach. Firstly, I summarised each of the central concepts into a few sentences. I then wrote several different possibilities of meaning to investigate how the items might be inter-related; what meanings might be ascribed to them, and to identify appropriate theoretical frameworks to analyse them. Attention was given to how pregnant adolescents constructed their meanings of agency as well as their subjectivities within the available discourses on challenges in pregnant adolescents' lives, and whether they positioned themselves within dominant or alternative discourses.

Secondly, I searched for evidence in the data that supported the summary statements relevant to pregnant adolescents' agency, as well as any that did not confirm the evidence, and thus requiring a revision of these statements. Codeweaving was then used as a topic sentence for a paragraph or extended narrative to explain the detail in the code. I used mind-mapping to emphasise the key assertions from the code labels by providing a simple text chart that outlined the findings and their connections, resulting in a tentative summary. I discussed each element with her supervisors, and then reflected on how each item connected and weaved together with others. I also considered the ordering of the concepts for the analytical discussion: from major to minor, minor to major, particular to general, and from 'initiating incident' to 'final consequence'. Three main concepts emerged from the second stage of coding, gender inequity, fear, and spirituality. All themes were presented as mapped below and are discussed in Chapter Six.

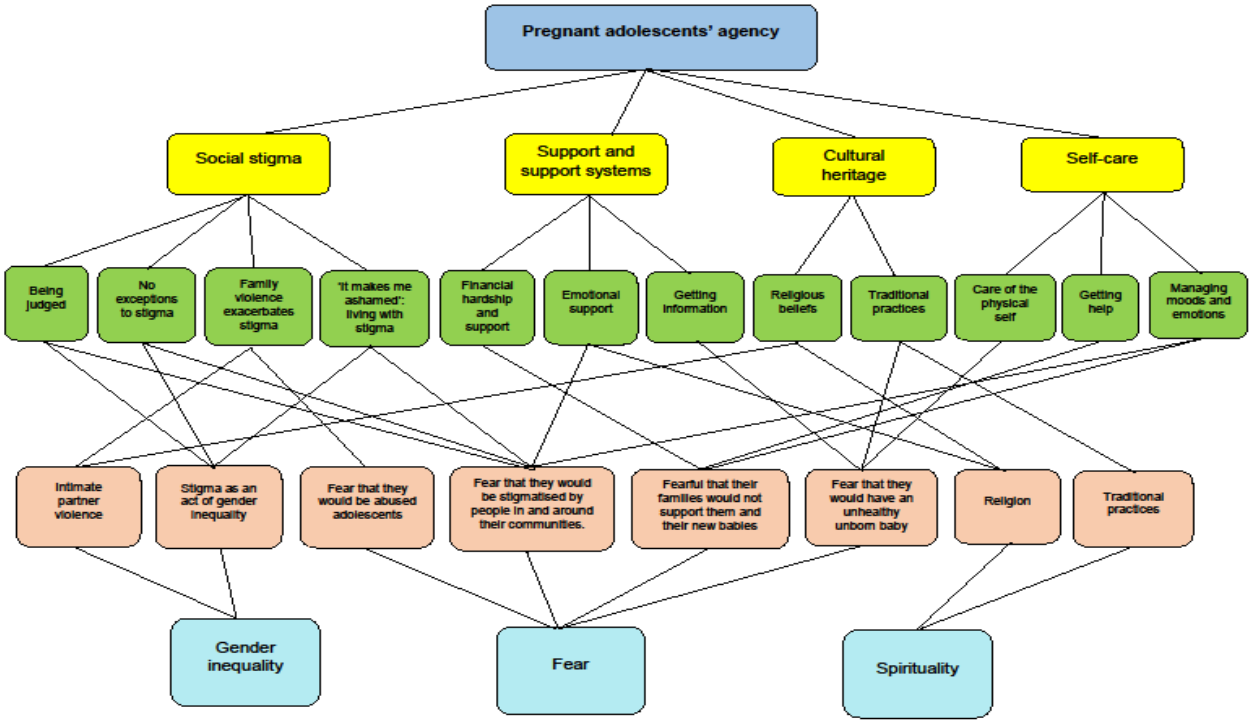


Figure 6 Four main themes and associated sub-themes arising from the data analysis

In addition, I conducted the data analysis through a second code cycle to highlight the themes or categories in the research data. However, it is important to highlight that as I was the person who had engaged in the process of coding the data, she cannot claim to be completely objective. Feminist researchers have become acutely aware of how their own experiences and biographies intersect with the people they gather data from, and I was no different in this study (Ramazanoglu & Holland, 2002). I noted the significance of locating herself in relation to her own work, which was detailed in Chapter 1.

Ecological model

This study employed Bronfenbrenner's (1979) bio-ecological model as a guide to organising the data. The ecological model focuses on the effect of multiple levels that operate to influence what a person becomes as she/he develops. These include the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The interactions between the individual and their environment depend on events, processes and constructs that occur within and across each level (McLaren & Hawe, 2005). In this study, I considered the important dynamics of interactions within and between each level of the participants' lives that might influence their agency.

The microsystem is the smallest social setting, in which an individual develops patterns of daily living and interpersonal relationships (McLaren & Hawe, 2005) In this study, the microsystem of

adolescent participants included their face-to-face contact with family, neighborhood, and school. The interaction within the microsystem of adolescent participants typically involved personal relationships with family members, partners, and partners' family members, peers, neighbours, teachers, and health care providers. I considered how these individuals and groups interacted with adolescent participants and how these interactions affected their capacity for agentic behaviour.

The exosystem comprises those systems that indirectly influence the developing person (McLaren & Hawe, 2005). In this study, the exosystem included social media, their parents' work places, partners' workplaces, extended family members and health care services.

The mesosystem is the interface where participants developed relationships between the microsystem and the exosystem (Swick & Williams, 2006). As such it is the place of connection between peer group and family, family and school, and family and partner's family. For example, adolescent participants invited their friends over to their home and spent time doing activities that affected their emotional wellbeing.

The macrosystem is the cultural and ideological setting within which patterns of culture and sub-culture interact with the microsystem, mesosystem, and exosystem (McLaren & Hawe, 2005) This overarching includes the historic and traditional beliefs, values and norms that shape relationships and behaviours at all levels (Campbell, Dworkin, & Cabral, 2009). This includes political, legal, religious, and educational systems. In this study, it was important in understand the macrosystem and its sphere of influence in the lives of pregnant adolescents.

In this study the bio-ecological model provided a structure to organise the data in a way that enabled an investigation of the complex interactions within and between the various dimensions of the participants' lives.

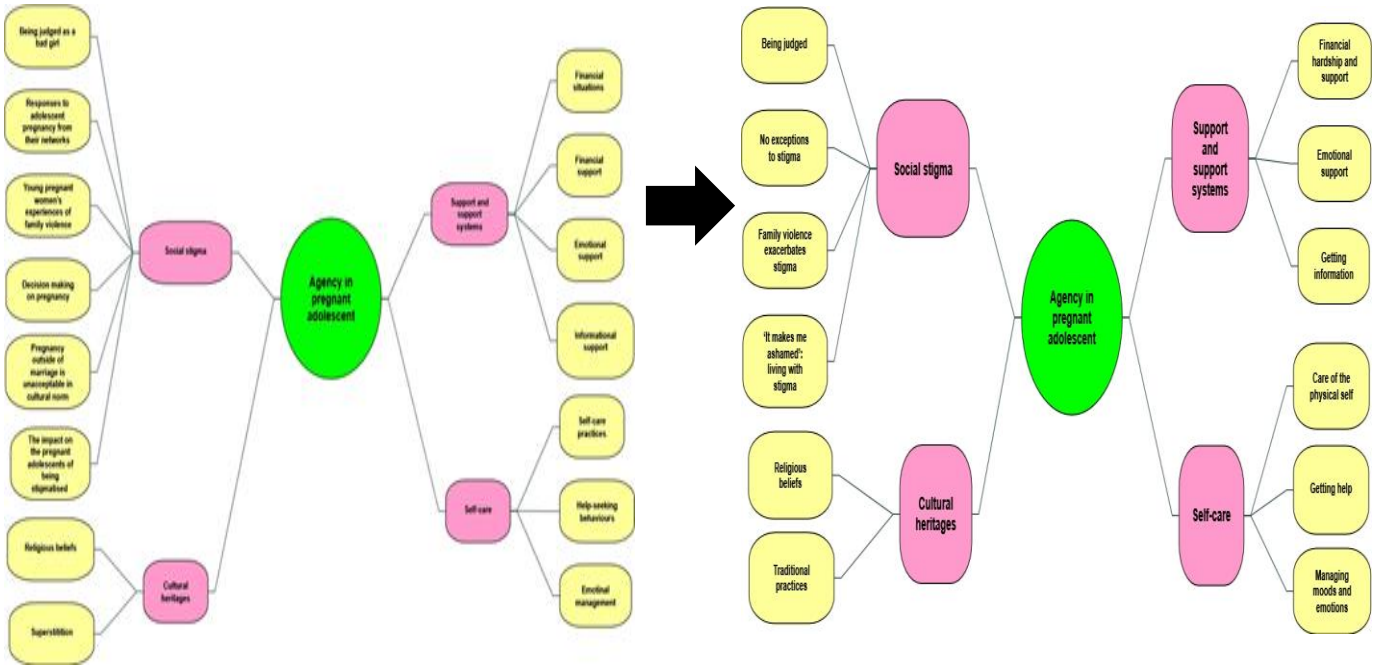
Summary

This chapter has provided an overview of the use of critical theory and ethnography to capture the exercise of agency by pregnant adolescents. The semi-structured interviews, photo-elicited interviews, and participant observations were the data generation methods used in the prenatal clinic and the 15 villages in Mahasarakharm Province, Thailand. The strategies used to ensure the trustworthiness of the study have been described. The data were analysed through the two stages of a thematic analysis and a theoretical analysis. In addition, the ecological model was employed as the guide to organise the data. The next two chapters will present the main themes and sub-themes that arose from the data about the exercise of pregnant adolescents' agency, and the factors that shape this agency.

CHAPTER 4 SOCIAL STIGMA, SUPPORT AND SUPPORT SYSTEMS

This chapter introduces and discusses two of the four major findings about how pregnant adolescents exercise their agency and the factors that shape this agency. As presented in the previous chapter, this study employed Bronfenbrenner's (1979) bio-ecological model as a guide to organising the data. The bio-ecological model used to assist in understanding the effect of multiple levels that operate to influence the adolescent participants. This approach places the adolescent participants as central, exploring how they interact with, and relate to various systems, including: the microsystem such as family members, partners, and partners' family members, peers, neighbours, teachers, and health care providers; the exosystem such as social media, extended family members and health care services; the mesosystem such as the connection between peer group and family, family and school, and family and partner's family; and the macrosystem such as religious, and educational systems.

The four major findings are social stigma, support and support systems, cultural heritage, and self-care (see Figure 7 below). This chapter presents the findings on social stigma and being supported, while cultural heritage and self-care will be presented in Chapter Five.



Prelimary themes and sub-themes Final themes and sub-themes

Figure 7 Four major themes

Theme 1. Social stigma: being a 'bad girl'

Pregnancy in adolescence was considered in the context of Thai culture and tradition; therefore, this resulted in pregnant adolescents being criticised and judged by other people. The resulting social stigma formed the first theme. Stigma can be defined as an attribute that is deeply discrediting and which occurs as the difference between a virtual social identity and an actual social identity (Goffman, 2009). 'Being judged', 'exceptions to stigma', 'family violence exacerbates stigma', and 'it makes me ashamed: living with stigma' are the sub-themes that will be explored below.

Being judged

Participants felt an overwhelming sense of being judged by other members of the community. Thirteen of the fifteen adolescent participants indicated that they experienced negative judgements from people in their community. Girls who were pregnant at a young age were called 'a bad girl' in the community, because they were too young to get pregnant, and adolescent pregnancy was considered to be improper in the villages.

Pregnant adolescents were attributed with names that marked them as different and led to them being devalued in the eyes of the community. The majority of adolescent participants were called a 'bad girl', because they were viewed as being unable to control their sexual desires by engaging in sexual activity at an early age. For example, Sand stated *"I'm "Dek jai teak" in society. It means bad girl, as I have a boyfriend when I'm too young".* Adolescent pregnancy was also characterised as 'Keaw', which they defined as 'a slut' because they were engaging in early sexual activity. In another example, Tik introduced the derogatory term 'Sading' when she said, *"people think early pregnancy is not good and the girls are blamed as 'Sading' because they have sex before getting married".*

Furthermore, some adolescent participants were judged because it was viewed as inappropriate at their age to have babies. Nam mentioned that "*my pregnancy is blamed because they think it is too early to get pregnant".* Pha also said, "*people in my village view teenage pregnancy isn't good as they can't take care of themselves and find it difficult to raise their child".*

Adolescent pregnancy was also considered to be an "*improper role model in community by the villagers*", as mentioned by Kit. Sand's observation was also congruent with this perspective. I incidentally spoke with Sand's neighbours at the local store while I was looking for Sand's home. The neighbour immediately expressed a negative view about early pregnancy without any questions from me. They indicated that such an unsuitable role model in the village could influence the village children to imitate the pregnant teenager's behaviour.

Noticeably, in all the interviews and observations, the males who had impregnated the girls were not criticised by the participants or by people with whom I had incidental contact. Only the pregnant adolescent girls were perceived as 'being bad'.

Adolescent pregnancy was recognised as a common occurrence in rural Thailand by some caregivers, as it frequently occurred in their families and communities. Jeab's father stated, *"my wife got pregnant when she was only 18 years old, so I think pregnancy in teenager is a common situation in my family".* Also, Pha's mother-in-law and Nok's mother indicated that there were many adolescents who became pregnant in their village, thus they supposed that adolescent pregnancy was a normal occurrence in society. While an observable common occurrence, adolescent pregnancy was seen as deviating from the ideal social norm. The adolescent participants were therefore judged as being bad girls, with their age rendering them unsuitable to have a baby. The resulting negative perspectives were experienced by the participants as social stigma which left them feeling excluded.

No exceptions to stigma

The responses of individuals and the community to adolescents who were pregnant were pervasive in the creation of stigma. The experience of stigma depended on how each young woman perceived judgement from others and how she made sense of the way she was treated. Stigma is defined as a physical or social trait that results in negative social reactions such as discrimination and exclusion (Goffman, 2009). Stigma was operationalised through the judgements of a range of people including family members and relatives, community members, school contacts, and health care providers.

Stigma was created by family members, particularly parents, when they expressed concerns that their daughter's behaviours did not meet family expectations. In Thai culture, parents often expect their daughters to follow a certain traditional route: to graduate from school, get a good job, meet a loving partner, get married, and then have children. They also expect that their daughters will keep their virginity until they get married. When parents learned that their daughters were pregnant, they expressed a wide range of responses.

Not accepting the pregnancy was a particular response from some parents; for example, Ann, Nim, and Noi's mothers. The occurrence of adolescent pregnancy itself appeared to destroy the dreams of the family and hurt the parents' feelings. These parents said that they were unable to accept their daughters' pregnancies. For example, Ann's mother dreamed that her daughter would graduate from vocational school and have a successful career, but pregnancy destroyed her dream. She said:

> *My daughter's pregnancy influences my feeling. I cannot accept it because she is too young to get pregnancy and raises the baby. I need her to continue studying and get a good job (Ann's mother, Interview 1).*

The adolescent participants also felt this loss of their dreams for the future very deeply. For example, Klang talked about how her pregnancy had ruined her parents' hopes stating, *"my parents are disappointed about my pregnancy as I can't continue studying".*

Some caregivers mentioned above also shared similar experiences of how their daughters' pregnancies brought them disappointment. For example, Sand's mother stated, *"my daughter is a beautiful flower in family, but isn't anymore".* She explained that pregnancy destroyed her daughter's future and her hopes. Nam's mother expressed feelings of disappointment when she stated, *"when daughter's boyfriend tells me that Nam's four months pregnant, I'm suddenly feeling numb and wordless. I see many pregnant teens in my village, but I don't think it happens with my daughter. This issue makes me feel disappointment".*

Some parents were also embarrassed and felt ashamed because they worried about how friends, neighbours, and the villagers would react. Nok's mother expressed feelings of shame: *"I'm embarrassed when I know my daughter get pregnant. I don't want my neighbours to know this issue".* Fang perceived that her parents would be blamed for behaving shamefully due to her pregnancy. She stated that *"I'm afraid people in the village blame my mum that makes her feels disgraced. I'm thinking over about what the people in community think to my pregnancy and blame my mum. I'm concerned about my mum".* In another example, Nok was constantly fearful of the blame directed at her family. She described her parents as being devoted to her having a better life and felt that she had let them down by going against her parents' expectations. Thus, it was seen as destroying their future hopes. Her eyes started to fill with tears when she said *"my pregnancy makes my mum a disgrace. Previously, my mum brought notebook for me and asked me to pay attention on the study. I leave school early, as I need to work. Unfortunately, I get pregnant and can't get any job".*

In addition, Fang, Nim, and Kit's mothers expressed feelings of sorrow. At the time of the interview and observations of Fang's mother, she was crying while the interviewer asked questions about the impact of adolescent pregnancy on her family members. Fang's mother revealed that when she found out that her daughter was pregnant, she became dejected as she did not think that this would happen to her daughter. She then asked her daughter to conceal the pregnancy from relatives and neighbours until she could get married stating,

> *I'm frightened and sad with this issue and my husband feels like me, so we decide to conceal our daughter's pregnancy from relatives and neighbours (Fang's mother, Interview 1).*

All adolescent participants had experienced a pervading sense of stigma from the broader community. This stigma was perpetrated through non-verbal communication such as facial expressions and verbal taunts resulting in offensive comments and discourteous behaviour by people in the communities where the adolescent participants lived.

Being blamed by community members was a verbal offensive that was interpreted as stigmatising by the adolescent participants. Many adolescent participants spoke of being blamed by villagers for becoming pregnant at an early age, pregnant in their school year, and pregnant without a husband. Klang gave an example of being criticised for being pregnant without a husband when she said,

"people in this village ask about my husband when I go to the market. They also say, "I'm pregnant without husband". The villagers had noted that her husband had never shown up in public. Klang said that she hesitated and avoided answering this question because she was embarrassed. She talked about feeling scrutinised and judged by the villagers. In another example, Nam was criticised for getting pregnant in her teenage years. She stated, *"some people blame me for getting pregnant and ask me "how are you able to raise the baby?".* They implied that she was too young and would not be able to manage the work of raising a baby.

Likewise, some caregivers mentioned that their daughters were blamed for being pregnant by people in their community. For instance, Ann's mother indicated that some villagers blamed and ridiculed her daughter for getting pregnant and not being able to graduate from school. As Ann's mother said:

> *The villagers blame and ridicule her pregnancy and that she can't graduate [from school] because of her behaviours (Ann's mother, Interview 1).*

Remarkably, only Nok said,

> *There are many teenage pregnant women in this community, so some people view it as a normal situation in society, but they view an abortion isn't appropriate behaviour. So, they blame this behaviour (Nok, Interview 1).*

Nok's explanation highlighted the tension between religious beliefs and social customs, indicating that abortion was viewed with more negative judgement than getting pregnant. This is because abortion constitutes killing a person, which is very bad karma in Buddhism.

Gossip was identified as a constant source of community stigma by some adolescent participants. Both Pha and Sand talked about gossip relating to *'why I get pregnant at this age'*, with Sand noting the *'sharp tongue'* of some neighbours. Sand explained that *"the neighbour gossiped about me, and about me getting pregnant without being married and said that my husband also ran away from me. This make me feel shameful"*. Nim's mother also indicated that adolescent pregnancy was rarely accepted in her village and that pregnancy outside of marriage was condemned by the villagers. She stated, *"people in my village are conservative perspective, so they don't accept girls who become pregnant without marriage. They condemn my behaviours."* Thus, being recognised for breaking the cultural norms created significant stigma for the adolescent participants.

Additional responses that participants felt from community members were non-verbal cues through facial expressions that made the girls feel stigmatised. For example, Nam indicated that people's eyes were watching her in public. This made Nam feel uncomfortable and reluctant to go outside. She expressed this by stating, *"they show facial expressions and look at me [in ways] that cause me to think they talk about me in a negative way".* In addition, many participants felt that they were

‘looked down’ upon by the villagers. Top, for example, stated, “*some people in this village look down on me as I like to hang out with many guys”.* This made Top feel disgraced.

Similarly, in all the field observations at both the antenatal clinic and in the participants’ homes, I noted that people paid attention to the participants’ public behaviours. This made the girls feel uncomfortable with going outside their home. For instance, when Nok and I went to the local store in the village to buy detergent, some of the villagers were watching Nok’s every move. Nok rushed out of the store after paying for the detergent, eager to leave the scrutiny, keeping her eyes averted from others in the store.

Feelings of being scrutinised also affected pregnant adolescents’ ability to continue to attend school. It is an uncommon occurrence in Thai society for pregnant adolescents to attend school. Young women find it challenging to stay in the traditional Thai school setting during pregnancy due to the stigma perpetrated by both teachers and peers.

Blame was the most common judgement that participants experienced from teachers. For example, Tik said “*although I get married, the teachers are still blaming that my pregnancy has put shame on the school”.* Nam was also blamed by a class instructor about getting pregnant and leaving school early; she expressed that *“my teacher blames me that I have a baby early and I ever told her about getting pregnant”.*

Another response from teachers was prohibiting students who got pregnant from continuing their studies. In trying to make sense of this situation, Tik said that: *“they’re afraid that pregnancy in school may destroy the school’s reputation”.* In addition, Nam’s mother pointed out another reason for teachers not wanting her daughter to attend school, stating: *“the teachers don’t want Nam to continue studying because they can’t take responsibility if Nam is endangered”.* This points to an assumed risk of both psychological and physical danger for female adolescents who break the social and cultural norms.

Noticeably, some of the adolescent participants’ partners were still in the education system. It was observed that they did not experience any stigma in the school environment. For example, Tik indicated that her partner could continue studying in the same school without being stigmatised by the teachers and peers, while Tik had to leave school early because of her negative experiences and the fear of ongoing stigma.

In addition to the teachers criticising the participant students, many of their school peers also perpetuated the stigma associated with adolescent pregnancy. Noi noted that her schoolmates tried to publicly reveal her pregnancy, despite her attempts to conceal it because of her fear of stigmatisation. Noi stated that:

> *Before I reveal my secret, I had a friend who wondered whether I was pregnant or not. She tried to ask me, but I didn't answer anything. After that, other friends try to ask me about my pregnancy as well. I'm also afraid that this friend will say something, which is not true about my pregnancy (Noi. Interview 1).*

Similarly, Ann tried to conceal her pregnancy from her friends to prevent and manage potential stigma. Ann always wore a big jacket over her uniform when she went to Vocational School. She tried to conceal her 'big bell' from her friends because she was afraid of being the subject of gossip. She also mentioned that the teachers knew about her pregnancy, but they asked her to hide her pregnancy from other students if she insisted on continuing her education. They argued that pregnancy during school years was inappropriate and made Ann a poor role model to the junior students and that this would reflect badly on the school's reputation.

Unlike the majority of participants, some adolescents were allowed to continue studying during their pregnancy. They also received support from their instructors and friends. Noi was one notable pregnant student who was attending the high school in her village. Not only was she encouraged to continue studying by the director, some teachers also provided assistance during school and supplemented her diet. Noi said:

> *The director meets me, and my advisor helps me to talk with him, so he allows me to continue studying until delivery. My teachers also share some foods with me when I'm hungry (Noi, Interview 1).*

All the adolescent participants found it difficult to attend the prenatal clinic because the attitudes towards adolescent pregnancy by both health care providers and other pregnant women made the participants feel stigmatised and unwelcome. Jeab explained this response using information that the doctor had provided her, suggesting that *"it's not good for pregnancy in this age because the doctor tells me that pregnant adolescents are risky group. They may confront many complications".*

Many nurses held negative attitudes towards adolescent pregnancy, but they did not express these in public. At the time of the observation, the nurses discussed the issue of adolescent pregnancy with me in secret while they showed a professional face in front of the participants. They often complained that the participants were not old enough to get pregnant and stated that they did not know how to take care of themselves.

Additionally, some doctors treated pregnant adolescents differently from other pregnant women, which was experienced as stigmatising by the pregnant adolescents. At the time of the observations in the antenatal clinic, when the adolescent participants met with the doctors, some doctors treated the pregnant adolescents as children by using the word 'daughter' during their conservations. The participants were observed to keep their heads down during their meetings with the doctors and avoided making eye contact.

At the time of observation, the majority of adolescent participants infrequently asked question about their health when they met the doctors and nurses. The blended their head and did not have eyes contacts. They also rarely attempted to obtain health care provider assistance to deal with health problems during pregnancy.

Tim and Sand provide examples of feeling alienated when attending a prenatal clinic. At the time of the observations at the antenatal clinic, Tim sat next to an older pregnant woman while she was waiting in the queue. The older pregnant woman asked Tim about her age and complained that she was too young. Tim looked unsettled, but she did not respond or argue with the older woman. She then moved to sit at a distance from all the other pregnant women. At the second observation, Tim continued to avoid conversation with the older pregnant women by sitting far away from them. This time, there were younger pregnant women present that she chose to sit closer to. In her interview, Tim explained:

> *I attend an antenatal clinic and I'm afraid to talk with older pregnant women who sat next to me as I feel alienated. I feel alienated as I look too young to get pregnant in this time and the pregnant women treated me like their daughter (Tim, Interview 1).*

Adolescents who became pregnant experienced stigma from family members, communities, school, and health care services. Within the family, adolescent pregnancy ruined the expectations of the family, and some family members responded negatively, such as not accepting or hiding the situation and feeling shame and sorrow. These responses created stigma for the participants when they found out they were pregnant and that the better future which their family dreamt of might no longer be possible. In the community, the pregnant participants also experienced stigma from people who blamed, gossiped, and looked down on them. Responses from the girls' school communities was mixed. Some school contacts had negative responses to adolescent pregnancy and, in most cases, this negativity was not shown towards the boys who were responsible for the girls' pregnancy. Some allowed the adolescent participants to continue their education, but the participants were treated differently from other students. In most cases, the girls felt stigmatised by their school communities, while others were excluded from school. The responses of health care providers and other pregnant women in the prenatal clinic made this environment uncomfortable for the girls. These responses made some of the adolescent participants perceive themselves as inferior to older and married pregnant women in particular, and created a feeling of being stigmatised.

Family violence exacerbates stigma

The adolescent participants reported that they had experienced violence from close family members such as their parents and their baby's father. This family violence included emotional abuse, physical abuse, and reproductive control, and this exacerbated the adolescent participants' experiences of stigma. The resultant stigma limited their capacity to exert their own power to confront the violence and to seek support from outside of the family.

Emotional abuse

Emotional abuse is one of the main characteristics of family violence observed in this study. This appeared to create feelings of stigma which affected the adolescent participants' sense of self. This stigma also appeared to affect their ability to defend themselves in abusive situations.

Four of the adolescent participants, Klang, Kit, Sand, and Pha reported feelings of helplessness when they were blamed, scolded, and belittled by family members for becoming pregnant and intending to raise their baby. For example, before becoming pregnant, Klang ran away from home with her partner because when she told her mother about her relationship, she severely scolded and repeatedly criticised her. Klang's mother was angry that she did not know the boy or his family and that she did not want her daughter to have a partner until she graduated from high school. In the interview, she said:

> *I rebuked my daughter intensely until she cried, then she ran away with her partner. I said that "you make me hurt, I don't want to raise your baby if you become pregnant". When she came back home, I'm still blaming her because a woman is worthless if she loses her virginity (Klang's mother, Interview 1).*

When she became pregnant, Klang had to return home as she was no longer welcome to live with her partner or his family. With this rejection, she returned home as a disgraced pregnant teenager. Upon her return, Klang's mother was relentless in scolding her about losing her virginity and bringing shame to the family. In response, Klang did not argue back. She said that she felt helpless from being scorned by her mother for bringing shame on the family and the additional financial burden. She said, *"I lack of support from the family because my mum blames me, saying that "our family doesn't have enough money to raise your baby".* During the observation visits, Klang looked sad and withdrawn. She avoided her mother by locking herself in a room or going frequently to her uncle's house.

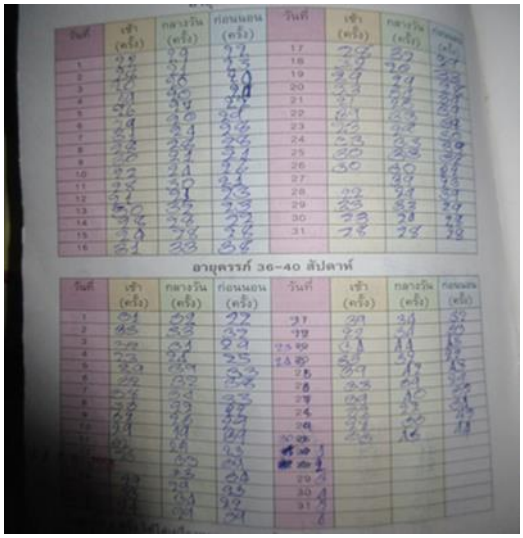
Some adolescent participants, Sand, Pha, and Klang indicated that they felt hurt and worthless when they experienced verbal abuse from their partners. For example, Sand stated, "*I'm hurt, as he has problems with his work and then he took out his bad mood on me".* Sand also felt worthless when her partner kept trying to hurt her; as she stated, *"He's still saying things to hurt me. I feel hurt and worthless when he says only one word".* Feelings of hurt and worthlessness were pervasive and reduced the participants' capacity to communicate openly with their partners and/or family.

A further some adolescent participants, Pha, Kit, and Klang reported that they felt emotionally neglected, which led to them feeling unworthy, insecure, and helpless. The participants talked about emotional neglect as receiving little kindness or attention from family members and their partners. For example, Pha mentioned feeling neglected by her brother, aunt, and other relatives. As well, Pha's brother left home and left Pha with her aunt when she was in grade six. Upon becoming

pregnant, Pha moved into her partner's house where she was treated with disdain by her partner's parents, because they did not believe the baby was 'of his blood'. Pha's partner has since moved overseas for work. Pha had expected some emotional support from her brother when she became pregnant, but he did not contact her or return her phone calls. Pha's aunt and relatives lived in a nearby village, but did not visit her or give her any emotional support after she moved into her partner's house. She said:

> *My brother left home as he can't be patient. He promised to take me from this house when I graduated from grade 9, but he didn't. Also, my aunt and relatives don't visit me and never called to me when I'm living here (Pha, Interview 1).*

Pha also felt deeply hurt by the emotional neglect of her partner. Pha described the hurt as a feeling of being worthless to her partner. During her photo-elicited interview. Pha showed me a photo of the recording of her baby's movement in her maternal handbook. She said that she had sent this photo overseas to her partner expecting him to respond with interest, but he did not reply at all.



(Pha, Interview 2)

Both Sand's mother and Pha's mother-in-law recognised the emotional abuse that their daughters had experienced from others. For example, Sand's mother stated, *"Sand's partner leaves my daughter after she becomes pregnant after only one month. I can't contact him. He makes my daughter feel hurt"*. In another example, Pha's mother-in-law indicated that Pha's father and grandmother neglected her, as she said that, *"Pha's dad leave her to find a new wife and he don't support her. Her grandma also doesn't pay attention to her, so she just watched TV".* The quotations above describe the adolescent participants being treated as separate and apart from others which created feelings of being stigmatised. While recognising the abuse from others, Sand's mother and Pha's mother-in-law did not recognise how their own behaviours reinforced the social stigma experienced by their daughters.

Physical abuse

Some family members used abusive behaviours to control and punish the pregnant adolescents. Only Pha experienced physical abuse from her aunt both prior to, and during, her pregnancy. Pha told a terrifying story with an unhappy face, about being kicked and hit by her aunt when she studied in primary school and when her aunt found out about her pregnancy. Pha was unable to ask for help from anyone, even her brother; therefore, she was unable to defend herself against the power of her aunt.

> *My aunt kicked me when she knows I get pregnant, but I don't argue with her or tell my brother as he's ordained [to make someone a monk in a religious ceremony] (Pha, Interview 1).*

Correspondingly, Pha's mother-in-law also mentioned that Pha's aunt hit Pha aggressively when the aunt found out about her pregnancy, and that the aunt views Pha's pregnancy as a burden on her, as described below:

> *I think the pregnancy affects her aunt. At first, Pha went back to her aunt's home around 10 days and she confirmed the pregnancy by using a pregnancy test kit, so her aunt knew about that and then Pha is hit strongly (Pha's mother-in-law, Interview 1).*

Moreover, Pha disclosed the consequences of the physical abuse she experienced from her aunt: *"my aunt is looking for trouble and begin hitting me, so I feel hurt"*. Pha defined the meaning of hurt as suffering and helplessness. This indicated that Pha lacked capacity when her aunt exerted power over her, instilling a sense of powerlessness through the punishment.

In addition, the breaking of valuable property is an aspect of physical abuse that contributes to a decreased ability to face abusive situations. Pha revealed that she called her brother because she wanted to tell him about her pregnancy and ask for advice. Her aunt accidentally came across her during her call to her brother. Subsequently, Pha said that: *"My aunt throws my mobile phone when she sees I call to my brother. This made me fearful"*. Pha was afraid of her aunt's behaviour, which indicated that she lacked the capacity to protect herself and her personal property from abuse.

Reproductive control

Reproductive control is a form of sexual abuse that constrained some of the adolescent participants' ability to negotiate contraceptive use and to make decisions about their own reproductive health.

Some adolescent participants, particularly Fang and Ann, reported feeling unable to demand the use of contraception, such as condoms, by their partners before having sex. As a result, they often made their decisions based on their partners' preferences. For example, Fang said, *"I become pregnant because my partner refused to use a condom. I don't use any contraception device and I didn't know how to use one"*. Fang provided more detail on this point, saying that she met her partner on

Facebook and chatted with him for several months. She then became involved in a romantic relationship with him for about 4 or 5 months. While they were having sex, her partner refused to use a condom and she made a decision to follow his choice without compromise, because she viewed sex to be an important way to demonstrate love in a relationship. Fang indicated that she had no knowledge of, or access to, other forms of contraception. As such, she was not able to negotiate contraceptive use.

Klang was the only participant who successfully negotiated the use of contraception. Klang was concerned that she was too young to have a baby, so she asked her partner to use condoms. When he refused to use them, she took the contraceptive pill to prevent pregnancy, stating: *"my partner never used condoms, so I have to take the contraceptive pills".* Despite this attempt at prevention, she still became pregnant. Concern about being too young to have a baby led Klang to assert her personal capacity to choose another option to prevent pregnancy.

Many of the participants' family members or partners attempted to influence their reproduction by forcing them to undergo an unwilling abortion or by forcing them to keep their baby when they would rather have had an abortion. This is a form of reproductive control and is considered an act of family violence (Barnett, Miller-Perrin, & Perrin, 2005). Kit and Pha initially felt pressured to have an abortion and to follow the decision of their partners and their partners' mothers. For example, Kit said:

> *My partner tells his mum that I get pregnant. His mum asked that "why do you have a child at this time? And you have to get abortion" (Kit, Interview 1).*

In Thai families, the mother has a powerful role and was described as making decisions on behalf of their adolescent daughters or daughters-in-law. This form of reproductive control is little discussed as it is viewed as the assumed role of a mother in the care of her daughter. For example, Noi told a story with a sad voice about her mother initially deciding to give her Thai herbal medicine to cause an abortion and then changing her mind to keep the baby. Noi followed her mother's decisions as follows:

> *My mum tells me that I'm not ready to have a baby as I'm studying. She buys the Satreepenpak drug to induce an abortion for me. Although I drink almost the whole bottle, the baby doesn't come out. So, my mum decides I should keep the baby (Noi, Interview 1).*

Similarly, Fang's mother initially decided to terminate her daughter's pregnancy and then also changed her mind. Fang's mother cried while talking about the story, so the interview was stopped for an hour. She indicated that her daughter was too young to be pregnant and that the baby would destroy her daughter's future. She decided to buy Thai herbal medicine from a convenience store in the village and give it to her daughter to terminate the pregnancy. Fang followed her mother's decision without argument. When the medicine did not work, Fang's mother determined there to be

a karmic reason for her daughter to not abort the baby, and therefore, decided that she should continue with the pregnancy.

Kit was the only participant who demonstrated the ability to face reproductive control from her mother-in-law and partner. Kit revealed that their partners and partner's mothers attempted to influence the consequences of pregnancy by forcing them to undergo an unwilling abortion. Kit demonstrated an inability to make her own decision to continue the pregnancy:

> *I retort her that "you love your son, my baby is a human, it isn't a dog, and why do you force me to get abortion?" I admit to my mistake, but I don't want to destroy one life (Kit, Interview 1).*

In other situations, parents and relatives influenced decisions to keep a pregnancy when the adolescents' preference was to have an abortion, particularly in the cases of Nam, Pha, and Kung. For instance, Nam said:

> *Actually, I need to have an abortion because I have no idea how to take care of a baby and myself. At my age, I'm not able to take care of another person. However, my mum won't allow me to have an abortion. My husband also wants the baby, so I decide to keep it (Nam, Interview 1).*

The aforementioned family violence was demonstrated in many forms, including through emotional abuse, physical abuse, and reproductive control from adolescent participants' families, partners, and partners' families who were all older than the adolescent participants. The adolescent participants experienced emotional abuse from family members and their partners for becoming pregnant and for intending to raise their baby through blaming, blocking schooling, belittling, and through emotional neglect. Such incidents demonstrated that the participants were oppressed as a result of being stigmatised. In relation to physical abuse, one participant's aunt exerted her power to perpetuate physical violence on her. Such oppression created stigma for the participants. In addition, the adolescent participants were controlled in their decisions about their own pregnancies. This control also resulted in stigma in the adolescent participants. Being exposed to family violence resulted in the adolescents experiencing feelings of helplessness, hurt, and worthlessness. This compounded their feelings of shame and stigma. This stigma, emanating from family violence, appeared to limit the adolescents' ability to protect themselves and their unborn babies, and to seek support from others.

'It makes me ashamed': living with stigma

The adolescent participants reported feelings of shame, embarrassment, low confidence, stress, guilt, fear, and anger in response to stigmatising experiences from the villagers. For example, both Nim and Sand talked about feeling ashamed, with Nim talking about the facial expressions of villagers and the unwanted attention:

I haven't heard people gossip me, but I see the eyes of the curious questions from them. It's unlike before as people ask and greet me (Nim, Interview 1).

I feel shame and embarrassment about my pregnancy (Sand, Interview 1).

Some participants, Tim, Nam, Ann, and Fang conveyed that they were now lacking in confidence due to being stigmatised by people in the villages they lived in. Tim said, *"I feel low confidence when they ask questions about my pregnancy".* Tim explained that this meant that she felt like a failure. She said that her heartbeat increased rapidly when the villagers asked about her pregnancy. She needed to walk away from them and avoid answering questions. Similarly, Nam stated that: *"I also don't have confidence to go outside. I always ask my mum and my sister go with me to improve my confidence".*

Stress was a significant negative emotional reaction to the stigmatisation. Klang mentioned that *"one thing that makes me feel stressful is people usually ask me who is my baby's father".* Klang gave many examples of this happening when she went to the local market. She also tried to avoid answering questions about her pregnancy that stimulated the feeling of stress. Similarly, some caregivers, Ann, Kit, Klang, and Nam's mothers, mentioned that being stigmatised in early pregnancy caused a lot of stress for their daughters. Ann and Kit's mothers gave an example of their daughter's experiences during early pregnancy:

Accusations and gossiping from people in the village affected her feelings. She tells me that she feels stressed and doesn't want to go inside the village (Ann's mother, Interview 1).

In early pregnancy, Kit was ridiculed by some people who hate my family. This makes my daughter feels stressed (Kit's mother, Interview 1).

Some adolescent participants, Nok, Klang, and Nam experienced feelings of guilt because they had disappointed their families. For example, Nok said that *"my pregnancy makes my mum feel disappointed, so I feel guilty to do like this. I should obey what mum tries to teach me, but I always not obey her teaching".*

Ann and Fang also showed feelings of anger about being stigmatised by the villagers. For example, Fang conveyed her fury stating that *"sometime, I want to kill them when they gossip about me".* Fang did not like what the villagers said behind her back. She felt angry when her mother told her about people in the community gossiping about her pregnancy.

Additionally, some adolescent participants, Noi, Top, Kung, and Pha expressed a fear of being stigmatised by people in their communities. This fear was based on the adolescent participants' beliefs that they had failed to meet their families' expectations. For example, Noi was fearful about her parents being blamed by villagers: *"I'm thinking over what the people in community think about*

my pregnancy and how they blame my mum. I feel sad for my mum". In another example, Top was afraid that people would gossip about her pregnancy: *"I'm afraid that people gossip about me and my pregnancy. I'm thinking about when someone says something that make me feel uncomfortable and I'm afraid they add something that is not true about my affair".*

Social stigma led some of the adolescent participants to take aversive action to control their exposure to situations in which they felt stigmatised. They employed strategies such as avoiding spaces where they felt stigmatised, lying, and avoiding answering questions. While this could be argued to be agentic behaviour to control their situation, this control did not directly address the experience of stigma, nor did it reduce feelings of fear, shame, and embarrassment. In fact, it may well have contributed to heightened isolation and social dislocation, even though none of the participants spoke about this.

Some adolescent participants, Nam, Tik, Top, Sand, Klang, and Nam tried to avoid spaces in which they felt stigmatised. For example, Nam stated that *"The accusations and blame make me not want to go outside of my home and talk with anybody. I just stay at my home and my farm because I don't want to hear people blaming me"*. Tik also mentioned that she stayed at home for around four months to avoid facing people who stigmatised her. The social pressure on pregnant adolescents was also conveyed by Top and Fang who moved to live with their partners in distant villages to avoid the accusations of the villagers. Top said, *"I'm afraid that people gossip about me and my pregnancy, so I move out from this village to live with my partner in another village. I come back home when I am four months pregnant".* This story indicates that when Top became pregnant, she would be seen as an improper role model in her community, so she left home to avoid being stigmatised.

Feelings of stigma associated with school peers and teachers also resulted in some pregnant adolescents leaving school early. For example, Tik stated that "*I'm afraid that the teachers will know about my pregnancy and won't allow me to study, so I decide to leave school early and ask my friend to tell the teacher about leaving school early because of my pregnancy".*

Sand explained that she lied about her living situation to avoid being stigmatised. When she broke up with her partner and went back home to live with her parents, she lied about her relationship with the baby's father because she was afraid that people in the village would blame her for being pregnant without a husband and calling her baby a bastard. She said:

> *Some people from another village ask about my husband, but I lie to them. I'm afraid that my friends know I separate with my partner. They gonna blame me. Maybe my baby is called bastard, so that's why I lie to them (Sand, Interview 1).*

Ignoring taunts and gossip and avoiding answering questions about the pregnancy were the strategies used by most of the adolescent participants to resist stigma. For example, Kit pointed out

that she did not pay attention to what the villagers said about her, "*I don't care about what people say behind my back. It is too bad to hear that, so I don't pay attention to what they say. I think I'm not better than them and they aren't better than me".* In another illustration, Tim said *"they ask many questions about my pregnancy, so I need to walk away from these people. I try to keep away from them anytime I see them".* Kung's mother indicated her support for this strategy when she said, *"my husband and I don't care that the villagers blame my daughter and my daughter won't pay attention to what people say either" (Kung's mother, Interview 1).*

Sand was the only participant who resisted stigma by confronting her accusers. Sand stated, *"I really dislike some people who are sarcastic to me, so I reply to them. I say non-specifically to them about how I wish their nieces are gonna get the same problems as me, so they stop talking behind my back".*

To minimise such feelings, the adolescent participants chose avoidance as a strategy to cope with being stigmatised. In this way they did not have to have contact with people. They also withheld information and avoided answering questions about their pregnancy.

A more socially constructive way to manage the stigma was implemented by some participants' families. This involved shifting the status of the pregnant adolescents from one of disgrace to one of social acceptance through marriage. Noi, Fang, and Top were all supported by their families and their partners' families to validate their relationships through a marriage ceremony. For example, Noi became pregnant without being married and lost her confidence in meeting and speaking with people in her village. Noi's mother provided a simple wedding ceremony for her by tying cotton on her wrist and asked relatives and people in her community to join the ceremony. Consequently, Noi had more confidence in meeting people in her village. Noi stated:

> *I just tied cotton on my wrist on July. This activity shows that I'm married. If I get pregnant without being married, I won't have confidence to meet people in this village (Noi, Interview 1).*

Fang also talked about how her mother needed Fang to have a wedding ceremony because she was afraid that people in the village would criticise her for being pregnant and unmarried. In this way, Fang's mother followed tradition to prevent social stigmatisation. Fang said:

> *My mum asks my partner to propose marriage, because she's afraid that people were gonna blame me for being pregnant without being married. Two days later, my partner's parents met my parents to arrange a wedding ceremony (Fang, Interview 1).*

In addition, receiving a bride-price means that the young woman receives more respect from her partner's family and other people in his community. Hence, some caregivers required their daughters to receive a bride-price. For example, Top's mother asked for a bride-price from Top's partner to be presented in front of the villagers during the wedding ceremony. She said:

> *"I was afraid that my daughter would feel shame about her pregnancy, so I asked for a bride-price from her partner and provided a simple wedding ceremony for her. I invited my relatives and neighbours to join this ceremony" (Top's mother 1).*

Pregnancy outside of marriage in adolescence goes against the Thai cultural norms; hence, people in the community stigmatised adolescent participants who were not married. Having a wedding ceremony and receiving a bride-price offered a way to minimise the stigma and to gain acceptance in society. Noi, Fang, and Top indicated that having a wedding ceremony improved their confidence in having contact with people in their communities because the villagers accepted a pregnant adolescent who was married more than one who was not.

Theme 2. Support and support systems

Issues of financial hardship and family capacity to support pregnant adolescents were discussed by all the participants. Providing support during pregnancy is an important approach that may improve adolescents' agency in facing the many challenges that lie ahead of them. Three sub-themes related to support and support systems for adolescent participants emerged from the data, including financial hardship and support, emotional support, and informational support.

Financial hardship and support

In this study, pregnant adolescents often experienced enormous financial hardship because they had to leave school early and give up their education. This issue reduced the pregnant adolescents' ability to control basic resources and to access health care services. Financial hardship was identified in two main areas including reduced employment opportunities and financial dependence.

Finding employment

Almost adolescent participants left school early. They had only limited skills and experience for gainful employment. If they were not able to be supported by their family or their partners' family, they had to accept poorly paid positions. Some adolescent participants, Klang, Nam, and Jeab, were unable to find a good job and took poor-paying work. The other adolescent participants asked for financial support from their parents or partners. Klang stated that *"my partner and I don't have enough money to pay household expenses, so I have to work at a construction site with him".* In this role, she had to endure the poor working conditions of a construction site, in which toilets, washing facilities, clean rest areas, drinking water, and meals were not provided. In another example, Nam was unable to find a job, and had to ask her aunt for work. In discussing one of the photos she had taken, Nam said, *"although, making the garlands is tough work and I earned little money, I have no choice but to take that job".* Nam was observed on two occasions working at this job. She sat on the floor for three to four hours without a break selecting flowers and making the garlands. She received around 200 Baht, enough to buy the ingredients for four meals in Thailand.

(Nam, Interview 2)

The minimum age for employment also had an impact on the girls' lack of ability to find a job. Klang explained, *"I need a job in department store. Unfortunately, that job requires a minimum age of 18, but I'm only 16".* According to labour rules and regulations in Thailand, the minimum age for employing a child is 15 years. However, no child under the age of 18 can be engaged in work without informing the labour inspector within 15 days of the date on which the child starts working (Department of Labour Protection and Welfare, 2015). As a result of this additional step, managers avoid employing people under 18 years of age. The manager in the department store set the minimum age as 18 years, meaning that Klang could not apply for a position.

The work environment also had a negative influence on some adolescent participants' capacity to keep their job. Some pregnant adolescents, Top, Kung, and Nok, had to quit their jobs because their work involved activities that were deemed to be unsuitable for pregnant women. These included standing for long periods and lifting heavy objects. The two quotations below highlight the impact of the work environment on pregnant adolescents' ability to keep their jobs.

> *It will be nice if I can work in the same restaurant, but it's impossible, as I become pregnant. The manager can't take responsibility if I get injured at work, so I have to quit the job (Top, Interview 1).*

> *The old store also does not allow pregnant woman to do hard work. So, I don't have a job and money right now (Kung, Interview 1).*

These quotations might also represent the employers' decisions to uphold societal values of moral integrity, where women were expected to be married before becoming pregnant. Like the shame brought upon the school when an adolescent becomes pregnant and so asks them to leave, employers may also prefer not to show that they support unmarried pregnant adolescents. These resulted in adolescent participants not being qualified or experienced due to leaving school early, not being able to apply for jobs due to the minimum age requirements, and facing unsuitable work

environments that place pressure on pregnant adolescents to attain financial security. However, three adolescent participants found a job, and ended up staying in unsuitable roles to support themselves.

All adolescent participants depended on others for financial support, including parents, partners, partners' parents, or relatives. For instance, Pha depended on financial support from her partner's parents because she was unemployed. She said *"I live with my parents-in-law and I don't have a job. So, they give me money about 100 Baht per time".* This was not enough for her to cover her basic needs. Similarly, Kung had to stop working after becoming pregnant and lost her income to support herself. She also depended on financial support from her parents stating, *"I do not have a job or money right now, I asked money from my mum to buy foods"*.

Some adolescent participants mentioned that they had delayed prenatal care because of a lack of financial resources. Jeab spoke of her financial hardship to the interviewer, saying that she earned only 300 Baht per day (about AUD$12) and indicated that this wage could only support necessities such as food and medicines. She did not attend the antenatal clinic until 34 weeks because she did not have enough money to afford medical treatment and transport to the clinic. She said, "*I can't leave my work, so I don't have time to attend the antenatal clinic. If I leave my work, the manager gonna cut off my monthly wage by about 1,000 Baht".* Not only does this illustrate that Jeab could not access health care services because of a lack of finances, it also indicated the degree of pressure that she experienced from her employer. While she did not overtly refer to the threat imposed by her employer, she felt the inherent pressure deeply. Similarly, Nam said *"I delay going to hospital as I can't afford health expenses. So, I have to go back to my hometown to qualify for a gold card for health insurance".* A Universal Coverage Gold Card provides access to free health services for the uninsured population, including poor and disadvantaged groups (Mbakwe, 2014).

Sand's mother was not happy to let her daughter use the Gold Card and wanted private cover for her daughter. She said:

> *I need private care for my daughter as I experienced a tough delivery myself and I had severe pain for about 2-3 day before I gave birth. I fear that it might happen with my daughter, so I'm looking for good care for her. People in my village also say that good financial support allows a pregnant woman to get the proper care from the doctors. Unfortunately, my daughter doesn't have enough money to afford private care (Sand's mother, Interview 1).*

In addition to not being able to afford basic needs and to access health care, a lack of money was identified as a major worry for many. Many adolescent participants worried about not having enough money to raise their baby, to pay household expenditures, and to pay their debts. Top explained, "*money is my anxiety. I worry about how to find money to raise my baby, because I don't have a job*

and my partner doesn't earn enough money from work" (Top, Interview 1). Nok also spoke of crying every night when she said:

> *I'm thinking over about how I can get money to raise my baby. I think I have to work for the rest of my life since I have a baby. Moreover, I feel stress about my debt, as I have to pay instalment for the motorbike. This debt makes me have a headache. I cry every night (Nok, Interview 1).*

Low education levels, the minimum age for employment, and the poor work environment impeded adolescent participants' ability to find and keep a job and this led to them experiencing financial hardship. In addition, there was pressure from their workplace to resign because they were pregnant, as well as threats made by their employers to cut their wages if they took time off to access health care.

The consequences of financial hardship were dependence on financial support from their family, which also had a negative impact on their capacity to exercise their agency to control their basic needs and to access health care services. Alternatively, some adolescent participants tried to find a job and worked in low-paid positions to support themselves.

Getting help from the family

The pregnant adolescents experiencing financial challenges depended on financial support from their family members and partners. Many adolescent participants identified that support from their parents helped to pay for food, household expenditures, and layettes, as a result of their having to leave school early and being unable to find a job. Kung asked her mother for financial support stating, *"an important problem is lacking of money, so I ask for money from my mum to buy foods".* In a photo-elicited interview, Jeab stated that *"dad buys foods and keeps them in the fridge and he give money 1,000 Baht for buying baby supplements before giving birth".* Jeab explained that baby supplements meant layettes, shampoo, towels, powder, and diapers.

(Jeab, Interview 2)

Some further adolescent participants were able to continue studying because of financial support from their partner and sister. For instance, Tim wanted to continue her education, so her partner provided money for her tuition fees and provided an allowance during her pregnancy:

> *He goes to work and gives me money for school. I think I feel better than ever as my partner supports finance for me as I'm afraid I can't continue studying after getting married (Tim, Interview 1).*

The majority of caregivers also indicated that they took responsibility for financially supporting pregnant adolescents in their care. This included support for food, tuition fees, household expenditures, and newborn supplements. For example, Kit's mother earned money to support all her family members. She divided some money for providing basic needs for her daughter, as she stated.

> *I divide money for my son who is living in Bangkok and spending for household expenditures. I also give money for her 100 Baht per week. If I don't have enough money, I provide foods and keep them in the fridge for her. I don't earn money for medical treatment during delivery (Kit's mother, Interview 1).*

Observation of the participants at the antenatal clinic and in the participant's residences confirmed that parents provided the main financial support for many adolescent participants. The parents provided finance for basic needs such as food, household expenditures, and some for health expenses. For instance, during the first observation with Nam at the antenatal clinic, she did not have a Gold Card to pay her health care expenses, so her mother paid for her medical examination and blood tests. Nam looked hesitant to ask for support, but her mother did so without complaint. In another observation at Fang's home, she asked her mother for money to buy household items such as shampoo, tissue paper, and detergent at a department store in the city. Her mother provided the money without hesitation.

Some caregivers pointed out the reasons why they provided financial support for their daughters. These centered around concern for the baby's wellbeing and fear of complications during delivery. Kung's mother explained:

> *I give money for her 100 Baht per day. Sometimes, she hadn't run out of money, so I don't give it. If she has ran out of money, she can ask from me anytime. I give more money as I'm worried the baby doesn't have enough food (Kung's mother, Interview 1).*

In another example, Sand's mother explained:

> *If my daughter is gonna have a delivery, I have to save money for the delivery charge. I need my daughter to have private care as I'm afraid of complications during delivery. I don't have enough money*

to afford it, so I have to find a job in Bangkok to earn money for health expenses, baby clothes, and formula (Sand's mother, Interview 1).

Feelings of financial security and increased confidence were reported by those participants who received support from families or partners. Some participants, Nam, Jeab, and Tim, spoke about their financial security. For example, Nam said *"my partner earns money for me and our baby, so I felt safe to have money to raise our baby".* Nam's partner supported her through working at an automobile repair store, which enabled her to feel that she had some control over her financial situation and a future for herself and her baby.

Tim talked about how her confidence improved with financial support from her partner: *"my partner earns money for our baby from working with his mom in the carwash, so I have confidence that I can face tough financial situations".* Nam also talked about the relationship between financial security and confidence when she said:

I think my life will be changing more, and I worry about money to raise my baby and buy clothes, napkins, and formula. After I get money from work with my relative, I have more confidence in my ability to raise my baby as I have money to buy baby supplements such as clothes, formulas, and prescriptions (Nam, Interview 1).

Jeab also indicated the importance of financial support from her father in enabling her to feel confident. She said:

I am happy and safe when I am living with dad, as mom abandoned me when I was young. I have confidence that dad can provide money for me when I am living with him (Jeab, Interview 2).

Noticeably, the number of parents providing financial support was higher than the number of adolescents who said that they had received such support. Perhaps the adolescents who did not identify the financial support of their families assumed that this was a normal part of being parented and did not see it as something out of the ordinary; hence, they felt that they did not need to say they were receiving support from their families.

Remarkably, no adolescent participants mentioned receipt of financial support from local government institutions. Nok and Top's mothers commented on the lack of financial support provided by government institutions. Nok's mother reported that her daughter did not have any support from the local government, stating that *"the Subdistrict Administrative Organisation doesn't pay anything for pregnant woman. I don't want support from them".* She suggested that the local government should provide financial support for pregnant women who did not have a job or any other support. Top's mother explained that her daughter could receive financial support after the birth of her baby from the Subdistrict Administrative Organisation after submitting a formal application. She said:

> *The Subdistrict Administrative Organisation supports finance of about 400 Baht per month when my daughter gonna get birth. I think this is a good support as I'm gonna keep money for my granddaughter (Top's mother, Interview 1).*

In Thai society, parents were the main financial support for adolescent participants. The adolescent participants who moved to live with their partners' families received support from their partners or parents-in-law. Those who did receive support reported higher levels of confidence and security that improved their ability to make their own decisions about finances to access basic needs and health care services, and to manage debt.

Emotional support

The adolescent participants faced significant emotional challenges in their lives. Some reported that their main emotional support came from family members and peers. Emotional support allows pregnant adolescents to feel as if they are part of a group, and that they are loved and cared about (Braga, Oliveira, Spanó, Nunes, & Silva, 2014; Cronin, 2003).

Emotional support from the family was provided through a wide range of approaches, including acceptance of their situation without blame or reprimand, empowering them to make decisions, consoling them in times of distress, and paying attention to their needs. Some reported receiving support from their partner in the form of having their needs attended to, and in empowering them through confidence in their body.

Some participants specifically reported the importance of their families accepting their pregnancy and not blaming or chastising them. They said that this made them feel supported and enhanced their capacity to manage emotional challenges as they arose. They identified a sense of relief and reduced stress in difficult situations. For instance, Jeab stated that *"my dad doesn't blame me for anything and doesn't tell me to get an abortion. So, I feel relieved".* When Jeab revealed her pregnancy to her father and asked him to support her, he did not blame her and allowed Jeab to live with him. This reaction enabled Jeab to feel emotionally supported. In another example, Kit was worried about revealing that she had sex with her partner and got pregnant. She stated:

> *I feel worried to talk about such a shameful issue and I'm afraid that my mom wouldn't accept me. Then, I tell my mom I have sex with my partner, but she didn't blame me. I don't have stress because my mom accepts my pregnancy (Kit, Interview 1).*

Kit's mother explained her actions as follows: *"I've never chastised my daughter as I have concerned for her. She does mistake already, so I have to accept it".* In another example, Sand's mother similarly stated:

I tell my family to avoid chastising her because there are many teenage pregnancies in the village. Actually, I can't accept but I've never blamed. I had to accept this, as I have realised that my daughter's living in current time and it's different from the past (Sand's mother, Interview 1).

Another form of emotional support from mothers was a sense of empowerment that enabled these adolescents to face challenges with strength. For example, Noi was encouraged by her mother to feel empowered to face feelings of exhaustion during pregnancy when she stated:

When I feel exhausted, my mom always tells me that "you must be patient for your baby". So, I get empowerment from her to do anything and train myself not to be inactive. This improves my ability to be pregnant (Noi, Interview 1).

In another example, Pha used her mother's photo to empower herself when she argued with her partner and was confronted with difficulties. Her mother had passed away, but she retained a strong connection to her sense of strength. She felt that her mother was with her and supporting her. She said:

Sometimes I argue with my partner as he reprimands me, so I look at my mum's photo. If my mum was alive, she would soothe me. My mum passed away, so I use her photo to empower myself. I also have power to face difficult work. It's hard to get this photo as my aunt doesn't allow me to take this photo outside of her home. When I get this photo, I feel she is living with me. I put the flower in front of her photo and pray to her. This improves my ability as I feel she is being with me (Pha, Interview 2).

(Pha, Interview 2)

Kit also identified that her mother's photo empowered her to have a greater ability to confront difficulties in her life when she felt discouraged, stating:

I'm looking at my mom's photo when I feel discouraged. I also say to myself that my mum is really strong too and she has done everything for me (Kit, interview 1).

In addition, Tim revealed that her partner gave her a sense of empowerment that helped when she was feeling worried about recovering her body shape after the delivery of the baby. She said:

I met my friends at the market and they didn't remember me because my previous photo on Facebook profile is beautiful. I don't have confidence with my shape. My partner said that "Your shape is gonna recover after delivery, don't worry". I feel confident that my shape is gonna recover (Tim, Interview 1).

Similarly, Ann's mother indicated that she tried to support her daughter in having confidence to confront the social stigma by referring to a proverb that said to *"not pay attention to people talking behind the back as you do not ask foods from them"*. This meant that Ann had not received any support from the people who were talking behind her back; therefore, she should not pay attention to them. She mentioned that:

I think pregnancy influences my daughter as she's shameful and doesn't go to the village. I try to empower her and say that "You don't pay attention to people talking behind your back as you don't ask foods from them". After that, she has confidence to go outside home (Ann's mother, Interview 1).

Mothers also consoled their daughters to calm their minds and strengthen them to manage themselves when they faced stigma, and to improve their confidence. Top described her mother consoling her about being mocked in public. She said, *"mom tells me that "you shouldn't pay any attention to what people say, we stand on our own feet and we don't make trouble for anyone".* Prompted by a photo of her mother, Nim said:

My mum is the one who asks me not to overthink about people in this village gossiping about my pregnancy. My mom also tells me that "You don't pay attention to them, but you have to take good care of the baby. This consolation calms my mind and develops positive thinking (Nim, Interview 2).

(Nim, Interview 2 with a photo of her mother)

Similarly, Ann's mother said:

> *I tell my daughter that "you have to accept that you've done something wrong and that's why people are gossiping about you. You shouldn't pay attention to what the villagers say as they don't raise you. Time will heal everything" (Ann's mother, Interview 1).*

This resulted in Ann feeling confident to go outside of her home to meet other people. Some of the mothers went further in suggesting how to manage emotional discomfort when confronted with stressful situations. Ann's mother used her previous experience to make suggestions about how to control her emotions:

> *I suggest to her to reduce stress as it can affect her baby. I give her examples from my experience. I tell her that I'm stressed when I get pregnant that led to my daughter having extreme emotions. So, getting more stressed may affect the baby. After that, she tries to control her mood (Ann's mother, Interview 1).*

In another example, Sand's mother suggested that her daughter use the doctrine of Buddha as a guide to face stigma and to reduce her stress. She said:

> *I try to relieve stress from her. I don't have more knowledge as I don't graduate high education. So, I ask her to pray with Buddha doctrine and don't pay attention to what people said. After she does this, she looks happy (Sand's mother, Interview 1).*

Nim and Tim also reported that when their families and partners paid more attention to them, they felt supported. Nim stated:

> *As for my family, they pay more attention to me particularly with my nutrition, driving, and all things. They give all conveniences to me. Previously, they had taken good care of me, but now they worry about their nephew, so they pay more attention to me. I feel supported by them (Nim, Interview 1).*

Nim also mentioned in her photo-elicited interview that her partner paid more attention to her, and this led to her feeling emotionally supported. She said, *"my partner is living with me. I can talk with him about everything. This makes me confident that he will never leave me alone".*

(Nim, Interview 2)

Emotional support from peers was also significant in helping eight of the pregnant adolescents to feel included and accepted. Their peers visited them at home or talked to, and comforted them, or advised them to reveal their pregnancy and solve their problems.

Some of adolescent participants (Tik, Nok, Noi, and Sand) mentioned that their friends had not excluded them from their peer groups, and that they were still talking with them as usual, even though they were now pregnant. These forms of support made them feel included. For example, Noi stated that "*my friends talk with me as usual when I'm attending school".* In another example from her photo interview, Sand showed me her close friend's photo and explained that she received emotional support from her friend.

> *When I get pregnant, I worried that my friends won't visit and love me. Actually, my friends don't mind that I am having a baby. They are still loving me and taking care of me as usual (Sand, Interview 2).*

(Sand, Interview 2 with a photo of her friend)

In both observations in Sand's home, I saw several of Sand's friends visiting her and spending time together cooking, playing games, and watching television. Sand looked happy when she was involved in activities with her friends.

Using Facebook to air emotional challenges and receive encouragement was a strategy that worked for some of the adolescent participants (Nok, Ann, and Tim). For example, Ann stated that *"I always post my feelings on Facebook when I feel anxiety. My friends cheer me up through their comments".* In another example, Nok consulted with her friends about how to reveal her pregnancy to her parents through Facebook, stating, *"I ask my friends who are pregnant, and on Facebook and they told me to reveal the truth to my mom".*

Some adolescent participants also spoke of how encouraged they felt by the assurances of their friends. For example, Sand said of her friend:

> *She helps me to do activities and study when I'm studying with her. She visits me after school and on the weekends. I feel happy and I don't feel lonely when she does activities with me. Sometimes, she encourages me, and she says, "Someone may be worse off than you". This support improves my confidence to confront problems (Sand, Interview 2).*

In another example, Jeab's friend shared her own problems in order to encourage her to have confidence in facing her own difficulties. She stated:

> *I saw my friend get pregnant and then she went back to school. She encouraged me and told me that she was under more pressure than me because her parents didn't accept her pregnancy. Eventually, her parents accepted and supported her when they saw her baby (Jeab, Interview 1).*

Some of the adolescent participants (Noi, Nam, and Ann) explained that their friends did not provide any emotional support for them and this made them sad and irritable. For example, Noi said:

> *Before I revealed my secret, I had a peer who didn't like me. She wondered whether I was pregnant or not. She also tried to ask me, but I didn't give her any answers. After that, some friends still asking me about my pregnancy that make me feel upset (Noi, Interview 1).*

Although some of the participants' friends had not provided any emotional support and created feelings of unease for them, only Nam reported that she had the ability to cope with these uneasy emotions, particularly her feelings of anger. She said, *"mostly, my friends make me get angry, but I can cope with it".* This indicates that Nam demonstrated an ability to manage her emotional difficulties.

Connection with peers was important for all of these participants for maintaining their emotional security. Expressed through acceptance, this sense of inclusion gave them strength and support to

face the everyday challenges of their pregnancies. The emotional support from their peers enhanced their ability to manage emotional difficulties.

Receiving emotional support from health care providers was rarely mentioned by either the adolescent participants or their caregivers. Only Fang identified that nurses offered her support, saying: *"she [the nurse] told me that if you don't understand anything, you can ask me directly".*

Although the participants rarely mentioned emotional support from health care providers, the provision of some emotional support was observed in the antenatal clinic. The nurses appeared to pay attention to, and to speak with, the pregnant adolescents more than the pregnant adults. They provided a friendly environment and used polite words to make conversation when the pregnant participants attended the clinic. Nevertheless, the adolescent participants still looked anxious when they were talking with the health care providers.

Mothers and peers were the main source of emotional support, with fathers and partners playing a lesser role in providing emotional support to the adolescent participants in this study. The adolescent participants rarely mentioned receiving emotional support from their fathers, except for Noi whose mother had left when she was a baby. Family members provided emotional support by accepting the adolescent participants' pregnancies and by not blaming or chastising them. They, empowered, consoled, and paid kind attention to the adolescents, and made suggestions about how to manage their emotions. These forms of support enhanced the confidence of the adolescent participants, which gave them a greater sense of agency to deal with social stigma and unfavourable emotions. In addition, their peers provided the same emotional support as some of the family members, including not ostracising the pregnant adolescents from peer groups, avoiding blame, and assisting them to feel part of the group. Face-to-face and social media encouragement by peers enhance the confidence of the pregnant participants which improved their agency in difficult situations. While the participants rarely mentioned receiving emotional support from health care providers, the observations indicated that the health care providers treated the participants with respect and kindness. However, not all the adolescent participants received emotional support. Klang and Pha mentioned in the previous section that they did not get emotional support from their family and peers, and that they faced unsupportive behaviours such as blaming and chastising. Therefore, emotional support played an important role in giving emotional strength to the adolescent participants, therefore allowing them to behave agentically in order to cope with unfavourable emotions in their lives.

Getting information

Informational support is the provision of information, knowledge, and advice that could assist in solving problems and providing feedback. Informational support is important for pregnant adolescents and may affect their capacity for agency by providing alternative solutions to address

specific issues. Family members were the main sources of informational support for the adolescent participants in this study, but health care providers were also important.

All adolescent participants reported that their family members provided useful information related to pregnancy. The main topics were about health behaviours and being a good wife. Only one participant received helpful information from their peers, while most of the participants discussed getting helpful information from the health service.

For example, Kit said, *"mum suggests that I should avoid having dessert as it causes diabetes"*. Noi's mother was also concerned about diabetes, but also about eating spicy foods:

> *My mum and relatives tell me what kind of foods I should eat. For example, I should avoid having spicy foods and fermented foods because these foods will make the baby feel pain at its mouth. I should avoid eating dessert as I will get diabetes, but I have no idea how it affects my baby (Noi, Interview 1).*

While this information was experienced as helpful, the adolescents were left with little understanding about the effects on their baby. Furthermore, the information was based on family traditions, such as "will make the baby feel pain in the mouth", rather than being based on evidence. Ann's mother added concerns about hygiene in her health information, but still focused on food choices:

> *I suggest to her about how to take care of her hygiene and what kind of foods that are useful for her health, especially milk. I warn her to avoid eating Thai spicy salad as it isn't clean and can cause diarrhoea (Ann's mother, Interview 1).*

Nok, Noi, and Pha were taught by their mothers and mothers-in-law about how to be a good wife through specific topics that included cooking and cleaning to provide for the husband and other family members. For example, Nok said:

> *My mum teaches me how to be a good wife. I have to diligence to do housework by getting up early morning before everybody in family, especially husband, to cook rice and foods. I have to clean house and don't make it messy (Nok, Interview 2).*

The participants suggested that receiving this type of information helped them to develop confidence to practice health behaviours. For example, during a photo-elicited interview, Kung stated, *"I have confidence to take care of myself during pregnancy as my mom gives me information about how to take care of myself".* Noi also indicated that she received information on nutrition from her mother that encouraged her to be confident and to practice health-conscious behaviours. Noi said:

> *At first, I didn't have confidence to practice healthy behaviours during my pregnancy, for example I wasn't sure if spicy foods affect my baby or not. The suggestions from my mom and information from pink book improve my ability to practice health behaviours (Noi, Interview 1).*

(Kung, Interview 2 with a photo of her mother)

Only Tik indicated that her friends provided informational support. For example, Tik said, *"I need to have a normal delivery as I am afraid of having a caesarean section. My friends also tell me that a normal delivery is rarely painful".* In addition, she received suggestions about nutrition. She stated, *"She [my friend] suggests that I should avoid having raw foods because they aren't good for an unborn baby".*

The majority of the adolescent participants indicated that they had received information from both doctors and nurses on a range of topics. These included healthy eating, resting, doing activities, avoiding stress, getting ready to breastfeed, and attending the antenatal clinic. For example, Ann spoke about getting information from the doctor during the prenatal clinic: *"the doctors give many useful suggestions for me such as to avoid lifting heavy stuff and avoiding stress, but I can't remember all suggestions".* Kit also received useful health information from her doctor, especially on the topic of nutrition. She mentioned, *"I meet a doctor and he told me that I should eat eggs as my body weight did not reach the standard, so I have to eat eggs every day".*

Noticeably, Jeab was the only participant who did not mention receiving informational support from health care providers because she had experienced negative responses from them in a previous hospital visit. In addition, she attended the prenatal clinic at Mahasarakharm hospital for the first time; hence, she did not talk about informational support.

From the observations at the antenatal clinic, it was seen that the nurses provided health care information and advice for about 10 to 15 minutes for each participant. The topics were suitable to the participant's gestational age such as nutrition, activities, baby movement, rest, and abnormal signs and symptoms. Additionally, the doctors offered the same information and provided opportunities to ask questions.

Many adolescent participants spoke of wanting more information from the health care providers. For example, Tim stated:

> *The health care providers should advise about health practices more than they do right now. Yesterday, they advised me about how to count the baby's movements, but they didn't tell me about the characteristic of the baby's movement (Tim, interview 1).*

Nim offered ideas for improvements to the service:

> *The health care providers should set up a group for pregnant adolescents, because some people may know about this and some people may have seen one another and then we can have shared experiences. I think I still don't know anything. Moreover, they should offer a club for pregnant adolescents to build our confidence and give us opportunities to share activities, because teenagers don't know anything and are less experienced (Nim, Interview 1).*

Likewise, Kit's mother suggested that health care providers set up a special group for new mothers:

> *They should provide a special group for the new mothers and suggest how to raise the baby and how to take care of the baby after delivery. Some pregnant women who have experience don't want to listen to the same information (Kit's mother, Interview 1).*

Almost of the adolescent participants and four caregivers indicated that they were satisfied with the information they received from their health care providers. For instance, Tik said, *"I think it's enough for me, because the health care providers give useful suggestions"*. Although seven of the adolescent participants thought the informational support was sufficient, two were concerned that they did not know what kind of health information they should receive during their pregnancy. For instance, Nok said, *"… I have never had a baby and I didn't know what information I should get more of".* However, some of the adolescent participants and many of caregivers did not talk about whether they were satisfied with the information. Perhaps, the adolescent participants were given information but, like Nok, did not know what kind of health information they should receive. As for the caregivers, they did not meet with the doctors or nurses in the room with the adolescent participants; hence, they did not mention whether they were satisfied with the information they received.

Noticeably, many of the adolescent participants rarely asked or answered questions in the antenatal clinic. They only nodded during the consultations, including when they were receiving information from the nurses and doctors. As Sand stated:

> *The doctor checks my urine and the baby's heartbeat. He tells me the baby is normal and he gives me an opportunity to ask questions. I don't ask the doctor anything as I have no idea how to ask questions (Sand, Interview 1).*

The main providers of informational support within the family for the adolescent participants was their mothers. The men in the family, including the father and the partners, did not have an important role in providing informational support. The main topics of informational support related to being conscious of one's health, practicing healthy behaviours, and the role of a good wife. Health care providers also had a role in providing health information, while peers were less likely to provide informational support. The additional health information in the prenatal clinic was required by some participants to improve their ability to practice healthy behaviours. Receiving informational support from family and health providers improved the participants' confidence. This confidence enhanced the adolescents' agency in looking after their health as they were then armed with more knowledge and confidence about how to do this effectively. However, the main informational support was from the mothers, while the information about pregnancy was most helpful from the nurses. This indicated that the quality of the information from their mothers was not always factual, which may at times not have helped the adolescent participants at all.

Summary

Social stigma and support and support systems were the first two themes that demonstrate the development of the adolescent participants' capacity, and improvements to their ability, to make decisions and act agentically. In Thai society, girls who become pregnant are judged as 'a bad girl', because it is considered to be inappropriate at their age to have a baby, and is seen as an improper role model in the community. These norms contribute to and reinforce the stigmatisation of pregnant adolescents. This stigma then limits their ability to exercise agentic behaviours. In this study, stigma was created by family members, villagers, school contacts, and health care providers. Within the family, some family members responded in negative ways that created stigma for the adolescent participants when they found out they were pregnant and that they did not meet family members' expectations. The negative responses from people in the community also created stigma for the adolescent participants. They experienced stigmatisation from the villagers who blamed, gossiped, and looked down on them. In the school context, the responses were varied. Some school contacts blamed the participants and stopped them from continuing their education. Some allowed the participants to continue studying, but they were treated differently from the other students. The responses of health care providers and other pregnant women in the prenatal clinic also made some of the adolescent participants perceive themselves as an inferior group, and this created a feeling of being stigmatised. In addition, family violence created stigma in the adolescent participants. Emotional abuse, physical abuse, and reproductive control were the main forms of violence mentioned by the participants. This violence was created by older family members and partners. As a result, the adolescent participants felt oppressed and controlled in their decisions, and this led to them being stigmatised. Being stigmatised resulted in the adolescents experiencing shame, embarrassment, low confidence, stress, guilt, fear, and anger. A number of avoidance strategies, particularly not contacting people, lying, and avoiding answering questions about their pregnancy,

were selected by the participants to minimise the stigma. Overall, the agency of pregnant adolescents is constrained by the social and structural dimensions of their lives. Stigmatisation restricted pregnant adolescents' capacity to exercise their agency to make their own decisions about their pregnancy, to access education, to defend themselves against the experience of stigma, and to access health care services.

As for support and support systems, the adolescent participants left school early. As a result, they had only limited skills and experience to find gainful employment, which led most of them to depend on support from their family members. Some of the participants found work in unsuitable poorly paid roles to support themselves. Parents, especially mothers, were the main source of support for the adolescent participants. Despite the parents feeling conflicted about the adolescent pregnancy, they provided financial, emotional, and informational support for their daughters. Peers also provided emotional support, but rarely informational support. The main health informational support came from health care providers. The adolescent participants expressed feeling more confident from receiving such support, which influenced their ability to make choices to access basic needs and health care services, and improved their ability to look after their health. The next chapter will present two important themes, cultural heritage and self-care, that relate to pregnant adolescents' agency.

CHAPTER 5 CULTURAL HERITAGE AND SELF-CARE

Introduction

This chapter will present the two remaining themes of the findings, 'cultural heritage' and 'self-care'. Thailand is a Buddhist country and the majority of the population are followers of Buddhism. Buddhism is steeped in myths, legends, and traditional practices that underpin the beliefs and practices of the Thai people. The pregnant adolescents in this study identified both religious beliefs and practices alongside many traditional practices as influencing their capacity to make decisions and to feel in control of their lives. In the theme of self-care, the participants discussed care of the physical self, 'help seeking' behaviours, and managing emotional difficulties. These will be presented as factors that both impede and enable agency in pregnant adolescents, and that have an influence on how they are able to practice self-care independently.

Theme 3. Cultural heritage

Religious beliefs

The findings reveal that religious beliefs and practices provided a range of internal coping resources that positively affected agentic behaviours in some of the adolescent participants, including Buddhist practices such as praying with chanting books and meditating. The resulting sense of control and increased capability were most evident when the adolescent participants faced everyday challenges such as being criticised, and feeling mocked and insecure about their future. In some cases, major life decisions around whether or not to terminate their pregnancies were based on Buddhist doctrine. While this could be interpreted as religious control over the adolescents' decisions, the participants spoke of this in terms of giving them strength.

Some of the adolescent participants identified that religious beliefs increased their ability to make sense of stressful events, interpret their meanings, and find strategies to deal with difficulties. For example, praying with Buddha was Tik's preferred way to decrease her feelings of unease: "*I'm praying with Buddha when I have anxiety. This activity makes me relaxed"*. In another example, Klang applied Buddhist practices by praying with the chanting book known as 'Apimonkonkhatha', and meditating when she argued with her mother and partner to reduce stress and to control her mind. She said:

> *I get uneasy feelings and thoughts when I argue with mom and my partner about my pregnancy. So, praying and meditating with this book help to reduce my stress and calm my mind (Klang, Interview 2).*

(Klang, Interview 2)

Relying on Buddhist doctrine assisted some of the adolescent participants to consider all their options carefully before making decisions and, as a result, they felt that the doctrine taught them how to think about the actual causes of their problems and to manage them. The photo-elicited interview with Noi was a clear example of how some of the adolescents made decisions based on Buddhist doctrine. When negative circumstances arose at any point in her life, Noi, being deeply religious, was able to completely rely on the Buddhist teachings in the Dharma book known as Phanaiban (a monk inside home). Noi claimed that *"previously, I did everything without consideration. After I read this book, it helps me think carefully before making decisions".*

(Noi, Interview 2)

In addition, religious beliefs enhanced the participants' confidence by providing psychological support for those who lacked confidence, which they found in the teachings of Buddha or in magic religious objects. For instance, during her interview, Noi said that *"praying with the Buddha makes me have confidence to continue a healthy pregnancy, have a healthy baby and may help my delivery become less difficult".* Noi explained that she had gained confidence after she prayed with Buddha.

As her pregnancy progressed, she found movement difficult, so she prayed with Buddha and asked him for help in having an easy delivery and a healthy baby. Thereafter, she felt more comfortable during her pregnancy, and as the baby's movement was normal, Noi believed that Buddha had assisted with her health. Normally, at home, Noi would go upstairs alone to pray with Buddha on holy days. Before praying, Noi lit candles and joss sticks, showing her appreciation of a healthy pregnancy and anticipation of having a healthy baby to the Buddha statues. Noi's praying space is illustrated below:

(Noi, Interview 2)

In another example, Tik presented a photo of a votive Buddha locket during a photo-elicited interview and indicated that she had confidence when she was wearing this locket. She believed that the Buddha image protected her and her baby from bad spirits. Across all observations with Tik, she always wore the Buddha locket. She stated:

> *I have confidence that the Buddha would protect me and my baby from bad deeds. Sometimes, I ask for a blessing that nothing bad will happen to my family. After I blessed with Buddha, my family doesn't have any troubles. So, I have confidence that the Buddha would protect me (Tik, Interview 2).*

(Tik, Interview 2)

Praying with Buddha also elicited feelings of hope for four of the adolescents, which they associated with wellness. For instance, Noi took a photo with the Buddha shrine and indicated that praying with Buddha images can provoke successful expectations, particularly a healthy pregnancy and baby. She said, *"If I take the baby with me to pray to the Buddha, he will help the baby to be kind-hearted and calm like the Buddha".*

Kit claimed that reading the Dharma book helped her to build a good relationship with her mother: *"The cartoon Dharma book builds a good relationship with mom and me".* Previously, Kit was not close with, and rarely talked to, her mother because her mother went to work early in the morning and was not home until late. After reading the Dharma book, she re-considered some issues, particularly the karmic consequences of abortion and felt comfortable enough to talk about these issues with her mother. She stated that "*After reading Dharma book, I feel comfortable when I accompany my mum to go outside home".* The photo below illustrates the Dharma book that contains information on how to practice for good karma.

(Kit, Interview 2)

Belief in karma influenced some of the adolescent participants to behave in ways that gave them strength and grew their confidence, thus resulting in agentic behaviour. In Buddhism, karma refers to good or bad luck resulting from past actions that determines future fate. Therefore, people behave well because the want to avoid suffering of a painful future existence and want to earn the reward of a future happy life (Davis, 2017). 'Making merit' is a religious practice that the girls adopted to accumulate good karma. Making merit is an act of giving in the Buddhist faith. Thai people make merit by giving food or bringing offerings for the monks in the temple or to Buddha statues in Buddha shrines in their own homes. According to Top, Klang, Nim, and Pha, the primary reason to make merit is to keep themselves healthy and to ensure that they had healthy babies. For example, Top

said, *"I Tak Bat and then I pray with Buddha to make my baby would be healthy.* 'Tak Bat' is a kind of making merit of Buddhism by offering food to put into the monks' bowls.

Similarly, Klang's mother pointed out that offering food for the monks in the morning accumulated merit that influenced a wealthy future life. She said, *"I take her to Tak Bat in the morning to make merit for herself and her baby so that they don't go downhill"*. Also, Nick's caregiver mentioned that making merit influenced pregnant adolescents and their babies in their present life. She stated, "*I ask my daughter to give foods for the monks in the morning because making-merit may influence her and her baby".*

Some of the adolescent participants reported that they had decided not to have an abortion because they were afraid that having one would bring bad karma to them and their babies. For example, Kung feared that the sin of abortion would result in bad consequences, so she changed her mind about getting an abortion. She said:

> *The abortion is just on sudden impulse. However, I have concern for my baby and I'm afraid of sin, so I change my mind. My aunt and friends have had abortions that led to unsuccessful jobs for many years (Kung, Interview 1).*

Also, fearing sin, Pha did not want to assist her friend in getting an abortion. She said:

> *One of my friends who studied the same major [as me] has a boyfriend and become pregnant, and her mum didn't know anything. She wasn't sure whether or not she's pregnant, so I told her to buy a pregnancy strip test to check it. The result was that she's pregnant, but then her boyfriend left her. Finally, her mom learned of the affair and wanted my friend to get an abortion. So, she asks me for help, but I don't give her any suggestions as I don't want to deal with her problems, as I fear dramatic sin (Pha, Interview 1).*

The strong religious beliefs of the caregivers also influenced the pregnant adolescents' decisions to keep their babies. Some of the caregivers defined abortion as bad karma, and they believed it would bring their daughters bad luck that would extend to others in the family; therefore, they did not allow their daughters to terminate their pregnancies. For example, both Nok and Fang's mothers cited abortion as 'a dramatic sin' and questioned how they could 'raise the dogs and cats', but could not raise their daughters' babies. The quotations below highlight how some of the caregivers understood abortion.

> *My daughter doesn't tell me about her pregnancy, but I see that she takes the Satreepenpak drug. I ask her about why she takes this drug. She tells me that her period doesn't come, so I prohibit her to take this drug immediately as I think she might be pregnant. I also tell her that abortion is a dramatic sin. I think how can I raise the dogs and cats which aren't human, but why can't I raise a child? (Fang's mother, Interview 1).*

> *I don't want my daughter to have an abortion as I really worry about the complications. Abortion is a dramatic sin in my religion, as it kills a human. I can raise dogs and provide foods for them, but why I can't raise a baby (Nok's caregiver, Interview 1).*

Both Nok and Fang's mothers mentioned the words 'how they could raise the dogs and cats, but could not raise their daughters' babies', which meant that if they could raise the dogs and cats, they had the capacity to support their daughters' babies.

Noi also believed that taking care of her mother would result in good karma for her and her baby's future life. She stated:

> *I believe that taking care of my mom will give good karma to my life and my baby. I have confidence that if I take care of my mom, the baby may follow my behaviours. Also, I won't know what to do if my daughter doesn't provide food for me when I'm old. In the same way, if I don't take care of my mom, what would she think? So, I'm a daughter of my mom and I should take care of her (Noi, Interview 1).*

Practicing religious beliefs influenced the participants' capacity to face constraining situations in their lives. In this study, the adolescent participants practiced religious beliefs by praying with Buddha, meditating, and making merit that gave them the strength to tolerate the stressful situations they faced. In addition, belief in karma influenced the adolescent participants to conduct their lives in ways that gave them strength and to feel confident to make their own decision to not abort the baby and decide to continue with the pregnancy. This belief also demonstrated that adolescent participants used religious beliefs to improve their strength to face reproductive control. In this way, religious beliefs provided the adolescents with an internal coping resource and a sense of being in control of their lives.

Traditional practices

Traditional practices incorporate irrational beliefs that an object, action, or circumstance that is not logically related to a course of events influences the outcome whether individually or collectively (Liamputtong, Yimyam, Parisunyakul, Baosoung, & Sansiriphun, 2005). In Thailand, many Thai people hold superstitious beliefs associated with pregnancy. For the participating adolescents, superstitious beliefs originated from various influences, including ideas passed down from one generation to another and watching family members and peers uphold traditional practices.

For example, Tik observed her sister clasping a safety pin onto her clothes when she (her sister) became pregnant, and found that her sister did not have any problems during her pregnancy. Tik wanted to have a successful pregnancy, so she found a safety pin and clasped it onto her clothes to protect her baby when she went outside. Tik said:

When my sister became pregnant, I saw that she clasped a safety pin on her clothes every day. Nothing bad happened with her pregnancy, so I believe that clasping the safety pin protected her baby (Tik, interview 2).

Tik also mentioned that following traditional practices not only helped to prevent unexpected consequences, it increased her ability to control her fear. In Tik's example, she believed that wearing a safety pin on her clothes would repel bad spirits because the sharp point was able to protect her from penetration by the spirits. As a result, she always clasped the small safety pin onto her clothes when she went outside, as she stated:

This photo is a safety pin. Nobody give it to me and I found it myself. I clasped this pin on my shirt or dress when I go outside. I just start clasping it last month. I believe that clasping pin helps to protect my baby from dangerous and bad spirits as its shape looks sharp (Tik, Interview 2).

(Tik, Interview 2)

During the observations, it was noted that all the adolescent participants were clasping safety pins onto their clothes around their belly when they attended the antenatal clinic and when they went outside into their village. They indicated that a sharp pin helped to repel bad spirits that could harm their babies. The type of pin was not a specific size, shape, or style. The core requirement was that it was sharp.

The interviews with the participants highlighted some beliefs in traditional practices that influenced their capacity to engage in behaviours to prevent health problems, and to control fear of unexpected situations. While these behaviours were not based on any scientific evidence, their practice gave the participants a sense that they were doing the best job they could to care for their unborn babies and to prepare for the birth.

Many adolescent participants indicated that following traditional practices that were passed on from older family members helped them to feel capable and in control of their situation. For instance, Sand said:

> *My mom, dad, aunt, and friends help me to improve my ability to practice suitable behaviours during pregnancy as they advised me not to put my legs up because the umbilical cord will stick around the back. This tends to lead to a difficult childbirth. They also suggested that to avoid taking showers at night time as it makes the blood clot. They also suggested that I avoid drinking cool water as it makes the baby difficult to raise (Sand, Interview 1).*

In another example, Kit indicated that she had more confidence in practicing appropriate behaviours and preventing an unhealthy baby after receiving suggestions from her family members. She said:

> *At the beginning of my pregnancy, my mom and grandma don't allow me to have eggs, as the skin of a baby would be covered with fat, so I can't have eggs. They also suggested that I avoid taking showers at night-time as the ghosts may eat the baby in the womb. These improve my ability to practice the suitable behaviour and I can protect my baby (Kit, Interview 1).*

Similarly, the majority of the caregivers mentioned that they suggested 'Kalum behaviours' during their daughter's pregnancy. The caregivers were passing on suggestions from the older people in their family to their daughters for preventing unhealthy pregnancies and babies. They described the meaning of Kalum as a taboo discourse of the Southeast region of Thailand, which was a guide both to the individual and the community for living together. This is a strategic piece of local wisdom that refers to holy things for defending people from making wrong decisions and creating wellbeing and a more harmonious society (Pimpa, 2012). For example, Nam's mother suggested that her daughter should avoid Kalum behaviours, particularly around food choices and rest, to prevent complications during her pregnancy. Nam's mother stated:

> *I teach many topics during pregnancy to my daughter, especially eating and sleeping habits. I also follow the older people's suggestions, particularly Kalum behaviours for pregnant woman. For example, I suggested that she avoid sleeping on her back because the cord might stick around the back, and to avoid having tamarin seeds as this could result in a difficult delivery. Also, I don't allow her to use a pillow, as it will cause abdominal discomfort (Nam's mother, Interview 1).*

While believing in, and acting on, traditional practices is considered by many westerners as irrational, the adolescents found that these practices improved their ability to control their fear of the unknown and the unexpected. Some of the adolescent participants were afraid that their babies may have abnormalities. Maintaining traditional practices alleviated these fears. For example, the older people in Tim's family believed that having spicy foods in pregnancy would cause 'balding' in the baby. Tim was afraid that her baby would be born bald, so she avoided spicy food to prevent hair loss in her baby:

My grandma tells me to avoid eating spicy foods, for it will make the baby bald. I'm concerned about my baby, so I tried to avoid having spicy foods (Tim, Interview 1).

In another example, Kung attempted to drink coconut water to prevent skin problems and to 'clear baby fat' on her baby's skin after giving birth. She said:

I hear my mom talk with my relatives about drinking coconut water to help to clear baby fat, so I follow her advice as I fear that my baby's skin would not be beautiful (Kung, Interview 1).

In another example from an interview with Top, she expressed her fear of having a difficult delivery. To manage this, she avoided using a needle to sew her clothes and to make garlands during her pregnancy. She stated that:

My mom doesn't allow me to make garlands, as it could be a cause of a difficult delivery. I have to follow her as I'm afraid that my baby may be endangered (Top, Interview 1).

Top also mentioned this in the photo-elicited interview and provided more detail about the reasons why she followed these traditional practices. The older people in Top's family indicated that using a pin for sewing could cause the closing of the birth canal and lead to difficulty and suffering during childbirth. Top was afraid of suffering in childbirth; thus, she followed the traditional practices although she did not clearly understand the reasons why. Top mentioned:

(Top, Interview 2)

This photo is the needle and string. I take this photo because older people believe that using a needle during pregnancy can cause closing of the birth canal. They don't allow a pregnant woman to sew clothes and make garland. Doing these things can cause difficulty and suffering during delivery. They don't tell me the actual reason why. They just tell me "do it and don't ask the reason", so I have to follow their words (Top, Interview 1).

Nam was the only participant who used a needle to make garlands. She was more concerned about the financial burden than the traditional practices, and she believed that the traditional practices were not really practical, hence she ignored them.

Conversely, pressure from family members to follow traditional practices acted, at times, to limit their ability to practice behaviours independently. Some of the adolescent participants were conflicted about practicing traditional practices when their family members forced them to. For instance, Top stated that *"I'm frustrated that they don't allow me to do many things such as sewing clothes and killing the fish. So, I have to follow them".* Top wanted to practice her usual behaviours that she had undertaken before her pregnancy, but she felt compelled to follow the traditional practices for fear that if she did not, there would be negative consequences for her and her baby.

Traditional practices influenced adolescent participants' agency. Believing in traditional practices improved their ability to engage in behaviours to prevent health problems, and to control the fear of unexpected situations. Although these practices were not based on any scientific evidence, this gave the participants a sense that they could care for their unborn babies and prepare for their birth. However, some of the participants had conflict in following the traditional practices. This limited their ability to make their own decisions in practicing their behaviours.

The aforementioned indicated that adolescent participants used both religious beliefs and traditional practices to provide the adolescents with an internal coping resource and a sense of being in control of their lives, to prevent health problems, and to control the fear of unexpected situations.

Theme 4. Self-care

This theme will provide an overview of how the pregnant adolescents described what they did to look after themselves while pregnant. It will describe their self-care abilities and the actions they took to care for themselves and their unborn babies. Three sub-themes resulted from the analysis, care of the physical self, help-seeking behaviours, and managing moods and emotions. Self-care practices encompass the capacity of pregnant adolescents to manage their health and health care, to seek help, and to cope with illness and challenges, with or without the support of their families and health care professionals.

Care of the physical self

The adolescent participants reported that they could care for themselves in many ways. Five main topics of self-care practice were identified by the participants, including nutrition, exercise, rest, work, and medication. These mostly related to care of the physical self.

The majority of the adolescent participants reported actively changing their eating habits during their pregnancy, demonstrating an interest in, and some level of ability to care for themselves. These

changes mostly related to trying to eat healthy foods and avoiding unhealthy foods. For example, Fang normally liked to eat “Somtum”, especially ‘Somtumpa’. Somtum is a spicy Thai papaya salad mixed with fermented fish sauce, while Somtumpa is a spicy papaya salad mixed with fermented fish sauce, vegetables, and cherry snails. She avoided having ‘Somtum’ and changed to eating more healthy foods when she became pregnant. Fang stated:

> *I’m changing my eating habits and I try to have more healthy foods such as eggs, pork, chicken, and fish. Normally, I like to have spicy foods, but I have to eat less spicy foods. I love to have Somtum especially Somtumpa. I have fruits as usual (Fang, Interview 1).*

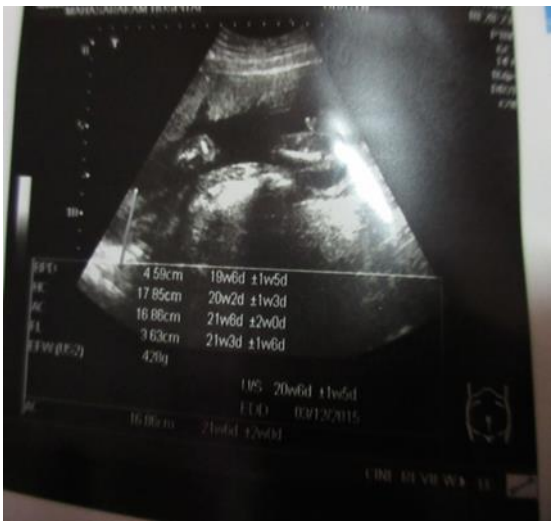
In another example, Noi attempted to control her diet primarily through eating fewer desserts. This was in response to an abnormal urine test. After she changed her eating habits, the urine results returned to normal. This testing reinforced her decision to continue eating more healthily.

> *Previously, the urine result was +1 but I had no idea what +1 is. I worried about the result. The nurse explained the result and suggested that I should decrease eating dessert and sticky rice. She also told me that I should have more eggs, fish, and vegetables that would help me to be healthier. [She said] if the urine result is +1, I will check blood for diabetes. I worry about myself and my baby, so I decreased eating desserts, avoided having sticky rice, and had more eggs. After that, the urine result became normal (Noi, Interview 1).*

Some of the caregivers also noticed that their daughters changed their eating habits during their pregnancy. They found that their daughters selected healthy foods and avoided spicy foods. For instance, Fang’s caregiver said, “*previously, my daughter liked spicy noodles and put more chili in the soup, but she ate less spicy foods when she got pregnant”*. In another example, Sand’s caregiver noticed that her daughter avoided drinking soft drinks, even though she drank them every day before she became pregnant. She stated:

> *My daughter likes soft drink, but she avoids drinking it when she gets pregnant. She’s drinking milk in the morning as she says milk is good for the baby (Sand’s mother, Interview 1).*

Fear was a major driver for many of the participants in changing their eating habits. Reflecting on an ultrasound image of her unborn baby, Sand said, *“I fear that my unborn baby is unhealthy. I must take care of myself and my baby. I drink milk and have healthy foods that can help my baby get healthy”.* Sand’s fear led her to change her eating habits and could be interpreted as increasing her agency to choose healthy foods for her baby.



(Sand, Interview 2)

Nim also changed her food choices because she feared for her unborn baby. She said, "*about foods, I'm more concerned about what I eat. I try to have healthy foods, particularly vegetables. I also avoid having starch such as noodles".* In another example, Pha became concerned about the ingredients in food that she bought from the food store: *"I have to ask the shopkeeper about the ingredients in the food wrapped in leaves before I buy it".*

Some of the participants identified certain pressures that led them to feel as though they could not eat healthily. These included work pressures and feelings of embarrassment when eating with their partners' families. For example, Nam had to do many jobs, therefore she ate few meals and skipped breakfast. She stated:

> *Although, I get up early in the morning, around 6 o'clock, I have to do many jobs that make me skip my breakfast. I have breakfast and lunch together. Normally, I have papaya salad, cucumber salad, fried chicken, and rice. I have boiled fish or canned fish for dinner. I drink milk sometimes, as I don't like it (Nam, Interview 1).*

Pha talked about not being able to eat as well as she would like to because she was embarrassed when having meals with her parents-in-law. She stated:

> *I don't have confidence to have food with them. I ate 2-3 spoons, so it isn't enough food for me, so I ask for foods from my relatives that live near to this house. After that, the father-in-law asks my relative about why I eat a little bit of food. My relative answers that "Your daughter-in-law feels embarrassed, so she asks for food from me" (Pha, Interview 1).*

When I visited Pha's home, she noticed that Pha refused to have lunch with her mother-in-law and grandmother, and only ate snacks for lunch.

Doing exercise was reported by some of the adolescent participants to decrease discomfort during pregnancy and to eliminate the fear of having an unhealthy baby. The types of exercise varied, but included yoga, riding a bicycle, walking, and doing housework. For instance, Sand stated that *"I'm walking around my house and riding my bicycle to the field. It's quite far from here and it takes about 30 minutes. These activities help to relieve my back pain".*

Again, fear for their unborn child was a major driver of these activities. For instance, Tik mentioned that she exercised because she was afraid the baby would be lazy. She stated:

> *As for exercise, I exercise by doing housework such as washing dishes, cooking rice, and washing clothes, as I don't want to sit still and do nothing. I'm also afraid my baby will be lazy (Tik, Interview 1).*

Nim and Korn indicated that lack of time and feeling uncomfortable during exercise had an impact on the adolescent participants' capacity to exercise. Nim continued to do yoga during her pregnancy but also expressed concerns that she had only limited time to do so because of her competing need to study. She had to do many assignments and often returned home late, hence she stopped exercising. She said, *"I have to stop doing yoga, as I had no time. I have to study and do homework".*

All adolescent participants identified that they prioritised rest by planning and scheduling it into their lives. For example, Ann said*, "I'm taking a nap in the afternoon for around one hour and going to bed early more than before".* In another example, Nok showed that she planned her time to take a nap in the afternoon to reduce fatigue during pregnancy. She stated:

> *Before pregnancy, I can get up anytime and I don't feel sleepy when I wake up. Now, I feel sleepy all the time, so I have to take a nap in the afternoon for around 1 hour before I go to do housework again (Nok, Interview 1).*

Only Top's mother mentioned that her daughter had changed her sleeping habits. She said, *"I noticed that previously Top went to bed late, but she goes to bed early around 8 pm when she was pregnant".*

A lack of time also had an impact on some of the adolescent participants' ability to look after themselves well. For example, Tik had a tight schedule that had an impact on her capacity to plan for rest during her pregnancy:

> *As for rest, I'm going to bed late at night because I like to watch TV, play games on the mobile phone, and chat with my friends on Facebook. I don't get enough sleep because I go to bed late. It was my habit and I didn't change anything (Tik, Interview 1).*

Work requirements shaped the girls' capacity to care for themselves in a range of ways. Many adolescent participants indicated health concerns related to their daily physical work, and their need

to monitor and manage this more closely to prevent complications in their pregnancies. For example, Ann mentioned that *"I'm more careful especially walking and lifting the heavy stuff. I always ask my younger sister to lift the heavy stuff".* In another example, Tik considered what kind of work she was able to do, and so avoided doing strenuous physical work. Tik said:

> *As for working, I can do hard work before I get pregnant, but now I don't do hard work. Sometimes, I go to mother-in-law's restaurant to help her work such as preparing recipes, washing dishes, and cleaning tables. I think it wasn't hard work and I can do it (Tik, Interview 1).*

Some of the caregivers also had similar concerns about the health of their daughters in relation to physical work. They indicated that they did not allow their daughters to do hard work such as raising cows, lifting heavy objects, or driving trucks. For example, Top's mother stated:

> *I don't allow her to do hard work, in particular raising the cows, as I fear the cows that they will injury from cow gore. I can't control them, even though I'm raising them (Top's caregiver, Interview 1).*

Additionally, some of the adolescent participants feared that they would endanger their babies by doing certain activities. For instance, Tik avoided riding a motorbike because she was afraid of having a miscarriage. She said, *"I rarely drive a motorbike as I'm afraid that I'll fall down and fall in a hole on the road. Then I will have a miscarriage if the motorbike falls over".* Tim also feared having an accident saying, *"I go up the stairs carefully as I'm afraid I'll have an accident from falling down the ladder".*

Taking medication was a major challenge in three of the adolescent participants' ability to take care of themselves. The adolescents spoke of feeling as if they were taking charge of their pregnancy by taking medications to give their baby the best chance in life. For example, Tik stated, *"as for medicine, I took the medicine following doctor's suggestions. Normally, I took medicines after breakfast".* Showing a photo of her mother, Kit explained how she remembered to take her medicines. She said:

> *My mom reminds me to take medicines, as I always forget to take them. I solved this problem by putting the medicines in the same pocket with my mobile phone, so this helps me remember to take my medicine (Kit, Interview 2).*

(Kit, Interview 2)

Some of the caregivers reported that the need to take medicine was a barrier to adolescent participants' ability to self-care. They reported that their daughters did not take any medicines for pregnant women. Fang's mother said, *"another problem is that my daughter isn't taking medicines, as I noticed her medicine isn't used up".* She also mentioned that her daughter was not interested in the advantages of taking medicine.

Some of the adolescent participants in this study practiced physical self-care independently in relation to nutrition, exercise, rest, work, and taking medicine. However, fear was often a driver for these activities. A number of factors were identified that made self-care difficult. These included lack of time, work pressures, and feeling embarrassed. Despite all of the participants attending antenatal services, surprisingly few identified taking up the recommendations for nutrition, exercise, and rest.

Getting help

The adolescent participants who faced these challenges reported that they sought help from others. All the participants talked about getting help from their mothers and partners. A few spoke of being confident in asking questions of the health care workers, and a few mentioned seeking information from social media sites.

Mothers were the people most commonly consulted for information and help. For example, Nok showed a picture of her mother and family saying how important they were to her and how she was able to ask them for help. She said:

> *Sometimes, I feel back pain and I'm afraid that it is a sign that something is abnormal. So, I ask my mom to make sure. My mom tells me that it's normal during pregnancy and then I have less anxiety (Nok, Interview 2).*

(Nok, Interview 2)

The main topics that the adolescents asked their family for support about included matters related to staying healthy in pregnancy, financial support, and raising their baby. Those fortunate enough to have such support identified that this was important to their developing abilities to manage difficulties as they arose. For example, Noi's sister went to work in another province to earn money for the family; therefore, Noi's mother had to look after her grandson. Noi recognised that she needed to know about how to look after the baby, hence she asked her mother to teach her. She said:

> *I asked my mum to teach me how to look after my nephew. She makes me have confidence to take care of my baby [when it comes], because I now have experience from taking care of my nephew. During the daytime, I help my mom to feed him milk, wash him, and change his nappies. At night time, my mom takes care of him alone. Initially, I don't have confidence to take care of him because he was too small when he was born, and I'm afraid to do anything with him. So, my mom was the only one who took care of him. After 2-3 months, I myself can do all of the activities to take care of him. I think these activities are easy if I try (Noi, Interview 2).*

(Noi, Interview 2- the importance of her mother teaching her to look after babies)

Top spoke of seeking support in solving problems from both her mother and her partner, stating:

> *I ask for suggestions from my mom and my partner to handle problems such as work and money. My mom is the first person who I ask for help. I also ask her what I can do and how I can deal with the problems (Top, Interview 1).*

In another example, Tim argued with her mother and partner. As a result, she turned to her sister to ask her for help to work through these troubled relationships. She said:

> *When I face all problems in my life, I ask for help from my elder sister; for example, I fight with my mom, so my elder sister conciliates between my mom and me. Sometimes, I fight with my partner and then I call my elder sister to ask for suggestions. She said that "Everybody is moody from work, so you have to understand, you don't do anything, you have to calm down" (Tim, Interview 1).*

Web browsing and social media were identified as other helpful sources of information by many adolescent participants. Through these sources, they sought health-related information on social media by asking their friends, and by using websites such as 'Enfamama'. For example, Kit said, *"I'm surfing the Enfamama website to search for information about baby development and health information during pregnancy".*

The Enfamama website provides health information for pregnant women sponsored by Mead Johnson & Company. In another example, Nok was observed watching 'YouTube' to seek information about how to relieve discomfort during pregnancy. She stated, *"I seek information about morning sickness from YouTube, so I can find out how to relieve this problem".*

All of the participants were comfortable in asking health care providers for help. The main topics covered included health information, and health problems in the mother and the baby. Fang pointed out that she asked for health information from the health care providers from the antenatal clinic to count the baby movements. She stated that:

> *Yesterday, I had a problem about baby movement count and I feel it not move well. So, I ask a nurse about how to do it, so a nurse teach me about how to count the baby movement and record it (Fang, Interview 1).*

Noticeably, the majority of the adolescent participants sought help from social media rather than from health care providers. The health professionals were employed to provide support when the adolescent participants faced complications during pregnancy.

Feelings of embarrassment and the fear of being chastised by health care providers were reported as barriers to seeking help from them. For example, Sand explained that she felt unable to ask for help from the doctor when she said, *"I am shy to ask questions and I have no idea how to ask the*

doctor". Jeab gave another example of being afraid of being blamed by the health care provider for doing the wrong thing and not knowing enough about her pregnancy. She said they told her that:

> *I have white blood cells in my urine and that made me scared, and I'm afraid that the baby will get sick. I don't ask any questions about the cause and what I should do next from the doctor. I'm afraid to ask questions as I fear that the doctor will blame me for not knowing anything about this (Jeab, Interview 1).*

The observations of all the adolescent participants at the antenatal clinic highlighted that the participants rarely asked questions about their health care or that of their unborn babies. This was despite the nurses and doctors appearing to provide a friendly environment and being observed to encourage the participants to ask questions. The adolescent participants mostly bowed their heads and did not make eye contact when they had conservations with the health care providers.

The main source of help for the adolescent participants was from family members. The adolescent participants had the confidence to ask for help from family members, especially from their mothers and partners. Family members could improve the adolescent participants' ability in transitioning to adulthood by teaching them to stand alone and by accepting that they needed to deal with the adolescent participants' problems. Feeling embarrassed and fearing blame from health care providers limited the adolescent participants' ability to seek help from more formal sources. A few spoke of being confident about asking questions of health care providers, while some mentioned seeking information from social media sites. In this way, the broader sociocultural factors in the relationship between health professionals and adolescents were considered.

Managing moods and emotions

The adolescent participants faced challenges in their lives that resulted in unfavourable emotions, hence the management of emotional difficulties varied.

Keeping away from people who upset them emotionally was a strategy that seven of the participants used to manage their emotions. As identified in Chapter 4, many of the participants isolated themselves so as to avoid meeting people and the associated feelings of shame and ostracism that came from village gossip. Others found ways to remove themselves from family conflict within their homes and to regulate their own moods by physically removing themselves from the family. Pha gave an example of how she managed living with her 'grumpy' aunt. She said*, "I'm in such a bad mood when she [my aunt] is grumpy. I also get moody easily now that I'm pregnant. I just stay alone and don't talk with anyone"*. Fang gave another example of coping by avoiding talking to people. She stated:

> *I get moody easily since around 4-5 months of my pregnancy. It happens spontaneously without any stimulation. So, I don't talk with anybody and that makes me calm down. Nobody helps me, so I try to find peace in my mind (Fang, Interview 1).*

Taking part in enjoyable activities was another strategy that the adolescents identified in order to manage unpleasant emotions. The majority of the adolescent participants mentioned that activities such as drawing, watching television, listening to music, playing games on the mobile phone, and reading cartoon books helped them to reduce their tension. For example, Klang stated that *"I listen to music and then don't think about what is making me stressed as I only think about my baby".* In another example, Kit showed a photo of one of her drawings (see picture below), saying that she drew when she faced difficulties.

(Kit, Interview 2)

She said:

> *Pregnant women have more anxiety and stress. Drawing can help me to compose myself, calming myself, and so to have a healthy baby. When I draw a picture, this improves my confidence that if I don't have stress, my life will be better (Kit, Interview 2).*

Focusing on their baby was another strategy that some of the adolescent participants used to deal with their emotional difficulties. For example, Tim said that she controlled her emotions by focusing on the unborn baby and talking with it: *"when I'm fighting with my partner, I always touch my belly and talk with my baby. After that I feel relaxed".*

Some of the adolescent participants were able to choose their own strategies to manage emotional difficulties, particularly keeping away from people who upset them emotionally, doing enjoyable activities, and focusing on their baby. These strategies demonstrated the ability of the adolescent participants to cope with unfavourable emotions.

Summary

Religious beliefs and traditional practices were paradoxical methods of both enabling and impeding the agency of the pregnant adolescents. Religious beliefs improved their ability to face emotional

challenges in their life through religious practice. As a result, religious beliefs provided an internal coping resource and psychological support. Belief in karma was another factor that influenced the adolescent participants in selecting good behaviours to gain good karma. This belief was also a reason why they faced reproductive control, as mentioned in the previous theme. In addition, belief in traditional practices improved the pregnant adolescents' ability to engage in behaviours to prevent health problems, and to control their fear of unexpected situations. However, some of them felt conflicted in following traditional practices. This limited their ability to make their own decisions in practicing behaviours. Therefore, the authority of religious beliefs and traditional practices are a consideration in the provision of health information for pregnant adolescents. In addition, the challenges of following both western medicine and traditional practices influenced the pregnant adolescents' ability to engage in behaviours to prevent health problems.

In relation to self-care, the adolescent participants demonstrated an ability to have some control over their self-care in relation to nutrition, exercise, rest, work, and taking medicine. Fear of having an unhealthy unborn baby had an impact on improving the ability of the participants to maintain their self-care. However, a lack of time, work pressures, and feelings of embarrassment were the barriers acting against the pregnant adolescents' sense of agency. The main sources for adolescent participants seeking help was from family members. The family plays an important role in improving the adolescent participants' ability to transition to adulthood, specifically accepting responsibility for their actions, learning to stand alone, and dealing with life problems (Arnett, 2001). Feelings of embarrassment and the fear of being blamed by health care providers also limited their ability to seek help from more formal sources. Some of the participants spoke about being confident in asking questions of health care providers, while others mentioned seeking information from social media sites. In relation to emotional management, the adolescent participants demonstrated agentic behaviours in selecting ways of dealing with emotional difficulties. Therefore, the recommendations that arise from the data relate to health care providers recognising their authority in the health care environment and taking action to rebalance power relations. Health workers also need to develop skills in recognising and valuing the importance of religious and traditional beliefs of the young women for whom they care. These will be explored more fully in the next chapter.

CHAPTER 6 DISCUSSION

Introduction

In this study, the findings chapters reported on the experiences of the selected adolescent participants and their caregivers that shaped their agentic behaviours, which were presented through four main themes including social stigma, support and support system, cultural heritage, and self-care. A secondary synthesis of these findings through a feminist theoretical lens resulted in three inter-related concepts of gender inequity, fear, and spirituality that permeated the findings. These concepts worked together, sometimes in paradoxical ways, to influence the pregnant adolescents' agency in the Thai context. In this chapter, feminist theories under the umbrella of critical theory were used to explore how these concepts manifested in the broader sociocultural context of pregnant adolescents living in rural Thailand. Feminist theory purports that gender domination in a society is a production of social structures, with women and marginalised people and groups being oppressed by the dominant (male) group (Tong, 2009). The feminist lens enables the investigation and understanding of gender inequity in more complex and contested ways than a direct content analysis, and offers a useful theoretical perspective to address how pregnant adolescents exercise their agency in the patriarchal social system of rural Thailand. This chapter presents the findings of this thesis in connection with their broader social environmental context to shed light on how agency has been alternately taken up or constrained for the pregnant adolescents in this study. Gender inequity, fear, and spirituality are considered as the main concepts that influence pregnant adolescents' agency. This chapter starts with a discussion of how the social structure of Thai society perpetuates inequality among females and males in contributing to intimate partner violence and social stigma, and how pregnant adolescents exercise their agentic behaviours in relation to gender inequity. The next section discusses how the fear experienced by the pregnant adolescents was supported by the patriarchal ideology and how they exercise agency in the context of oppression. The final section discusses how spirituality, particularly religion and traditional practices, influenced the agentic behaviours of the pregnant adolescents in the context of oppression and gender inequity. These three concepts of gender inequity, fear, and spirituality are presented in Figure 8 below.

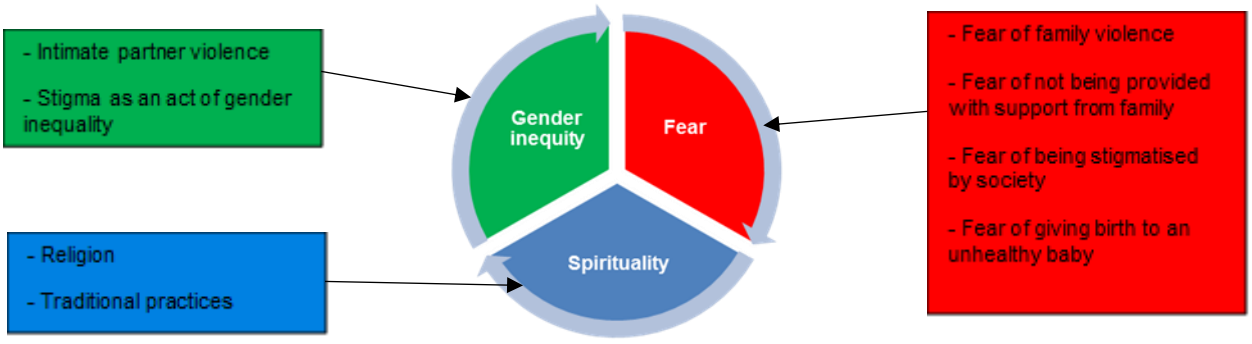


Figure 8: Three concepts of gender inequity, fear, and spirituality

Gender inequity

The main difficulty facing pregnant adolescents in Thailand is the gender inequity experienced by girls who have sexual relations and become pregnant before being married. Pre-marital abstinence is an expected attribute of girls in Thailand, hence they face harsh disapproval and experience disadvantage if they become pregnant, whereas premarital sexual relations for boys goes unheeded. For the adolescents in this study, the resulting gender inequity occurred at multiple levels, including in the family, at school, in health care services, and at the broadest level of their historical and situational cultural experiences. These experiences were nested within and across systems, interacting to produce a web of gender inequity for the adolescent girls that constantly challenged their capacity to behave agentically. The following sections explore the mechanism of gender inequity identified through the participants' narratives.

Intimate partner violence

In this study, the adolescent participants experienced intimate partner violence in the privacy of their family home, in the new family home they shared with their partner, and in the community. Through these experiences, their inferior status was identified and maintained to ensure that male dominance was sustained. The participants reported that their partners were violent against them in a variety of ways including emotional abuse, emotional neglect, and through reproductive coercion. Through these actions, the male partners exerted control over the young women's behaviours and restricted their agency. They experienced emotional abuse from their partners for becoming pregnant and for intending to raise their baby. This abuse was manifested through blaming, scolding, belittling, and emotional neglect. The initial attempts at reproductive coercion by their partners included forcing the participants to have sex without a condom (see for example Fang and Ann), to undergo an unwilling abortion (see for example Kit and Pha), or to keep their baby (see for example Nam and Kung). The adolescent participants who experienced partner violence voiced feelings of suffering, helplessness, worthlessness, and neglect when confronted with threatening situations. Most of them did not report these issues to other family members, nor had they directly confronted their partners. As a result, they feared losing custody of the unborn baby because of possible separation (see for example Sand) and feared not having financial support (see for example Pha and Noi). As well, they did not identify any strategies and resources to manage the violence. Only a few of the participants identified being able to resist their partner's pressure to terminate their pregnancy through the fear of bad karma.

The participant narratives of experiencing violence can be understood as inequality in gender power relations that is rooted in a patriarchal ideology. This is ever-present in the Thai social system in which male domination is the main feature. In traditional Thai belief systems, the male is referred to as 'the front leg of the elephant'. This means that the male is the head or the leader of the family (Chirawatkul et al., 2012; Tangmunkongvorakul, Kane, & Wellings, 2005). The authority for decision-

making in the household is held by the male and takes precedence over other family members. They must act in accordance with his decisions. Furthermore, the male has the right to exercise authority over other family members using whatever means he chooses (Andajani-Sutjahjo, Chirawatkul, & Saito, 2015). While this belief is historic and explained through fable, it retains relevance for the contemporary family. Thai social conventions also position the male partner as superior to the female partner without consideration of basic human rights. Male partners have the right to exercise control of the behaviours of their family members and to punish them without limitation (Archawanitkul & Im-am, 2003). In the family unit, females are expected to remain as 'the hind leg of the elephant' (Chirawatkul et al., 2012), always following the male leader of the family. A female partner's role in the family is to respect her husband, devote herself to him, and to make sacrifices for her family (Xu et al., 2011). This results in female partners enacting and maintaining a subordinate status. Following this social construct, the Thai cultural system gives advantages to male partners, actively supporting them to rightfully use violence to control the female partner, and in the case of this study, the adolescent participants. The male partners regulated the adolescent participants' emotional availability and influenced decision-making around remaining pregnant. The adolescent participants, as young women, were attributed a lower status within the patriarchy and were thus provided with less opportunity in decision-making and control. Feminists have argued that domestic violence and other forms of violence against women, such as homicide, rape, and sexual assault, are a consequence of the patriarchal structure; hence, violence maintains male power and privilege in relationships (Hunnicutt, 2009).

In this study, the findings revealed that gender inequity, based on violence, was closely connected to other forms of inequality such as financial dependency. Pregnancy was associated with increased financial pressures and increased adolescent participants' financial dependency on their partners. For example, Kung had to stop working after becoming pregnant and lost her income to support herself; hence, she depended on financial support from her partner. When the participants could no longer engage in paid work, their partners were able to take on another form of relational control through restricting their access to money. For example, Klang had only limited skills and experience to lead to gainful employment; hence, she depended on financial support from her partner. The influence of financial hardship within her family led to her partner forcing her to work at a construction site where she experienced poor working conditions. This left her in the position of having to choose between having finances and negatively affecting the wellbeing of herself and her baby or being healthy and having no money.

The combination of both intimate partner and financial control suggested that the majority of the adolescent participants were subject to systematic conditioning resulting in oppression that created the structure of gender inequity. Hunnicutt (2009) has argued that systematic conditioning is an inherent way in which patriarchal societies perpetuate hierarchies of gender inequity, because patriarchal systems are tied to other systems of domination; hence, this concept is positioned within

fields of hierarchy in which males dominate females. Gender inequity in teenage populations with high levels of intimate partner violence has been reported in many studies where violence is reported to stem from the male's need to enforce power in his relationship (Bochow, 2012; Bornstein, 2006; DePadilla, Windle, Wingood, Cooper, & DiClemente, 2011; Deuba, Mainali, Alvesson, & Karki, 2016; Miller et al., 2010; Silverman et al., 2011; Varga, 2003). These studies have shown that teenage women are exposed to male partner violence by forbidding them from using contraception (DePadilla et al., 2011; Miller et al., 2010; Silverman et al., 2011), being sexually active and aggressive (Varga, 2003), appealing to them to get pregnant to prove their love (Bochow, 2012), and becoming dependent on their male partners for economic support (Bornstein, 2006; Deuba et al., 2016). The violence and domination experienced by the participants and exerted by their male partners is directly related to Thai sociocultural constructs based on unequal relations of power that exist to maintain the dominant stance that males hold in a patriarchal society.

The adolescent participants' agency was constrained by the social and structural dimensions of their lives, especially the overarching structure of patriarchy. These social and structural dimensions limited the agentic behaviours of the girls because it compelled them to adopt their partners' desires rather than to fulfil their own. Such situations were fraught with power imbalances between the adolescent participants and their partners, resulting in the adolescent participants feeling constrained in their ability to resist violent situations and seek assistance. The violence also hindered their ability to freely make decisions about becoming and staying pregnant. Some of the participants (Kit and Pha) demonstrated an ability to make their own decisions about remaining pregnant despite encountering significant pressures. For example, Kit insisted that she should continue with her pregnancy, even though her partner was trying to force her to have an abortion. She argued with him stating, *"My baby is a human, it isn't a dog, and why do you force me to have an abortion?' I admit to my mistake, but I don't want to destroy one life"*. While this resistance to the socially-constructed gendered hierarchy was unusual in the Thai context, Kit used another social construction, that of religious morality, to formulate her arguments stating, *"I don't want to destroy one life".* Thai people are predominantly Buddhist. A core Buddhist belief is that taking a life in the form of an abortion goes against the doctrine of Buddhist values and, as it constitutes murder, is prohibited. Furthermore, in Buddhist values, abortion reflects unkindness in the mind, through wishing to harm or torture a fellow human.

From this example, those adolescent participants who had strong religious and moral beliefs were able to counter the traditional gendered authority by using traditional religious constructs that enhanced their agency to make reproductive decisions. This is an interesting tension, for while the Buddhist doctrine requires a female to be subservient to her male partner, which enables him the right of control over his wife, it conversely teaches against harming a fellow human. Buddhism supports the patriarchal society that influences the relationship between men and women and many of the practices portrayed as part of the religion which impinge upon the notion of monogamy with

its attendant female subordination and domestication (Attoh, 2017). However, the essence of spirituality can be argued to act with kindness and for men to support women, but it is often men's interpretations that bring harm to women. Learman (2005) supported this idea by illustrating that on the part of males in Taiwan, domestic violence was legitimate and common in taking care of their families, despite the fact that in Buddhism, violence is prohibited and viewed as wrong.

Stigma as an act of gender inequity

The adolescent participants involved in this study experienced stigma at school, in their local community, and in the health care services they attended. Girls who became pregnant out of marriage also reported being judged and treated differently to their partners. Within the school context, most of the adolescent participants found it challenging to stay in the Thai traditional school setting due to the stigma perpetrated by their school contacts. Tik and Nam were even excluded from school. The adolescent participants felt strongly that the staff did not want to see their pregnancy and were thus embarrassed to be identified as pregnant. Two of the adolescent participants who remained at school were treated differently from the other students; therefore, they attempted to conceal their pregnancy by wearing loose jackets to cover their 'tummies' to prevent ridicule. Some school contacts responded negatively to the adolescents who were pregnant, particularly criticising the young women for becoming pregnant and prohibiting them from continuing their study. This was a very different experience for their partners, who were able to continue studying, were not criticised, and did not face any barriers.

As with intimate partner violence, the stigma experienced by the adolescent participants was also related to gender inequity within the Thai social structure. Feminists have argued that the social structure devalues females as being inferior as a result of operant patriarchy (Wendt & Zannettino, 2015). This structure operates within Thai society at the social, political, and religious levels. It supports male supremacy in terms of both educational opportunity and sexuality. In term of education, gendered stereotypes in Thailand have historically been based on religious instruction from Buddhist monks to young boys demonstrating their potential (Kuasirikun, 2011). Access to education has always been a male privilege (Sa-ngiamsak, 2016; Sultana, 2010) which has never been availed to young women in the same way. Compounded by family perceptions that sons would benefit more than daughters from education, Thai society has historically given greater educational opportunities to male children (Kuasirikun, 2011). Similarly, in Bangladeshi culture, sons have been provided with greater educational support. As a result, the son maintains the lineage for the ownership of family property and as holders of the family name (Sultana, 2010).

In terms of sexual proclivity, the Thai social structure privileges male sexual freedom, actively empowering them to have intercourse with multiple partners without criticism, whereas for females to be valued by society, they must guard their virginity for their (future or current) husband and avoid lustfulness (Ounjit, 2011; Tantiwiramanond, 2007). This practice remains evident in the current study

as the majority of girls who became pregnant while at school were denied attendance. This act of denial represents society's response to them behaving against gender norms. Where they were allowed to stay in school, they hid their pregnancy with baggy clothes to protect themselves from negative public responses. In a double act through access to education, the patriarchal nature of society at once enabled the progression of males who were becoming fathers and blocked the social progression of girls who were becoming mothers. Gender inequity in the schooling of girls who became pregnant has long been reported in previous studies (Chigona & Chetty, 2008; Mensch, Clark, Lloyd, & Erulkar, 2001; Moore, 2003). These studies indicate that pregnant schoolgirls are discouraged from remaining in school, whereas boys are provided with ongoing support (Mensch et al., 2001). Girls are ridiculed, put down, and not welcomed (Chigona & Chetty, 2008), and are labelled as a 'stupid slut', a 'welfare mom', and a 'neglectful mother' by other students and sometimes by teachers (Moore, 2003). This demonstrates that pregnant adolescents experience the stigma of social oppression in many societies with patriarchal social structures. In addition, a number of previous studies have confirmed that pregnant adolescents are unable to attend schools in a range of countries as a result of being stigmatised by their school contacts, including in Malawi, the USA, and Nairobi (Levandowski et al., 2012; Mumah, Kabiru, Izugbara, & Mukiira, 2014; Wiemann, Rickert, Berenson, & Volk, 2005).

In this study, gender inequity limited the ability of the adolescent participants to attend and achieve success at school, unlike their partners. Even though constrained by social structures, can we claim that these adolescents exercised their agency by choosing not to attend school and thus avoiding ridicule? Did they exercise agency by hiding their pregnancy and staying in school? If the end result was that they were not educated, perhaps despite their attempts to exercise their agency, they were indeed thwarted by the social structures. It follows that into the future, they will only be able to develop agentic behaviours if the structure of society changes. Leaving school became a defensive act against experiencing stigma, but it also limited their social and economic futures by cutting short their access to education. Hence, these small agentic acts to protect themselves in the short-term had a negative impact on the girls' capacity to act agentically in the future.

Girls who became pregnant out of marriage reported being judged differently to their partners by people in the community. The pregnant participants experienced stigma from people who judged and blamed them, gossiped about them, and looked down on them. The adolescent participants were judged as 'Keaw', 'Sading', and 'Dek jai teak' by people in their communities. Each term holds a specific meaning in the Thai language. The word 'Keaw' refers to a girl who has uncontrolled sexual desires, 'Sading' refers to a slut, and 'Dek jai teak' refers to a girl who has indulged in the wrong things. All these terms were characterised in terms of being a 'bad girl' based on the Thai traditional value of women maintaining their virginity before marriage. The adolescent participants avoided being stigmatised by not meeting people in their villages, lying about their pregnancy, and refusing to answer any questions about their pregnancy. Three sets of participants' parents supported them

by organising a wedding ceremony. In this way, they were able to gain acceptance from other people in their communities. An ideology that values virginity and prohibits sexual activity for girls is the hallmark of a patriarchal society (Tong, 2007; Wendt & Zannettino, 2015).

The girls in this study who became pregnant were judged differently to their partners because their sexual behaviours were regarded as being 'out of control'. The girls who became pregnant out of marriage were further subordinated by society through the marriage ceremony. This is because marriage requires the partners' families to pay a 'bride-price' to the family of the girl. This is conceptualised as paying respect to the girl and her family, maintaining status, and receiving acknowledgement within society. As the amount of the bride price payment is unclear in Thai society, this often depends on negotiations between the two involved families based on their economic status. In a patriarchal society, not receiving a bride price payment or having a wedding ceremony result in the pregnant adolescent being considered as tarnished. The male partner, in contrast, holds a superior gendered status, particularly in relation to their sexual freedoms. They were not required to be responsible for controlling their sexual urges whereas the girls were. Due to the imbalance in the gender power relations inherent in broader Thai society, women were doubly constrained. They were pressured at once by society to be restrained sexually and to fulfill their Madonna status, and yet they were also pressured by their partners who held power in the relationship, to give them pleasure them as a whore. Despite the Madonna-whore dichotomy being a western construct, it has relevance in the case of Thailand because it reinforces the fact that women face gender inequity which restricts their sexual expression. The Madonna-whore dichotomy engages culturally-prescribed scripts and explains that women are not able to be actively sexual in the way that men are. The importance of male preference is through acting as a sexual gatekeeper by restricting sexual activities (Frith, 2009) and limiting women's ability to deny unwanted sex (Frith & Kitzinger, 2001). The Madonna-whore dichotomy contributes to the maintenance of the image of mothers and wives. The negative impacts of sexual reputation contributed to counter much of the shame about sexual desire experienced by women. Shame about sexual desire limits sexual agency in women (Tolman, 2009). Therefore, the Madonna-whore dichotomy alleviates the perception of threat in men when they limit sexual agency in women (Bareket, Kahalon, Shnabel, & Glick, 2018). A patriarchal society does not require male partners to control their urges and blames women if they cannot do so. It also provides males with the power to reject the legitimisation of women's status to Madonna through the social legitimacy of the wedding and giving a bride price. In so doing, they remain in the realm of the whore. This reinforces women's subordinate position enabling the perpetuation of the social stigma experienced by women.

Previous studies in Thailand and other countries have shown that girls are labelled, stigmatised, and often blamed for sexual intercourse resulting in pregnancy compared with boys (Awopetu, Ihuoma, & Temitope, 2013; Jackson & Cram, 2003; Kaljee, Green, Riel, Lerdboon, & Minh, 2007; Mensch et al., 2001; Sridawruang et al., 2010; Varga, 2003; Yardley, 2008). For example, in Africa, gender bias

was also demonstrated when girls who had multiple sexual partners were condemned as ‘bad’, ‘promiscuous’, ‘irresponsible’, ‘misbehaving’, and ‘loose woman and whore’. Also, girls who were pregnant outside of marriage would be blamed and criticised, while boys were only slightly rebuked in society (Awopetu et al., 2013). Similarly, in conforming to traditional Thai normative values, girls who had sexual relationships were portrayed as loose, but boys who had many girlfriends were praised as normal (Sridawruang et al., 2010). The perpetuation of the stigma could be argued to be a tool through which society reinforces gender inequity and the superiority of males over females. In this study, it effectively acted to restrict the adolescent participants’ capacity to continue schooling, confront challenging circumstances, and access social activities. The adolescent participants avoided interacting with people in their communities and would often move to live with relatives in another village. Alternatively, the findings illustrated that three of the adolescent participants who were well supported by their mothers were able to collectively resist these cultural norms. The girls’ mothers resisted the patriarchal norms and advocated for their daughters by going ahead and organising a wedding ceremony, a role usually reserved for the male’s family. Arranging a wedding for the girls who became pregnant also assisted them and their families to maintain their status within society (Levandowski et al., 2012; Neamsakul, 2008). Many of these women cannot step out of the ‘whore identity’ and perhaps this is why the mothers facilitated the transition to ’Madonna’. Nevertheless, while they supported their daughters to legitimate their relationships to reduce stigma, they also reinforced the patriarchal social structures. This raises the question of what alternatives there are for adolescent women to act agentically, and returns the argument to the point that unless the social structure changes, these adolescents are locked into their positions without agency.

A further act of constraint was reported by the adolescent participants when they tried to access care in the health services. Health care providers treated the pregnant adolescents differently from older pregnant women. They treated them as children, always using the word ‘daughter’ during their conversations. In addition, the older pregnant women judged girls who had become pregnant as ‘bad girls’, complaining that they were too young to have a baby and to know how to raise children. Here, the patriarchal norms were maintained when the unmarried adolescent participants were infantilised by the health providers and by married pregnant women who were older than them.

Patriarchy in Thai society was reflected in unequal power relations between the participants and the health care providers, that placed the health care providers above the participants in the health care setting (Keating & Fleming, 2009). The health care providers and the older pregnant women appeared to have greater authority than the adolescent participants in this setting. Hierarchal authority seemed to form naturally in the health care setting following a line of ranking based on age and professional status (Muntarbhorn, Jamnarnvej, & Boonlue, 1990). In this way, even female health professionals and older women outranked adolescent females due firstly to their professional status, followed by their age. In the Thai sociocultural context, the older married women were also positioned as superior due to the legitimacy of their pregnancies. Although the health care providers

were working as professionals and appeared to attempt to avoid showing bias towards the adolescent participants, they did not seem to be aware of their inherent authority and how it affected the care received by the participants. For example, despite the health care professionals appearing kind and supportive, the adolescent participants, such as Sand, identified that they were too afraid to ask questions for fear of being judged. This prevented the adolescent participants from getting the help they needed from the health care professionals because they feared being judged and blamed for their lack of knowledge, thus reaffirming the prevailing view that they were not worthy of becoming mothers. In this way, the gender scripts associated with being a pregnant adolescent in Thailand were inadvertently reinforced by the health care providers despite their seemingly professional approach. Previous studies have also found aspects of gender inequity in the health care setting (Tangmunkongvorakul et al., 2005; Wood & Jewkes, 2006). Tangmunkongvorakul et al (2005) found that young Thai women faced threatening and judgmental attitudes, indifferent counselling, and violation of their confidentiality. Wood and Jewkes (2006) found that in South Africa, young pregnant women were ostracised and felt confronted and unwilling to give information about their use of contraception. These types of treatment of pregnant adolescents in the health care setting reinforced the patriarchal gender mores present in greater Thai society.

In conclusion, the narratives of these pregnant adolescents contain strong culturally-embedded stories of a patriarchal social system that reinforces gender inequity. Patriarchy is a social structure in which males dominate and oppress females. This system supports male partners to 'rightfully' use violence to regulate emotional availability, influence decision-making around remaining pregnant, and control economic matters for pregnant adolescents. It also privileges male partners' sexual freedom, actively empowering them to have intercourse with multiple female partners without criticism, whereas pregnant adolescents are devalued and labelled as inferior in school, the community, and in the health care setting which leads to their stigmatisation. The perpetuation of violence and stigma could be argued to be a tool through which society reinforces gender inequity and the superiority of males over female. Due to gender inequity in a patriarchal society, pregnant adolescents are doubly constrained. They are pressured at once by society to be sexually restrained and to fulfill their Madonna status, and yet at the same time, they are pressured by their partners who hold power in the relationship, to please them as a whore. Hence, the agency of pregnant adolescents is constrained by the social and structural dimensions of their lives. This effectively acts to restrict pregnant adolescents' capacity to exercise their agency to freely make important decisions about their pregnancy, to seek help for the abuse they are experiencing, to access education, to defend themselves against the experience of stigma, and to access health care services and health knowledge. Alternatively, strong religious and moral beliefs and the support of their mothers are the main forms of resistance to the patriarchy, thus enhancing their opportunities to work, which in turn enables their agency.

Fear

In this study, the girls who became pregnant faced many challenges in their lives with a core construct of fear permeating their experiences. The adolescent participants reported that they were fearful in many ways, including the fear that they would be abused, and that they would be stigmatised by people in and around their communities. They were also fearful that their families would not support them and their new babies emotionally and financially, and that they would have an unhealthy unborn baby. A feminist perspective was used as a lens to understand how pregnant adolescents lived with fear in the context of a patriarchal social system and how they exercised agency in the context of oppression.

Of particular interest in this analysis was the finding that the adolescent participants were afraid that they would be abused by family members; see for example Pha, Kit, and Klang. Many did experience violence within the family, particularly emotional violence, physical violence, and reproductive coercion; for example Pha, Kit, Klang, and Noi. Emotional abuse was far more frequently experienced than other forms of violence, and all such incidents were reported to have been perpetrated by parents and partners in the private sphere. From these narratives, feminist theory suggests that the creation of fear in a context of domestic violence allows the perpetrator to have greater control over their victims, as the victim fears what will happen to them if they do not conform to the perpetrator's wishes (Wendt & Zannettino, 2015). The fear generated through violence from the family appeared to be related to power imbalances between family members and the adolescent participants within the hierarchical structure that was used to maintain the patriarchal norms. Kern argued that fear is a tool used to maintain power imbalances in a patriarchal social system affording men and hierarchical superiors control to maintain female subordination (Kern, 2003). The adolescent participants' experience of fear in this study was a direct result of power being exerted by those superior to them in order to control their behaviours.

Relations of power are interwoven with other types of relations such as family, kinship, and sexuality (Tong, 2009). In the Thai family structure, parents, particularly fathers, are considered to hold superior status. They hold legitimate authority over their children in relation to matters of religion, traditional cultural values and beliefs, and morality. Children are taught to honour and obey their parents without hesitation or question, and to submit to their authority (Kuwinpant, 2002). In addition, male heads of the family hold superior status to their female partners; hence, they also hold legitimate authority to control the behaviours of their wives (Archawanitkul & Im-am, 2003). With this hierarchy of status within the family, a normative imbalance of power relations exists and is supported culturally. What is unclear, is the legitimacy of the use of fear in Thai culture to maintain this hierarchy.

In a Canadian study, Yodanis (2004) reported that violence, or the threat of violence, was used as a tool by parents and partners to keep adolescent participants subordinate, and thereby to maintain

power and control. Meyer and Post (2006) concurred, arguing that the use of violence to maintain power and control created and kept adolescents in fear. The current study has found that fear was linked to a perceived threat and the uncontrollability of violence in the private sphere. Parents and partners or partners tended to use the adolescent participants' fear to control their response to partner emotional availability and their decision-making around pregnancy. In addition, the adolescent participants continued to live with people who perpetrated violence against them. They did not believe that they had the capacity to escape, nor could they resist an attack of violence. This was because they depended on support from their parents and partners due to their complex life experiences and financial hardship. A perception of vulnerability based on feeling unable to escape violence has been reported to result in women becoming more fearful (Killias & Clerici, 2000; Meyer & Post, 2006). Meyer and Post (2006) argued that while females continue to live in a patriarchal society, this fear will not end any time soon. With patriarchy so strongly embedded within Thai social, religious, and cultural norms, it is difficult to see spaces of resistance for adolescent women who become pregnant.

These experiences of fear had a negative impact on the pregnant adolescents' agency. In recognising the constraints on their agency, some of them kept silent and did not argue with family members. None of the participants reported the violence to other family members or the authorities. Some of them avoided abuse by concealing their pregnancy. They also reported experiences of helplessness, hurt, and worthlessness following the violence. These actions and feelings indicate how fear limited their ability to exert agency in facing violent situations and in seeking help from others. Similarly, a study by Sussex and Corcoran (2005) found that avoidance due to fear or a feeling of threat had been reported as strategies by teen mothers who faced violence. In a more recent study in Ghana, pregnant adolescents identified that they did not reveal their pregnancy to their mothers as they feared that their mothers would shout at them and beat them (Aziato et al., 2016).

The adolescent participants also expressed a pervading fear of being stigmatised by people in and around their communities. The concept of stigma was introduced by sociologist Erving Goffman (2009) whose work suggested that stigma is defined as an attribute of disgrace which is socially constructed. In Goffman's view, stigma occurs as the difference between virtual identity and actual identity. The concept of gender-based stigma labels the individual with 'undesirable characteristics that justified and supported gender norms and stereotypes' (Yang et al., 2007). Traditionally, patriarchal society has expected women's sexuality to encompass virtue and obedience (Nelson & Paek, 2005). However, women who deviate from these social norms are stigmatised, stereotyped, and subjected to labelling and criticism (East, Jackson, O'Brien, & Peters, 2012). This is because girls who become pregnant do not meet the traditional idea of remaining virtuous until their wedding day. They are labelled and criticised which tarnishes a woman's character, and this process exists to uphold male sexual dominance by oppressing and sanctioning women through their sexuality. In

this study, these types of labels assigned to the adolescent participants were entrenched within society and were the reason why they felt that becoming pregnant had tarnished their character. Therefore, the patriarchal ideology of being a 'good lady' promotes a form of stigma that constricts sexuality in female adolescents. Thus, girls who become pregnant, and their subsequent pregnancy decisions, are strongly influenced by their attempts to avoid social stigma for themselves and their families.

The adolescent participants in this study reported that they feared being labelled and looked down upon as a 'bad girl' and gossiped about. The suffering they described resulted from their fear of failing to meet the culturally entrenched ideals of female sexual honour. They also reported that they feared for both themselves and their parents being stigmatised by people in their community. This was clear in the following comment by Top: *I was afraid of people gossiped me on my pregnancy and I was afraid they added something that was not true about my affair.* Fear was also linked with the adolescent participants' perceptions that they were labelled and looked down upon because of their pregnancy. Wiemann et al. (2005) supported the idea that stigma or worry about what others might think for some adolescents may actually result in fear. Previous studies among pregnant adolescents confirmed that those who experienced stigma also reported this as a feeling of fear (Crandall, 2013; Ellison, 2003; Wiemann et al., 2005; Yardley, 2008). Fear of stigma could be argued to have prompted agentic resistance by some of the adolescent participants in this study. The strategies employed included mainly protecting themselves and avoidance. Protective strategies included speaking out aggressively when they were being criticised. Many young women told stories of attempting to minimise their exposure to stigma by avoiding places where they had encountered stigma, especially in the community and at school. Previous studies have also shown that some pregnant adolescents avoided stigmatising situations by separating themselves from others, leaving school early (Malahlela, 2012), and moving to live in another place (Sridawruang et al., 2010). In studies undertaken in the UK and the USA, pregnant adolescents resisted stigma by ignoring it (Yardley, 2008), rejecting the 'teen mom' stereotype and re-positioning themselves as a 'good mom' (Fessler, 2008), and describing how mothering strengthened their aspirations and improved their lives (Brubaker, 2007; Warnes & Daiches, 2011). As with management of the stigma experienced in the school setting, we question if avoidance and speaking aggressively are constructive acts of agency. Being forced to avoid social situations can lead to social isolation, which is not healthy for either the adolescent or their unborn baby. Furthermore, while being aggressive may result in an immediate feeling of reducing stigma, it may not have positive long-term social or psychological effects for both the mother and the baby.

The adolescent participants reported feeling fearful that their families would not financially support them and their new babies. They faced current and future financial hardship because of their low education level, the minimum age for employment, and a gendered work environment that impeded their ability to find and keep paid work. Without a source of income, the adolescent participants were

impoverished and thrown back into the traditional status of financial dependence on their parents and partners. It was difficult for those adolescent participants without financial independence to sustain themselves, and this experience fueled their fear for their future. Their fear that their families would not financially support them relates to two main mechanisms of action to maintain unequal power relations in a patriarchal society. Firstly, the model of the male breadwinner reinforces the role of men being responsible for the economic survival of the family through employment, while the female is responsible for the home and care of the family (Lewis & Giullari, 2005; Nadim, 2016). Within the households of these adolescent participants, parents, partners, or partners were always perceived as the primary breadwinners, and therefore, as the primary sources of income for the family. The adolescent participants had a low capacity for earning money, which was further reduced by their status as pregnant women. See for example Top, Kung, and Nok who were told they were not suitable for employment because of their pregnancy. As such, their dependence on financial support from their parents or partners increased. Secondly, the patriarchal system provides parents and male partners with more authority to control resources within the household (Archawanitkul & Im-am, 2003; Kuwinpant, 2002). Furthermore, the parents in this study expressed their concerns that pregnancy brings additional financial burden to the family, straining their economic situation. This can be seen in a comment by Kit's mother: … *I give money for her 100 Baht per week. If I don't have enough money, I provide foods and keep them in the fridge for her. I don't earn money for medical treatment during delivery.* Not only did this negate the adolescents' agency, but also the burden they felt due to the additional financial pressure on their parents which, in turn, reinforced their sense of wrong-doing and shame. Both mechanisms of action demonstrate financial dependence as a form of reinforcement of the systemic power imbalances of patriarchy that resulted in the financial vulnerability of the adolescent participants. Ultimately, such economic vulnerability results in feelings of fear.

Some of the participants however did not identify fear for their current or future financial situation. For example, Tim did not at any stage mention her financial situation. This may be because she felt secure living with her partner in her family situation. As an adolescent still living with her family of origin, she may have assumed that financial support was a normal part of being parented and did not see it as something out of the ordinary. As such, she did not need to mention that they were receiving support from their family. For some of the participants, such as Nam, the fear that their families would not financially support them and their new babies appeared to prompt agentic behaviours. They sought out resources to support themselves and their baby into the future by seeking paid work and overtly asking for financial support from their parents. This indicates that in this situation, as Maxwell and Aggleton (2010) indicated, agentive action can be applied to regain power. In this way, the fear of financial instability can both impede and enable adolescent capacity to seek support.

The experience of fear was also described in relation to the health of the participants' unborn babies. The adolescent participants reported that this fear mostly related to their decisions around whether to follow the health behaviours directed by the health services, and/or to follow traditional cultural and religious practices. In this study, the tensions between adopting traditional practices and/or western medical practices was a critical consideration. Some of the adolescent participants practiced health behaviours based on traditional practices, believing that this would ensure the wellbeing of their unborn baby. For example, Top said: *I'm frustrated that they don't allow me to do many things such as sewing clothes and killing the fish. So, I have to follow them.* While they were all exposed to western medical practices through attending the antenatal clinic, and appreciated the broader scientific basis of this information, the long-standing cultural fears of not practicing what their mothers and grandmothers taught were more constantly present, and therefore, more acutely felt. It could be argued that the patriarchal hierarchy shaped both of these positions of fear; in the medical field through a fear of feeling shamed by not doing the 'right' thing and thus feeling too subordinate to ask questions, and in the family domain through the hierarchy of family member status whereby the opinions of mothers and grandmothers must be obeyed. Interestingly, those who ardently adopted traditional practices, such as Tik placing a needle on her clothing to ward off bad spirits, and Noi praying with Buddha in front of the Buddha shrine, reported that in doing so, they improved their ability to control their fear of the unexpected, and gained reassurance that they were doing everything to keep their babies well. It could be argued that these traditional discourses interfered with the adolescent participants' choices in relation to the adoption of western scientific health practices. The professionals in the antenatal clinic predominantly viewed these practices as 'irrational' and unscientific. However, given the reassurance these practices afforded the adolescent participants, this raises the question of how health service personnel might incorporate them into their practices and thus open a door for increased engagement with adolescents in their care. Such an approach would also increase trust with the parents, aunties, and grandparents who were the main support for the pregnant adolescents.

In conclusion, the adolescent participants reported being in fear of family violence, of not being supported by their family, of social stigma, and of having an unhealthy unborn baby. The findings reveal that fear in the adolescent participants relates to the power imbalance within the social structure which maintains patriarchy. The patriarchal social system supports the authority to perpetrate violence and allows male family members to maintain power and control resources within the household. Patriarchal society also creates expectations that women's sexuality encompasses virtuous behaviour. This promotes a form of stigma that results in pregnant adolescents having a fear of failing to meet the culturally entrenched ideals of female sexual honour. In addition, the patriarchal hierarchy shapes fear and uncertainty around following health service-directed health behaviours and/or following traditional cultural and religious practices. These fears reflect the main mechanisms of action to reinforce the systemic power imbalances of patriarchy that result in fear.

These experiences of fear both impede and enable pregnant adolescents' agency. Fear limits their ability to exert their agency in facing violent situations, seeking support from others, and interfering with their choices in relation to the adoption of western scientific health practices, whereas protecting themselves and avoidance are strategies to minimise the fear of exposure to stigma. In addition, the fear of financial instability leads to pregnant adolescents seeking support.

Spirituality

The pregnant adolescents identified a spiritual aspect to their lives in the sense of seeking meaning and social connection for themselves and their unborn babies. In the context of oppression and gender inequity, a feminist lens, particularly a radical feminist approach, was seen as suitable in understanding how spirituality, particularly religion and traditional practices, influenced the agentic behaviours of these pregnant adolescents. The following section describes the influence of religion and traditional practices on pregnant adolescents' agency.

Religion

In this study, the pregnant adolescents relied on religious beliefs to help them face difficulties in their lives. They practiced religious beliefs in many ways, particularly praying with Buddha, meditating, and making merit for generating strength in their lives. In addition, 15 of the adolescent participants reported that they believe in karma. In Buddhism, gaining 'good karma' means to make merit and to follow ceremonial practices, traditional injunctions, Buddhist teachings and customary law, whereas a person who sins will gain 'bad karma'. Achieving good karma was the reason for people gaining happiness, good health, and prosperity in their present life and in their future incarnation (Foley, 2005). This influenced the adolescent participants to act in ways that might build good karma, and thus wellbeing for themselves and their baby. They specifically offered food to the monks and resisted abortion. In Thailand, Buddhism is the primary religion that shapes cultural beliefs (Skirbekk et al., 2015). All the adolescent participants in this study lived in the small villages where people had strong religious and cultural beliefs. The temple and Buddhism are the centre of life for most villagers, and they gather at the temple for religious activities and making merit; for example, the villagers prepare foods and take them as offerings for the monks in the temple every morning, while the monks lead the villagers to pray. Not only can the villagers make merit in the temple, they can also pray with the Buddha statue in their home to make merit. Thus, most families have a Buddha shrine in their family home for chanting or praying in front of. The Buddha statue gives one a sense of inner satisfaction which, in turn, gives peace to the mind, heart, and soul. Many feminists regard religion as perpetuating the patriarchal ideology as it legitimises female subordination (Attoh, 2017). This can certainly be claimed of the patriarchy seen in Buddhist doctrine where the female is positioned as inferior to the male and female sexuality is negatively valued (Sa-ngiamsak, 2016). In this study, spirituality and religious practices are viewed as both constraining and enabling the agency of pregnant adolescents.

Although structurally, religion oppressed the adolescent participants positioning them as inferior to their partners in relation to sexuality, and to family members in terms of age and gender, they drew solace from the Buddha doctrines to manage and resist patriarchy. By enacting their religious beliefs through prayer, meditation, and the making of offerings, they created feelings of empowerment and capability. In particular, by praying with Buddha and meditating, they developed strong internal coping resources that they identified as helping them to adjust in times of difficulty. For example, Klang said *I get uneasy feelings and thoughts when I argue with mom and my partner about my pregnancy. So, praying and meditating with this book help to reduce my stress and calm my mind.* They attached importance to Buddhist doctrine when they did not have direct control over their own difficulties or the agency to regulate their own behaviours. This was because of the belief that they could look to Buddha, who holds ultimate power to control others, for support. This communication with Buddha provided opportunities for reflection through which the adolescents could solve problems and build up their emotional and psychological reserves for use during troubling times. Murray and Ali (2017) argued that emotion-focused coping through religious practices provides strategies that help ethnic and gendered minority groups. Applied to the pregnant adolescent women in this study, by looking to Buddha for support, they are sustained in their day-to-day lives and are provided with a guide to daily action. Seeking God's [Buddha's] support is argued as an active and latent form of coping after a stressful event (Murray & Ali, 2017).

The pregnant adolescent participants also believed that by following religious practices, Buddha could guide their actions into their future lives. Those who were optimistic about gaining happiness, good health, and prosperity in their present lives and for future incarnations chose to follow religious rituals to increase their chances of achieving these outcomes. Again, activities to achieve this included making merit and praying with Buddha. For example, in trying to ensure a healthy baby, some participants did 'Tak Bat'. This is a religious ritual involving putting food into the monks' bowls to fulfill their expectations. This could be interpreted as religion providing a medium for developing forethought and providing pregnant adolescents with direction and meaning in their lives (Koenig, Koenig, King, & Carson, 2012).

Another consideration is that strong religious beliefs, particularly karma, shaped the adolescent participants' decision-making in resisting their partners' attempts to force them to have an abortion. Religious beliefs underpinned acceptance of the participants' pregnancy and provided a rationale for taking comfort in believing that keeping the baby was the right thing to do. Abortion was considered to be a life-destroying act that represented a serious case of negative Buddhist karma (Whittaker, 2002). Furthermore, such an act holds a ruinous karmic affect for the self and others (Srikanthan & Reid, 2008). In addition, keeping their baby reinforced the participants' belief that they acted agentically in order to gain good karma. Achieving good karma, which is necessary to achieve enlightenment, carries much weight in Thai society (Kelley, 2015). Previous studies have similarly

found that religious beliefs appear to influence adolescents' decisions about abortion (Fengxue et al., 2003; Netmuy, 2014; Nithitantiwat, 2013; Sa-ngiamsak, 2016).

On the one hand, the adolescent participants in this study suggested that they were able to, and did, make choices through the use of religious constructs as a form of collective agency to enhance their ability to make decisions about their pregnancy and to manage and confront the difficulties in their lives. They also used religion to improve their ability to prepare for their future lives. In this way, the adolescent participants relied on religion to enable agency. Alternatively, viewed as controlling pressures, religious beliefs also maintain the gender imbalance in society in a highly structured way. The net result for the pregnant adolescents in this study was that many could not go to school to be educated, which resulted in a reduced capacity to care for themselves and their children into the future. Drawing from the western literature, this also leads to reduced overall outcomes for their child (Lall, 2007; Rosenberg et al., 2015). Furthermore, this means that as young women, they are subject to family and social stigma and remain reliant on male financial providers in their realm. In this way, the cycle of patriarchy is maintained.

Traditional practices

The adolescent participants engaged in a range of traditional practices to prevent health problems for themselves and their unborn babies. They reported that they learned about such practices by watching family members and their peers. In this way, practices were upheld intergenerationally. The majority of traditional practices undertaken during pregnancy were related to 'Kalum behaviours'. 'Kalum' is a taboo discourse from the Southeast region of Thailand. It is the formative order of Isan people. Kalum was developed from religion and live experiences from Isan people. It relates to strategic local wisdom, including holy objects or practices that defend people from making wrong decisions and which create wellbeing and a more harmonious society (Pimpa, 2012). For instance, clasping a safety pin onto one's clothing is believed to prevent bad spirits from harming a baby in the womb, while prohibiting the use of a needle for sewing is believed to prevent a difficult delivery. There are also many kalum beliefs around foods believed to be unhealthy during pregnancy. The majority of the adolescent participants in this study believed in and practiced Kalum behaviours. They believed that in doing so, they would prevent a range of health problems. As such, this enhanced their sense of being able to control their world. Some of the adolescent participants were conflicted about following the traditional practices when their family members attempted to force them to do so. For example, Top felt conflicted when her mother did not allow her to do many things, such as sewing clothes and killing the fish. However, she felt compelled to follow the traditional practices for fear that if she did not, there would be negative consequences for her and her baby. Eventually, she followed her mother's suggestions.

The adolescent participants reported that they were controlled in following traditional practices by older members of their families. These traditional practices reflected the values and beliefs held by

members of society across a number of generations. The influence of grandmothers and mothers in Thai society is hard to ignore. Older people hold high status in the hierarchy of the Thai family which means that they hold greater authority than other family members (Muntarbhorn et al., 1990). In this study, the system privileged the beliefs and values of older people enabling them to pressure or control the adolescent participants to follow traditional practices.

The control associated with following the traditional beliefs of older family members shaped the adolescent participants' agency. They reported that some of the traditional practices constrained rather than assisted them. The participants struggled with the inner conflict produced by scientific reason in following traditional practices that limited their ability to control their own behaviours during pregnancy. Previous studies have also identified constraints through following traditional practices (Liamputtong et al., 2005; Maduforo, Nwosu, Ndiokwelu, & Obiakor-Okeke, 2013). For example, a study of pregnant Nigerian women found that some of them mentioned food superstitions through which their social norms prohibited a wide range of foods for women during pregnancy making it difficult for them to maintain a balanced diet (Maduforo et al., 2013).

Alternatively, some of the adolescent participants perceived that following traditional practices enhanced their ability to engage in behaviours to prevent health problems and to control their fear of unexpected situations. They employed a form of collective agency with other pregnant women by observing and successfully engaging in traditional practices and comparing their experiences with other pregnant women in similar situations. For example, one of the participants observed her sister clasping a safety pin onto her clothes when she was pregnant. Her sister did not have any complications during her pregnancy, so she believed that this practice would prevent any problems for her unborn baby. In addition, economic pressures influenced the adolescent participants' agency to go against following some of the traditional practices; for example, a precaution given to pregnant women to avoid the use of pins to prevent birthing difficulties. This was difficult for one adolescent participant whose work involved making garlands, because this job provided financial support for her family; therefore, she used financial hardship as a justification to resist this traditional practice.

Traditional practices both impeded and enabled agency in the adolescent participants in this study. The social structure, especially the hierarchal structure within the family, controlled the adolescent participants in following traditional practices that impeded their agency to choose their own practices and behaviours during pregnancy. Alternatively, other pregnant women's behaviours, and economic pressures were the factors that enabled agency for the adolescent participants.

Summary

In this study, gender inequity, fear, and spirituality were the main concepts synthesised from the four main themes of social stigma, support and support systems, cultural heritage, and self-care from the two findings chapters. A feminist lens was used to gain an understanding of gender inequity, fear,

and spirituality, and for the examination of the agentic behaviours of pregnant adolescents in the context of oppression by the dominant group. This study has found that the patriarchal social system of Thai society supports male authority and privilege and subordinate females in many ways. This system supports the rights of male partners to perpetrate violence on pregnant adolescents, and privileges the male partner in matters of sexuality without fear of labelling. Hence, violence and stigma are tools through which society reinforces gender inequity which, in turn, leads to the subordination of pregnant adolescents. This also impedes agentic behaviours in pregnant adolescents to make their own decisions about their pregnancy, and to face abusive situations, seek help from others, access education, defend themselves against the experience of stigma, and to access health care services and health knowledge. However, moral beliefs and the support of their mothers were used as forms of collective agency to resist the patriarchal norms of society.

In addition, the study found that power imbalances in the social structure are used to maintain patriarchy-related fear in pregnant adolescents. The system supports the authority of parents and partners to perpetrate violence, control resources within the household, support male supremacy in relation to sexuality, and to influence the following of traditional practices. These actions demonstrate the mechanism of power imbalances in patriarchal society that keeps pregnant adolescents in fear. However, fear both impedes and enables pregnant adolescents' agency. The experience of fear limits their ability to exert their agency in facing violent situations, seeking support from others, and in making choices in relation to the adoption of western scientific health practices. Alternatively, some pregnant adolescents are able to exert strategies to minimise their fear, particularly protection and avoidance strategies. In relation to spirituality, religious and traditional practices perpetuate the patriarchal ideology that legitimises the subordination of pregnant adolescents. However, many pregnant adolescents draw solace from the Buddhist doctrines, religious practices, and the law of karma to resist patriarchy in society. They employ religious constructs as a form of collective agency to enhance their ability to make decisions, to confront the difficulties in their lives, and to act in preparation for their future lives. In addition, they use the collective agency of other pregnant women, and economic pressures, to enhance their ability to engage in behaviours to prevent health problems, control their fear of unexpected situations, and to confront the control inherent in following traditional beliefs. Therefore, spiritual beliefs are able to maintain the gender imbalance in society in a highly structured way.

Chapter 7 Conclusion and recommendations

Introduction

Previously, Chapters, Four, Five, and Six discussed the experiences of the adolescent participants and their caregivers that shaped their agentic behaviours through four main themes, social stigma, support and support systems, cultural heritage, and self-care. These findings were subject to secondary analysis through a feminist theoretical lens, which resulted in the three inter-related concepts of gender inequity, fear, and spirituality as influencing the capacity of pregnant adolescents to act agentically. This chapter will show how this research contributes to new knowledge, will describe the implications of the findings for policy, nursing practice and education, and for future research, and will identify specific recommendations that stem from the findings and the new knowledge produced.

Summary of key findings

In Thailand, although the prevention of adolescent pregnancy is a policy priority of the Ministry of Public Health, the number of adolescents who become pregnant continues to increase. From 2003 to 2016, the rate of births for adolescent girls aged 10-19 years rose from 12.9 to 14.2 per cent respectively (Bureau of Reproductive Health, 2016). Adolescent pregnancy is associated with educational and financial disadvantage (Neamsakul, 2008; Sriyasak, 2016; UNFPA, 2013), and unfavourable health outcomes (Areemit et al., 2012; Nkansah-Amankra, 2018; Thaithae & Thato, 2011). The agency of pregnant adolescents has been identified as an important determinant in enabling them to have a sense of control over the course of their own lives (Ortner, 2006). This study has aimed to explore how pregnant adolescents exercise their agency and to explore the factors that shape their capacity to exercise agency. Ethnography was selected as the research method as it was viewed as the most appropriate approach to capture the fullness of the experiences of the pregnant adolescents in the study (Fetterman, 2010). The study was conducted in an antenatal clinic and in 15 villages in Mahasarakham Province, Thailand. Data was collected over a 6 month period from 15 pregnant adolescents and 15 caregivers. There were three stages of data collection; the first stage involved semi-structured interviews with the pregnant adolescents and their caregivers, the second stage involved participant-observation of both groups, and the third and final stage involved photo-elicited interviews with the pregnant adolescents.

A thematic approach was initially used to analyse the data. Four main themes emerged from the analysis that shaped the participants' agentic behaviours, social stigma, support and support systems, cultural heritage, and self-care. Using a feminist theoretical lens for a secondary analysis enabled a deeper understanding of the participants' connections with the broader social and environmental context. This approach shed light on how agency was alternately taken up or

constrained for the pregnant adolescents in this study. This study highlights how gender inequity, fear, and spirituality are inextricably related to Thai adolescents' capacity to act agentically within their intimate and family relationships and in the communities in which they live.

The participants reported that the exercise of agentic behaviour is challenged due to the Thai social structure. Core to this is the dominant stance that males hold the power to maintain an historically patriarchal society. The patriarchal ideology that exists within Thai social constructs advantages male partners in perpetuating violence against pregnant adolescents. The participants reported that their partners were violent against them in a variety of ways, including through emotional abuse and neglect, and through reproductive coercion. Control was also experienced through partners and family members restricting their access to money. The resultant financial dependence was also identified as a coexisting factor in their relationships with their intimate partners and family. The fear of losing custody of their unborn baby and of not having financial support impeded the adolescent participants' agency to resist violent situations, seek assistance, and freely make decisions about becoming and staying pregnant. Despite being steeped in a historical patriarchy, spirituality and religious beliefs were experienced as key belief systems that enhanced the agency of the participants to act against reproductive coercion and to stay safe during their pregnancy.

The Thai social structure relegated sexually active adolescent participants to an inequitable position by stigmatising their behaviours as the 'bad girl' and ignoring the sexual activity of their male partners. The resultant stigma experienced by the participants occurred at multiple levels; in their homes, at school, in their local communities, and in health care services. In the school context, the pregnant adolescents reported a limited ability to continue their education and achieve success at school. Their narratives reflected clear gender inequity and a resulting lack of support from their school at both the individual and system levels. The adolescent participants attempted to exercise their agency by leaving school to resist experiencing stigma, but this resulted in limiting their social and economic futures by cutting short their access to education. These results confirm previous Thai studies identifying the pressures of social stigma experienced by girls who become pregnant while still in school (Sa-ngiamsak, 2016; UNFPA, 2013; UNICEF, 2015). This study expands upon these findings by identifying how this stigma pervades not only the school environment, but also their intimate partners and family relationships and the broader community environment.

This study also identifies the key supportive actors in the lives of pregnant adolescents. In the local community, girls who became pregnant were stigmatised in terms of being a 'bad girl' based on the Thai traditional value of women maintaining their virginity before marriage. This constrained their agency in facing stigma. Parents, especially mothers, acted with collective agency in providing support to the pregnant adolescents to resist patriarchy; for example, by organising a wedding ceremony in order to gain acceptance from other people in their community.

The study found that in the health care services, health care providers were unaware of their inherent authority and how it affected the care received by the participants. In addition, health care providers did not seem to be aware of the differences in power relations between the adolescent participants and other pregnant women. This limited the adolescent participants' agency to access health care services that they needed from health care providers because they feared being judged for their lack of knowledge and also felt unworthy of becoming a mother. Where previous studies identified health care providers' negative behaviours and attitudes in creating stigma (Tangmunkongvorakul et al., 2005; Wood & Jewkes, 2006), this study has identified the unrecognised differences in power relations that create and perpetuate stigma. This is of major concern given that these health services require young pregnant women to attend. If they do not attend, they are labelled negatively as irresponsible, yet if they do comply with attendance, they are repeatedly subject to unequal power relations that reinforce their position of subservience and their assumed incapacity as a mother who is 'too young'.

The fear experienced by the adolescent participants is explained as being a mechanism of action that reinforces the systemic power imbalances of patriarchy. Fear was experienced in many forms, including the fear of violence and stigma, and the fear of not being supported and of not being able to keep their baby or of having an unhealthy baby. The adolescent participants reported that the use of violence by family members to maintain power over their decision making, to control their emotional availability, and to influence decisions about maintaining their pregnancy, created and maintained this fear. The availability of financial and other forms of support from parents and partners made it difficult for the pregnant adolescents to escape violence, resulting in further compounding of the experience of fear. Fear impeded their ability to exert agency in facing violent situations and in seeking help from others.

The participants also described the suffering caused by being stigmatised by society, resulting in a fear of failing to meet the culturally entrenched ideals of female sexual honour. They feared for both themselves and their parents in relation to being stigmatised by people in their community. Strategies to manage these situations were identified as protecting themselves and the avoidance of settings in which they might be brought to face such fear. This included places in which they had encountered stigma in the community and at school. Some of the participants also spoke out aggressively when being criticised.

Without a source of income, the adolescent participants reported feeling fearful that their families would not financially support them and their new babies. This fear related to the model of the male breadwinner and the patriarchal system. The male breadwinner reinforced the idea that parents and the male partner had responsibility for the economic survival of the family; hence, this resulted in the control of money for those adolescent participants who had a low capacity to earn their own money. The patriarchal system also provided parents and the male partner with more authority to control

money in the family. Nevertheless, some of the adolescent participants did not identify fear for their current or future financial situation. This is understood to be because, as adolescents still living in the family home, they assumed that financial support was a normal part of being parented. Some of the participants who worried that their families might not financially support them, acted agentically to ask for support from family members, and in this way, sought out resources to support themselves and set themselves up to be able to care for their baby.

Fear also drove the pregnant adolescents in their decision making around whether to follow the health behaviours directed by the health services, and/or to follow traditional practices to ensure a healthy pregnancy, an uncomplicated birth, and a healthy baby. This fear is very complex as it relates both to a fear of feeling shamed of not doing 'the right thing' according to western medicine and a fear of not obeying the opinions of their mothers and grandmothers. Traditional care discourses and the cultural hierarchy that requires young women to respect their mothers and grandmothers, interfered with the adolescent participants' choices in relation to the adoption of western scientific health practices. This raises significant questions of how health care providers might incorporate these traditional knowledges into their practices, rather than relegating them to a traditional periphery.

The hierarchal structure within the Thai family privileged the older members in controlling the adolescent participants to follow traditional practices. In turn, some of these traditional practices constrained the adolescent participants' agency. Some of the adolescent participants perceived that following traditional practices enhanced their ability to engage in behaviours to prevent health problems and to control their fear of unexpected situations. Traditional practices therefore both impeded and enabled agency for the adolescent participants in this study.

Overall, this study has contributed to knowledge about how pregnant adolescents living in rural Thai communities exercise their agency, and has explored the factors that shape the capacity of these pregnant adolescents to exercise agency. The key findings of this study indicate that the patriarchal structure in Thai society positions adolescent participants as subordinate, which limits their capacity to act agentically. The violence against adolescent participants, their experience of social stigma and fear, and their engagement with spiritual beliefs reflect oppression by the patriarchal ideology within the Thai social structure. The adolescent participants demonstrated that gender inequity based on violence and stigma impeded their capacity to act agentically. Fear also impeded agentic behaviours. Some of the adolescent participants resisted social forces by acting agentically. Most of these were supported by a significant other, such as a mother who supported her daughter despite the stigma of adolescent pregnancy. Spirituality presented as a paradox that both enabled and impeded agency.

Although the adolescent participants faced reproductive coercion and social stigma, the study found

the roles of the mother and of religion to be used as forms of collective agency to support the adolescent participants. Mothers often provided support for the adolescent participants to resist patriarchy in Thai society, while religion and spiritual beliefs enhanced their ability to make decisions about their pregnancy and to manage and confront the difficulties in their lives.

The relationship between gender inequity, fear, and spirituality and the adolescent participants' agency demonstrates the importance of interpersonal, social, and environmental factors in shaping adolescent participants' capacity to make decisions to control their own lives. This study did not focus on explaining individual psychological constructs that shape decision making, but rather, it provides an insight into the relationship between the social constructs in which pregnant adolescents' in rural Thailand live, work, and play and their capacity to act agentically. These understandings will fill the knowledge gap about the mechanisms of action shaping the relationships between the individual and society for pregnant adolescents in Thailand. It will also contribute to informing changes in policy, health care practices, and education, and will provide recommendations for further research into the issues facing pregnant adolescents in Thailand.

Limitations of the study

This study was conducted as an in-depth localised ethnography. Following Hammersley (2006), the study was not designed for generalisability. This might, however, be viewed as a limitation. The study was undertaken in one prenatal clinic at Mahasarakham hospital and in 15 villages in the rural area of Mahasarakham Province in the Northeast region of Thailand. Most of the participants were from middle- to low-income families and had parents to support them. The study could have gained a more representative sample if there was wider representation from varying social contexts and backgrounds, such as pregnant adolescents attending or not attending the prenatal clinic from urban areas. However, this was out of the scope of research undertaken in the context of a higher degree thesis. To ensure rigorous ethnographic data (Anney, 2014), I interviewed and observed the adolescent participants on six occasions and their caregivers on five occasions.

A significant amount of time was required by me to collect the data and to develop a relationship with the participants, as is required in ethnographic research of this nature (Fetterman, 2010). I had to learn the social and cultural environment by visiting the participants' villages on one or two occasions. In doing so, there were times that I experienced considerable discomfort, and felt awkward and out of place. At other times, she rescheduled appointments to prevent further discomfort such as travelling by herself for long distances in monsoonal rain in rural areas on dirt roads. On such occasions, I felt that in protecting herself, she may have let down the participants she had planned to visit.

A potential methodological limitation was managing two languages at the same time in the data collection, translation, and analysis. It was difficult to present the meanings in different languages

because Thai and English were different concept of conversation. I attempted to minimise this limitation by using a translator to bring the English language as close as possible in meaning to the Thai language to ensure the trustworthiness of the study. All language is subject to a range of interpretations, so despite attempts to ensure clarity and consistency in translation and transcription, the possibility of misinterpretation always remains.

Strengths of the study

Employing a range of different ethnographic methods, including semi-structured in-depth interviews, photo-elicited interviews, and participant observation, with the pregnant adolescents and caregivers was a significant strength of this study. The interviews and photo-elicited interviews enabled the participants to express their views in an independent manner. This resulted in I gaining deep insight into the viewpoints of the participants by asking about their interpretations of the images they had taken. This process elicited information about their construct of self and led to in-depth discussions around sensitive issues about themselves and the society in which they live. The participant observations enabled identification of non-verbal expressions and cues and provided the context for the participants' lived experiences and interactions. The participant observations also enabled richly detailed descriptions of behaviours between the adolescent participants and their caregivers. Having both the adolescent participants and their caregivers talk about their perspectives and experiences also contributed to the richness of the data.

The photo-elicited interviews are considered to be a major strength of this study. Photo-elicited interviews have previously been used in adolescent research (Charmaraman & McKamey, 2011; Noone et al., 2014). As part of ethnographic inquiry, these studies added photo interviews to 'strengthen' the voice of the participants. In this study, I asked the adolescent participants to take photos of things that, or people who, had influenced them in making their own choices. I asked them to select the photos they most wanted to talk about in the interview. Each adolescent participant selected 3-4 photos to talk about. These photo interviews provided advantages that influenced the strength of this study in many ways. Firstly, the photo elicitation contributed to building the relationship, and facilitating communication, between me and the adolescent participants. For example, a photo of Sand's ultrasound facilitated Sand talking about her fear of having an unhealthy baby. The photo elicitation also assisted the smooth process of the interview as it enabled the adolescents to feel more relaxed. I was able to gauge this through the participants' emotional engagement in talking about their photos; how they talked with pride or sadness about an issue or laughed out loud. Secondly, the photos stimulated the adolescent participants to talk about the unforeseen dimensions of their lives. These included, for example, spiritual beliefs, the relationship between them and their caregivers, and their sources of social support and their social networks. Of significance were the photos and discussions around spiritual beliefs. These were not mentioned or discussed in the initial interviews, but were spoken about in great detail in relation to the photographs

taken by the participants about places, people, and things from which they drew strength. Thirdly, the discussions centering on the photographs enabled me to grasp the adolescent participants' viewpoints more clearly. For example, one of the participants, Ann, discussed her point of view about the photos and how she confronted criticism from people in the community, and how her mother and partner enhanced her ability to face stigma and raise her confidence. Finally, and importantly, the photo-elicited interviews enabled greater analytical scope, as they operated as a bridge between the social and cultural world of the adolescent participants and I. In this way, the data provided by the participants was interpreted readily by me, as they were rich, deep, and contextual.

An additional strength of the study was the use of Bronfenbrenner's bioecological model (Bronfenbrenner, 1979) in analysing the data. Using the bioecological model allowed me to organise and arrange the data according to the various dimensions of the pregnant adolescents' lives. This was very helpful as it allowed me to examine the factors that shape the agentic behaviors of adolescents across the different dimensions of their lives, e.g. individual, family, community, and religion.

Reflexivity in ethnography was also a considerable strength of this study. Marshall, Fraser and Baker (2010) used reflexivity in all their research processes to clarify and contextualise the researchers' experiences and interpretations. In this way, the researchers' occasional conflicting positions were held back and considered so that they did not compromise the voice of the participants. There have been three specific occasions in which reflexivity has been particularly relevant to the current study. The first was in choosing the topics of the study in which I reflected on her own perspectives, personal background, and experiences in the field while working with pregnant youth. These experiences inspired me to tackle a social and cultural study that was out of her usual area of research comfort. My experiences as a nursing instructor assisted her in being aware of the social biases constructed in Thailand around the place of pregnant adolescents. Furthermore, she was often called upon to reflect deeply on her own middle-class constructs and views about adolescent pregnancy.

The second major call for reflexivity was during the field work data collection process. Here, I ensured that the interview questions were semi-structured and followed the directions of the participants. Even though, at times during the interviews, I thought to ask questions for her own interest, she actively re-focused by encouraging the participants to talk about their own perspectives, and giving them the opportunity to modify, clarify, or add more information. During the participant observations, I not only recorded the participants' actions, interactions, and environments, she also took the opportunity to reflect upon her own responses and interactions. This critical self-reflection enabled me to develop an awareness of her own thoughts, assumptions, positioning, and feelings. I then used these reflections to check back in with the participants to confirm or reject her assumptions. For example, when observing Nam, I asked her to confirm the meaning of 'bad girl'. The final place

for deep reflexivity was during the data analysis process. During this time, I constantly reflected upon her own assumptions during the transcription and translation phases, and while conducting the thematic analysis and the theoretical analysis. During this process, I used fieldnotes to document her presuppositions. My active reflection on all the processes she used throughout the study strengthened the rigour of the research. This is particularly important given that I am a woman raised and educated in middle-class Thailand whose experience with research has been predominantly in the quantitative domain.

I also took time to gain the trust of the pregnant adolescents and their caregivers in seeking permissions before conducting data collection. In the Thai culture, I was a stranger in the participants' families and in their villages. Therefore, I spent time with their family members, such as grandparents, cousins, friends, and neighbours, in order to build relationships with other family members to make them comfortable around me before interviewing and observing. In addition, I spent more than six months observing the participants' lives on an almost daily basis to understand their cultural norms and traditions.

Implications and recommendations

This study has identified many factors that impede and some that enable pregnant adolescents' capacity to act agentically. This information can significantly inform health care and education policy, nursing and education practice, nursing education, and future research. Given the broad sociocultural context of this study, the implications of the findings range from the broadest level of public policy to the specific needs of individual clinicians. Such changes have the potential to improve quality of life for pregnant adolescents and their unborn children. They also provide scope to improve the health care and education system in Thailand.

The challenges faced by pregnant adolescents should be central to public policy to ensure health equality for women and their unborn babies. In acknowledging the requirement for gender equity to improve women's lives, the World Health Organisation (WHO) has recommended a national policy framework to promote gender equity in society (World Health Organisation, 2002). Embedded in patriarchy, the Thai social structure creates a tension between pregnant adolescents and the social system, particularly in the family, at school, in the health care setting, and in the community. This constrains their capacity to act agentically to care for themselves and their unborn babies in the present, and to plan for the future. This study has found that the social structure reinforces the subordinate position of pregnant adolescents in many ways in society. There is a need to address this historic subordination through policy action. Changes can be embedded in public policy, educational policy, welfare policy, and health care policy that can support and facilitate pregnant adolescents to have a voice.

Public policy

To enable public education programs and the allocation of resources towards gender equality requires changes in public policy. In general terms, there is a need to take a whole of population approach to increase awareness in Thailand of the mechanisms of gender inequity and the impact of gender inequity on society. The UNFPA study (2015) indicated that adolescent pregnancy is a global issue, and that these adolescents are more likely to be marginalised due to poverty and a lack of educational and employment opportunities. UNESCO (2017) also indicated that gender inequity affects pregnant adolescents in their decision-making power to refuse sex, to negotiate access to health services or family planning, and to face intimate partner violence and school violence. Within this context, there is a need for a broad education and raising of awareness, particularly in relation to how gender inequity affects adolescents who become pregnant. The long-term goal must be to accomplish gender equality and a subsequent change in social attitudes towards adolescent pregnancy.

Programs must aim to increase the awareness of people in society and to reduce unequal opportunity for pregnant adolescents at all levels, particularly in relation to education, job opportunities, and health care services. Programs must be cross-sectional, with involvement from both government and non-government institutions to drive change in people's attitudes and to provide support for pregnant adolescents. In addition, policies need to address the role of social media in providing education. For example, Praparpun (2009) has argued that social media can play an important role in reconstructing the attitude process. Given the increasing usage of social media, this option provides much scope to present the gender issues experienced by pregnant adolescents. A cultural shift may occur over time with improved understanding by people across the lifespan and across the various sociocultural sectors of society.

Recommendation 1: That public policy be constructed to enable the development and delivery of population-wide programs to promote gender equality.

Educational policy

Developing educational policy in which gender equality is central is essential for supporting pregnant adolescents to stay in the school environment. Thai education policy already identifies a requirement to support students who become pregnant by allowing them to continue their studies until they graduate (Suwansuntorn, 2012). Students can ask for intermission, and then return to the regular school system after the birth of their baby (Suwansuntorn, 2012). Allowing students to continue to study and actively supporting their continued engagement in study are very different things. Suwansuntorn (2012) highlighted that despite this policy directive, adolescents who become pregnant are judged and treated differently to their partners by teachers and peers. It was a major challenge for them to stay in the school environment. Previous studies have also reported that the

negative reactions toward pregnant adolescents by school contacts contributed to some of them not staying in school and leaving school early in order to avoid being stigmatised (Asnong et al., 2018; Mensch et al., 2001; Neamsakul, 2008; Sa-ngiamsak, 2016). These studies also indicated that the challenges experienced by pregnant adolescents in the school context were not supported by educational policy. Policies need to address the issue of stigmatising behaviours in schools proffered by both teachers and fellow students. This should also be accompanied by appropriate programs within the school system to eradicate gender stereotypes and stigmas within the school context.

Policy must be established to support pregnant adolescents to return and finish their schooling once they have given birth to their babies. Many studies report on the difficulties faced by adolescents who leave school early to give birth and who wish to return (Chigona & Chetty, 2008; Sa-ngiamsak, 2016). There are, however, many examples of targeted educational programs for pregnant adolescents to stay in school and return after the birth of their babies (Basch, 2011; Ruedinger & Cox, 2012; Strunk, 2008; Vuttanont et al., 2006). These have been enabled by specific educational policies and programs that identify and eliminate the barriers experienced by adolescents wishing to return to school. Thai school policies need to include special educational programs for supporting pregnant adolescents when they leave school to attend doctor's appointments and provide peer support to encourage school attendance. Hence, the educational policy in providing pregnant adolescents to return to school should be developed to support pregnant adolescents in order to prevent financial hardship in the future.

A further requirement to enact this is to ensure that physical and human resources are allocated to implement such change. Resources must then be accessible and targeted to address the specific issues experienced by pregnant adolescents to enable both preventative and responsive action when challenges in schools arise. In this study, the pregnant adolescents reported that their teachers and peers criticised them, and that the majority did not support their pregnancy. This indicated a lack human resources in supporting students who become pregnant. Bhana, et al. (2013) suggested that interventions for supporting pregnant adolescents in school should provide professional development and specific strategies to decrease the gender gap in the school environment. Educational policies should enable the development of programs to provide specific training for teachers to increase knowledge and skills on issues relating to pregnant adolescents, particularly reducing judgement based on long-held and socially-accepted gender inequalities. They also need to target the empowerment of pregnant adolescents to have a voice to resist stigma based on gender inequity. Therefore, human resource training programs need to be developed in educational policy to support pregnant adolescents in the school context.

Recommendation 2: That educational policy in Thailand should be developed and implemented widely to reduce gender-based stigma in schools and to actively support pregnant adolescents to stay in school when pregnant and return to school following the birth of their baby. This includes the

development of training programs to empower adolescent women and to support those who become pregnant.

Welfare policy

Pregnant adolescents must have adequate financial means to meet their basic needs and to access health care services. This study found that the pregnant participants faced considerable financial hardship resulting in low education levels, a minimum age for employment, and a gendered environment of work that led to their being dependent on tenuous and unpredictable sources of financial support. The participants also reported that they did not receive any welfare support from the government during their pregnancy. This lack of finances forced them to become financially dependent on others and to lack the power to meet their basic needs and to access health care services. In 2015, the Thai Ministry of Social Development and Human Security (2015) announced that the government would support a monthly minimum income of about 400 Baht (about $16 AUD) for 12 months to new mothers in financial difficulty and a monthly income where the family earns less than 3,000 Baht (about $120 AUD). This indicates a significant shift in policy to recognise the needs of women, but it has not yet been extended to the provision of financial support for girls who become pregnant during adolescence. These policies must be reviewed to include welfare support for pregnant adolescents who are not employed. In addition, the policy must provide funding for emergency situations in which a pregnant adolescent is experiencing intimate partner or family violence and needs the financial means to remove herself from such a situation.

Recommendation 3: Welfare policy must be reviewed to enable the provision of support for pregnant adolescents to enable some degree of financial independence.

Health care policy

Health care providers must be enabled to develop knowledge and skills to confront their own personal biases about adolescent pregnancy and to address deep-seated power imbalances in their relationships with pregnant adolescents. Imbalances in relations of power between health care providers and pregnant adolescents were identified in this study. Adolescents reported being treated as children. This, alongside feelings of overt stigma from health professionals and other mothers, limited the pregnant adolescents' capacity to access health care services. In the health care setting, particularly in the prenatal clinic, the power imbalance between health care providers and pregnant adolescents is another challenge to be overcome through health policy in relation to developing the knowledge and skills of health care providers. Geibel et al. (2017) argued that training programs in Bangladesh that targeted stigma, reduced negative attitudes and judgements by health care providers. The health care providers attended two days of training on stigma related to human rights in reproductive health. Health care policy should include recommendations for programs that assist health care professionals to confront their personal biases in relation to adolescent pregnancy and

to enhance their ability to recognise and address gender inequity. They must also be enabled to address gender issues in local policy development. This must include multidisciplinary professional collaboration in planning and implementing programs, and evaluating the results of such programs (Black, Fleming, & Rome, 2012).

Existing community health care services and service providers must be reviewed in order to increase service responses and resources in the community. This study has found that there is a lack of clarity around the role of community health care providers in supporting pregnant adolescents. The pregnant participants and their caregivers reported that health care providers in their communities did not provide health services during their pregnancy except for a home visit after birth. There is an opportunity for health care providers in the community to develop policy to support community health services to provide care for pregnant adolescents. Policies should be developed to extend services to antenatal care through individual consultations, home visits, and group meetings. In the context of this study, both pregnant adolescents and their caregivers would have benefitted from a home visit service. This role could also include the provision of health education to promote health and wellbeing, offering guidance to families and people in the community, and acting as a contact with schools to empower pregnant adolescents (UNICEF, 2015). They would also be able to provide access to information on health care services for future use. Moreover, health care programs should be developed in collaboration with educational institutions within the community to provide support and to empower pregnant adolescents.

Recommendation 4: That health care policy must be developed that addresses gender inequity in practice. This includes recommendations for programs to assist health care professionals to confront their personal biases about adolescent pregnancy, and to enhance their ability to recognise and address gender inequity and to support gender equality.

Recommendation 5: That policy be reviewed and developed to support the extension of community home visiting services to antenatal care, including health promotion, health education, and care for pregnant adolescents.

Implications for nursing practice

In using a feminist lens to analyse the data, this study has identified that health care providers demonstrate little understanding of how gender oppression operates within society and how their resultant actions can impede or enable agentic behaviours in the adolescent for whom they are providing care. Knowledge of these mechanisms of action has the potential to assist health care providers to launch programs, nursing interventions, and nursing care that address these socially constructed forces, and to ultimately enhance the quality of pregnant adolescents' lives.

Firstly, exposing the gender-based violence experienced by pregnant adolescents is essential. This knowledge can contribute to the development of guidelines and nursing programs that recognise the

need to promote gender equality. This study has found that adolescent participants felt constrained in their ability to resist violent situations arising from their relationships with their intimate partners and in their families. They were unable to freely make decisions about becoming, and then staying, pregnant as they were compelled to adopt their partners' desires rather than to fulfil their own. They were also compromised in seeking support due to having to satisfy their male partners' desires and their own lack of financial agency. The socially constructed power imbalances between the adolescent participants and their partners sanctioned these behaviours. Programs to understand, recognise, and promote gender equality are urgently required. A study by Mejdoubi et al (2013) found that home visitation programs by nurses reduced victimisation and enhanced self-reporting that led to the reduction of intimate partner violence. Programs offered by health professionals, particularly community nurses, should address strategies needed to empower pregnant adolescents to have a voice in which to reposition themselves within society. This will enable them to have an increased capacity to discuss the issues that challenge them and to report abuse and seek assistance. In addition, programs should provide strategies for pregnant adolescents who are at risk of the negative effects of violence by providing knowledge on how to manage conflict and emotional difficulties, and to access shelter when needed. In addition, the development of systems of referral and cooperation might provide better care and services to pregnant adolescents. Evaluation at each stage of these programs is essential to assist health care providers to ensure that the programs developed for pregnant adolescents are suitable and effective. Hence, developing programs to prevent violence against pregnant adolescents is required (Deuba et al., 2016; Filson, Ulloa, Runfola, & Hokoda, 2010).

Recommendation 6: That programs be developed and delivered by community health nurses to empower pregnant adolescents. In particular, programs should be focused on providing safety strategies for pregnant adolescents who are at risk of experiencing family violence.

The barriers to accessing health care services for pregnant adolescents should be removed. The unequal power relations these pregnant participants experience from health care providers and other pregnant women was a barrier for them in accessing health care services. A wide-ranging program could be implemented to eliminate barriers to accessing services and to reduce power imbalances in the health care setting. Programs targeting health care providers should address strategies that redress unequal power relations in the health care setting. A cultural shift is possible through the provision of knowledge about social hierarchies, including patriarchy and paternalistic behaviours, alongside the examination of values and beliefs about gender and society.

Health care providers also need to be sensitive to the particular needs of adolescents who are pregnant, providing them with age- and culturally-appropriate information about self-care and service access. Health care providers are in an ideal position to create an environment of power re-balancing for pregnant adolescents by listening to them carefully without interrupting, maintaining eye contact,

attentive posture and facial expressions, asking open questions, and explaining their problems and options for treatment (Neamsakul, 2008). The behaviour of health care providers must show pregnant adolescents that they are recognised as women, that they are respected, and which explain clearly any procedures that the pregnant adolescent is about to undergo. This can enhance confidence in pregnant adolescents' ability to take control of their own health.

Group activities could also be created to encourage equal power relations between pregnant adolescents and other pregnant women (Grady & Bloom, 2004). To encourage such equal power relations, health care providers should provide group activities to make new friends, share experiences with other pregnant women, and to support each other. In this way, health care providers can act as facilitators to encourage group activities and provide sources of knowledge or additional help if needed during group activities. Such activities for pregnant adolescents should be provided to assist them in finding balance in power relations and to reduce the gender gap in the health care setting.

Recommendation 7: That barriers to accessing health care services for pregnant adolescents be removed. This includes redressing power imbalances in the health care provided, and the provision of programs to enhance the quality of the health care experience and improve accessibility to services for pregnant adolescents.

Long-term psychological support for the mother and her baby are of concern. Health care providers must acknowledge the social construction of male sexual dominance in Thai society and the resultant oppression experienced by pregnant adolescents. In providing care in the antenatal clinic, health care providers should prioritise the assessment of adolescent mental health and the details of their social support network (Hiremath, 2016). This may help to minimise mental health difficulties resulting from social isolation (Grady & Bloom, 2004; Wiemann et al., 2005). Counselling services, especially for pregnant adolescents, must be provided to prevent the adverse social and/or psychological consequences of adolescent pregnancy.

To address this, health care providers should be encouraged to launch a range of programs in collaboration with families, schools, and the community that can assist in the creation of advantageous environments and the reduction of the stigma and fear experienced by pregnant adolescents (Chambers & Erausquin, 2015). The strategies in this program could include providing accurate information about adolescent pregnancy to reduce biases and discriminatory behaviour towards pregnant adolescents. Developing strategies to encourage and empower pregnant adolescents to interact with people in their communities, and teaching them how to manage emotional difficulties, would also be valuable.

Recommendation 8: That programs be developed in antenatal and/or community health services to provide mental health assessment and support to pregnant adolescents.

Pregnant adolescents in the Thai context need support to manage the sometimes conflicting ideologies of care presented by western health services and their family networks. This study has found that adolescent participants have conflicts and tensions between not practicing what their mothers and grandmothers taught them and information from the medical field through a fear of feeling ashamed of not doing 'the right thing'. Health care providers should be aware of pregnant adolescents' traditional beliefs and practices and consider the extent to which their care complements these. Health care providers must offer a practical framework for their nursing care with the inclusion of both traditional practices and western medical practices. This framework could then be used to educate pregnant adolescents about the advantages and disadvantages of both practices. Health care providers should also provide strategies to assist pregnant adolescents to deal with the conflict about their beliefs and take the opportunity for other family members to discuss the integration of traditional practices with western medical practices.

Recommendation 9: An educational framework should be developed for pregnant adolescents to help them manage the tensions between complying with both traditional practices and western medical practices.

The role of collective agency needs to be addressed to support pregnant adolescents. In this study, the pregnant adolescents acknowledged that their mothers and their spiritual beliefs were used as a form of collective agency in resisting patriarchy in the social structure. In providing programs, the role of the mother and the spiritual beliefs must be addressed in planning interventions for pregnant adolescents. For example, health care providers could encourage family members, particularly the pregnant adolescent's mother and partner, to participate in the activities provided by the clinical services, such as health education when the pregnant adolescents come to the prenatal care clinic.

Recommendation 10: An inclusive educational framework should be developed for pregnant adolescents to help them manage the tensions between complying with both traditional practices and western medical practices.

Implications for nursing education

This study has indicated that gender inequity, fear, and spirituality are three core socially constructed factors within the patriarchal system that predominantly oppress pregnant adolescents and limit their capacity to act agentically. To address these issues in practice, nurse educators and curriculum developers must intergrade knowledge of the social constructs that shape health and wellbeing into nursing education. This includes culturally appropriate methods for learning about gender and health equality for nursing students to effectively apply to practice in health care services.

Nursing curriculum

In order to consider the factors that shape care for pregnant adolescents, the curriculum must incorporate an exploration of how society is socially constructed and how these social constructs have an impact on the health and wellbeing of all people. In the Thai context, this includes careful consideration of patriarchy, the social hierarchy, and of how these structures operate to reinforce gender inequity. The curriculum should provide information on the provision of gender sensitive care that can help nursing students' recognition of the potential gender issues being experienced by those for whom they are providing care, including how to promote gender awareness and gender equality (Verdonk, Benschop, De Haes, & Lagro-Janssen, 2009; Vlassoff & Moreno, 2002). As an extension of this, the particular consequences experienced by pregnant adolescents who are oppressed by the patriarchal social system must be incorporated into education for the nursing care of adolescents who become pregnant. Important to this would be education related to the assessment of the sociocultural factors that shape the care needed by pregnant adolescents. Following this, nurses must be able to plan care to reduce the unwanted consequences of oppression to improve agentic behaviours and to develop appropriate interventions for pregnant adolescents.

Recommendation 11: That the nursing curriculum be designed to include learning about the sociocultural constructs that shape health and wellbeing, including patriarchy and gender sensitivity.

Recommendation 12: That the curriculum should include learning about the specific sociocultural issues experienced by pregnant adolescents in Thailand.

Practicing in clinics

Working with pregnant adolescents and families during clinical placement, nursing instructors must teach their students to consider their behaviours carefully when communicating with pregnant adolescents, particularly during assessments and when delivering nursing care. Sociocultural factors need to be considered as a core component of assessment, in addition to physical and psychological factors. The students also need to avoid asking judgemental questions and to approach pregnant adolescents with understanding and an open mind. During nursing practice activities, the instructors should emphasise to their students that they be aware of the power relations between nursing students and pregnant adolescents. The student should actively respond to the pregnant adolescents' requests and respectfully attend to their needs. The students also need to act in a friendly and approachable way and avoid labelling pregnant adolescents. Practicing in the clinical setting assists nursing students to incorporate knowledge from practice with pregnant adolescents into real clinical situations. Thus, improving the practical skills of nursing students is integral to improving the future nursing care of pregnant adolescents.

Implications for further research

The predominant caregivers who were recruited into this study were females. In nominating a caregiver, the participants did not have specific criteria regarding gender. Selection was based on self-nomination to be a participant in the study. The adolescent participants identified that their mothers and mothers-in-law as caregivers enabled them, at times, to act agentically. This reflection has been previously recognised in studies about the role of the mother in improving the ability of pregnant adolescents to develop maternal tasks and move into adulthood (Herrman, 2008; Quinlivan, Luehr, & Evans, 2004). What has not been explored is the impact of the relationships between pregnant adolescents and their male caregivers. Indeed, in this study, some of the nominated caregivers were male who also appeared to enhance agentic behaviours in the participant group. Including male caregivers in further research may provide a broader picture of the experiences of caregivers in supporting pregnant adolescents in Thai society.

Replication of this study with adolescents from different cultural backgrounds would enable an exploration of how much poverty and financial concerns shape agency. Pregnant adolescents who decided to continue their pregnancy and attend the prenatal clinic were involved in this study. Future research may benefit from including pregnant adolescents who do not attend the prenatal clinic to understand why this is the case, as well as to capture those whose disadvantage and lack of support may prevent them from attending the prenatal clinic. A better understanding of how pregnant adolescents from various backgrounds exercise agency, such as those with different religious beliefs and those living in urban areas, would show how different backgrounds can have an impact on agentic behaviours, as well as how health care policy can be shaped to improve the quality of life of pregnant adolescents from a range of backgrounds.

This study also found that support from mothers, spirituality, and financial hardship acted to promote pregnant adolescents' agency. Further exploration of how these forms of support and hardship can enhance pregnant adolescents' agency is needed. A qualitative study investigating the role of collective agency and how to increase the remaining support networks to support pregnant adolescents is also required.

According to the findings of this study, gender inequity, fear, and spirituality are the main aspects related to social structure that shape agentic behaviours in pregnant adolescents. Further research should explore and identify suitable strategies to improve pregnant adolescents' agency that embed family, school, and community engagement within the research to understand how these systems can be used to enhance agency. Longitudinal research is required to explore the success of these strategies in the long-term.

Further research could also focus on improving the quality of health care services provided to pregnant adolescents. For example, future studies could focus on the attitudes and experiences of

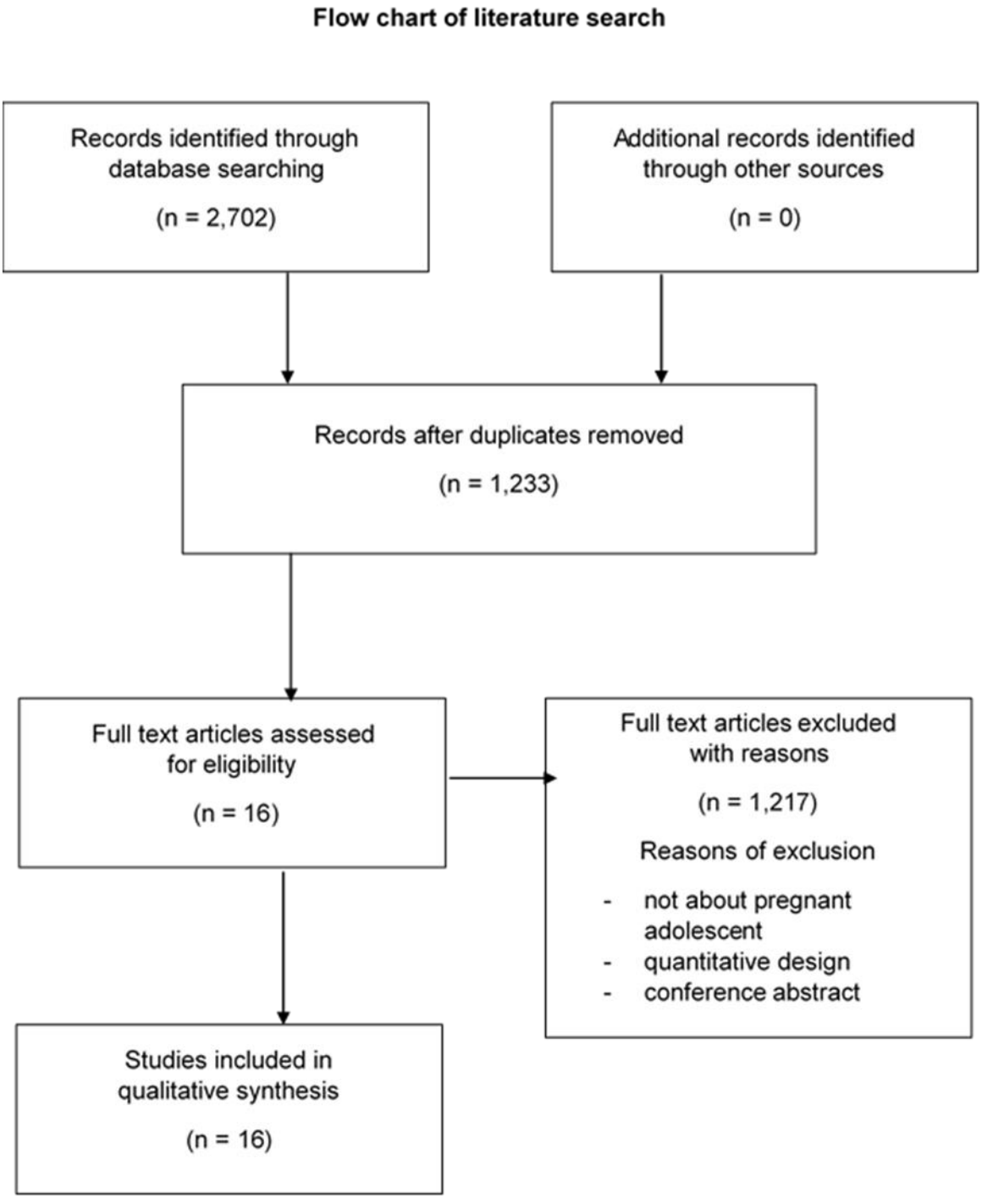
nurses providing services to pregnant adolescents and identify where nursing professionals can be supported to improve their practices in both nursing education and in the clinical setting.

Summary

This qualitative study has used a feminist lens to provide important insights into the experiences of adolescents who live in the rural areas of Thailand and who make the decision to continue their pregnancies. The findings have demonstrated that the patriarchal social structure of Thai society has a very strong influence over the lives of pregnant adolescents and often positions them in subordinate ways. This patriarchal social structure influences the gender inequity, fear, and spiritual beliefs of pregnant adolescents, and these aspects both impede and enable their agentic behaviours. The support of family members and spiritual beliefs were identified as important factors that were used as a form of collective agency to negotiate and resist the oppressive aspects of patriarchy. The experiences of pregnant adolescents in this study provide important insights about what can be done to enhance the agency of pregnant adolescents who face many challenges in their social and cultural contexts. Efforts toward building collaborations between the family, the school system, and the health care setting can assist pregnant adolescents to enhance their capacity for agency and can go some way to changing the society that so often stigmatises them. The recommendations made in relation to policy, nursing practice, nursing education, and further research provide a way forward in improving the agency of pregnant adolescents as well as the society in which they live.

APPENDICIES

APPENDIX A Flow chart of literature search



APPENDIX B Summary of critical appraisal

No.	Authors and Date	Q1 Aim	Q2 Methodology	Q3 Design	Q4 Sampling	Q5 Data collection	Q6 Researcher	Q7 Ethics	Q8 Data analysis	Q9 Finding	Q10 Value
1.	Mantovani and Thomas (2014)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
2.	Tatum et al (2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3.	Shahabuddin et al (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4.	Sadler et al (2016)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
5.	Owusu-Addo et al (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6.	Hoggart (2012)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
7.	Klingberg-Allvin et al (2008)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
8.	Loke and Lam (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9.	Wilson-Mitchell et al (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10.	Singh and Hamid (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11.	Mantovania and Thomas (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12.	Sa-ngiamsak (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13.	Lenkiewicz (2013)	Y	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y
14.	Haddrill et al (2014)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
15.	Bhana and Mcambi (2013)	Y	Y	Y	Y	Y	Y	Can't tell	Y	Y	Y
16.	Atuyambe et al 2009	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

APPENDIX C Interview guide for pregnant adolescents

Questions for semi-structured interview

1. Can you tell me about your experiences of being pregnant?

2. How has your life changed since finding out that you are pregnant?

3. What has made you feel like you should do and not doing to stay healthy during pregnancy.

4. How have you managed your life changing?

5. Can you tell me about what significant personal factors that influence your live? And how?

6. What do you do when you are facing difficulties?

7. Can you tell me about how do you improve ability in make decision in your live?

8. Some people in the community have negative attitudes toward adolescent pregnancy. What do you think about this?

9. Can you tell me what things in your community influence your live?

10. How do things in society and the environment affect your live?

11. What support do you want from family members, health care providers, and friends?

12. How do you personally feel about these supports?

Questions for interview with photo

1. Can you tell me about the photo that you took?

2. Can you tell me about how this photo is importance for you?

3. What things in this photo influence to your live? And how?

4. How do things in this photo influence to your ability in making freely decision and face challenges?

APPENDIX D Interview guide for caregivers

Questions for semi-structured interview

1. Can you tell me about your experiences of taking care of pregnant adolescent?

2. Has adolescent pregnancy affected other family members and people in community? How?

3. Can you tell me about the support you give to the pregnant adolescent for whom you care?

4. What are the obstacles when you take care of pregnant adolescent? How?

5. What makes pregnant adolescent to make freely decision in their live and how to improve?

6. Can you tell me about what other supports do you want for improving ability to make decision of pregnant adolescent?

APPENDIX E Ethics Approval to Conduct Research

FINAL APPROVAL NOTICE

Project No.:	**6900**
Project Title:	An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic
Principal Researcher:	Miss Supiya Wirifai
Email:	wiri0004@flinders.edu.au
Approval Date:	8 July 2015
Ethics Approval Expiry Date:	**31 December 2019**

The above proposed project has been approved on the basis of the information contained in the application, its attachments and the information subsequently provided.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1.Participant Documentation

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

• all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.

• the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.

•the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the National Statement on Ethical Conduct in Human Research (March 2007) an annual progress report must be submitted each year on the 8 July (approval anniversary date) for the duration of the ethics approval using the report template available from the Managing Your Ethics Approval SBREC web page. Please retain this notice for

reference when completing annual progress or final reports.

If the project is completed before ethics approval has expired, please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your next report is due on 8 July 2016 or on completion of the project, whichever is the earliest. The report template is available from the Managing Your Ethics Approval SBREC web page. Please retain this notice for reference when completing annual progress or final reports

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;
- change to research team (e.g., additions, removals, principal researcher or supervisor change);
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to reimbursements provided to participants;
- changes / additions to information and/or documentation to be provided to potential participants;
- changes to research tools (e.g., questionnaire, interview questions, focus group questions);
- extensions of time

To notify the Committee of any proposed modifications to the project please complete and submit the Modification Request Form which is available from the Managing Your Ethics Approval SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to

ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforeseen event occurs that may affect the ethical acceptability of the project.

MODIFICATION (No.1) APPROVAL NOTICE

Project No.:	**6900**
Project Title:	An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic
Principal Researcher:	Miss Supiya Wirifai
Email:	wiri0004@flinders.edu.au
Modification Approval Date:	8 July 2015
Ethics Approval Expiry Date:	**31 December 2019**

I am pleased to inform you that the modification request submitted for project 6900 on the 2 July 2015 has been reviewed and approved by the SBREC Chairperson. Please see below for a list of the approved modifications. Any additional information that may be required from you will be listed in the second table shown below called 'Additional Information Required'.

Approved Modifications	
Extension of ethics approval expiry date	
Project title change	
Personnel change	
Research objectives change	
Research method change	X
Participants – addition +/- change	
Consent process change	X
Recruitment process change	
Research tools change	X
Document / Information Changes	X
Other (if yes, please specify)	

Additional Information Required
None.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1.Participant Documentation

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

• all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above-mentioned errors.

• the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used, and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.

•the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the National Statement on Ethical Conduct in Human Research (March 2007) an annual progress report must be submitted each year on the 8 July (approval anniversary date) for the duration of the ethics approval using the report template available from the Managing Your Ethics Approval SBREC web page. Please retain this notice for reference when completing annual progress or final reports.

If the project is completed before ethics approval has expired, please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your next report is due on 8 July 2016 or on completion of the project, whichever is the earliest. The report template is available from the Managing Your Ethics Approval SBREC web page. Please retain this notice for reference when completing annual progress or final reports.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

· change of project title;
· change to research team (e.g., additions, removals, principal researcher or supervisor change);
· changes to research objectives;
· changes to research protocol;
· changes to participant recruitment methods;
· changes / additions to source(s) of participants;
· changes of procedures used to seek informed consent;
· changes to reimbursements provided to participants;
· changes / additions to information and/or documentation to be provided to potential participants;
· changes to research tools (e.g., questionnaire, interview questions, focus group questions);
· extensions of time.

To notify the Committee of any proposed modifications to the project please complete and submit the Modification Request Form which is available from the Managing Your Ethics Approval SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

· any complaints regarding the research are received;
· a serious or unexpected adverse event occurs that effects participants;
· an unforeseen event occurs that may affect the ethical acceptability of the project.

APPENDIX F Ethics Approval to Conduct Research form Mahasarakham Hospital (English and Thai version)

ที่ มค ๐๐๓๒.๒๐๑/๓๙๖

โรงพยาบาลมหาสารคาม
๑๖๘ ถนนผดุงวิถี
มค ๔๔๐๐๐

๑๙ มิถุนายน ๒๕๕๘

เรื่อง แจ้งผลการพิจารณาจริยธรรมทางการวิจัยและผลการอนุญาตให้เข้าเก็บข้อมูล

เรียน คณบดีคณะพยาบาลศาสตร์ มหาวิทยาลัย Flinders

อ้างถึง หนังสือ มหาวิทยาลัย Flinders ลงวันที่ ๘ พฤษภาคม ๒๕๕๘

สิ่งที่ส่งมาด้วย ๑. เอกสารรับรองจริยธรรมทางการวิจัยในมนุษย์ จำนวน ๑ ฉบับ
๒. แบบรายงานผลการวิพากษ์จริยธรรมทางการวิจัย จำนวน ๑ ฉบับ

ตามหนังสือที่อ้างถึง นางสาวสุปิยา วิริไพ นักศึกษาปริญญาเอกสาขาพยาบาลศาสตร์ มหาวิทยาลัย Flinders ประเทศออสเตรเลีย มีความประสงค์จะดำเนินการเก็บข้อมูลวิจัยเรื่อง "การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์" ตามรายละเอียดที่แจ้งอยู่แล้วนั้น

ในการนี้ โรงพยาบาลมหาสารคาม โดยกรรมการจริยธรรมทางการวิจัยได้พิจารณาแล้ว เห็นควรให้ออกเอกสารรับรองจริยธรรมทางการวิจัยในมนุษย์ โดยอนุญาตให้ผู้วิจัยเข้าเก็บข้อมูลดังกล่าวได้ และผู้วิจัยต้องส่งงานวิจัยฉบับสมบูรณ์ให้กับโรงพยาบาลมหาสารคาม จำนวน ๑ ฉบับ

จึงเรียนมาเพื่อโปรดทราบและดำเนินการต่อไป

ขอแสดงความนับถือ

(นายสุนทร ยนต์ตระกูล)
ผู้อำนวยการโรงพยาบาลมหาสารคาม

ศูนย์ข้อมูล กลุ่มพัฒนาระบบบริการสุขภาพ
โทร. ๐ ๔๓๗๔ ๐๙๙๓-๖ ต่อ ๒๒๔
โทรสาร ๐ ๔๓๗๑ ๑๔๓๓

หมายเลขเอกสารรับรอง mskhe 016/2558

เอกสารรับรองจริยธรรมทางการวิจัยในมนุษย์

คณะกรรมการจริยธรรมการวิจัยในมนุษย์ โรงพยาบาลมหาสารคาม

ชื่อโครงการ การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

ผู้วิจัยหลัก นางสาวสุปิยา วิริไฟ

สังกัดหน่วยงาน คณะพยาบาลศาสตร์ มหาวิทยาลัย Flinders ประเทศออสเตรเลีย

ได้ผ่านการพิจารณาจากคณะกรรมการจริยธรรมทางการวิจัย โรงพยาบาลมหาสารคามแล้ว โดยผู้วิจัยต้องดำเนินการตามโครงการวิจัยที่ได้กำหนดไว้แล้ว หากจะมีการปรับเปลี่ยนหรือแก้ไขใดๆ ควรผ่านความเห็นชอบหรือแจ้งต่อคณะกรรมการจริยธรรมทางการวิจัยอีกครั้ง

.....	.....
(นายศักดิ์ชัย ทอนมาตย์)	(นายสุนทร ยนต์ตระกูล)
ประธานคณะกรรมการจริยธรรมทางการวิจัย	ผู้อำนวยการโรงพยาบาลมหาสารคาม

วันที่รับรอง : 19 มิ.ย. 2558 **วันหมดอายุการรับรอง :** 18 มิ.ย. 2559

ผู้วิจัยที่ผ่านการรับรองจริยธรรมการวิจัยในมนุษย์ต้องปฏิบัติดังนี้

1. ใช้เอกสารชี้แจงอาสาสมัคร เอกสารแสดงความยินยอม และเครื่องมือที่ใช้ในการดำเนินโครงการตามที่ผ่านการพิจารณาจากคณะกรรมการจริยธรรมทางการวิจัยในมนุษย์เท่านั้น
2. หากไม่สามารถดำเนินการเสร็จสิ้นภายในระยะเวลาที่กำหนด ผู้วิจัยต้องยื่นขออนุมัติใหม่ก่อนอย่างน้อย 1 เดือน
3. ผู้วิจัยต้องส่งรายงานการวิจัยฉบับสมบูรณ์หลังดำเนินโครงการวิจัยเสร็จสิ้น จำนวน 1 ฉบับ

บันทึกข้อความ

ส่วนราชการ คณะกรรมการจริยธรรมทางการวิจัย โรงพยาบาลมหาสารคาม โทร ๒๒๔

ที่ มค ๐๐๓๒.๒๐๒/ **วันที่** ๑๗ มิถุนายน ๒๕๕๘

เรื่อง ขออนุมัติใบรับรองจริยธรรมทางการวิจัย

เรียน ผู้อำนวยการโรงพยาบาลมหาสารคาม

ตามที่ นางสาวสุปิยา วิริไพ นักศึกษาปริญญาเอกสาขาพยาบาลศาสตร์ มหาวิทยาลัย Flinders ประเทศออสเตรเลีย มีความประสงค์จะขอดำเนินการงานวิจัยเรื่อง "การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์" นั้น

บัดนี้ คณะกรรมการจริยธรรมทางการวิจัย โรงพยาบาลมหาสารคาม ได้พิจารณาด้านจริยธรรมการวิจัยของโครงการฯ แล้วมีผลสรุปว่า "เห็นชอบให้ออกใบรับรองจริยธรรมทางการวิจัย"

จึงเรียนมาเพื่อโปรดพิจารณา หากเห็นชอบขอได้โปรดลงนามในเอกสารรับรองจริยธรรมทางการวิจัยตามเอกสารที่แนบมาพร้อมนี้จะเป็นพระคุณยิ่ง

(นายศักดิ์ชัย ทอนมาตย์)
ประธานคณะกรรมการจริยธรรมทางการวิจัย

ลงนามแล้ว

(นายสุนทร ยนต์ตระกูล)
ผู้อำนวยการโรงพยาบาลมหาสารคาม

No. 0032.201/3956

19 June 2015

Subject: Ethics approval and permission to conduct research
Dear Dean of School of Nursing and Midwifery, Flinders University
Reference: The letter from Flinders University, 8 May 2015
Documents: 1. Certificate of ethics approval 1 copy
2. Memorandum 1 copy

This letter is in response to the correspondences requesting for Miss Supiya Wirifai to approve ethics and conduct research leading to the production of a thesis of an exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

As we have been informed that the Ethics Committee of Mahasarakham Hospital has considered the research project on the basic of information contained in the application and its attachments, the project has been granted ethics approval and permission is granted for data collection in Mahasarakham Hospital. The researcher also must submit a full report upon completion to the ethics committee.

Yours sincerely,

XXX

Mr. Sonthorn Yontakhun
Director of Mahasarakham Hospital

Information Center, Department of Health Services and Development
Telephone: 043 740993-6 dial 224
Fax: 043711433

No. mskhe 016/2558

Certificate of Ethics Approval

Ethics Committee of Mahasarakham Hospital

The research title: An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

The researcher: Miss Supiya Wirifai

University: Flinders University

The project has been granted ethics approval by the Ethics Committee of Mahasarakham Hospital. If the researcher requires modification, the researcher should apply to the Ethics Committee for permission.

XXX	XXX
……..	……
Mr. Sakchai Thornmart	Mr. Sonthorn Yontakhun
The Chairman of Ethics Committee	Director of Mahasarakham Hospital

Date 19 June 2015 Expired date 18 June 2016

Note:

1. The researcher ensures that all documents to be distributed to potential participants have permission from the Ethics Committee of Mahasarakham hospital.
2. If the process of research cannot be completed at this time, the researcher should apply the permission again before 1 month.
3. The researcher must submit a full report upon completion to the Ethics Committee of Mahasarakham Hospital.

Memorandum

Department Ethics Committee of Mahasarakham Hospital
No. 0032.202 **Date** 17 June 2015
Subject Ethics approval

Dear Director of Mahasarakham Hospital:

According to the correspondences requesting for Miss Supiya Wirifai to approve ethics and conduct the research leading to the production of a thesis of an exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic:

The project has been granted ethics approval from Ethics Committee of Mahasarakham Hospital. If you permit to grant permission for ethics approval, please sign your name in the certificate of ethics approval and official correspondence.

Yours sincerely,

XXX

Mr. Sakchai Thornmart
The Chairman of Ethics Committee

APPENDIX G Introductory letter (English and Thai version)

Dr Juliant Grant
School of Nursing and Midwifery

GPO Box 2100
Adelaide SA 5001

Tel: +61882012126
Fax: +61882761602
julian.grant@flinders.edu.au

www.flinders.edu.au

CRICOS Provider No. 00114A

LETTER OF INTRODUCTION

Dear Parent/Guardian

This letter is to introduce Miss Supiya Wirifai who is a PhD student in the School of Nursing and Midwifery at Flinders University. She will produce her student card, which carries a photograph, as proof of identity. She is undertaking research leading to the production of a thesis or other publications on the subject of "an exploration of perceived self-efficacy of young women, aged 15-19, in Thailand who are pregnant and attending a prenatal clinic".

She would like to invite you to assist with this project by granting consent to be involved in an interview and agreeing to being observed in antenatal clinic. The researcher will be observed in the clinic on two separate occasions. The researcher expects to observe in participant's homes on approximately two separate occasions, which covers certain aspects of this topic. More than one hour on four occasions would be required.

The researcher also will be asked the participants to take photo the participants to take photos about what perceived self-efficacy means to them and what sort of environments or activities or things shape their self-efficacy. All photos will be discussed on one occasion for duration approximately one hour.

Any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Supiya will make an audio recording of the interview. She will seek your consent, on the attached form, to record the interview. She may also request to record conversations during the period of observation. During period of observation, Supiya will request consent to take notes. She will request to use the recordings and notes in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and to only make the recording and notes available to other researchers on the same conditions.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on +61882012126, fax +61882761602 or e-mail julian.grant@flinders.edu.au Thank you for your attention and assistance.

Yours sincerely

Dr Julian Grant

Senior Lecturer

School of Nursing and Midwifery

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 6900). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

Dr Julian Grant
School of Nursing and Midwifery

Flinders UniversityGPO Box 2100
Adelaide SA 5001
Tel: +61882012126
julian.grant@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

จดหมายแนะนำตัวของผู้วิจัย

เรียนผู้ปครองและผู้เข้าร่วมวิจัย

จดหมายฉบับนี้เป็นจดหมายแนะนำตัวของ นางสาวสุปิยา วิริไฟ นักศึกษาปริญญาเอก คณะพยาบาล ศาสตร์ มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย ซึ่งนักศึกษาได้เตรียมบัตรนักศึกษาและภาพถ่าย เพื่อแสดงตัวแก่ผู้เข้าร่วมวิจัย นางสาวสุปิยา วิริไฟ ได้ศึกษา หัวข้อการวิจัยเรื่อง การศึกษาการรับรู้ สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่มี ประสบการณ์การตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

นักศึกษาของข้าพเจ้าขอเรียนเชิญท่านที่สนใจเข้าร่วมโครงการวิจัยโดยการวิจัยครั้งนี้มีการสัมภาษณ์ การสังเกตแบบ มีส่วนร่วมในคลินิกฝากครรภ์และที่บ้านของท่านหรือตามที่ท่าน สะดวกซึ่งการสัมภาษณ์ใช้เวลา 1 ครั้งประมาณ 60-90 นาที ในขณะที่การสังเกตแบบมีส่วนร่วม ใช้เวลา 4 ครั้ง ประมาณ 1-2 ชั่วโมง

อีกทั้งจะขออนุญาตท่านในการถ่ายภาพสิ่งที่ทำให้ท่าน รู้สึกมีความมั่นใจในตนเอง เช่น สถานที่ คน หรือกิจกรรม และจะทำการสัมภาษณ์หลังจากถ่ายภาพแล้วใช้เวลา 1 ครั้งประมาณ 1 ชั่วโมง

ข้าพเจ้าขอรับรองว่าข้อมูลดังกล่าวจะถูกปิดเป็นความลับและข้อมูลส่วนตัวของท่านจะไม่ถูก เปิดเผยในผลการวิจัย, รายงานการวิจัยหรือการตีพิมพ์ใดๆท่านมีสิทธิ์ที่จะถอนตัวจากโครงการ วิจัยได้ตลอดเวลาและมีสิทธิ์ที่จะปฏิเสธ การตอบคำถามในการวิจัยโดยไม่มีผลกระทบใดๆต่อ ตัวท่าน

นักศึกษาของข้าพเจ้าต้องได้รับการเซ็นต์ยินยอมจากท่านก่อนการบันทึกเสียงขณะทำการสัมภาษณ์ และสังเกต อีกทั้งในระหว่างการสังเกตนักศึกษาจะขออนุญาตในการจดบันทึกข้อมูล ร่วมด้วย ข้อมูลจากการบันทึกเสียง และบันทึกจะถูกใช้ในการเตรียมข้อมูลการวิจัย รายงานหรือสิ่งตีพิมพ์ โดยมีเงื่อนไขว่าชื่อหรือการอ้างอิงใดๆ ที่เกี่ยวข้องกับลักษณะตัวท่าน จะไม่ถูกเปิดเผย และการบันทึกเสียงจะไม่ถูกนำไปใช้ ประโยชน์ในรายงานอื่น ซึ่งมีลักษณะคล้ายคลึงกัน

หากท่านต้องการสอบถามข้อมูลเพิ่มเติมเกี่ยวกับการวิจัยครั้งนี้ กรุณาติดต่อข้าพเจ้าได้ตามที่อยู่ด้านบนหรือทางโทรศัพท์หมายเลข +61882012126 หรือได้ที่อีเมล์ julian.grant@flinders.edu.au

ขอแสดงความนับถือ

Dr Julian Grant

การวิจัยนี้ได้ผ่านคณะกรรมการจริยธรรมของมหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย (โครงการวิจัยหมายเลข 6900)
หากท่านต้องการสอบถามข้อมูลเพิ่มเติมเกี่ยวกับกระบวนการจริยธรรมการวิจัยของโครงการนี้ สามารถติดต่อได้ที่ สำนักงานจริยธรรมของมหาวิทยาลัย เบอร์โทรศัพท์ +6682013116 หรือแฟกซ์ 8201 2035 หรืออีเมลล์ human.researchethics@flinders.

APPENDIX H information sheets for pregnant adolescents and caregivers (English and Thai version)

Miss Supiya Wirifai
School of Nursing and Midwifery
Faculty of Nursing and Health Science
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: +61 478712831
wiri0004@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

INFORMATION SHEET FOR PREGNAT ADOLESCENTS

Title: 'An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic'

Investigators:
Miss Supiya Wirifai
School of Nursing and Midwifery
Flinders University
Ph: +61478712831

Supervisors:
Dr Julian Grant
School of Nursing and Midwifery
Flinders University
Ph: +61882012126

Dr Yvonne Parry
School of Nursing and Midwifery
Flinders University
Ph: +61882013354

Dr Lana Zannettino
School of Nursing and Midwifery
Flinders University
Ph: +61882013236

Description of the study:
This study is part of the project entitled '*An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.'* This project will investigate the perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic. This project is supported by Flinders University, Nursing & Midwifery & Health Science department.

Purpose of the study:
This project aims

- To explore the perceived self-efficacy of pregnant adolescents.

- To identify current and potential interpersonal factors that shape self-efficacy during pregnancy for adolescents.
- To investigate the social and environmental factors that shape self-efficacy in pregnant adolescents.

What will I be asked to do?
You are invited to attend a semi-structured interview with a PhD student who will ask you a few questions about your self-efficacy or confidence in your abilities, the current and potential interpersonal factors that shape your self-efficacy during pregnancy, and the social and environmental factors that shape your self-efficacy. The interview will take approximately 60-90 minutes. The interview will be recorded using an audio recorder to help with reviewing the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised.

I also ask your permission to observe while you participate in activities in the antenatal clinic such as assessments, screening, health care education classes, examinations, and counselling sessions. We plan to observe you in the clinic on two separate occasions for a period of approximately 1-2 hours or as long as you are comfortable.

I also ask to observe your interactions in your private residence or somewhere in the community where you participate in everyday activities. The location is your choice. We expect to observe in your home on approximately two separate occasions for a period of approximately 1-2 hours or as long as you are comfortable.

During these periods of observation, I might ask to record some of conversation. This will only happen if you say 'yes' to record the conversation at the time. If you say 'no' the recorder will not be turned on.

The researcher also will be asked the participants to take photo the participants to take photos about what perceived self-efficacy means to them and what sort of environments or activities or things shape their self-efficacy. All photos will be discussed on one occasion for duration approximately one hour.

What benefit will I gain from being involved in this study?
You may not directly benefit from this study. You will have the opportunity to talk about your experiences. Sometimes this is enjoyable for participants. We hope that the findings from this study will benefit other young women who are pregnant as the findings will be used to improve care.

Will I be identifiable by being involved in this study?
We will make every effort to ensure that you will not be identifiable though this study. You name will note be recorded and you will be asked to choose a pseudonym (pretend name) to use for all recoding. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed, and the typed-up file will be stored on a password protected computer that only the researcher will have access to. Your comments will not be linked directly to you in any publications resulting from this study.

Are there any risks or discomforts if I am involved?
You may experience emotional distress during interview because some questions may make you feel uncomfortable. You can say that you would like the recorder turned off at any time or to stop being in the study at any time. If you have any concerns about anticipated or actual risks or discomfort, please raise them with the researcher. You can also access free and confidential counseling through the following services:

- Psychiatric clinic, Mahasarakham hospital
  168, Padungwithi Road,
  Talad sub district, Muang district,
  Mahasarakham Province
  Thailand 44000

Tel: (+66-43) 741225
Fax: (+66-43) 740993

- Khon Kaen Rajanagarinda Psychiatric hospital
  169, Chatapadung Road,
  Naimuang sub district, Muang district,
  Khonkaen province,
  Thailand 40000
  Tel: (+66-43) 209999
  Fax: (+66-43) 224722

How do I agree to participate?
Participation is voluntary. Please call me +61478712831 or come and see me at the antenatal clinic. A consent form accompanies this information sheet. If you agree to participate, please read and sign the form and give it back to me.

How will I receive feedback?
The finding from the project will be summarised and given to you by the investigator if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6900). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Miss Supiya Wirifai
School of Nursing and Midwifery
Faculty of Nursing and Health Science
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: +61 478712831
wiri0004@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

INFORMATION SHEET FOR SUPPORT PERSONS

Title: 'An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic'

Investigators:
Miss Supiya Wirifai
School of Nursing and Midwifery
Flinders University
Ph: +61478712831

Supervisors:
Dr Julian Grant
School of Nursing and Midwifery
Flinders University
Ph: +61882012126

Dr Yvonne Parry
School of Nursing and Midwifery
Flinders University
Ph: +61882013354

Dr Lana Zannettino
School of Nursing and Midwifery
Flinders University
Ph: +61882013236

Description of the study:
This study is part of the project entitled '*An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.'* This project will investigate the perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic. This project is supported by Flinders University, Nursing & Midwifery & Health Science department.

Purpose of the study:
This project aims

- To explore the perceived self-efficacy of pregnant adolescents.
- To identify current and potential interpersonal factors that shape self-efficacy during pregnancy for adolescents.
- To investigate the social and environmental factors that shape self-efficacy in pregnant adolescents.

What will I be asked to do?
You are invited to attend a semi-structured interview with a PhD student who will ask you a few questions about the self-efficacy or confidence of young women who you are supporting through her pregnancy. These will include questions about the current and potential interpersonal factors that shape her self-efficacy during pregnancy, and the social and environmental factors that shape her self-efficacy. The interview will take approximately 60-90 minutes. The interview will be recorded using an audio recorder to help with reviewing the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised.

I also ask your permission to observe while the young women you support participate in activities in the antenatal clinic such as assessments, screening, health care education classes, examinations, and counselling sessions. We plan to observe her in the clinic on two separate occasions for a period of approximately 1-2 hours or as long as she and you are comfortable.

I also ask to observe your interactions of the young women you support in her private residence or somewhere in the community where she participates in everyday activities. The location is her choice. We expect to observe in your home on approximately two separate occasions for a period of approximately 1-2 hours or as long as you are comfortable.

During the periods of observation, I might ask to record some of conversation. This will only happen if you say 'yes' to recording the conversation at the time. If you say 'no' the recorder will not be turned on.

What benefit will I gain from being involved in this study?
You may not directly benefit from this study. You will have the opportunity to talk about your experiences. Sometimes this is enjoyable for participants. We hope that the findings from this study will benefit other young women who are pregnant as the findings will be used to improve care.

Will I be identifiable by being involved in this study?
We will make every effort to ensure that you will not be identifiable though this study. You name will note be recorded and you will be asked to choose a pseudonym (pretend name) to use for all recoding. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed, and the typed-up file will be stored on a password protected computer that only the researcher will have access to. Your comments will not be linked directly to you in any publications resulting from this study.

Are there any risks or discomforts if I am involved?
You may experience emotional distress during interview because some questions may make you feel uncomfortable. You can say that you would like the recorder turned off at any time or to stop being in the study at any time. If you have any concerns about anticipated or actual risks or discomfort, please raise them with the researcher. You can also access free and confidential counseling through the following services:

- Psychiatric clinic, Mahasarakham hospital
  168, Padungwithi Road,
  Talad sub district, Muang district,
  Mahasarakham Province
  Thailand 44000
  Tel: (+66-43) 741225
  Fax: (+66-43) 740993
- Khon Kaen Rajanagarinda Psychiatric hospital
  169, Chatapadung Road,
  Naimuang sub district, Muang district,
  Khonkaen province,
  Thailand 40000
  Tel: (+66-43) 209999
  Fax: (+66-43) 224722

How do I agree to participate?
Participation is voluntary. Please call me +61478712831 or come and see me at the antenatal clinic. A consent form accompanies this information sheet. If you agree to participate, please read and sign the form and give it back to me.

How will I receive feedback?
The finding from the project will be summarised and given to you by the investigator if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6900). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Miss Supiya Wirifai
School of Nursing and Midwifery
Faculty of Nursing and Health Science
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: +61 478712831
wiri0004@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

รายละเอียดโครงการวิจัยสำหรับหญิงตั้งครรภ์วัยรุ่น

เรื่อง การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

ผู้วิจัย
นางสาวสุปิยา วิริไฟ
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61478712831

อาจารย์ที่ปรึกษาวิจัย
ดร. จูเลี่ยน แกรนท์
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882012126

ดร. อีวอน แพรี่
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882013354

ดร. ลาน่า เซ็นเนตทิโอ้
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882013236

รายละเอียดของโครงการ:

การศึกษาครั้งนี้เป็นส่วนหนึ่งของโครงการวิจัยเรื่อง การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทย ที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์ โดยได้รับการสนับสนุนจากคณะพยาบาลศาสตร์ มหาวิทยาลัยฟรินเดอร์

วัตถุประสงค์การวิจัย:

โครงการวิจัยนี้มี 3 วัตถุประสงค์หลักดังนี้

- เพื่อศึกษาการรับรู้สมรรถนะของหญิงตั้งครรภ์วัยรุ่น
- เพื่อค้นหาปัจจัยภายในของหญิงตั้งครรภ์วัยรุ่นที่ส่งเสริมการรับรู้สมรรถนะในระหว่างตั้งครรภ์
- เพื่อค้นหาปัจจัยทางด้านสังคมและสิ่งแวดล้อมที่ส่งเสริมสมรรถนะของหญิงตั้งครรภ์วัยรุ่น

ขั้นตอนการวิจัยเป็นอย่างไร?

ท่านจะถูกสัมภาษณ์โดยนักศึกษาปริญญาเอก เกี่ยวกับการรับรู้สมรรถนะแห่งตนหรือความมั่นใจในความสามารถของท่าน ปัจจัยภายในและปัจจัยทางด้านสังคมและสิ่งแวดล้อมที่ส่งผลต่อการรับรู้สมรรถนะของท่าน การสัมภาษณ์ จะใช้เวลาประมาณ 60-90 นาที เพียง 1 ครั้ง ขณะสัมภาษณ์จะถูกบันทึกข้อมูลด้วยเครื่องบันทึกเสียงร่วมด้วย หลังจากนั้นจะถูกถอดเทปการสัมภาษณ์และบันทึกลงในคอมพิวเตอร์ ข้อมูลดังกล่าวจะถูกทำลายภายหลังจากเสร็จสิ้นการวิจัย

ท่านจะถูกสังเกตในขณะมีส่วนร่วมในการทำกิจกรรมที่คลินิกฝากครรภ์ เช่น การประเมินสุขภาพ การได้รับความรู้ทางด้านสุขภาพ การตรวจร่างกาย และการได้รับคำปรึกษา ซึ่งการสังเกตจะใช้เวลา 1-2 ชั่วโมง หรือใช้เวลานานเท่าที่ท่านรู้สุขสบายเป็นเวลา 2 ครั้ง

นอกจากนั้นท่านจะถูกสังเกตพฤติกรรมที่บ้านหรือในชุมชนที่ท่านเข้าร่วมกิจกรรม ซึ่งการสังเกตจะใช้เวลา 1-2 ชั่วโมงหรือใช้เวลานานเท่าที่ท่านรู้สึกสุขสบายเป็นเวลา 2 ครั้ง

ในกรณีที่ท่านอนุญาตให้บันทึกเสียง ผู้วิจัยจะขออนุญาตบันทึกเสียงในประเด็นที่สำคัญขณะทำการสังเกต แต่ถ้าท่านไม่อนุญาตจะไม่มีการบันทึกเสียงใดๆเกิดขึ้น

อีกทั้งจะขออนุญาตท่านในการถ่ายภาพสิ่งที่ทำให้ท่าน รู้สึกมีความมั่นใจในตนเอง เช่น สถานที่ คน หรือกิจกรรม และจะทำการสัมภาษณ์หลังจากถ่ายภาพแล้วใช้เวลา 1 ครั้งประมาณ 1 ชั่วโมง

ประโยชน์ที่ได้รับจากโครงการวิจัย?

ท่านอาจจะไม่ได้รับประโยชน์โดยตรงสำหรับงานวิจัยครั้งนี้ แต่ท่านจะได้มีโอกาสในการแลกเปลี่ยนประสบการณ์เกี่ยวกับตัวท่าน ซึ่งผู้วิจัยหวังเป็นอย่างยิ่งว่าผลการวิจัยจะเกิดประโยชน์ในการพัฒนาการดูแลหญิงตั้งครรภ์วัยรุ่นต่อไป

มีการพิทักษ์สิทธิ์ของการเข้าร่วมวิจัยหรือไม่?

ผู้วิจัยได้มีการจัดการเพื่อให้เกิดความมั่นใจว่าท่านจะไม่ถูกเปิดเผยชื่อเมื่อเข้าร่วมวิจัย ชื่อของท่านจะไม่บันทึกและจะใช้ชื่อสมมุติในการบันทึกข้อมูลทั้งหมด หลังจากการถอดเทปการสัมภาษณ์และบันทึกข้อมูลลงในแฟ้มข้อมูล ข้อมูลเสียงทั้งหมดจะถูกทำลาย ส่วนข้อมูลอื่นๆที่แสดงตัวตนของผู้เข้าร่วมวิจัยจะถูกตัดออกและข้อมูลที่บันทึก จะถูกเก็บไว้ในคอมพิวเตอร์ที่มีรหัสผ่าน ซึ่งมีเพียงผู้วิจัยสามารถเข้าถึงได้ ส่วนข้อเสนอแนะของท่านจะไม่สามารถอ้างอิงไปถึงตัวท่านได้

มีความเสี่ยงหรือความไม่สุขสบายในการเข้าร่วมการวิจัยหรือไม่?

การวิจัยอาจมีผลกระทบทางด้านจิตใจในขณะที่ให้สัมภาษณ์ เนื่องจากบางคำถามการวิจัยอาจจะทำให้ผู้เข้าร่วมวิจัยรู้สึกอึดอัดและไม่สบายใจ ดังนั้นผู้เข้าร่วมวิจัยสามารถปฏิเสธการตอบคำถาม หรือปิดการบันทึกเสียงได้ตลอดเวลา ถ้าท่านมีความกังวลใจเกี่ยวกับผลกระทบดังกล่าวกรุณาแจ้งผู้วิจัยโดยตรง ซึ่งผู้วิจัยได้เตรียมข้อมูลการให้คำปรึกษาแก่ผู้ที่มีปัญหาดังกล่าวดังนี้

- คลินิกจิตเวช โรงพยาบาลมหาสารคาม
  168 ถนนผดุงวิถี
  ตำบล ตลาด อำเภอ เมือง
  จังหวัด มหาสารคาม 44000
  โทรศัพท์ 043-741225
  แฟกซ์ 043-740993
- โรงพยาบาลจิตเวชราชนครินทร์
  169 ถนนชาตะผดุง
  ตำบล ในเมือง อำเภอ เมือง
  จังหวัด ขอนแก่น 40000
  โทรศัพท์ 043-209999
  แฟกซ์ 043-224722

เข้าร่วมการวิจัยได้อย่างไร?

ท่านสามารถเข้าร่วมการวิจัยโดยความสมัครใจ หากท่านสนใจเข้าร่วมวิจัยกรุณาติดต่อที่โทรศัพท์หมายเลข +61478712831 หรือพบผู้วิจัยโดยตรงที่คลินิกฝากครรภ์ ถ้าท่านยินยอมเข้าร่วมการวิจัยกรุณาเซ็นต์ใบยินยอม เข้าร่วมวิจัยและส่งกลับมาที่ผู้วิจัย

วิธีได้รับข้อมูลย้อนกลับ?

เมื่อเสร็จสิ้นการวิจัย ผลการวิจัยจะแจ้งให้ผู้เข้าร่วมวิจัยทราบหากท่านต้องการทราบผลการวิจัยดังกล่าว

ขอขอบคุณท่านที่เสียสละเวลาในการอ่านรายละเอียดโครงการวิจัยและหวังเป็นอย่างยิ่งว่าท่านจะยินดีเข้าร่วม การวิจัยในครั้งนี้

การวิจัยนี้ได้ผ่านคณะกรรมการจริยธรรมของมหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย (โครงการวิจัยหมายเลข 6900)

หากท่านต้องการสอบถามข้อมูลเพิ่มเติมเกี่ยวกับกระบวนการจริยธรรมการวิจัยของโครงการนี้ สามารถติดต่อได้ที่ สำนักงานจริยธรรมของมหาวิทยาลัย เบอร์โทรศัพท์ +6682013116 หรือแฟกซ์ 8201 2035 หรืออีเมลล์ human.researchethics@flinders.edu.au

Miss Supiya Wirifai
School of Nursing and Midwifery
Faculty of Nursing and Health Science
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: +61 478712831
wiri0004@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

รายละเอียดโครงการวิจัยสำหรับผู้ปกครอง

เรื่อง การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

ผู้วิจัย
นางสาวสุปิยา วิริไฟ
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61478712831

อาจารย์ที่ปรึกษาวิจัย
ดร. จูเลี่ยน แกรนท์
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882012126

ดร. อีวอน แพรี่
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882013354

ดร. ลาน่า เซ็นเนตทิโอ้
คณะพยาบาลศาสตร์
มหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย
โทรศัพท์: + 61882013236

รายละเอียดของโครงการ:

การศึกษาครั้งนี้เป็นส่วนหนึ่งของโครงการวิจัยเรื่อง การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่ตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์ โดยได้รับการสนับสนุนจากคณะพยาบาลศาสตร์ มหาวิทยาลัยฟรินเดอร์

วัตถุประสงค์การวิจัย:

โครงการวิจัยนี้มี 3 วัตถุประสงค์หลักดังนี้

- เพื่อศึกษาการรับรู้สมรรถนะของหญิงตั้งครรภ์วัยรุ่น
- เพื่อค้นหาปัจจัยภายในของหญิงตั้งครรภ์วัยรุ่นที่ส่งเสริมการรับรู้สมรรถนะในระหว่างตั้งครรภ์
- เพื่อค้นหาปัจจัยทางด้านสังคมและสิ่งแวดล้อมที่ส่งเสริมสมรรถนะของหญิงตั้งครรภ์วัยรุ่น

ขั้นตอนการวิจัยเป็นอย่างไร?

ท่านจะถูกสัมภาษณ์โดยนักศึกษาปริญญาเอก เกี่ยวกับการรับรู้สมรรถนะแห่งตนหรือความมั่นใจในตนเองของหญิงตั้งครรภ์วัยรุ่น รวมทั้งคำถามเกี่ยวกับปัจจัยภายในและปัจจัยทางด้านสังคมและสิ่งแวดล้อมที่ส่งผลต่อการรับรู้สมรรถนะของหญิงตั้งครรภ์ที่ท่านดูแล การสัมภาษณ์จะใช้เวลาประมาณ 60-90 นาที เพียง 1 ครั้ง ขณะสัมภาษณ์จะถูกบันทึกข้อมูลด้วยเครื่องบันทึกเสียงร่วมด้วย หลังจากนั้นจะถูกถอดเทปการสัมภาษณ์และบันทึกลงในคอมพิวเตอร์ ข้อมูลดังกล่าวจะถูกทำลายภายหลังจากเสร็จสิ้นการวิจัย

หญิงตั้งครรภ์วัยรุ่นที่ท่านดูแลจะถูกสังเกตในขณะมีส่วนร่วมในการทำกิจกรรมที่คลินิกฝากครรภ์ เช่น การประเมินสุขภาพ การได้รับความรู้ทางด้านสุขภาพ การตรวจร่างกาย และการได้รับคำปรึกษา ซึ่งการสังเกตจะใช้เวลา 1-2 ชั่วโมงหรือใช้เวลานานเท่าที่หญิงตั้งครรภ์และท่านรู้สุขสบายเป็นเวลา 2 ครั้ง

นอกจากนั้นหญิงตั้งครรภ์จะถูกสังเกตพฤติกรรมที่บ้านหรือในชุมชนที่ท่านเข้าร่วมกิจกรรม หรือสถานที่หญิงตั้งครรภ์ระบุ ซึ่งการสังเกตจะใช้เวลา 1-2 ชั่วโมงหรือใช้เวลานานเท่าที่หญิงตั้งครรภ์และท่านรู้สึกสุขสบายเป็นเวลา 2 ครั้ง

ในกรณีที่ท่านอนุญาตให้บันทึกเสียง ผู้วิจัยจะขออนุญาตบันทึกเสียงในประเด็นที่สำคัญขณะทำการสังเกต แต่ถ้าท่าน ไม่อนุญาตจะไม่มีการบันทึกเสียงใดๆเกิดขึ้น

ประโยชน์ที่ได้รับจากโครงการวิจัย?

ท่านอาจจะไม่ได้รับประโยชน์โดยตรงสำหรับงานวิจัยครั้งนี้ แต่ท่านจะได้มีโอกาสในการแลกเปลี่ยนประสบการณ์เกี่ยวกับตัวท่าน ซึ่งผู้วิจัยหวังเป็นอย่างยิ่งว่าผลการวิจัยจะเกิดประโยชน์ในการพัฒนาการดูแลหญิงตั้งครรภ์วัยรุ่นต่อไป

มีการพิทักษ์สิทธิ์ของการเข้าร่วมวิจัยหรือไม่?

ผู้วิจัยได้มีการจัดการเพื่อให้เกิดความมั่นใจว่า ท่านจะไม่ถูกเปิดเผยชื่อเมื่อเข้าร่วมวิจัย ชื่อของท่านจะไม่บันทึกและจะใช้ชื่อสมมุติในการบันทึกข้อมูลทั้งหมด หลังจากการถอดเทปการสัมภาษณ์และบันทึกข้อมูลลงในแฟ้มข้อมูลข้อมูลเสียงทั้งหมดจะถูกทำลาย ส่วนข้อมูลอื่นๆที่แสดงตัวตนของผู้เข้าร่วมวิจัยจะถูกตัดออกและข้อมูลที่บันทึก จะ

ถูกเก็บไว้ในคอมพิวเตอร์ที่มีรหัสผ่าน ซึ่งมีเพียงผู้วิจัยสามารถเข้าถึงได้ส่วนข้อเสนอแนะของท่านจะไม่สามารถอ้างอิงไปถึงตัวท่านได้

มีความเสี่ยงหรือความไม่สุขสบายในการเข้าร่วมการวิจัยหรือไม่?

การวิจัยอาจมีผลกระทบทางด้านจิตใจในขณะที่ให้สัมภาษณ์ เนื่องจากบางคำถามการวิจัยอาจจะทำให้ผู้เข้าร่วม วิจัยรู้สึกอึดอัดและไม่สบายใจ ดังนั้นผู้เข้าร่วมวิจัยสามารถปฏิเสธการตอบคำถามหรือปิดการบันทึกเสียงได้ ตลอดเวลา ถ้าท่านมีความกังวลใจเกี่ยวกับผลกระทบดังกล่าวกรุณาแจ้งผู้วิจัยโดยตรงซึ่งผู้วิจัยได้เตรียมข้อมูล การให้คำปรึกษาแก่ผู้ที่มีปัญหาดังกล่าว ดังนี้

- คลินิกจิตเวช โรงพยาบาลมหาสารคาม
  168 ถนนผดุงวิถี
  ตำบล ตลาด อำเภอ เมือง
  จังหวัด มหาสารคาม 44000
  โทรศัพท์ 043-741225
  แฟกซ์ 043-740993
- โรงพยาบาลจิตเวชราชนครินทร์
  169 ถนนชาตะผดุง
  ตำบล ในเมือง อำเภอ เมือง
  จังหวัด ขอนแก่น 40000
  โทรศัพท์ 043-209999
  แฟกซ์ 043-224722

เข้าร่วมการวิจัยได้อย่างไร?

ท่านสามารถเข้าร่วมการวิจัยโดยความสมัครใจ หากท่านสนใจเข้าร่วมวิจัยกรุณาติดต่อที่โทรศัพท์ หมายเลข +61478712831 หรือพบผู้วิจัยโดยตรงที่คลินิกฝากครรภ์ ถ้าท่านยินยอมเข้าร่วมการวิจัย กรุณาเซ็นต์ใบยินยอม เข้าร่วมวิจัยและส่งกลับมาที่ผู้วิจัย

วิธีได้รับข้อมูลย้อนกลับ?

เมื่อเสร็จสิ้นการวิจัย ผลการวิจัยจะแจ้งให้ผู้เข้าร่วมวิจัยทราบหากท่านต้องการทราบผลการวิจัย ดังกล่าว

ขอขอบคุณท่านที่เสียสละเวลาในการอ่านรายละเอียดโครงการวิจัยและหวังเป็นอย่างยิ่งว่าท่านจะยินดีเข้าร่วม การวิจัยในครั้งนี้

การวิจัยนี้ได้ผ่านคณะกรรมการจริยธรรมของมหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย (โครงการวิจัยหมายเลข 6900)

หากท่านต้องการสอบถามข้อมูลเพิ่มเติมเกี่ยวกับกระบวนการจริยธรรมการวิจัยของโครงการนี้ สามารถติดต่อได้ที่ สำนักงานจริยธรรมของมหาวิทยาลัย เบอร์โทรศัพท์ +6682013116 หรือแฟกซ์ 8201 2035 หรืออีเมลล์ human.researchethics@flinders.edu.au

APPENDIX I Consent forms for caregivers (English and Thai version)

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(By semi- structured interview and participant observation)

An exploration of perceived self-efficacy of young women in Thailand

who are pregnant and attending a prenatal clinic

I ….....

being over the age of 18 years hereby consent to participate as requested in the introductory letter and information sheet for the research project on an exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
    - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
5. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature…….Date…….
NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 6 and 7, as appropriate.

6. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature……Date……...

7. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature……Date……...

ใบยินยอมเข้าร่วมวิจัย

(โดยการสัมภาษณ์และการสังเกตแบบมีส่วนร่วม)

การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทย

ที่มีประสบการณ์การตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

ข้าพเจ้า.....

เป็นผู้มีอายุมากกว่า 18 ปี มีความประสงค์เข้าร่วมโครงการวิจัยนี้ โดยผู้วิจัยได้แนะนำตัว

และอธิบายข้อมูลของโครงการวิจัยเกี่ยวกับ การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่น

ในประเทศไทยที่มีประสบการณ์การตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์ โดยข้าพเจ้า

1. ได้รับทราบเกี่ยวกับโครงการวิจัย
2. ได้รับทราบรายละเอียดเกี่ยวกับขั้นตอนการวิจัย และภาวะเสี่ยงที่อาจจะเกิดขึ้น ขณะเข้าร่วมการวิจัย
3. ยินยอมให้มีการบันทึกบทสนทนาระหว่างการสัมภาษณ์และการมีส่วนร่วม
4. ข้าพเจ้ามีความเข้าใจดีว่า
    - ข้าพเจ้าไม่ได้รับผลประโยชน์ใดๆจากการเข้าร่วมการวิจัยครั้งนี้
    - ข้าพเจ้ามีสิทธิ์ที่จะถอนตัวจากโครงการวิจัยได้ตลอดเวลา และมีสิทธิ์ที่จะปฏิเสธการตอบคำถามในการวิจัย
    - ข้อมูลของการวิจัยที่ถูกตีพิมพ์ จะไม่ปรากฏชื่อข้าพเจ้า และข้อมูลส่วนตัว จะไม่ถูกเปิดเผย
    - ถึงแม้ว่าข้าพเจ้าเข้าร่วมการวิจัย หรือไม่เข้าร่วมการวิจัย หรือ ถอนตัว จากการวิจัย จะไม่มีผลต่อการรักษาหรือสิทธิ์อื่นๆที่ข้าพเจ้าพึงได้รับต่อไป
    - ข้าพเจ้ามีสิทธิ์ที่จะให้หยุดการบันทึกการสนทนา/การสังเกตได้ตลอดเวลา และสามารถถอนตัวขณะทำการวิจัยหรือจากโครงการวิจัยโดยปราศจาก ผลกระทบใดๆทั้งสิ้น
5. ข้าพเจ้าสามารถที่จะพูดคุยหรือแลกเปลี่ยนความคิดเห็นกับครอบครัวหรือเพื่อนต่อการเข้าร่วมโครงการวิจัย

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

ผู้วิจัยขอรับรองว่าได้อธิบายข้อมูลทั้งหมดแก่ผู้เข้าร่วมโครงการ และผู้เข้าร่วมโครงการเข้าใจ

ต่อโครงการวิจัยและยินยอมเข้าร่วมโครงการวิจัย

ชื่อผู้วิจัย.....

ลายเซ็นต์ผู้วิจัย.....วันที่.....

6. ข้าพเจ้าเป็นผู้เข้าร่วมโครงการวิจัยซึ่งเป็นผู้เซ็นต์ลายเซ็นต์ด้านล่าง ได้อ่านบันทึก ข้อมูลจากการเข้าร่วมการวิจัย ข้าพเจ้าเห็นด้วยเป็นอย่างยิ่งกับการอธิบายข้อมูล ของผู้วิจัย

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

7. ข้าพเจ้าเป็นผู้เข้าร่วมโครงการวิจัยซึ่งเป็นผู้เซ็นต์ลายเซ็นต์ด้านล่าง ได้อ่านรายงานการวิจัย ข้าพเจ้าเห็นด้วยเป็นอย่างยิ่งกับตีพิมพ์ข้อมูลดังกล่าว
8. ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

APPENDIX J Consent forms for the permission of the parents or guardians (English and Thai version)

PARENTAL CONSENT FORM FOR CHILD PARTICIPATION IN RESEARCH
CONSENT FORM FOR PARTICIPATION IN RESEARCH
(By semi- structured interview and participant observation)

An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic

I ….....

being over the age of 18 years hereby consent to my child .....

participating, as requested, in the introductory letter and information sheet for the research project on an exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

1. I have read the information provided.

2. Details of procedures and any risks have been explained to my satisfaction.

3. I agree to audio recording of my child's information and participation.

4. I understand that:

- My child may not directly benefit from taking part in this research.
- My child is free to withdraw from the project at any time and is free to decline to answer particular questions.
- While the information gained in this study will be published as explained, my child will not be identified, and individual information will remain confidential.
- Whether my child participates or not, or withdraws after participating, will have no effect on any treatment or service that is being provided to her.
- My child may ask that the recording/observation be stopped at any time, and she may withdraw at any time from the session or the research without disadvantage.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……. Date…….
NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 5 and 6, as appropriate.

5. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature……Date……...

6. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature……Date……...

PREGNANT ADOLESCENT CONSENT FORM FOR PARTICIPANT PHOTOGRAPH RELEASE FORM

An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic.

I ….....
agree to the photographs I have taken for the *research study* 'An exploration of perceived self-efficacy of young women in Thailand who are pregnant and attending a prenatal clinic' (as requested in the Participant Information Sheet) to be used for:
[please circle whichever applies]

researcher's background analysis only / not for display	agree/don't agree
display in thesis materials	agree/don't agree
display in academic articles and presentations	agree/don't agree

4. I have read the information provided in the Participant Information Sheet.
5. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Participant Photograph Release Form for future reference.
4. I understand that:
    - All photographs will be de-identified using computer editing software
    - Photographs will be numbered not labelled to maintain anonymity.

Participant's signature…… **Date……...**

I certify that I have explained how photographs will be used to the volunteer and consider that she understands what is involved and freely consents to participation.

Researcher's name……

Researcher's signature……. **Date…….**

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (project number 6900). *For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au*

ใบยินยอมเข้าร่วมวิจัยของผู้ปกครองสำหรับผู้อยู่ในความปกครองเข้าร่วมการวิจัย
(โดยการสัมภาษณ์และการสังเกตแบบมีส่วนร่วม)

การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทย

ที่มีประสบการณ์การตั้งครรภ์และฝากครรภ์ที่คลินิกฝากครรภ์

ข้าพเจ้า…….

เป็นผู้มีอายุมากกว่า 18 ปี ขอแสดงความยินยอมให้ผู้อยู่ในความปกครอง..... เข้าร่วมโครงการวิจัยนี้ โดยผู้วิจัยได้แนะนำตัวและอธิบายข้อมูลของโครงการวิจัย เกี่ยวกับ

การศึกษาการรับรู้สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่มีประสบการณ์การตั้งครรภ์ และ

ฝากครรภ์ที่คลินิกฝากครรภ์ โดยข้าพเจ้า

1. ได้รับทราบเกี่ยวกับโครงการวิจัย
2. ได้รับทราบรายละเอียดเกี่ยวกับขั้นตอนการวิจัย และภาวะเสี่ยงที่อาจจะเกิดขึ้นขณะเข้าร่วม การวิจัย
3. ยินยอมให้มีการบันทึกบทสนทนาของผู้อยู่ในความปกครองระหว่างการสัมภาษณ์และการ มีส่วนร่วม
4. ข้าพเจ้ามีความเข้าใจดีว่า

- ผู้อยู่ในความปกครองของข้าพเจ้าไม่ได้รับผลประโยชน์ใดๆจากการเข้าร่วมการ วิจัยครั้งนี้
- ผู้อยู่ในความปกครองของข้าพเจ้ามีสิทธิ์ที่จะถอนตัวจากโครงการวิจัยได้ตลอดเวลา และมีสิทธิ์ที่จะปฏิเสธการตอบคำถามในการวิจัย
- ข้อมูลของการวิจัยที่ถูกตีพิมพ์ จะไม่ปรากฏชื่อผู้อยู่ในความปกครอง ของข้าพเจ้า และข้อมูลส่วนตัวจะไม่ถูกเปิดเผย

- ถึงแม้ว่าผู้อยู่ในความปกครองของข้าพเจ้าเข้าร่วมการวิจัย หรือ ไม่เข้าร่วมการวิจัย หรือถอนตัวจากการวิจัย จะไม่มีผลต่อการรักษาหรือสิทธิ์อื่นๆที่พึงได้รับต่อไป
- ผู้อยู่ในความปกครองของข้าพเจ้ามีสิทธิ์ที่จะให้หยุดการบันทึกการ สนทนา/การสังเกตได้ตลอดเวลา และสามารถถอนตัวขณะทำการวิจัยหรือจากโครงการวิจัยโดยปราศจากผลกระทบใดๆทั้งสิ้น

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

ผู้วิจัยขอรับรองว่าได้อธิบายข้อมูลทั้งหมดแก่ผู้เข้าร่วมโครงการ และผู้เข้าร่วมโครงการเข้าใจต่อโครงการวิจัยและยินยอมเข้าร่วมโครงการวิจัย

ชื่อผู้วิจัย.....

ลายเซ็นต์ผู้วิจัย.....วันที่.....

5. ข้าพเจ้าเป็นผู้เข้าร่วมโครงการวิจัยซึ่งเป็นผู้เซ็นต์ลายเซ็นต์ด้านล่าง ได้อ่านบันทึกข้อมูลจากการเข้าร่วมการวิจัย ข้าพเจ้าเห็นด้วยเป็นอย่างยิ่งกับการอธิบายข้อมูล ของผู้วิจัย

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

6. ข้าพเจ้าเป็นผู้เข้าร่วมโครงการวิจัยซึ่งเป็นผู้เซ็นต์ลายเซ็นต์ด้านล่าง ได้อ่านรายงานการวิจัย ข้าพเจ้าเห็นด้วยเป็นอย่างยิ่งกับตีพิมพ์ข้อมูลดังกล่าว

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

ใบยินยอมเข้าร่วมวิจัยของหญิงตั้งครรภ์ในการใช้ภาพถ่าย

ข้าพเจ้า…….

ยินยอมให้ใช้ภาพถ่ายของผู้อยู่ในความปกครองในโครงการวิจัยเกี่ยวกับ การศึกษาการรับรู้

สมรรถนะของหญิงวัยรุ่นในประเทศไทยที่มีประสบการณ์การตั้งครรภ์และฝากครรภ์ ที่คลินิกฝากครรภ์

(จากรายละเอียดโครงการวิจัย) เพื่อใช้สำหรับ

(กรุณาวงกลมในการยินยอม)

เพื่อใช้ในการวิเคราะห์ข้อมูลงานวิจัย/ไม่แสดงรายละเอียด	เห็นด้วย/ ไม่เห็นด้วย
นำเสนอในเล่มวิจัย	เห็นด้วย/ ไม่เห็นด้วย
นำเสนอในวารสารและการนำเสนอ	เห็นด้วย/ ไม่เห็นด้วย

1. ได้รับทราบเกี่ยวกับโครงการวิจัย

2. ได้รับทราบรายละเอียดเกี่ยวกับขั้นตอนการวิจัย และภาวะเสี่ยงที่อาจจะเกิดขึ้นขณะเข้าร่วม การวิจัย

3. ข้าพเจ้าเข้าใจดีว่าสามารถสงวนสิทธิ์ในสำเนาเอการและรูปภาพที่ถ่ายไว้ในอนาคตได้

4. ข้าพเจ้าเข้าใจดีว่า

- รูปถ่ายทั้งหมดไม่สารมารถระบุตัวได้โดยคอมพิวเตอร์
- รูปถ่ายจะใช้หมายเลขในการปกปิดความลับของผู้เข้าร่วมวิจัย

ลายเซ็นต์ผู้เข้าร่วมโครงการวิจัย.....วันที่.....

ผู้วิจัยขอรับรองว่าได้อธิบายข้อมูลทั้งหมดแก่ผู้เข้าร่วมโครงการ และผู้เข้าร่วมโครงการเข้าใจต่อ

โครงการวิจัยและยินยอมเข้าร่วมโครงการวิจัย

ชื่อผู้วิจัย.....

ลายเซ็นต์ผู้วิจัย.....วันที่.....

การวิจัยนี้ได้ผ่านคณะกรรมการจริยธรรมของมหาวิทยาลัยฟรินเดอร์ ประเทศออสเตรเลีย (โครงการวิจัยหมายเลข 6900)
หากท่านต้องการสอบถามข้อมูลเพิ่มเติมเกี่ยวกับกระบวนการจริยธรรมการวิจัยของโครงการนี้ สามารถติดต่อได้ที่ สำนักงานจริยธรรมของมหาวิทยาลัย เบอร์โทรศัพท์ +6682013116 หรือแฟกซ์ 8201 2035 หรืออีเมลล์ human.researchethics@flinders.edu.au

APPENDIX K Conference arises from this study

Oral presentation in the sixth Asian international conference on humanised health care2017 AIC 2017: Humanised health care in the challenges of the transforming world 6-8 December, 2017 at Khon Kaen Province, Thailand.

BIBLIOGRAPHY

Aarnoudse-Moens, C. S. H., Weisglas-Kuperus, N., van Goudoever, J. B., & Oosterlaan, J. (2009). Meta-analysis of neurobehavioral outcomes in very preterm and/or very low birth weight children. *Pediatrics, 124*(2), 717-728. doi:10.1542/peds.2008-2816

Abu-Heija, A., Ali, A. M., & Al-Dakheil, S. (2002). Obstetrics and perinatal outcome of adolescent nulliparous pregnant women. *Gynecologic and Obstetric Investigation, 53*(2), 90-92. doi:10.1159/000053000

AlBuhairan, F., Areemit, R., Harrison, A., & Kaufman, M. (2012). Adolescent psychosocial development and evaluation: Global perspectives. In Ö. Özdemir (Ed.), *Complementary Pediatrics*. Croatia: InTech.

Andajani-Sutjahjo, S., Chirawatkul, S., & Saito, E. (2015). Gender and water in Northeast Thailand: inequalities and women's realities. *Journal of International Women's Studies, 16*(2), 200.

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies, 5*(2), 272-281.

Archawanitkul, K., & Im-am, W. (2003). *Violence against women* Thailand: Institute for Population and Social, Mahidol University.

Areemit, R., Thinkhamrop, J., Kosuwon, P., Kiatchoosakun, P., Sutra, S., & Thepsuthammarat, K. (2012). Adolescent pregnancy: Thailand's national agenda. *Journal of the Medical Association of Thailand, 95*(Suppl 7), S134-S142.

Arnett, J. J. (2001). Conceptions of the transition to adulthood: Perspectives from adolescence through midlife. *Journal of adult development, 8*(2), 133-143.

Asnong, C., Fellmeth, G., Plugge, E., San Wai, N., Pimanpanarak, M., Paw, M. K., . . . McGready, R. (2018). Adolescents' perceptions and experiences of pregnancy in refugee and migrant communities on the Thailand-Myanmar border: A qualitative study. *Reproductive Health, 15*(1), 83. doi:10.1186/s12978-018-0522-7

Attoh, F. C. (2017). Gender, religion and patriarchy: A sociological analysis of catholicism and pentecostalism in Nigeria. *Advances in Social Sciences Research Journal, 4*(14), 158-170. doi:10.14738/assrj.414.3482

Atuyambe, L., ., Mirembe, F., Johansson, A., Kirumira, E. K., & Faxelid, E. (2005). Experiences of

pregnant adolescents-voices from Wakiso district, Uganda. *African Health Sciences, 5*(4), 304-309.

Atuyambe, L., Mirembe, F., Annika, J., Kirumira, E. K., & Faxelid, E. (2009). Seeking safety and empathy: Adolescent health seeking behavior during pregnancy and early motherhood in central Uganda. *Journal of Adolescence, 32*(4), 781-796. doi:10.1016/j.adolescence.2008.10.012

Awopetu, R. G., Ihuoma, I. H., & Temitope, N. R. (2013). Attitude and perception of adolescents towards teenage pregnancy in Makurdi metropolis. *Gender and Behaviour, 11*(1), 5272-5277.

Aziato, L., Hindin, M. J., Maya, E. T., Manu, A., Amuasi, S. A., Lawerh, R. M., & Ankomah, A. (2016). Adolescents' responses to an unintended pregnancy in Ghana: A qualitative study. *Journal of pediatric and adolescent gynecology, 29*(6), 653-658. doi:101016/j.jpag.2016.06.005

Bah, Y. M. (2016). Teenage Pregnancy: Teenage Mothers' Experiences and Perspectives: A Qualitative Study. *Journal of Health, Medicine and Nursing, 29*, 2.

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice, 25*(2), 127-131. doi:10.1093/fampra/cmn003

Banerjee, B., Pandey, G., Dutt, D., Sengupta, B., Mondal, M., & Deb, S. (2009). Teenage pregnancy: A socially inflicted health hazard. *Indian Journal of Community Medicine, 34*(3), 227. doi:10.4103/2F0970-0218.55289

Bareket, O., Kahalon, R., Shnabel, N., & Glick, P. (2018). The madonna-whore dichotomy: Men who perceive women's nurturance and sexuality as mutually exclusive endorse patriarchy and show Lower relationship satisfaction. *Sex Roles*, 1-14. doi:10.1007/s11199-018-0895-7

Barnett, O., Miller-Perrin, C. L., & Perrin, R. D. (2005). *Family violence across the lifespan: An introduction*. USA: Sage

Basch, C. E. (2011). Teen pregnancy and the achievement gap among urban minority youth. *Journal of School Health, 81*(10), 614-618.

Begum, S., & Sen, B. (2005). Maternal health, child well-being and intergenerationally transmitted chronic poverty: Does women's agency matter? *Bangladesh Institute of Development Studies, 32*(4), 69-94. doi:10.2139/ssrn.1757959

Bhana, D., & Mcambi, S. J. (2013). When schoolgirls become mothers: Reflections from a selected group of teenage girls in Durban. *Perspectives in Education, 31*(1), 11-19.

Birkeland, R., Thompson, J. K., & Phares, V. (2005). Adolescent motherhood and postpartum depression. *Journal of Clinical Child and Adolescent Psychology, 34*(2), 292-300.

Black, A. Y., Fleming, N. A., & Rome, E. S. (2012). Pregnancy in adolescents. *Adolescent Medicine, 23*(1), 123-138.

Blum, R. W., & Nelson-Mmari, K. (2004). The health of young people in a global context. *Journal of Adolescent Health, 35*(5), 402-418.

Bochow, A. (2012). Let's talk about sex: Reflections on conversations about love and sexuality in Kumasi and Endwa, Ghana. *Culture, Health & Sexuality, 14*(sup1), S15-S26. doi:10.1080/13691058.2012.723751

Bornstein, F. R. (2006). The complex relationship between dependency and domestic violence: Converging psychological factors and social forces. *American Psychologist, 61*(6), 595-606. doi:10.1037/0003-066X.61.6.595

Boucher, M. L. (2018). Interrogating whiteness: Using photo-elicitation to empower teachers to talk about race. In L. Michael & J. Boucher (Eds.), *Participant empowerment through photo-elicitation in ethnographic education research* (pp. 201-225). USA: Springer.

Braga, I. F., Oliveira, W. A. d., Spanó, A. M. N., Nunes, M. R., & Silva, M. A. I. (2014). Perceptions of adolescents concerning social support provided during maternity in the context of primary care. *Escola Anna Nery, 18*(3), 448-455.

Braun, V., & Clarke, V. (2012). *APA handbook of research methods in psychology. Vol. 2, Research designs: Quantitative, qualitative, neuropsychological, and biological*. Washington, D.C.: American Psychological Association.

Brewer, J. (2000). *Ethnography*. UK: McGraw-Hill

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behaviour. *Journal of Child Psychology and Psychiatry, 47*(3-4), 372-394. doi:10.1111/j.1469-7610.2006.01615.x

Bronfenbrenner, U. (1979). *The ecology of human development*. USA: Harvard University Press.

Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender & Society, 21*(4), 528-552.

Bureau of Reproductive Health. (2016). *The situations of reproductive health in adolescences 2016*. Retrieved from http://rh.anamai.moph.go.th/ewt_dl_link.php?nid=86

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*(3), 225-246.

doi:10.1177/1524838009334456

Chambers, B. D., & Erausquin, J. T. (2015). The promise of intersectional stigma to understand the complexities of adolescent pregnancy and motherhood. *Journal of Child and Adolescent Behavior, 3*(5), 249. doi:10.4172/2375-4494.1000249

Charmaraman, L., & McKamey, C. (2011). Urban early adolescent narratives on sexuality: Accidental and intentional influences of family, peers, and the media. *Sexuality Research and Social Policy, 8*(4), 253. doi:10.1007/s13178-011-0052-3

Chen, H. Y., & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing, 19*(1-2), 234-239. doi:10.1111/j.1365-2702.2009.02896.x

Chigona, A., & Chetty, R. (2008). Teen mothers and schooling: Lacunae and challenges. *South African Journal of Education, 28*(2), 261-282.

Chirawatkul, S., Rungreangkulkij, S., Sawanchareon, K., & Watananukooliat, S. (2012). Ethnic traditions: Women's well-being in four ethnic groups in northern Thailand. *Journal of Nursing Science and Health, 34*(2), 80-91.

Chirayus, S., & Chandeying, V. (2012). Outcome of adolescent pregnancy in different periods: Vachira Phuket Hospital. *Journal of the Medical Association of Thailand, 95*(11), 1384.

Clark-Ibáñez, M. (2004). Framing the social world with photo-elicitation interviews. *American Behavioral Scientist, 47*(12), 1507-1527. doi:10.1177/2F0002764204266236

Clark, B. S., & Anderson, D. M. (2014). Not yet a woman, not yet a mom: The leisure experiences of pregnant adolescents. *Journal of Leisure Research, 46*(5), 509-524.

Clarke, L. (2005). Fighting the" dual fight"-early pregnancy and HIV/AIDS. *AIDS Bulletin, 14*(2), 12-13.

Coelho, F. M. d. C., Pinheiro, R. T., Silva, R. A., Quevedo, L. d. A., Castelli, L. D. d. M. S. R. D., Matos, M. B. d., & Pinheiro, K. A. T. (2013). Major depressive disorder during teenage pregnacy: Socio-demographic, obstetric and psychosocial correlats. *Rev Bras Pslqulatr, 35*(1), 51-56. doi:10.1016/j.rbp.2012.03.006

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education.* London: Routledge.

Connor, J. J., & Rueter, M. A. (2006). Parent-child relationships as systems of support or risk for adolescent suicidality. *Journal of Family Psychology, 20*(1), 143.

Copeland, F. (2011). *Conflicting context: Midwives' interpretation of childbirth through photo elicitation.* (Master's thesis), University of Technology, Sydney, Australia.

Crandall, S. M. (2013). *How African American adolescent females construct sexuality: A qualitative ethnographic study.* (Doctoral dissertation), The University of Texas, USA.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches*. USA: Sage publications.

Critical Appraisal Skills Programme. (2018). Checklist. Retrieved from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist.pdf

Croghan, R., Griffin, C., Hunter, J., & Phoenix, A. (2008). Young people's constructions of self: Notes on the use and analysis of the photo-elicitation methods. *International Journal of Social Research Methodology, 11*(4), 345-356. doi:10.1080/13645570701605707

Cronin, C. (2003). First-time mothers–identifying their needs, perceptions and experiences. *Journal of Clinical Nursing, 12*(2), 260-267.

Darroch, J. E., Woog, V., Bankole, A., & Ashford, L. S. (2016). *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute.

Davis, J. H. (2017). *A Mirror is for reflection: Understanding Buddhist Ethics*: Oxford University Press.

DeKeseredy, W. S. (2011). Feminist contributions to understanding woman abuse: Myths, controversies, and realities. *Aggression and Violent Behavior, 16*(4), 297-302.

DePadilla, L., Windle, M., Wingood, G., Cooper, H., & DiClemente, R. (2011). Condom use among young women: Modeling the theory of gender and power. *Health Psychology, 30*(3), 310-319.

Department of Labour Protection and Welfare. (2015). General information on the Thai labour laws. Retrieved from https://www.labour.go.th/th/index.php?searchword=child+labour&ordering=&searchphrase=all&Itemid=1&option=com_search

Deuba, K., Mainali, A., Alvesson, H. M., & Karki, D. K. (2016). Experience of intimate partner violence among young pregnant women in urban slums of Kathmandu valley, Nepal: a qualitative study. *BMC women's health, 16*(1), 11-19.

DeWalt, K. M., & DeWalt, B. R. (2011). *Participant observation: A guide for fieldworkers*. New York: Rowman Altamira.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interviews. *Medical Education, 40*(4), 314-321. doi:10.1111/j.1365-2929.2006.02418.x

Dommaraju, P., & Tan, J. (2014). Households in Contemporary Southeast Asia. *Journal of Comparative Family Studies, 45*(4), 559-580.

Dore, I. (2009). Foucault on power. *UMKC L. Rev., 78*, 737.

Dutton, D. G. (2010). The gender paradigm and the architecture of antiscience. *Partner Abuse, 1*(1), 5-25.

East, L., Jackson, D., O'Brien, L., & Peters, K. (2012). Stigma and stereotypes: Women and sexually transmitted infections. *Collegian, 19*(1), 15-21. doi:10.1016/j.colegn.2011.10.001

Ellison, M. A. (2003). Authoritative knowledge and single women's unintentional pregnancies, abortions, adoption, and single motherhood: Social stigma and structural violence. *Medical Anthropology Quarterly, 17*(3), 322-347. doi:10.1525/maq.2003.17.3.322

Eloundou-Enyegue, P. M. (2004). Pregnancy-related dropouts and gender inequality in education: A life-table approach and application to Cameroon. *Demography, 41*(3), 509-528.

Embassy of the Kingdom of Thailand. (2007). *Culture grams: World edition 2008*. Retrieved from http://www.nw-services.com/culture%20grams/thailand.pdf

Epstein, I., Stevens, B., McKeever, P., & Baruchel, S. (2006). Photo elicitation interview (PEI): Using photos to elicit children's perspectives. *International Journal of Qualitative Methods, 5*(3), 1-11.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4.

Fengxue, Y., Isaranurug, S., Nanthamongkolchai, S., & Wongsawass, S. (2003). Attitudes toward adolescent pregnancy, induced abortion and supporting health services among high school students in Phuttamonthon district, Nakhon Pathom province, Thailand. *Journal of Public Health and Development, 1*(1), 25-33.

Fernquest, J. (2013, 8 Mar 2013). Teen pregnancy: Growing problem in Thailand. *Bangkok Post*.

Fessler, K. B. (2008). *Reclaiming a spoiled maternal identity: Young mothers' experiences and rejection of stigma.* (Doctoral dissertation), University of Michigan, USA.

Fetterman, D. M. (2010). *Ethnography: Step-by-step* (3 ed.). USA: Sage.

Figueiredo, B., Bifulco, A., Pacheco, A., Costa, R., & Magarinho, R. (2006). Teenage pregnancy, attachment style, and depression: A comparison of teenage and adult pregnant women in a Portuguese series. *Attachment & Human Development, 8*(2), 123-138.

Filson, J., Ulloa, E., Runfola, C., & Hokoda, A. (2010). Does powerlessness explain the relationship between intimate partner violence and depression? *Journal of Interpersonal Violence, 25*(3), 400-415.

Fleming, N., Ng, N., Osborne, C., Biederman, S., Yasseen III, A. S., Dy, J., . . . Walker, M. (2013). Adolescent pregnancy outcomes in the province of Ontario: A cohort study. *Journal of Obstetrics and Gynaecology Canada, 35*(3), 234-245.

Foley, J. A. (2005). English in… Thailand. *RELC journal, 36*(2), 223-234.

Foshaugen, E. (2004). Thompson's modes of operation of ideology and depth hermeneutics as hermeneutical tools: Ideology and the Sermon on the Mount (Matthew 4: 23-7: 29). *Acta Theologica, 24*(1), 186-200.

Frith, H. (2009). Sexual scripts, sexual refusals and rape *Rape* (pp. 122-145). USA: Willan.

Frith, H., & Kitzinger, C. (2001). Reformulating sexual script theory: Developing a discursive psychology of sexual negotiation. *Theory & Psychology, 11*(2), 209-232.

Fuchs, C. (2015). *The international encyclopedia of political communication*. UK: John Wiley & Sons.

Fuery, P., & Mansfield, N. (2000). *Cultural studies and critical study*. Singapore: Oxford university press.

Gailey, J. A., & Prohaska, A. (2011). Power and gender negotiations during interviews with men about sex and sexually degrading practices. *Qualitative Research, 11*(4), 365-380.

Galvez-Myles, R., & Myles, T. D. (2005). Teenage pregnancy in the Texas Panhandle. *The Journal of Rural Health, 21*(3), 259-262.

Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., . . . Tunçalp, Ö. (2014). Pregnancy and childbirth outcomes among adolescent mothers: A World Health Organisation multicountry study. *BJOG: An International Journal of Obstetrics & Gynaecology, 121*(s1), 40-48.

Gavin, A. R., Chae, D. H., Mustillo, S., & Kiefe, C. I. (2009). Prepregnancy depressive mood and preterm birth in black and white women: Findings from the CARDIA study. *Journal of Women's*

Health, 18(6), 803-811.

Geertz, C. (2000). *Available light: Anthropological Reflections on Philosophical Topics*. USA: Princeton.

Geibel, S., Hossain, S. M., Pulerwitz, J., Sultana, N., Hossain, T., Roy, S., . . . Yasmin, R. (2017). Stigma reduction training improves healthcare provider attitudes toward, and experiences of, young marginalized people in Bangladesh. *Journal of Adolescent Health, 60*(2), S35-S44. doi:10.1016/j.jadohealth.2016.09.026

Gennari, P. J. (2013). Adolescent Pregnancy. *International Journal of Childbirth Education, 28*(1), 57-62.

Germov, J., & Poole, M. (2006). *Public sociology: An introduction to Austrailan society*. Australia: Southwood Press.

Gneezy, U., Leonard, K. L., & List, J. A. (2009). Gender differences in competition: Evidence from a matrilineal and a patriarchal society. *Econometrica, 77*(5), 1637-1664.

Goffman, E. (2009). *Stigma: notes on the management of spoiled identity*. USA: Simon and Schuster.

Grady, M. A., & Bloom, K. C. (2004). Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy program. *Journal of Midwifery & Women's Health, 49*(5), 412-420.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi:10.1016/j.nedt.2003.10.001

Grant, M. J., & Hallman, K. K. (2008). Pregnancy-related school dropout and prior school performance in KwaZulu-Natal, South Africa. *Studies in Family Planning, 39*(4), 369-382.

Gross, K., Alba, S., Glass, T. R., Schellenberg, J. A., & Obrist, B. (2012). Timing of antenatal care for adolescent and adult pregnant women in south-eastern Tanzania. *BMC Pregnancy and Childbirth, 12*(1), 16.

Grote, N. K., Bridge, J. A., Gavin, A. R., Melville, J. L., Iyengar, S., & Katon, W. J. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Archives of General Psychiatry, 67*(10), 1012-1024.

Gueorguieva, R. V., Carter, R. L., Ariet, M., Roth, J., Mahan, C. S., & Resnick, M. B. (2001). Effect of teenage pregnancy on educational disabilities in kindergarten. *American Journal of*

Epidemiology, 154(3), 212-220.

Gupta, N., Kiran, U., & Bhal, K. (2008). Teenage Pregnancies: Obstetric characteristics and outcome. *European Journal of Obstetrics and Gynecology and Reproductive Biology, 137*(2), 165-171.

Haddrill, R., Jones, G. L., Mitchell, C. A., & Anumba, D. O. (2014). Understanding delayed access to antenatal care: A qualitative interview study. *BMC Pregnancy and Childbirth, 14*(1), 207.

Hammersley, M. (2006). Ethnography: Problems and prospects. *Ethnography and Education, 1*(1), 3-14. doi:10.1080/17457820500512697

Haralambos, M., & Holborn, M. (2008). *Sociology: Themes and perspectives*. London: Harper Collins Publications Limited.

Hardy, C., Phillips, N., & Clegg, S. (2001). Reflexivity in organisation and management theory: A study of the production of the research subject. *Human Relations, 54*(5), 531-560.

Harley, K., & Eskenazi, B. (2006). Time in the United States, social support and health behaviors during pregnancy among women of Mexican descent. *Social Science & Medicine, 62*(12), 3048-3061. doi:10.1016/j.socscimed.2005.11.036

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies, 17*(1), 13-26. doi:10.1080/14725860220137345

Hergenrather, K. C., Rhodes, S. D., Cowan, C. A., Bardhoshi, G., & Pula, S. (2009). Photovoice as community-based participatory research: A qualitative review. *American Journal of Health Behavior, 33*(6), 686-698.

Herrman, J. W. (2008). Adolescent perceptions of teen births. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 37*(1), 42-50. doi:10.1111/J.1552-6909.2007.00201.x

Hewitt, M. A. (2004). *Michel Foucault : Power/knowledge and epistemological prescriptions.* (Honors Thesis), University of Richmond, USA.

Hiremath, P. (2016). Need for psychological assessment during pregnancy- A nursing perspective *Global Journal of Nursing & Forensic Studies in family planning, 1*(3), 107. doi:10.4172/2572-0899.1000107

Hoare, K. J., Buetow, S., Mills, J., & Francis, K. (2013). Using an emic and etic ethnographic technique in a grounded theory study of information use by practice nurses in New Zealand. *Journal of Research in Nursing, 18*(8), 720-731.

Hoey, B. A. (2014). A simple introduction to the practice of ethnography and guide to ethnographic fieldnotes. *Marshall University Digital Scholar*. Retrieved from https://works.bepress.com/brian_hoey/12/

Hoggart, L. (2012). 'I'm pregnant… what am I going to do?'An examination of value judgements and moral frameworks in teenage pregnancy decision making. *Health, Risk & Society, 14*(6), 533-549.

Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12*(2), 307-312.

Howson, R., & Smith, K. (2008). *Hegemony: Studies in consensus and coercion*. New York: Routledge.

Humayun, A., Haider, I., Imran, N., Iqbal, H., & Humayun, N. (2013). Antenatal depression and its predictors in Lahore, Pakistan. *Eastern Mediterranean Health Journal, 19*(4), 327.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy" as a theoretical tool. *Violence Against Women, 15*(5), 553-573.

Hurworth, R. (2003). Photo Interviewing for research. *Social research Update, Spring 2003*(40), 1-7.

Jackson, S. M., & Cram, F. (2003). Disrupting the sexual double standard: Young women's talk about heterosexuality. *British Journal of Social Psychology, 42*(1), 113-127.

James, S., Van Rooyen, D., & Juanita Strümpher, D. (2012). Experiences of teenage pregnancy among Xhosa families. *Midwifery, 28*(2), 190-197.

Jantacumma, N., Powwattana, A., Lagampan, S., & Chansatitporn, N. (2018). Predictive Model of Quality of Life among Thai Pregnant Teenagers. *Pacific Rim International Journal of Nursing Research, 22*(1), 30-42.

Jiumpanyarach, W. (2011). *Single-parent Families in Bangkok, Thailand: Factors Affecting Children Living in Single-parent Families.* (Doctoral dissertation), University of Kentucky, USA.

Kaljee, L. M., Green, M., Riel, R., Lerdboon, P., & Minh, T. T. (2007). Sexual stigma, sexual behaviors, and abstinence among Vietnamese adolescents: Implications for risk and protective behaviors for HIV, sexually transmitted infections, and unwanted pregnancy. *Journal of the Association of Nurses in AIDS Care, 18*(2), 48-59.

Kaur, R. (2016). Feminism: Introduction and Aims. *Imperial Journal of Interdisciplinary Research,*

2(6), 1107-1109.

Kawulich, B. B. (2005). *Participant observation as a data collection method*. Forum: Qualitative Social Research Sozialforschung, 6(2). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/466/996

Keating, A., & Fleming, V. E. (2009). Midwives' experiences of facilitating normal birth in an obstetric-led unit: A feminist perspective. *Midwifery, 25*(5), 518-527.

Keller, S., & Conradin, K. (2018). Semi-Structured Interviews. Retrieved from https://www.sswm.info/planning-and-programming/decision-making/gathering-ideas/semi-structured-interviews

Kelley, K. (2015). *Patriarchy, empire, and ping pong shows: The political economy of sex tourism in Thailand.* (Bachelor), Columbia College Chicago, USA.

Kern, L. (2003). *Gendered fears and racialized spaces: social exclusions and women's fear of violence in suburban and urban environments.* (Master's thesis), USA, University of Toronto.

Khashan, A. S., Baker, P. N., & Kenny, L. C. (2010). Preterm birth and reduced birthweight in first and second teenage pregnancies: a register-based cohort study. *BMC Pregnancy and Childbirth, 10*(1), 36.

Killias, M., & Clerici, C. (2000). Different measures of vulnerability in their relation to different dimensions of fear of crime. *British Journal of Criminology, 40*(3), 437-450.

Kincheloe, J., L, & McLaren, P. (2002). Rethinking critical theory and qualitative research. In Yali Zou & E. T. Trueba (Eds.), *Ethnography and schools: Qualitative approaches to the study of education* (pp. 87-113). USA: Rowman & Littlefield

Kincheloe, J., L, & McLaren, P. (2003). Rethinking critical theory and qualitative research. In J. L. Kincheloe, K. Hayes, S. R. Steinberg, & K. Tobin (Eds.), *Key works in critical pedagogy* (pp. 285). Netherland: Sense Publisher.

King, C. A., & Merchant, C. R. (2008). Social and interpersonal factors relating to adolescent suicidality: A review of the literature. *Archives of Suicide Research, 12*(3), 181-196.

Klein, D. A., & Adelman, W. P. (2008). Adolescent pregnancy in the US military: What we know and what we need to know. *Military Medicine, 173*(7), 658-665.

Klingberg-Allvin, M., Binh, N., Johansson, A., & Berggren, V. (2008). One foot wet and one foot dry: Transition into motherhood among married adolescent women in rural Vietnam. *Journal of*

Transcultural Nursing, 19(4), 338-346. doi:10.1177/2F1043659608322419

Klis, K. A., Westenberg, L., Chan, A., Dekker, G., & Keane, R. J. (2002). Health Inequalities: Teenage pregnancy: Trends, characteristics and outcomes in South Australia and Australia. *Australian and New Zealand Journal of Public health, 26*(2), 125-131.

Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., & Santamaria, J. (2014). *Voice and agency: Empowering women and girls for shared prosperity*. Washington DC: World Bank Group.

Klunklin, A., & Greenwood, J. (2005). Buddhism, the status of women and the spread of HIV/AIDS in Thailand. *Health Care for Women International, 26*(1), 46-61.

Koenig, H., Koenig, H. G., King, D., & Carson, V. B. (2012). *Handbook of religion and health*. New York: Oxford University Press.

Kongnyuy, E. J., Nana, P. N., Fomulu, N., Wiysonge, S. C., Kouam, L., & Doh, A. S. (2008). Adverse perinatal outcomes of adolescent pregnancies in Cameroon. *Maternal and Child health journal, 12*(2), 149-154. doi:10.1007/s10995-007-0235-y

Kovavisarach, E., Chairaj, S., Tosang, K., Asavapiriyanont, S., & Chotigeat, U. (2010). Outcome of teenage pregnancy in Rajavithi Hospital. *Journal of the Medical Association of Thailand, 93*(1), 1.

Kuasirikun, N. (2011). The portrayal of gender in annual reports in Thailand. *Critical Perspectives on Accounting, 22*(1), 53-78.

Kuwinpant, P. (2002). *Thai society and culture.* (Doctoral dissertation), Nagoya University, Japan.

Laiphrakpam, M., & Aroonsrimorakot, S. (2017). Dowry in India and bride price in Thailand. *Journal of Thai Interdisciplinary Research, 11*(6), 33-39.

Lall, M. (2007). Exclusion from school: Teenage pregnancy and the denial of education. *Sex Education, 7*(3), 219-237.

Langhout, R. D. (2014). Photovoice as a methodology. In M. B. Schenker, X. Castañeda, & A. Rodriguez-Lainz (Eds.), *Migration and health: A research methods handbook*. California: University of California Press.

Lay, K., & Daley, J. G. (2007). A critique of feminist theory. *Advances in Social Work, 8*(1), 49-61.

Learman, L. (2005). *Modernity, marriage, and religion: Buddhist marriages in Taiwan.* (Doctoral dissertation), Boston University, USA.

Lee, C., Aules, Y., Sami, S., Lar, P. K., Schlect, J., & Robinson, C. (2017). Sexual and reproductive health needs and risks of very young adolescent refugees and migrants from Myanmar living in Thailand. *Conflict and Health, 11*(1), 30. doi:10.1186/s13031-017-0130-0

Lerner, R. M., & Steinberg, L. (2009). *Handbook of adolescent psychology, volume 1: Individual bases of adolescent development* (Vol. 1). USA: John Wiley & Sons.

Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma. *International Journal of Gynecology & Obstetrics, 118*(S2), S167–S171.

Lewis, J., & Giullari, S. (2005). The adult worker model family, gender equality and care: The search for new policy principles and the possibilities and problems of a capabilities approach. *Economy and Society, 34*(1), 76-104.

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among five approaches. *Health promotion practice, 16*(4), 473-475.

Liamputtong, P. (2013). *Qualitative research methods*. (4 ed.). South Melbourne, Victoria: Oxford University Press.

Liamputtong, P., Yimyam, S., Parisunyakul, S., Baosoung, C., & Sansiriphun, N. (2005). Traditional beliefs about pregnancy and child birth among women from Chiang Mai, Northern Thailand. *Midwifery, 21*(2), 139-153.

Lim, M. (2011). Women of Northeast Thailand: Privilege and Obligation. Retrieved from https://berkleycenter.georgetown.edu/posts/women-of-northeast-thailand-privilege-and-obligation

Limlomwongse, N., & Liabsuetrakul, T. (2006). Cohort study of depressive moods in Thai women during late pregnancy and 6–8 weeks of postpartum using the Edinburgh Postnatal Depression Scale (EPDS). *Archives of Women's Mental Health, 9*(3), 131-138. doi:10.1007/s00737-005-0115-7

Lincoln, Y. S., & Guba, E. G. (2003). *The Landscape of Qualitative Research Theories and Issue*. USA: SAGE.

Loke, A. Y., & Lam, P.-l. (2014). Pregnancy resolutions among pregnant teens: Termination, parenting or adoption? *BMC Pregnancy and Childbirth, 14*(1), 421.

Lorber, J. (2001). *Gender inequality: Feminist theories and politics*. USA: Roxbury Pub.

Madden, R. (2010). *Being Ethnographic*. India: SAGE.

Maduforo, A., Nwosu, O., Ndiokwelu, C., & Obiakor-Okeke, P. (2013). Food superstition, feeding practices and nutritional anthropometry of pregnant women. *Journal of Research in National Development, 11*(1), 12-28.

Mahasarakham Hospital. (2015). *Statistic report of pregnant women in Mahasarakham Hospital*. Prenatal clinic. Mahasarakham.

Mahasarakham Province. (2014). Information of Mahasarakham Province. Retrieved from http://www.mahasarakham.go.th/mkweb/new-data/238

Mahasarakham Provincial Public Health Office. (2018). *Information of Mahasarakham Province*. Retrieved from Mahasarakham: http://mkho.moph.go.th/mko/frontend/web/index.php/site/index

Malahlela, M. K. (2012). *The effects of teenage pregnancy on the behaviour of learners at secondary schools in the Mankweng area, Limpopo.* (Master's thesis), University of South Africa, South Africa.

Mantovani, N., & Thomas, H. (2014a). Choosing motherhood: The complexities of pregnancy decision-making among young black women 'looked after'by the State. *Midwifery, 30*(3), e72-e78.

Mantovani, N., & Thomas, H. (2014b). Stigma, intersectionality and motherhood: Exploring the relations of stigma in the accounts of black teenage mothers 'looked after'by the State. *Social Theory & Health, 12*(1), 45-62.

Marshall, J. E., Fraser, D. M., & Baker, P. N. (2010). Reflexivity: The experience of undertaking an ethnographic study to explore issues of consent to intrapartum procedures. *Evidence Based Midwifery, 8*(1), 21-25.

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology, 37*(3), 413-431.

Maxwell, C., & Aggleton, P. (2010). Agency in action–young women and their sexual relationships in a private school. *Gender and Education, 22*(3), 327-343.

Mbakwe, D. K. (2014). *Maternal Health Care in Thailand in Post-MDG Framework–Learning Points & Pressure Points*. Retrieved from Thailand: http://www.lse.ac.uk/asiaResearchCentre/_files/ThaiGovScholarDeborahMbakwe.pdf

McHale, J. P., Dinh, K. T., & Rao, N. (2014). Understanding coparenting and family systems among East and Southeast Asian-heritage families. In H. Selin (Ed.), *Parenting across cultures* (pp. 163-173). USA: Springer.

McLaren, L., & Hawe, P. (2005). Ecological perspectives in health research. *Journal of Epidemiology & Community Health, 59*(1), 6-14. doi:10.1136/jech.2003.018044

McNay, L. (2013). *Foucault and feminism: Power, gender and the self*. UK: John Wiley & Sons.

Mejdoubi, J., van den Heijkant, S. C., van Leerdam, F. J., Heymans, M. W., Hirasing, R. A., & Crijnen, A. A. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: a randomized controlled trial. *PLoS One, 8*(10), e78185. doi:10.1371/journal.pone.0078185

Mensch, B. S., Clark, W. H., Lloyd, C. B., & Erulkar, A. S. (2001). Premarital sex, schoolgirl pregnancy, and school quality in rural Kenya. *Studies in Family Planning, 32*(4), 285-301.

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

Meyer, E., & Post, L. A. (2006). Alone at night: a feminist ecological model of community violence. *Feminist Criminology, 1*(3), 207-227.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., . . . Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81*(4), 316-322.

Ministry of Social Development and Human Security, T. (2015). Registration of income support for new born child caring. Retrieved from http://www.m-society.go.th/ewt_news.php?nid=15258

Moen, K., & Middelthon, A.-L. (2015). Qualitative research methods *Research in Medical and Biological Sciences (Second Edition)* (pp. 321-378): Elsevier.

Moore, S. (2003). Pregnant with meaning: Teen mothers and the politics of inclusive schooling. *Journal of the Motherhood Initiative for Research and Community Involvement, 5*(1). Retrieved from https://jarm.journals.yorku.ca/index.php/jarm/article/viewFile/1943/1152

Morinis, J., Carson, C., & Quigley, M. A. (2013). Effect of teenage motherhood on cognitive outcomes in children: A population-based cohort study. *Archives of Disease in Childhood, 98*, 959-964. doi:10.1136/archdischild-2012-302525

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology, 52*(2), 250. doi:10.1037/0022-0167.52.2.250

Moster, D., Lie, R. T., & Markestad, T. (2008). Long-term medical and social consequences of

preterm birth. *New England Journal of Medicine, 359*(3), 262-273.

Mpanza, N. D., & Nzima, D. R. (2010). Attitudes of educators towards teenage pregnancy. *Procedia-Social and Behavioral Sciences, 5*, 431-439.

Muangpin, S., Tiansawad, S., Kantaruksa, K., Yimyam, S., & Vonderheid, S. C. (2010). Northeastern Thai adolescents' perceptions of being unmarried and pregnant. *Pacific Rim International Journal of Nursing Research, 14*(2), 149-161.

Mukhopadhyay, P., Chaudhuri, R., & Paul, B. (2010). Hospital-based perinatal outcomes and complications in teenage pregnancy in India. *Journal of Health, Population, and Nutrition, 28*(5), 494.

Mumah, J., Kabiru, C. W., Izugbara, C., & Mukiira, C. (2014). *Coping with unintended pregnancies: Narratives from adolescents in Nairobi's slums*. Retrieved from UK: http://www.popcouncil.org/uploads/pdfs/2014STEPUP_APHRC-ResearchReport.pdf

Munro, V. E. (2003). On power and domination: Feminism and the final Foucault. *European Journal of Political Theory, 2*(1), 79-99.

Muntarbhorn, V., Jamnarnvej, W., & Boonlue, T. (1990). *Status of women: Thailand*. Thailand UNESCO principle regional office for Asia and the Pacific.

Murray, P. A., & Ali, F. (2017). Agency and coping strategies for ethnic and gendered minorities at work. *The International Journal of Human Resource Management, 28*(8), 1236-1260.

Nadim, M. (2016). Undermining the male breadwinner ideal? Understandings of women's paid work among second-generation immigrants in Norway. *Sociology, 50*(1), 109-124. doi:10.1177/0038038514560259

Narukhutrpichai, P., Khrutmuang, D., & Chattrapiban, T. (2016). The Obstetrics and Neonatal Outcomes of Teenage Pregnancy in Naresuan University Hospital. *Journal of the Medical Association of Thailand, 99*(4), 361-367.

National Health and Medical Research Council. (2007). National Statement on Ethical Conduct in Human Research 2007 National Health and Medical Research Council.

Neamsakul, W. (2008). *Unintended Thai adolescent pregnancy: A grounded theory study.* (Doctoral dissertation), University of California, San Francisco, USA.

Nelson, M. R., & Paek, H.-J. (2005). Cross-cultural differences in sexual advertising content in a transnational women's magazine. *Sex Roles, 53*(5-6), 371-383.

Netmuy, P. (2014). The women's voice of unwanted pregnancy among Thai teen mom: A feminist perspective. *Global Education Magazine* (8), 56-61.

Nithitantiwat, P. (2013). *Thai college students: unwanted pregnancy and abortion.* (Doctoral dissertation), University of Illinois at Chicago, USA.

Nkansah-Amankra, S. (2018). Pre-pregnancy maternal depressive symptoms and low birth weight and preterm birth outcomes: Assessment of adolescent background characteristics and birth outcomes in adulthood. *Midwifery, 58*, 120-129. doi:org/10.1016/j.midw.2017.12.004

Noone, J., Allen, T. L., Sullivan, M., McKenzie, G., Esqueda, T., & Ibarra, N. (2014). Escuchando a nuestros jóvenes: a Latino youth Photovoice project on teen pregnancy. *Hispanic Health Care International, 12*(2), 63-70.

Nurani, L. M. (2008). Critical review of ethnographic approach. *Jurnal Sosioteknologi Edisi, 7*(14), 441-447.

O'Reilly, M., & Parker, N. (2013). Unsatisfactory saturation: A critical exploration of the notion of saturated sample sizes in qualitative research. Qualitative Research, 13(2), 190-197. doi:10.1177/1468794112446106.

Ogbor, J. O. (2001). Critical theory and the hegemony of corporate culture. *Journal of Organisational Change Management, 14*(6), 590-608.

Oh, S.-A., & Van Der Stouwe, M. (2008). Education, diversity, and inclusion in Burmese refugee camps in Thailand. *Comparative Education Review, 52*(4), 589-617.

Olsson, P., & Wijewardena, K. (2010). Unmarried women's decisions on pregnancy termination: qualitative interviews in Colombo, Sri Lanka. *Sexual & Reproductive Healthcare, 1*(4), 135-141.

Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and qualitative research: An oxymoron? *Quality & Quantity, 41*(2), 233-249.

Orr, S. T., Blazer, D. G., James, S. A., & Reiter, J. P. (2007). Depressive symptoms and indicators of maternal health status during pregnancy. *Journal of Women's Health, 16*(4), 535-542.

Ortner, S. (2006). Power and projects: Reflections on agency. In S. Ortner (Ed.), *Anthropology and social theory: culture, power, and the acting subject* (pp. 129-153). USA: Duke University Press.

Ounjit, W. (2011). Becoming pregnant before marriage: the value of sex without forgiveness. *International Proceedings of Economics Development & Research, 5*(1), p397.

Owusu-Addo, S. B., Owusu-Addo, E., & Morhe, E. S. (2016). Health information-seeking

behaviours among pregnant teenagers in Ejisu-Juaben Municipality, Ghana. *Midwifery, 41*, 110-117.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-544.

Panthumas, S., Kittipichai, W., Pitikultang, S., & Chamroonsawadi, K. (2012). Self-care behaviours among Thai primigravida teeagers. *Global Journal of Health Science, 4* (3), 139-147.

Pattanapisalsak, C. (2011). Obstetric outcomes of teenage pimigravida in Su-Ngai Kolok Hospital, Narathiwat, Thailand. *Journal of the Medical Association of Thailand, 94*(2), 139.

Patton, M. Q. (2015). Qualitative research & evaluation methods. (4 ed). Thousand Oaks, California: Sage.

Pimpa, N. (2012). Amazing Thailand: Organisational culture in the thai public sector. *International Business Research, 5*(11), 35-42.

Pinheiro, R. T., da Cunha Coelho, F. M., da Silva, R. A., de Ávila Quevedo, L., de Mattos Souza, L. D., Castelli, R. D., . . . Pinheiro, K. A. T. (2012). Suicidal behavior in pregnant teenagers in Southern Brazil: Social, obstetric and psychiatric correlates. *Journal of Affective Disorders, 136*(3), 520-525. doi:10.1016/j.jad.2011.10.037

Pipat, K. P. (2007). Gender and sexual discrimination in popular Thai Buddhism. *Journal for Faith, Spirituality and Social Change, 1*(1), 520-525.

Pomsema, C., Yodmalee, B., & Lao-Akka, S. (2015). Foreigners' wives: Cross-cultural marriage of rural Thai women in Isan, Thailand. *Asia Pacific Journal of Multidisciplinary Research, 3*(3), 11-15.

Ponterotto, J. G. (2006). Brief note on the origins, evolution, and meaning of the qualitative research concept thick description. *The Qualitative Report, 11*(3), 538-549.

Praparpun, Y. (2009). *Gender sensitivity & accountability in Thai government policy formulation, implementation & evaluation from an historical perspective.* Paper presented at the IAFFE 2009 conference, Boston, USA, available at<https://editorialexpress. com/cgi-bin/conference/download. cgi, USA.

Prasertwit, J., Reznik, Y., & Halpern-Felsher, B. (2010). Attitude toward pregnancy among racially and ethnically diverse young adolescents. *Journal of Adolescent Health, 46*(2 suppl 1), S31.

Prasitlumkum, M. (2009). Risk of low birth weight and adverse pregnancy outcomes in adolescent pregnancies at Chainat Hospital. *Thai Journal of Obstetrics and Gynaecology, 17*(2), 93-97.

Pungbangkadee, R., Parisunyakul, S., Kantaruksa, K., Sripichyakarn, K., & Kools, S. (2008). Experiences of early motherhood among Thai adolescents: Perceiving conflict between needs as a mother and an adolescent. *Pacific Rim International Journal of Nursing Research, 12*(1), 70-82.

Punsuwun, S., Sungwan, P., Monsang, I., & Chaiban, P. (2014). Experiences after pregnancy among unmarried adolescents in upper North. *Songklanagarind Journal of Nursing, 33*(3), 17-36.

Quah, S. R. (2008). *Families in Asia: Home and kin* (2 ed.). USA: Routledge.

Quinlivan, J. A., Luehr, B., & Evans, S. F. (2004). Teenage mother's predictions of their support levels before and actual support levels after having a child. *Journal of Pediatric and Adolescent Gynecology, 17*(4), 273-278.

Ralph, L., Gould, H., Baker, A., & Foster, D. G. (2014). The role of parents and partners in minors' decisions to have an abortion and anticipated coping after abortion. *Journal of Adolescent Health, 54*(4), 428-434.

Ramazanoglu, C., & Holland, J. (2002). *Feminist methodology: Challenges and choices*. UK: Sage.

Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative research methodologies: Ethnography. *British Medical Journal, 337*, 512-514. doi:10.1136/bmj.a1020

Regmi, K., Naidoo, J., & Pilkington, P. (2010). Understanding the processes of translation and transliteration in qualitative research. *International Journal of Qualitative Methods, 9*(1), 16-26.

Reszel, J., Peterson, W. E., & Moreau, D. (2014). Young women’s experiences of expected health behaviors during pregnancy: The importance of emotional support. *Journal of community health nursing, 31*(4), 198-211. doi:10.1080/07370016.2014.958395

Richards, L., & Morse, J. (2007). *Readme first for an introduction to qualitative methods*: Newbury Park, CA: Sage.

Richardson, D. M., & Nuru-Jeter, A. M. (2012). Neighborhood contexts experienced by young Mexican-American women: Enhancing our understanding of risk for early childbearing. *Journal of Urban Health, 89*(1), 59-73. doi:10.1007/s11524-011-9627-9

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. Great Britain: Sage.

Rojsutapong, T. (2011). *Report mortality of mothers and infants in 2010-2011* Ubonrachathani

Provincial Health Office. Thailand.

Rosenberg, M., Pettifor, A., Miller, W. C., Thirumurthy, H., Emch, M., Afolabi, S. A., . . . Tollman, S. (2015). Relationship between school dropout and teen pregnancy among rural South African young women. *International Journal of Epidemiology, 44*(3), 928-936.

Ruedinger, E., & Cox, J. E. (2012). Adolescent childbearing: Consequences and interventions. *Current Opinion in Pediatrics, 24*(4), 446-452. doi:10.1097/MOP.0b013e3283557b89

Sa-ngiamsak, P. (2016). *The life experiences of unmarried teenage mothers in Thailand.* (Doctoral dissertation), The University of Queensland, Australia.

Sadler, L. S., Novick, G., & Meadows-Oliver, M. (2016). “Having a baby changes everything” reflective functioning in pregnant adolescents. *Journal of Pediatric Nursing: Nursing Care of Children and Families, 31*(3), e219-e231.

Saldaña, J. (2015). *The coding manual for qualitative researchers* (2 ed.). India: Sage.

Sansanee, C., Sari, A., & Tagaloatele Peggy, F.D., (2017). *Influencing factors towards Thai adolescents’ decision making on contraceptive use: Preliminary results.* Paper presented at the 13th International Conference on Thai Studies Globalized Thailand, Connectivity, Conflict and Conundrums of Thai Studies, Chiangmai, Thailand. Abstract retrieved from http://www.google.co.th/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=2ahUKEwjZg6fz7e3gAhVN73MBHeySClQQFjAEegQIBhAC&url=http%3A%2F%2Fwww.icts13.chiangmai.cmu.ac.th%2Fdownload_pub.php%3Fct%3DcMXxfhstXNgdImBzBAqLv0b%257Cplus%257C%26&usg=AOvVaw2N6WLr5N_a0MiPSd-l0cRe.

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The Lancet Child & Adolescent Health*. Retrieved from doi:10.1016/S2352-4642(18)30022-1

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9), 9.

Shah, M., Prajapati, S., & Sheneeshkumar, V. (2012). Adolescent pregnancy: Problems and consequences. *Apollo Medicine, 9*(3), 176-180.

Shahabuddin, A., Nöstlinger, C., Delvaux, T., Sarker, M., Delamou, A., Bardají, A., . . . De Brouwere, V. (2017). Exploring maternal health care-seeking behavior of married adolescent girls in Bangladesh: A social-ecological approach. *PLoS One, 12*(1), e0169109. doi:101371/journal.pone.0169109

Shaw, M., Lawlor, D. A., & Najman, J. M. (2006). Teenage children of teenage mothers: Psychological, behavioural and health outcomes from an Australian prospective longitudinal study. *Social science & medicine, 62*(10), 2526-2539.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information, 22*(2), 63-75.

Sibeoni, J., Costa-Drolon, E., Poulmarc'h, L., Colin, S., Valentin, M., Pradère, J., & Revah-Levy, A. (2017). Photo-elicitation with adolescents in qualitative research: An example of its use in exploring family interactions in adolescent psychiatry. *Child and Adolescent Psychiatry and Mental Health, 11*(1), 49. doi:10.1186/s13034-017-0186-z

Silverman, J. G., McCauley, H. L., Decker, M. R., Miller, E., Reed, E., & Raj, A. (2011). Coercive forms of sexual risk and associated violence perpetrated by male partners of female adolescents. *Perspectives on Sexual and Reproductive Health, 43*(1), 60-65.

Singh, S., & Hamid, A. (2016). Reflections of a group of South African teenage mothers: Sexual health implications. *Health Education Journal, 75*(3), 278-288.

Skirbekk, V., Fukuda, S., Hackett, C., Stonawski, M., Spoorenberg, T., & Muttarak, R. (2015). Is Buddhism the low fertility religion of Asia? *Demographic Research, 32*, 1.

Smith, B. P., Jones, K. H., & Hall, H. C. (2001). Adolescent pregnancy and sexual behavior: Through the lenses of family and consumer sciences teachers. *Journal of Family and Consumer Sciences, 93*(2), 35.

Soung, E. K. (2015). *Bride wealth and its implications for Hmong women.* (Master's thesis), St. Catherine University, USA.

Sridawruang, C., Crozier, K., & Pfeil, M. (2010). Attitudes of adolescents and parents towards premarital sex in rural Thailand: A qualitative exploration. *Sexual & Reproductive Healthcare, 1*(4), 181-187. doi: 10.1016/j.srhc.2010.06.003

Srikanthan, A., & Reid, R. L. (2008). Religious and cultural influences on contraception. *Journal of Obstetrics and Gynaecology Canada, 30*(2), 129-137.

Srisaeng, P. (2003). *Self esteem, stressful life events, social support and postpartum depression in adolescent mothers in Thailand* (Doctoral dissertation), Case Western Reserve University, USA.

Sriyasak, A. (2016). *Becoming a Thai teenage parent.* (Doctoral dissertation), Mälardalen University, Sweden.

Stewart, D. E. (2011). Depression during pregnancy. *New England Journal of Medicine, 365*(17), 1605-1611.

Stoddart, M. C. (2007). Ideology, hegemony, discourse: A critical review of theories of knowledge and power. *Social Thought & Research*, 191-225.

Strunk, J. A. (2008). The effect of school-based health clinics on teenage pregnancy and parenting outcomes: An integrated literature review. *The Journal of School Nursing, 24*(1), 13-20. doi:10.1177/10598405080240010301

Suebnukarn, K., & Phupong, V. (2005). Pregnancy outcomes in adolescent< 15 years old. *Journal of Medical Association of Thailand, 88*(12), 1758-1762.

Sukhawaha, S., Arunpongpaisal, S., & Rungreangkulkij, S. (2016). Attempted suicide triggers in Thai adolescent perspectives. *Archives of psychiatric nursing, 30*(3), 334-341.

Sukrat, B. (2014). Thailand adolescent birth rate: Trend and related indicators. *Thai Journal of Obstetrics and Gynaecology, 22*(1), 15-21.

Sukrat, B., & Eamkong, P. (2015). *Statistics of Adolescent Births, Thailand 2015*. Retrieved from Retrieved from Nonthaburi: http://rh.anamai.moph.go.th/download/all_file/brochure/statistics_adolescent15.pdf

Sultana, A. (2010). Patriarchy and women's gender ideology: A socio-cultural perspective. *Journal of Social Sciences, 6*(1), 123-126.

Sultana, A. (2012). Patriarchy and Women s Subordination: A Theoretical Analysis. *Arts Faculty Journal, 4*, 1-18.

Sunstein, B. S. (2012). *Fieldworking: reading and writing research*. Boston: St. Martin.

Sussex, B. M., & Corcoran, K. (2005). The impact of domestic violence on depression in teen mothers: Is the fear or threat of violence sufficient? *Brief Treatment and Crisis Intervention, 5*(1), 109-120. doi:10.1093/brief-treatment/mhi005

Suwansuntorn, P., & Laeheem, K. (2012). *The social effects on pregnant teenagers in Na Mom district, Songkhla Province*. Paper presented at the 4th international conference on humanities and social sciences, Prince of Songkla University,Thailand.

Swick, K. J., & Williams, R. D. (2006). An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33*(5), 371-378. doi:10.1007/s10643-006-0078-y

Tan, J., & Ko, Y.-C. (2004). Using feature films to teach observation in undergraduate research methods. *Teaching Sociology, 32*(1), 109-118.

Tangcharoensathien, V., Chaturachinda, K., & Im-em, W. (2015). Commentary: Thailand: Sexual and reproductive health before and after universal health coverage in 2002. *Global Public Health,*10(2), 246–248.doi:10.1080/17441692.2014.98616688

Tangmunkongvorakul, A., Kane, R., & Wellings, K. (2005). Gender double standards in young people attending sexual health services in Northern Thailand. *Culture, health & sexuality, 7*(4), 361-373. doi:10.1080/13691050500100740

Tantiwiramanond, D. (2007). The growth and challenges of women's studies in Thailand. *interventions, 9*(2), 194-208.

Tatum, C., Rueda, M., Bain, J., Clyde, J., & Carino, G. (2012). Decisionmaking regarding unwanted pregnancy among adolescents in Mexico City: A qualitative study. *Studies in family planning, 43*(1), 43-56.

Teijlingen, E. V. (Producer). (2014). Semi-structured interviews. Retrieved from https://intranetsp.bournemouth.ac.uk/documentsrep/PGR%20Workshop%20%20Interviews%20Dec%202014.pdf

Thaithae, S., & Thato, R. (2011). Obstetric and perinatal outcomes of teenage pregnancies in Thailand. *Journal of pediatric and adolescent gynecology, 24*(6), 342-346. doi:10.1016/j.jpag.2011.02.009

Thato, R., Jenkins, R., & Dusitsin, N. (2008). Effects of the culturally-sensitive comprehensive sex education programme among Thai secondary school students. *Journal of Advanced Nursing, 62*(4), 457-469.

Thato, S., Rachukul, S., & Sopajaree, C. (2007). Obstetrics and perinatal outcomes of Thai pregnant adolescents: A retrospective study. *International journal of nursing studies, 44*(7), 1158-1164.

Thianthai, C. (2004). Gender and class differences in young people's sexuality and HIV/AIDS risk-taking behaviours in Thailand. *Culture, health & sexuality, 6*(3), 189-203. doi:10.1080/1369105031000156379

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8*(1), 45.

Thompson, D. (2001). *Radical feminism today*. Great Britain: Sage.

Thompson, J. B. (2013). *Ideology and modern culture: Critical social theory in the era of mass communication*. Great Britain: John Wiley & Sons.

Tippawan, L., & Suchonwanich, Y. (2014). Birth rates and pregnancy complications in adolescent pregnant women giving birth in the hospitals of Thailand. *Journal of the Medical Association of Thailand, 97*(8), 785-790.

Tolman, D. L. (2009). *Dilemmas of desire: Teenage girls talk about sexuality*. USA: Harvard University Press.

Tong, R. (2007). Feminist thought in transition: Never a dull moment. *The Social Science Journal, 44*(1), 23-39.

Tong, R. (2009). *Feminist thought* (3 ed.). USA: Westview Press.

Tzilos, G. K., Zlotnick, C., Raker, C., Kuo, C., & Phipps, M. G. (2012). Psychosocial factors associated with depression severity in pregnant adolescents. *Archives of Women's Mental Health, 15*(5), 397-401. doi:10.1007/s00737-012-0296-9

UNESCO. (2017). *Early and unintended pregnancy: Recommendations for the education sector*. France: The United Nations Educational, Scientific and Cultural Organisation.

UNFPA. (2013). *Motherhood in Childhood: Facing the challenge of adolescent pregnancy.* Retrieved from Thailand: http://countryoffice.unfpa.org/thailand/

UNFPA. (2015). *Girlhood, not motherhood: Preventing adolescent pregnancy.* Retrieved from New York: http://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

UNICEF. (2008). *Young People and Family Planning: Teenage Pregnancy*. Retrieved from https://www.unicef.org/malaysia/Teenage_Pregnancies_-_Overview.pdf

UNICEF. (2012). *Progress for Children: A report Card on Adolescents*. Retrieved from https://www.unicef.org/publications/files/Progress_for_Children_-_No._10_EN_04232012.pdf

UNICEF. (2015). *Situation analysis of adolescent pregnancy in Thailand: Synthesis report 2015*. Retrieved from Thailand: http://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjU5YKhlYfdAhUBc3AKHYHcC94QFjABegQICRAC&url=http%3A%2F%2Fhivhealthclearinghouse.unesco.org%2Fprintpdf%2Fnode%2F22118&usg=AOvVaw3zZ77HpyVoiEYaPCtcXMBe

United Nations. (2009). Definition of youth. Retrieved from http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

Uthaipaisanwong, A., Rungruxsirivorn, T., Roomruangwong, C., Taechakraichana, N., Chaithongwongwatthana, S., Jiusitthipraphai, T., . . . Tharavanij, T. (2015). Associated factors of prenatal depression among teenage pregnant women at King Chulalongkorn Memorial Hospital. *Journal of the Medical Association of Thailand, 98*(5), 437-443.

Varga, C. A. (2003). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning, 34*(3), 160-172.

Verdonk, P., Benschop, Y. W., De Haes, H. C., & Lagro-Janssen, T. L. (2009). From gender bias to gender awareness in medical education. *Advances in Health Sciences Education, 14*(1), 135-152. doi:10.1007/s10459-008-9100-z

Vlassoff, C., & Moreno, C. G. (2002). Placing gender at the centre of health programming: Challenges and limitations. *Social Science & Medicine, 54*(11), 1713-1723. doi:10.1016/S0277-9536(01)00339-2

Vuttanont, U., Greenhalgh, T., Griffin, M., & Boynton, P. (2006). “Smart boys” and “sweet girls”—sex education needs in Thai teenagers: A mixed-method study. *The Lancet, 368*(9552), 2068-2080.

Warnes, J., & Daiches, A. (2011). ‘Rebuilding after the storm’: Stories of young motherhood. *Narrative Inquiry, 21*(1), 109-129.

Watcharaserance, N., Pinchantra, P., & Piyaman, S. (2006). The Incidence and Complications of Teenage Pregnancy at Chonburi Hospital. *Journal of the Medical Association of Thailand, 89*(suppl 4), 118-123.

Watcharaseranee, N., Pinchantra, P., & Piyaman, S. (2006). The incidence and complications of teenage pregnancy at Chonburi Hospital. *Journal of the Medical Association of Thailand, 89*(Suppl 4), S118-123.

Wendt, S., & Zannettino, L. (2015). *Domestic violence in diverse contexts: A re-examination of gender*. London: Routledge.

Whittaker, A. (2002). 'The truth of our day by day lives': Abortion decision making in rural Thailand. *Culture, Health & Sexuality, 4*(1), 1-20. doi:10.1080/136910502753389350

Wiemann, C. M., Rickert, V. I., Berenson, A. B., & Volk, R. J. (2005). Are pregnant adolescents stigmatized by pregnancy? *Journal of Adolescent Health, 36*(4), 352.e1- 352. e7.

Wilson-Mitchell, K., Bennett, J., & Stennett, R. (2014). Psychological health and life experiences of pregnant adolescent mothers in Jamaica. *International journal of environmental research and*

public health, 11(5), 4729-4744.

Woldometers. (2018). The Thailand Population (Live) counter shows a continuously updated estimate of the current population of Thailand delivered by Worldometers' RTS algorithm, which processes data collected from the United Nations Population Division. Retrieved from http://www.worldometers.info/world-population/thailand-population/

Wood, K., & Jewkes, R. (2006). Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters, 14*(27), 109-118.

World Bank. (2016). World development indicator. Retrieved from http://data.worldbank.org/country/thailand

World Health Organisation. (2002). *Integrating Gender Perspectives in the work of WHO*. Retrieved from http://www.who.int/gender/mainstreaming/ENGwhole.pdf

World Health Organisation. (2015). Adolescent health. Retrieved from Retrieved from http://www.who.int/topics/adolescent_health/en/

World Health Organisation. (2016). *Adolescent Pregnancy Situation in South- East Asia Region*. Retrieved from http://apps.searo.who.int/PDS_DOCS/B5164.pdf

World Vision. (2010). Country profile Thailand Retrieved from https://www.worldvision.com.au/docs/default-source/school-resources/thailand-country-profile.pdf?sfvrsn=0

Wu, S. F. (2006). A two-stage translation and test the validity and reliability of a foreign instrument. *Hu li za zhi The journal of nursing, 53*(1), 65-71.

Xu, X., Kerley, K. R., & Sirisunyaluck, B. (2011). Understanding gender and domestic violence from a sample of married women in urban Thailand. *Journal of Family Issues, 32*(6), 791-819.

Yadav, S., Choudhary, D., Narayan, K., Mandal, R. K., Sharma, A., Chauhan, S. S., & Agrawal, P. (2008). Adverse reproductive outcomes associated with teenage pregnancy. *McGill Journal of Medicine: MJM, 11*(2), 141.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social science & medicine, 64*(7), 1524-1535. doi:10.1016/j.socscimed.2006.11.013

Yardley, E. (2008). Teenage mothers' experiences of stigma. *Journal of Youth Studies, 11*(6), 671-684. doi:10.1080/13676260802392940

Yeung, W. J., Desai, S., & Jones, G. (2017). Families in Southeast and South Asia. *Annual Review of Sociology, 44*, 469-495. doi:10.1146/annurev-soc-073117-041124

Yilmaz, S. (2010). State, power, and hegemony. *International Journal of Business and Social Science, 1*(3), 192-205.

Yodanis, C. L. (2004). Gender inequality, violence against women, and fear: A cross-national test of the feminist theory of violence against women. *Journal of interpersonal violence, 19*(6), 655-675.

Zou, Y., & Trueba, E. T. (2002). *Ethnography and schools: Qualitative approaches to the study of education*. USA: Rowman & Littlefield Publishers.