Decision Making and Contraception: Perceptions and Experiences of Thai-Isan Adolescents

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A thesis submitted to
Auckland University of Technology
In fulfilment of the requirements for the degree of
Doctor of Philosophy (PhD)

2018

School of Public Health and Psychosocial Studies
Faculty of Health and Environmental Sciences

Abstract

Adolescent pregnancy became a nationally recognised public health priority in Thailand in 2008, at first National Health Assembly of Thailand. The prevalence of contraceptive use by Thai adolescents still remains low, compared to adults. Contraceptive use could significantly reduce the physical, emotional and financial risks associated with early life pregnancies for Thai adolescents. Many previous studies have recruited female participants aged 18–49 years, but little is known about how adolescents in the 15–19-year-old age group make their decisions about contraceptives and what factors influence their choices. Furthermore, few published studies have described what adolescents expect or need in order to meet their sexual and reproductive health needs to make informed decisions. The issue of human rights has not been explored, either.

This research used a qualitative approach to explore perceptions and experiences of Thai adolescents during the contraceptive decision-making process and factors that influenced those choices. This approach allowed me to hear the previously unheard opinions of Thai adolescents regarding their sexual and reproductive health, and their rights. Thirty-eight secondary school-age adolescents participated in the study; 29 took part in focus group discussions (FGDs), and 11 consented to in-depth interviews. Another nine teenagers who were not part of FGDs also engaged in in-depth interviews. Audio-recordings were transcribed verbatim in Thai. Data was analysed using thematic analysis.

Regardless of initial contraceptive discussions and decisions made before initiating sexual relationships, final contraceptive decisions made were unplanned and happened just before each sexual encounter. Typically, males were expected to provide condoms, and girls were expected to request condoms though males were likely to negotiate for no condoms. When the female failed to negotiate or willingly allowed her boyfriend to have sex with no condoms, withdrawal rules were likely to apply. Emergency pills were used when the female was uncertain about successful use of the withdrawal method and when one or both partners had drunken unprotected sex. Long acting hormonal implants were used after abortion on parental demand.

Fear of the negative consequences of pregnancy, such as burdening parents and being punished by parents, was a factor influencing prevention of unplanned pregnancies. Condoms were likely to be their first choice. All participants knew that condoms were more effective than the withdrawal method, but many were ill-informed about hormone pills. Accessibility and cost of condoms affected adolescents' choice of method. Female's negotiation skills affected contraceptive decisions. Interestingly, having an older girlfriend or fear of HIV/AIDS infection could lead young males to use condoms. Young females' fears of being in social and financial difficulties, or of being unable to fulfil cultural expectations as the firstborn daughter, affected their decisions.

The sexual and reproductive needs and the human rights requirements of adolescents in Thailand have not yet been met. Participants suggested that allowing them to express their views might help increase understanding between adolescents and previous generations. They felt that people in their age group should have an understanding of their own sexuality, and should be consulted about sex and contraceptive use by older adults. Participants felt that some social beliefs/values should be changed to increase accessibility to condoms and other effective contraceptive methods. Confidentiality and privacy were recurring issues in discussions about youth-friendly sexual health services currently provided in Thailand.

The findings of this study suggest that applying a holistic approach to improve adolescents' decisions about contraception would benefit Thai society as a whole. It is recommended that policy-makers in Thailand should integrate morals-cultural based, rights-based and gender-based public health interventions to increase adolescents' knowledge about contraceptives, to help them access effective contraceptive methods, and to allow them to make informed decisions about their reproductive health.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Sansanee Chanthasukh Date: 17 October 2018

Ethics Approval

The Auckland University of Technology Ethic Committee (AUTEC) approved this research on 3 August 2015, AUTEC reference no. 15/225, shown in Appendix A.

Acknowledgements

First, I would like to express my deep gratitude to the Kings of Thailand. With the generous consideration of His Majesty the Kings of Thailand, Thai students have been sponsored to study overseas since BE 2400 (1857). In the early period of this initiative, only male students from royal families had this great opportunity. Approximately 150 years later, I, a female from a minority group (Khmer) living in the countryside of Thailand, also had this great opportunity to study in England (2010–2011) and in New Zealand (2014–2017). I wholeheartedly thank the Kings of Thailand, past and present, for these wonderful and challenging opportunities.

This thesis would not have been possible without my supervisors, Dr Sari Andajani and Tagaloatele Professor Peggy Fairbairn-Dunlop. They worked very hard with me and made sure my work met the high standards expected by the Auckland University of Technology (AUT). They have never given up on me. Thank you so much for your support and encouragement. My wholehearted thanks also go to Associate Professor John F. Smith, who suggested I should study in New Zealand. Also, I am really grateful for suggestions about working in the field which came from Associate Professor Wongsa Laosiriwong.

Thanks are also due for all the contributions from the staff of the Office of Educational Affairs, the Royal Thai Embassy in Australia; the Ministry of Public Health, Thailand; the office of Khon Kaen Provincial Social Development and Human Security; the Sirindhorn College of Public Health; the 6th Khon Kaen Health Centre; and two anonymous schools in Khon Kaen.

I will never forget the 38 teenagers who opened their hearts and shared their viewpoints and past experiences with me. I would like to thank them all for their contributions to building new knowledge, and for helping to create tailored, adolescent-friendly health promotion programmes. I also thank them for teaching me to be a human and to work as a researcher ethically. Thank you.

I am really grateful for the love and support from my family. With the deepest respect for my parents, I always thank them for letting me be a bird that flies adventurously around the world, and for being patient in allowing me to experience my own triumphs

and tragedies during my adventurous journeys. This thesis is dedicated to you, Father Prasert Chanthasukh and Mother Saowakorn Jindawong. Many thanks to my husband, Rachan Phakham, who has worked very hard to provide our costs of living and patiently taken care of me and my daughters (his non-biological daughters). Also, I would like to say thank you to my ex-husbands, who totally changed my life and let me have a good chance to see the other beauties of living on this earth: Philip Harding and Khem Khenkhok. All the best.

Most importantly, I would like to say thank you to the spiritual energy I received at this place, the AUT Manukau Campus. My experiences of being on the AUT Manukau Campus will always be remembered. Also thank you for encouragements from all of my friends, particularly Dr Shabnam Jalili-Moghaddam, and thank you for the smiles from the people I met on the way from Onehunga to AUT Manukau. Whole heartedly thanks.

I am always concerned that a part of scholarship funding is from taxes, which are paid by people living in Thailand. I would like to express my gratitude to their contribution. Without this contribution, there would be no Sansanee standing here in this social position. Thank you.

Sansanee Chanthasukh

17 October 2018

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Abbreviations and Acronym

ASEAN	Association of Southeast Asian Nations
AUTEC	Auckland University of Technology Ethics Committee
AUT	Auckland University of Technology
BORA	Bureau of Registration Administration, Thailand
EC	Emergency contraception
ECPs	Emergency contraceptive pills
FG	Female group or girl group
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIOMS	The Council for International Organisation of Medical Sciences
CRC	Convention on the Rights of the Child
CSMBS	The Civil Servant Medical Benefit Scheme
FERCIT	The National Forum for Ethical Review Committee in Thailand
GDP	Gross domestic product
GNI	Gross national income
HDI	Human development index
HIS	Health insurance scheme
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
HE	Health education, a study subject for Thai students
ICPD	International Conference on Population Development
IUD	Intra-uterine device
IPPF	International Planned Parenthood Federation
LARC	Long-acting reversible contraception
MG	Male group or boy group
MoE	Ministry of Education, Thailand
MoPH	Ministry of Public Health, Thailand
MoSDHS	Ministry of Social Development and Human Security, Thailand
NGOs	Non-governmental organisations
NHA	National Health Assembly, Thailand
OTC	Over the counter

PATH	Programme for Appropriate Technology in Health, Thailand
PHC	Primary health care
PM	Prime Minister
PPAT	Planned Parenthood Association of Thailand
SARC	Short-acting reversible contraception
SOTUS	Seniority, order, tradition, unity and spirit
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
STDs	Sexual transmitted diseases
SS	Secondary school
TNSO	National Statistical Office of Thailand
UDHR	Universal Declaration of Human Rights
UHS	Universal Healthcare Scheme
UIS	UNESCO Institute for Statistics
UN	United Nations
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UK	United Kingdom
US$	The currency of United States (dollars)
VC	vocational college
VDO	Video
WAS	World Association for Sexual Health
WHO	World Health Organization
YFHSs/YFHC	Youth-friendly health services/clinic

Thai Glossary

Thai word	English translation
Anakot dab	Dark future
Baht	The currency of Thailand (one New Zealand dollar, NZD, is approximately 25 Thai Baht)
Bun	Merit
Bunkhum	Contribution: If a person give *bunkhun* to you, they have done something good for you
Dai	Get, gain, receive
Dai sia gan	Engaged in a sexual relationship
Dichan/Chan	I, for female, polite form in written language
Dee	A female who loves a female with feminine expression
Dek	Children, young people
Dek wan	Boys who wear short jeans, tight T-shirts and slippers, who ride a motorbike
Hai	Give, allow
Huang	Intra-uterine device (IUD)
Isan	The North-eastern region of Thailand
Jareet/Jareet prapaynee	Social norms
Ku/Kha	I, for both male and female, impolite form or language used with close friends
Kamawitthan	Sexually degenerated
Kaniyom	Social values
Karma	The spiritual principle based on cause and effect, where intentions and actions of an individual (cause) influence the future of that individual (effect), or where actions in a previous life, or the past in the current life, affect the current life
Kotkaow	Old rules, social norms
Kwamdee	Virtue
Les	Lesbian
Lang nock	Withdrawal method

Thai word	**English translation**
Lang nai	To ejaculate inside the vaginal cavity
Loog	My children, or my son, or my daughter
Mai hai	Not give, not allow
Moom paern jai wai roon	Friends' corners where adolescents can openly talk to each other
Nirvana	Freedom from reincarnation
Nong	Younger sister/brother
Nu	I, for young people or you, used by adults calling children
Pa	Auntie
Panha	A problem
Pagati	Normal
Phom/kraphom	I, male (polite form)
Phi	Older sister/brother
Plad	Mistake
Phet thee sam	The third sex, transgender
Rabnong	Welcome ceremony for freshman in university
Rak nuan sa-nguan tua	To love and preserve your young and feminine body and self
Ran	Promiscuous
Raung saun tua	Personal business
Sia	Lose
Sao praphetsorng	This term describes the transgender, a woman of a second women
Sia tua	Lose the body, used with females who have premarital or extramarital sexual relationships
Sia tua ya sia jai	Sympathising phrase for girls or women who *sia tua* that 'please do not be upset when they *sia tua'*
Sitthi	Rights
Sitthi anamai chareanpan	Sexual and reproductive health and rights
Skoy	A girl who sits behind *dek wan* on motorbike
Sod/Sod sai	To have sex without condoms
Tag nock	Withdrawal method
Tag nai	To ejaculate inside the vaginal cavity
Tammachat	Natural

Thai word	**English translation**
Tammada	Normal
Tom	A female who loves another female with masculine expression
Wairoon	Adolescents, teenagers
Wiparit	Deviant
Ya tumjai	Painkiller, which include aspirin (Salicylic acid) 650 mg
Yacheet	Hormonal injection
Yafang tai pewnang	Hormonal implants
Yakum	Contraceptive pills
Yakum chugchern	Emergency contraceptive pills
Yawwachon	Youth
ying Thai jai gla	A brave Thai lady

Transcription Conventions

Descriptor	Meaning
UPPER CASE	Speaking loudly
Italics	Stressing or emphasising a point
[Pause]	Pauses more than five seconds
[Laugh]	Laugh
[…]	Explanation of additional information
:::	Long words

CHAPTER 1. **Introduction**

1.1 Chapter outline

This chapter begins with how my professional and personal interests led to this study. The second section presents the background of study including adolescent pregnancy and contraceptive use. A gap of knowledge is also stated briefly in this section. The third section shows my purpose of the study and research questions. In the next section, I briefly describe the overview of the methodology I used in this study. The importance and delimitation of this study are presented after that. Lastly, I describe the structure of this thesis.

1.2 My personal and professional background

In 2012, while working as a pharmacist in a community pharmacy in an urban area of Khon Kaen, a province in Northeast Thailand, I was asked many times by young people to supply emergency contraceptive pills (ECPs). Most of these young people were males. They parked their motorbikes in front of the pharmacy, left the engine running and came into the pharmacy. Some came alone, and some came with a male friend. After I chose a box of pills and had just started to inform them about the ECPs, they always told me that they had come to buy ECPs for their friends, who knew how to use the "emergency contraceptive pills". Then, they rushed to their motorbikes and left me feeling curious.

As a health professional, I wondered why young people made ECPs their contraceptive of choice and why they rejected condoms. I personally believe that condoms are the most effective method for preventing not only unwanted pregnancy but also sexually transmitted diseases (STDs). I wondered whether these young, sexually active teen males were afraid of their girlfriends' pregnancy more than of being infected by STDs.

I tried to put myself in their shoes and thought about situations which young people might engage before coming to buy ECPs. Surely, they had sex without condoms, and the female took these ECPs to prevent unplanned pregnancy. Adolescent girls might be afraid or shy to come to and ask a pharmacist for ECPs. They might possibly ask their boyfriend to buy these pills instead. The boyfriend might also have fear and

embarrassment, and might ask his friend to go for ECPs. In another possible scenario, these young men who came to me could be the boyfriend of a girl who wants to use ECPs but pretends to be a friend of those who needs emergency contraceptive pills. I sympathised with their uncomfortable accessibility to ECPs. I was questioning that what happened to young male and female adolescents before choosing ECPs as the contraceptive choice, and how they then made their decision on contraceptive use.

Being a mother of two adolescent girls, I considered on adolescent pregnancy. I acknowledged that my daughters and other adolescents are socialised differently from my generation. They now learn about sexuality from not only face-to-face interaction but also through social media. I believe that, for my two adolescent daughters, I could not stop their searching to answer their curiosity on sexuality and sexual-relevant issues. I may neither stop them engaging in a sexual relationship.

My opinion was that to be safe from unplanned pregnancy, my daughters should merely say "no" to sex. I had already told them about my views. I had also mentioned that if it was impossible to say "no" to sex, condoms were the best contraceptive method. However, in Thailand, female condoms are hard to find. Although male condoms are widely available, what would happen if my daughters' boyfriends refused to apply male condoms? My daughters and their boyfriends might become involved in a negotiation, and who would be the dominant decision maker then? If my daughters could not convince their boyfriends to use (male) condoms, would they be at risk of pregnancy, and would they suffer from negative consequences? These personal inquiries and my concern inspired me to increase my understanding about how Thai adolescents make decisions about contraception, to write this thesis, and to enrol in the PhD course of study in the first place.

1.3 Study Background

Adolescent pregnancy can have numerous impacts on adolescents, both individually and collectively. Worldwide, pregnancy and the complications of childbearing are the second leading cause of death among adolescent girls aged 15–19 years (World Health Organization [WHO], 2015b). Pregnant teenagers have a higher risk of mental health problems such as depression, compared to pregnant women of other age groups (Siegel & Brandon, 2014). Moreover, they are likely to drop out of school, rarely return to school and end up in low-paid work (WHO, 2012a). Studies show that adolescent mothers and their children struggle with social and financial problems, and need

additional support from their families and communities I (Hoffman, 2006; WHO, 2012a).

Thailand, a country in the Indochinese peninsula, also confronts adolescent pregnancy problems. The 2016 teenage pregnancy rate of Thailand is the highest in Southeast Asia, after Philippines and Laos PDR (World Bank, 2017a). The Ministry of Public Health, Thailand (MoPH) reported that the latest record of Thai adolescent birth rate was at 54 per thousand of adolescent girls aged 15-19 (MoPH, 2012). Approximately 70% of the pregnancies during adolescence are unplanned (Hemachandra, Rungruxsirivorn, Taneepanichskul, & Prunksananonda, 2012; MoPH, 2012).

Pregnancy out of wedlock has negative consequences for adolescents. A study conducted by Muangpin, Tiansawad, Kantaruksa, Yimyam, and Vonderheid (2010) noted that a Thai teenager who became pregnant out of wedlock would be socially condemned or labelled as a naughty and promiscuous girl. She might also be ostracised by her own family or her partner's family. These unplanned pregnancies have even led some adolescent girls to take sometimes dangerous abortifacient agents from the black market (A. Tangmunkongvorakul, Banwell, Carmichael, Utomo, & Sleigh, 2011) and to seek the services of illegal abortionists (Manopaiboon et al., 2003).

Contraception has, over the past decades, become an effective means for sexually active adolescents to prevent unplanned pregnancies. In Thailand, government healthcare providers are the main authority providing contraception. In fact, male condoms can also be accessed 24/7 from many convenience stores. Contraceptive pills are also obtainable from any pharmacy without parental consent and without a prescription.

However, contraceptive use among unmarried, sexually active Thai teenagers is relatively low, compared to Thai adults (Jenkins et al., 2002; MoPH, 2012; MoPH, 2013; Tangmunkongvorakul et al., 2011). Previous studies have shown that up to 60% of Thai youth participate in sexual activities, but only 30%–50% of them use effective contraceptive methods (Jenkins et al., 2002; MoPH, 2013; Tangmunkongvorakul et al., 2011). Furthermore, relatively ineffective contraceptive methods, including early withdrawal, are frequently used by Thai adolescents (A. Tangmunkongvorakul et al., 2011).

Individuals' decisions about their sexual and reproductive health (SRH), including contraceptive use, influence not only world population numbers but also the health and

well-being of people around the world (United Nations Population Fund [UNFPA], 2006). Contraceptive choices and how they are made by teenagers are topics that have been investigated in many countries, but not in Thailand (Bangpan & Operario, 2014; Beaulieu, Kools, Kennedy, & Humphreys, 2011; Daugherty, 2011; Merkh, Whittaker, Baker, Hock-Long, & Armstrong, 2009; Schuler, Rottach, & Mukiri, 2011; Subedi, Mahato, Acharya, & Kafle, 2013; Tong, Low, Wong, Choong, & Jegasothy, 2014). Few studies have focused on adolescents in the 15–19-year age group, and only a minority of research papers have explored the issues from the point of view of the adolescent female (Hemachandra et al., 2012; Nelson, 2009).

In Thailand, previously published literature has focussed on how many teenagers use contraceptives, their knowledge about contraceptives and barriers they face in accessing SRH services (Aimnoi, Taeboisutikul, Chuenbunngam, Ngaechareankul, & Lermankul, 2004; Hemachandra et al., 2012; Jenkins et al., 2002; Lerkiatbundit & Reanmongkol, 2000; Tangmunkongorakul, 2011). However, almost nothing is known about how Thai teenagers make choices about their SRH.

1.3.1 Purpose of this study

The primary purpose of the current research is to explore adolescent pregnancy problems in Thailand, to identify the underlying reasons why adolescents are unlikely to use contraceptive methods, and ultimately, to help Thai authorities develop youth-friendly SRH services tailored to young people's needs. The study specifically aims to increase understanding about how unmarried, sexually active Thai adolescents make decisions about contraception. The goal is to close knowledge gaps evident in the field of youth SRH in Thailand by describing 1) the main decision maker and what factors make that individual the main decision maker; and 2) the factors that influence adolescent decision making. It is also the objective of this study to raise the volume of the unheard voices of both male and female adolescents in their quest to have their SRH needs and expectations met.

1.3.2 Main research questions

The research aims to answer these questions:

1. How do Thai adolescents make their decisions about contraception?
2. What factors and which circumstances influence their decision making?

3. What are Thai adolescents' contraceptive and SRH needs and expectations, in their own words?

1.3.3 Research methodology overview

Qualitative research was used to gain an understanding of subjective perceptions and/or experiences of Thai adolescents. I believe, as a constructivist, that reality is socially constructed and that an individual's socially constructed reality is subjective and informed by their social skills and roles, social norms and experiences (Creswell, 2014). I, as a feminist, am concerned that adolescents are vulnerable because they live in an adult and male dominated world, so in this work, I advocate for political, socio-cultural and economic equality (Burns & Chantler, 2011; Liamputtong, 2013).

I have been challenged in raising a sensitive topic, however. I invited 38 Thailand-based adolescents aged 15–19 years to participate in the research. Of these, 29 participants opted to join in five single-gender focus group discussions. Of those I subsequently invited to participate in in-depth interviews, only 11 of them were confident enough to engage. Another nine participants, who had not participated in group discussions, were comfortable in with being interviewed one on one.

I transcribed digital audio recordings of focus group discussions and in-depth interviews verbatim in Thai to maintain authenticity, and then translated Thai words into English with the help of Thai youth living in the Auckland, New Zealand community. To complete a thematic analysis according to commonly accepted, robust methods, I read transcriptions several times and coded them line-by-line. Manual coding techniques were used to generate categories and themes, while NVivo software was applied to organise data. The time necessary to complete these tasks was an additional challenge.

1.3.4 Significance of the study

The significance of this exploratory research is that it provides an in-depth understanding about the complications involved in Thai adolescents' choices of contraceptive methods. Herein, for the first time, I gathered the perspectives and experiences of unmarried, sexually active Thai male and female adolescents of a younger age (15–19 years).

Little is known about how Thai adolescents who live within the constructs of the Buddhist faith exercise their rights to SRH. Thus, the current research is a prototype case study for Thailand and neighbouring countries, which have similar, Buddhist-

dominant cultures. The work is also important for the wider global community because it illustrates how adolescents in a predominantly Buddhist society exercise their rights to make informed decisions about contraception, information policy makers in the United Nations (UN) do not currently have.

This study also has significance for Southeast Asian and global communities with respect to adolescents' rights. Adolescents, as individuals or couples, have a right to make decisions about SRH as stipulated in the *Universal Declaration of Human Rights* (UDHR), the *Convention on Elimination of All Forms of Discrimination Against Women* (CEDAW) and the *Convention on the Rights of Children* (CRC) (UNs, 2003; UNs, 2009). Thailand is a member of the UN. Membership in the UN obliges its state members to protect, promote and fulfil rights for all people, which may be at odds with values of the Buddhist faith, a challenging juxtaposition that the current work aims to explore.

The current research also has importance for academic communities worldwide, because teenage pregnancy is an issue studied by many scholars. Sexual and reproductive health is not only a woman's responsibility, but is also the man's concern, an issue that often surfaces for researchers in the field (UNFPA, 1995). Encouraging men and boys to participate in SRH promotion/prevention programmes is crucial for improving sexual and reproductive health for all men/boys and women/girls (International Planned Parenthood Federation [IPPF], 2013).

1.3.5 Study limitations

To avoid being at risk of adolescent pregnancy, it appears from anecdotal evidence that some young people in Thailand initiate sexual activities with a same-sex partner. Also, those who engage in a heterosexual relationship might choose to engage in sexual activities without vaginal penetration. Young people favour oral sex, anal sex and mutual masturbation between sexual partners. Although such sexual activities could, in some way or another, protect young people from pregnancy, the current work has not focused on these sexual issues.

I recruited adolescents in school settings in one urban area only. However, adolescents who are in paid employment, or even in an informal school setting, or live in rural areas might have different perceptions about SRH and contraception. Moreover, the locations in which adolescents spend their time including urban, semi-urban or rural areas could

also affect accessibility to contraceptive methods and therefore, could influence their decisions. Thus, I might have discovered different things if I had conducted the study in (a) different (or multiple) setting(s) with a different participant population.

Because of a mismatch in timetables between youth research assistants and participants, only one discussion group was co-facilitated by an assistant. Involving youth research assistants in all of the group discussions may have helped participants feel more relaxed, and may have allowed them to share their perceptions and experiences more freely, which may have led to different results.

1.4 Thesis structure

This thesis is divided into nine chapters. **Chapter One** outlines the origin of the study, study background and purpose, the significance of the study and its limitations.

Chapter Two presents the groundwork for the investigation. The Thai context is introduced, including demographic information, the country's politics and its educational, socio-economic, health and socio-cultural profiles. Focus topics include exploring life as an adolescent in Thailand, and the health status of Thai teenagers today. The central issue of adolescent pregnancy, and its complications, are discussed. The magnitude of the adolescent pregnancy problem is explored in the Thai and in the global contexts, and public interventions in Thailand are also critiqued.

Chapter Three reviews previously published literature describing contraceptive methods, available contraceptive methods in Thailand, and global and domestic contraceptive use rates. Dilemmas in providing sex education and in providing improved access to effective contraceptive services are also discussed in both the global and Thai contexts. The significance of contraceptive decisions and previous published literature elucidating the process of adolescent decision making are explored. Influencing factors on contraceptive decisions are subsequently presented. The multiple factors defining SRH and sexual and reproductive health rights (SRHR) are introduced.

Chapter Four describes study methodology. Research paradigms and the qualitative approach are presented as central tenets framing the current work. I also discuss reasons for using focus group discussions and in-depth interviews to deliver research outcomes. Finally, I explain how I organised the work, the participants' demographic information, data management and data analysis.

Chapter Five presents findings for the first research question, and engages the reader in exploring how Thai adolescents make decisions about contraception, whether they use it, what they use and how they use it. This chapter explores what it is like to be a teenager in Khon Kaen, and how teenagers growing up in this setting think about sex and pregnancy. Their contraceptive decisions are also explained.

Chapter Six describes factors that influence the choices of young people in Khon Kaen. Influencing factors are presented in three sections: 1) perceptions commonly held by genders, 2) male-specific influencing factors, and 3) female-specific influencing factors.

Chapter Seven illustrates adolescents' expectations and needs for SRH services in the context of their SRHR. The expectations and needs of adolescents in participating in this study are categorised by gender. No specific needs for SRH services stated by only female. Therefore, I divide adolescents' expectations and needs for SRH services into two categories: 1) the needs of both genders, and 2) needs specific to young men.

Chapter Eight presents discussion about the topics raised in previous chapters. Previously published literature and my reflections on working with adolescents are compared as a way of identifying the issues inherent in working with young adults.

Chapter Nine offers concluding remarks and recaps study limitations. Recommendations for further work are also presented.

CHAPTER 2. **The Thai Context**

2.1 Chapter outline

This chapter provides an overview of the Thai context as background explanation for the research. The first section provides country-specific geographic and demographic data. It also summarises Thai political, socio-economic and educational systems. Issues relating to the healthcare system are also explored, fostering an understanding of health-related behaviours evident in Thai adolescents. The second section introduces the situational and cultural contexts Thai adolescents operate within. The main focus is on adolescent pregnancy. Public health interventions addressing adolescent pregnancy in Thailand are also described in this section.

2.2 Country profile

Thailand is a country located in South-East Asia (Figure 1). Thailand was established in the 13th and 14th Centuries as the Tai Kingdom of *Sukhothai* and was called Siam until 1939 (Lyttleton, 2004). It is the only country in this region that has never been colonised by Western/European countries.

Thailand is bounded by Myanmar (previously called Burma) to the West and Northwest, by the Laos People's Democratic Republic to the East and Northeast, by Cambodia to the Southeast and by Malaysia to the South. The southern region of Thailand has coastlines abutting the Gulf of Thailand to the Southeast, and to the Southwest, the Andaman Sea. According to the US Central Intelligence Agency (2014), the total area of Thailand is 513,120 km^2, or 198,456 mi^2 (approximately three times the size of New Zealand). Bangkok is the capital city of Thailand. For local government administrative purposes, Thailand is divided into 76 provinces.

Khon Kaen, a province in the Northeast of Thailand (Isan), was the study site I chose for the current work. Khon Kaen is 444 km from the capital of Thailand. It is divided into 26 districts. In the end of 2016, the estimated total population in Khon Kaen was 1.8 million (Khon Kaen Provincial Statistics Office, 2016) (Khon Kaen Provincial Statistical Office, 2016). Approximately, 28% of the population (510, 219 people) lived in Khon Kaen City, the provincial capital of Khon Kaen. Adolescents aged 15-19 years

old were 23% of those who lived in this urban area (Khon Kaen Provincial Statistical Office, 2016). Khon Kaen is educational centre for those who live in Northeast Thailand. Khon Kaen University was ranked by www.topuniversities.com as the 8th top university in Thailand in 2017 (QS Quacquarelli Symonds, 2017). This renowned tertiary governmental institution and other private educational institutes locate in the city attract young people from neighbouring provinces into urban Khon Kaen to further their education.

Figure 1: Map of Thailand (2013)
Source: http://ontheworldmap.com/thailand/thailand-political-map.html

2.2.1 Population characteristics

By the end of 2016, the estimated total population of Thailand was 68.1 million, with the population growth rate at 0.4 (UNFPA, 2016). Human sex ratio is 96.4 males per 100 females (National Statistical Office of Thailand [TNSO],2016a). The sex ratio in 2016 was 96.4 males per 100 females (UNFPA, 2016). Some variation occurs between age groups categorised as adolescents: those aged 10–14 years, 15–19 years and 20–24 years comprised 6.18%, 6.73% and 7.46% of young adults, respectively (Bureau of Registration Administration [BORA], 2016).

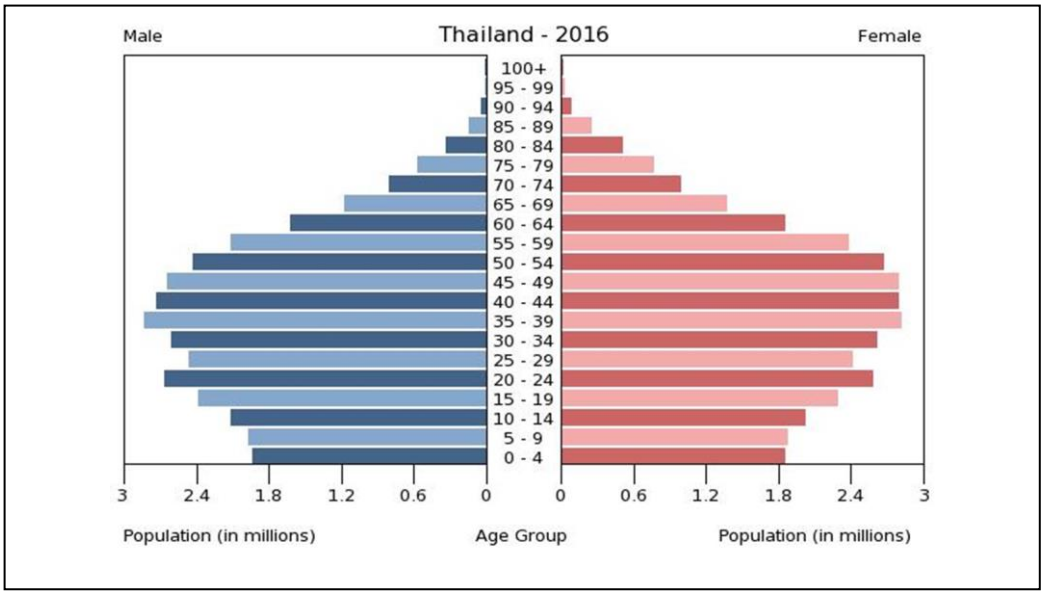

Figure 2: Population pyramid of Thailand
Source: Central Intelligence Agency (2016), retrieved on 3 November 2017 from https://www.cia.gov/library/publications/the-world-factbook/geos/th.html

The majority of people who live in Thailand are Thai (Siamese), they habitually speak Thai in their everyday lives, and they live in the central part of Thailand (Visser, 2008). The second largest group are known as Thai Isan, they mostly speak Laotian, and they live in the Northeastern region of Thailand (Isan). Other ethnic groups include Chinese (11%), Malay (6%), Khmer (2.4%), unspecified groups (3%) and permanent residents of foreign origins (0.8%) (Visser, 2008). Although Thailand includes a mixture of ethnicities, most people in Thailand are likely to consider themselves as Thai. King Rama V decreed in 1894 that everyone in Thailand should think of themselves as Thai (Visser, 2008). Of the whole of the Thai population, 94.8% are Buddhists, 4.5% are Muslim and 0.7% are Christian (TNSO,2016b).

2.2.2 Political profile

Thailand had been under an absolute monarchy for more than seven centuries. Since 1932, Thailand has changed to a constitutional monarchy (British Broadcasting Corporation [BBC], 2017). Currently, the 10th King of the Chakri dynasty Maha Vajiralongkorn was proclaimed as head of Thailand after former King Bhumibol Adulyadej died on 13 October 2016 (BBC, 2016).

Even under constitutional monarchy government, Thais have spent their life in unstable political circumstances with 19 military coups since 1932 ("the Gaurdian", 2014).. In 2010, a severe political protest was organised by the yellow-shirts (the conservative), who accused former Prime Minister (PM) Thaksin Shinawat of corruption ("Independent", 2010). After the former PM Taksin resigned, the first female Prime Minister of Thailand Yingluck Shinawatra his sister was elected in 2011. Later, Thailand confronted severe protest by "The Red Shirt" who supports the former PM Taksin. The latest Thai Military seizer of political power was in 2014 when the first female Prime Minister was ousted (BBC, 2014).

2.2.3 Socio-economical profile

Thailand is a middle–upper income country with a gross national income (GNI) of US$5,720 per capita in 2015. Gross domestic product (GDP) has increased from US$126.392 in the year 2000 to US$395.168 in 2015 (World Bank, 2017c). Poverty has reduced from 42.3% in the year 2000 to 10.5% in 2015 (World Bank, 2017c). Although Thailand has been progressing well in its economic development in last two decades, growth in GPD dropped dramatically to 0.8% in the two-year period of 2013–2014, related to political instability. A summary of the key social and economic factors influencing Thai society is provided in Table 1.

Table 1: Economic indicators for Thailand, 2012–2015

Economic indicator	Year			
	2012	2013	2014	2015
GNI per capita (US$)	5,590	5,790	5,810	5,720
GDP (US$ billion)	397.29	419.89	404.32	395.168
Annual GDP growth (%)	7.2	2.7	0.8	2.8
Poverty ratio (% of population)	12.6	10.9	10.5	n/a

Notes. All dollar values were calculated using current currency valuations. Poverty calculations were made using domestic Thai poverty line demarcators. All statistics are sourced from the World Bank (2017c)

Table 2: Human development index of ASEAN countries

Country	HDI		Life expectancy (years)		Expected schooling (years)		Mean schooling (years)		GNI per capita (2011 PPP $)	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Singapore	0.91	0.93	86	80	15.5	15.3	11.1	12.1	60,787	96,001
Brunei	0.85	0.87	81	77	15.4	14.6	9.0	9.1	55,402	89,256
Malaysia	n/a	n/a	77	73	n/a	n/a	10.0	10.8	17,170	32,208
Thailand	**0.74**	**0.74**	**78**	**71**	**14.1**	**13.1**	**7.7**	**8.2**	**12,938**	**16,145**
Indonesia	0.66	0.71	71	67	12.9	12.9	7.4	8.5	6,668	13,391
Vietnam	0.69	0.68	81	71	12.9	12.5	7.9	8.2	4,834	5,846
Philippines	0.68	0.68	72	65	12.1	11.4	9.5	9.2	6,845	9,917
Lao PDR	0.56	0.61	68	65	10.4	11.2	4.5	5.6	4,408	5,696
Cambodia	0.53	0.59	71	67	10.1	11.7	3.7	5.5	2,650	3,563
Myanmar	n/a	n/a	68	64	n/a	n/a	4.9	4.9	4,182	5,740
World	0.69	0.74	74	70	12.4	12.3	7.7	8.8	10,306	18,555

Abbreviations. ASEAN, Association of Southeast Asian Nations; GNI, gross national income; PDR, People's Democratic Republic; PPP, Power Purchasing Parity; n/a, not available.
All statistics are sourced from the United Nations Development Programmes (UNDP, 2016)

Among Southeast Asian countries, Thailand has undergone through the process of human development behind Singapore, Brunei Darussalam and Malaysia. Thailand's human development index (HDI),which measures a population's health, education and income, was the 4th and the 88th in the list of Southeast Asian countries and that of 188 countries around the world (United Nations Development Programme [UNDP],2016),

Of Thailand, human development has been the same for both sexes: the HDI was 0.74 for both males and females in 2016. As shown in Table 2, Thai women are likely to live longer and are likely to spend more time at educational institutes. Thai females, however, realise a lower GNI per capita than men. The situation of females earning lower incomes can also be observed in other Southeast Asian countries

2.2.4 Educational profile

Thai people have a high literacy rate (for Thai language). In 2015, the adult literacy rate, measured in people aged 15 years and older, was 93.95% (United Nations Educational, Scientific and Cultural Organization [UNESCO] Institute for Statistics, 2017). Male adults have a slightly higher literacy rate than females (95.43% versus 92.6%). The literacy rates for teenaged males and females are 98.95% and 98.33%, respectively.

According to Ministry of Education of Thailand (MoE) (2008), compulsory education lasts 12 years, beginning at Grade 1 and ending at Grade 12. At Grade 9 (called *Mattayom* 3 in Thailand), when students are 14–15 years old, they can choose to continue their education in a upper secondary school (aka *Mattayom* 4–6) or move to study in a vocational/technical college (to earn a vocational certificate, Years 1–3), as shown in Table 3. After completing the compulsory educational period (through Grade 12), students may choose to go to universities, vocational/technical colleges or continue with informal education. Some of them choose to work, because youth aged >18 years are eligible to work.

The UNESCO Institues for statistics (2017) reported that more than 80% of young people were enrolled to study in primary and secondary schools in Thailand. Slightly more boys were enrolled in courses than girls. The percentage of young people attending tertiary institutes was lower, 40% for females and 60% for males.

Table 3: Educational system in Thailand

<table>
<tr><th colspan="6">The educational system in Thailand</th></tr>
<tr><th>Age</th><th>Grade</th><th>Grade (in Thai)</th><th colspan="2">Formal education</th><th rowspan="12">Non-formal& informal education/training</th></tr>
<tr><td>21</td><td rowspan="4">n/a</td><td rowspan="4">n/a</td><td rowspan="4">University
(undergraduate level)</td><td>n/a</td></tr>
<tr><td>20</td><td rowspan="3">VC
(diploma, years 1-2)</td></tr>
<tr><td>19</td></tr>
<tr><td>18</td><td>13</td></tr>
<tr><td>17</td><td>12</td><td>Mattayom 6</td><td rowspan="3">Upper SS</td><td rowspan="3">VC
(certificate, years 1-3)</td></tr>
<tr><td>16</td><td>11</td><td>Mattayom 5</td></tr>
<tr><td>15</td><td>10</td><td>Mattayom 4</td></tr>
<tr><td>14</td><td>9</td><td>Mattayom 3</td><td rowspan="3">Lower SS</td><td rowspan="5">n/a</td></tr>
<tr><td>13</td><td>8</td><td>Mattayom 2</td></tr>
<tr><td>12</td><td>7</td><td>Mattayom 1</td></tr>
<tr><td>6-11</td><td>1-6</td><td>Prathom 1-6</td><td>Primary school</td></tr>
<tr><td>3-5</td><td>n/a</td><td>Anuban</td><td>Pre-primary school</td></tr>
</table>

Abbreviations.: SS= secondary school, VC=vocational college
Source: Ministry of Education, Thailand (2008)

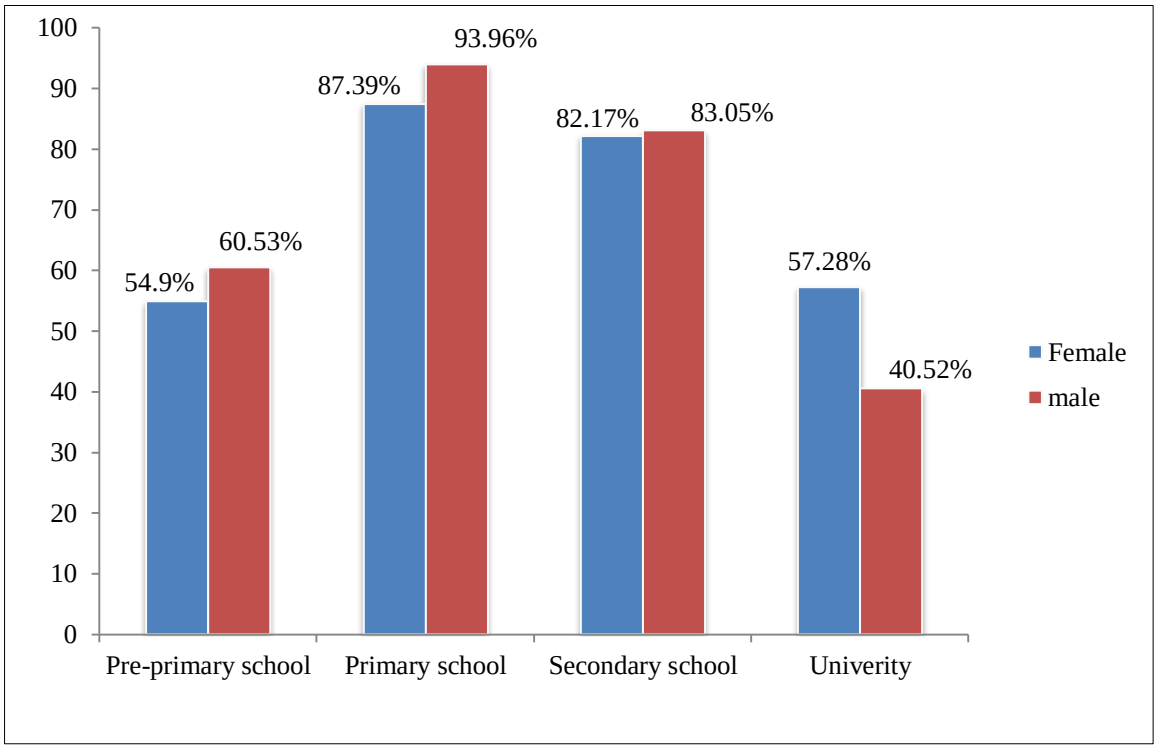

Figure 3: Enrolment rates of students in four educational levels in 2015
Source: UNESCO Institues for statistics (2017)

2.2.5 Socio-cultural profile

"To learn culture is to learn peoples' values, the ideas of what is a desire in life" (Henslin, 2015).

Buddhism and the hierarchal system in Thai society

Thai social values and norms are commonly derived from Buddhist teachings. According to Hanks (1962), Buddhists believe that the hierarchy of all living beings is categorised by the composite quality of *kwamdee* (virtue) or *bun* (merit). Angels and gods have a higher amount of merit than humans, whereas animals are at the lowest level. Although angels and gods are perceived as those who have the highest merit, only humans can achieve Nirvana, which is defined as a state free from suffering, or reincarnation (Limanonda, 1995). Only humans can follow the Buddha's teaching to reach Nirvana, and Buddhists therefore perceive that being human is a great blessing (Lyttleton, 2002).

Parents are considered "a store of merit", or people who have *bunkhun* because they give birth to their children (Lyttleton, 2002). Therefore, as Buddhists, Thai children are expected to show their gratitude to the *bunkhun* of their parents, or pay back a debt of gratitude to their parents (Liamputtong, Yimyam, Parisunyakul, Baosoung, & Sansiriphun, 2004).

The Buddhist religious principle of the hierarchical order of nature has been used to assign social positions and behaviours since the first establishment of Thailand in the 13th or 14th Century (Visser, 2008). The elderly and the older aged are considered as people who have lived experiences more than the younger and have capabilities to advise the younger about general and life matters (Lyttleton, 2002). Senior citizens are also a cultural resource; they safeguard traditional ethics and values, and transfer them to the younger generations (Lyttleton, 2002). In the Thai kinship system, younger siblings are expected to respect and obey their older siblings (Limanonda, 1995).

Hierarchal relationships are expressed in the personal pronouns used in the Thai language. Chirasombutti and Diller (1999) noted how Thai people express the first person singular, "I", in according with their gender and relationship with people surrounding them. For instance, females can call themselves "I" politely as *dichan* in formal situations, *chan* with their friends or in literature, and *nu* to show their respect when talking to a senior female. In contrast, males use *phom* in general, and *kraphom*

in a formal situation with their elders. However, females and males can use some similar words, such *ku* and *kha* to express "I", to show their anger or when being rude. Females and males can also refer to themselves as *phi* to show their seniority when talking to *nong*, or younger people.

Hierarchal relationships between seniors and juniors are also reinforced in educational institutes. According to Grubbs (2012), *Rab* (welcome) plus *nong* (the younger) describes a traditional welcoming period, which includes a number of activities aiming to bind freshman in a university to other new students and to help them to adapt to a new social and academic environment. During the period of *rab nong*, the SOTUS (seniority, order, tradition, unity and spirit) system is introduced through team-based activities such as painting freshmen's faces with colours and singing university songs (Grubb, 2012). According to Grubbs (2012), Thai university freshmen must join and complete activities as required by upperclassmen, and they are also asked to give respect to the upperclassmen. Although violence or verbal abuse has been reported, as in hazing, this tradition still operates in Thai educational institutes. The *rab nong* tradition can implicitly transfer and reinforce the Thai tradition of showing respect to older people. Currently, from my personal observations, the *rab nong* tradition is being conducted not only in universities but also in upper secondary schools and vocational colleges. Unfortunately, there are no published documents describing *rab nong* traditions among the young in the Thai educational setting.

Gender socialisation in Thailand

Gender norms are used as a tool by the dominant group in a given society to set people's roles and to control male and female (Rutter & Schwartz, 2011). Carroll (2013) noted that norms clarify issues around sexual contact, attitudes about moral and immoral sexuality, habit and sexual behaviours, patterns of couple relations and so on. Such social norms or behaviour guidelines are not written, but they are accepted and shared within societies (Elster, 2009). Moreover, they can be changed from time to time (Ricardo, Barker, Pulerwitz, & Rocha, 2006). However, breaking these social norms can cause negative legal or cultural consequences, such as imprisonment, fines, blame, gossips and ostracism (Schaefer, 2011).

In Thailand, Buddhist beliefs shape gender norms. Buddhists believe that to be born a male means having more religious merit than a female, because males can be ordained (Lyttleton, 2002). Being a Buddhist monk is believed to gain the highest Buddhist

merits and to be a way for sons to pay the debt of gratitude to their parents, particularly the mother, who cannot be ordained as a monk herself (Tantiwiramanond, 1997). In contrast, females are considered as pollutants or the danger of the sanctity of the transcendent (Tantiwiramanond, 1997). Although mature females or girls are allowed to be nuns, nuns are unlikely to be allowed to take actions that will gain supreme religious merit (Tantiwiramanond, 1997).

Girls can, however, gain religious merit by performing a set of behaviours like becoming caregivers of their parents, elders in the family and/or other family members (Tantiwiramanond, 1997). Girls can also pay their parents back when they marry by asking for a bride price. The bride price is regarded as payment for breast feeding. Some young women might choose to marry a man with higher socio-economic status to help their parents and to be regarded as a good person for looking after their parents (Fongkaew, 2002). To obtain a higher level of merit and to have a chance to reincarnate as a boy/man, Thai girls or women are expected to prepare food and clothes for monks or to help manage finances at a temple (Lyttleton, 2002).

Girls and boys are socialised in different ways. Fongkaew (2002) noted that Thai girls are expected to stay at home, do housework and look after other family members including siblings. They are supposed to dress modestly, they are forbidden to express their feelings and they are expected to obey their parents (Thianthai, 2004). Girls are likely to be asked to come home before sunset and to follow parents' instructions strictly because of parents' concerns about premarital sexual relationships and rape (Fongkaew, 2002). The firstborn daughter is likely to be expected to complete household domestic chores more often than her younger sisters (Lapimon, Boonmongkhon, Singthongwan, Nayai, & Samakkeekharoom, 2008). Lyttleton (2002) also noted that the expectations on the firstborn daughter who lives in Northeast of Thailand are higher than the younger:

> If a mother has a boy as her first born it will be a problem; If she has a daughter [the firstborn: my translation], it will be easier because of the help around the house and caring for subsequent children, p.170.

Boys in this area are less likely to be requested to help with domestic work, and rarely have to take domestic responsibility (Lyttleton, 2002). Teenaged males are given more

freedom to make their decisions to spend their time outdoors, and are allowed to go to pubs (Fongkaew, 2002; Thianthai, 2004).

In the Northeast region of Thailand (Isan), the dominant ethnic group, Thai-Isan, or Thai-Lao, have a long-established body of cultural mores/traditions guiding appropriate behavior called *heet sibsong kong sibsee* (literally refers to 12 customs and 14 mores). These derive from Buddhism and agricultural culture and practices (NaTalang, 2001). *Heet sibsong* relates to cultural and/or religious activities over the 12 months of the year, *kong sibsee* assigns sets of appropriate social/interpersonal communication and roles for Thai-Isan people - including kings or community leaders, monks and community members (NaTalang, 2001).

Kong sibsee, assigns sets of appropriate social roles and interactions for Thai-Isan males and females as, husband and wife; son/daughter-in-law and parents-in-law; son/daughter and parents; and grandson/granddaughter and grandparents (Raksutthi, 2002). A Thai-Isan male is expected to be a good husband, father, son and son/grandson-in-law. As a good husband, they are also expected to be the breadwinner of the family, respect and love his wife and her relatives, and avoid gambling, drinking alcohol and engaging in extramarital relationship (Prabnock, 2014). A Thai-Isan female is expected to be a good wife, daughter, daughter/granddaughter-in-law, and good mother. She ought to speak and dress politely, give respect and love to her husband and husbands' parents and relatives, have no extramarital relationship, be helpful, humble and patience, follow her husband's, parents' and the elderly's instructions, and take responsibilities on domestic work (Ruksutthi, 2002). Andajani, Chirawatkul, and Saito (2015) found that Thai-Isan women in Khon Kaen also took major responsibility to advocate health and well-being of the family members by providing adequate water for domestic use.

Even with major social/lifestyle transitions due to Thailand's recent decades of modernization there is still understanding and respect for *kong sibsee*. Prammanee (2013) reported that Thai-Isan village members in Eastern of Thailand still acknowledged heet *sibsong kong sibsee*, but behaved slightly different from previous generations. For instance, both husband and wife had similar roles as family breadwinners by working outside the village, had more opportunities to meet many people, and were likely to have less honesty to their partner about engaging in secret love (Prammanee, 2013). Another study also found that Thai-Isan males in a province

of Northeast of Thailand were less likely to be expected to follow *kong sibsee* regarding drinking alcohol and having extramarital sexual relationships (Rungreangkulkij et al., 2012). These two studies suggest that *heet sibsong kong sibsee* while still a major guiding cultural philosophy is in transition in modernising Thailand.

Thai sexual culture

According to Buddha's teachings, the purpose of a sexual relationship is for reproduction. The heterosexual relationship, therefore, is acceptable because the couple can give birth to a baby (Archavanitkul & Saekaoy, 2008). In a heterosexual relationship, Thai men have more freedom than women in expressing their sexual impulses. Males' sexual drives are regarded as a emotion, a need for "release" and the enjoyment of new and different sexual favours (Jackson, 2016). Men are traditionally accepted as having sexual relations with their first wives, mistresses or sex workers, without condemnation (Jackson, 2016).

While the sexual drive of Thai men is viewed as an emotional need for enjoyment, sex for women is likely to be seen as a loss. The contemporary use of the term *sia tua* describes the transferral of the social value of chastity and the loss of females' virginity, or literally, *sia* (lose), and *tua* (body). In 2014, the term *sia tua* was used in a title of a famous contemporary song, "*sia tua, ya sia jai*" (Lose the Body, Don't Lose Your Heart [my translation]). This song underlines virginity as a female loss: "For your virginity that you lose to him, lose your body, don't be upset. Later, you will recover. Your value is in your heart [my translation]".

Currently, in Thailand, the term *sia tua* is used slightly differently from when I first heard it about 30 years ago. However, its core principle remains — it describes the loss of the female. Currently, *sia tua* is used to describe a girl or woman who has already engaged in sexual intercourse, whether she is a virgin or not. Non-virgin girls or women who engage in premarital sexual relations, and married girls or women who engage in extramarital sexual relationships, are likely to be labelled with the term *sia tua* when their extramarital sexual relationship is disclosed. In cases where they are in a stable relationship, they are sometimes called *dai sia gan*. When their relationship with the man is bad, they are likely to be described as the person who loses her body, or *sia tua*, to her sexual partner. Thai males are never labelled as *sia tua* when they engage in extramarital sex.

The terms *dai* (get, gain or receive) and *gan* (each other or together), joined in the phrase *dai gan* is widely used to describe sexual behaviour. In the *National Thai Dictionary*, this term refers to being a husband and a wife (Office of the Royal Society, 2017). However, in most instances, this phrase is used to describe an unmarried couple who have already engaged in sexual intercourse. The term, *dai sia gan* has the same meaning as *dai gan*, but includes two verbs: *dai* (get, gain or receive) and *sia* (lose). There is no clarification within the phrase about who is the gainer or loser. Each might be the gainer or the loser at the same time, or one party could be the gainer (*dai*), and another one could be the loser (*sia*). Based on the terms *dai sia gan* and *sia tua*, these words could imply that, in a sexual relationship, females are likely to *sia* (lose) and males tend to *dai* (gain). Considering these two terms, it seems that a double sexual standard exists in Thai society, and that the sexual inferiority of girls/women to boys/men is still prevalent in modern Thai society.

Despite the fact that heterosexual relationships are considered the acceptable norm, homosexual relationships are likely to be uninhibited in Thai society (Jackson, 2016). According to Jackson (2016), many Thai terms illustrate the diversity of sexual identities, such as *phet thee sam* (the third gender), *sao* (or *phuying*) *praphetsorng* (a woman with a second woman), *katoey* (male-to-female transgender), *bai* (a bisexual man), *les* (a lesbian), *tom* (a female who loves another female, with masculine expression) and *dee* (a female who love another female, with feminine expression). Although homosexual relationships are likely to be accepted among Thais, homosexuals are condemned as *wiparit* (deviant), or *kamawitthan* (sexually degenerated) (Jackson, 2016). They are believed to be people who have been engaged in sexual misbehaviour in a previous life (Jackson, 2016).

As with females losing their virginity, it could be seen that people in Thailand, including adolescents, are living in a society with sexual diversity, but are bound together in unequal relationships and often conflicting standards.

In brief, Thai people live in a hierarchal society that has been heavily influenced by Buddhism. Social values and hierarchal systems have been transferred from generations to generations through social interactions within Thai society. Regarding sexuality, males/boys are likely to be in a superior social position over females/girls. Elders also have the higher social position in Thai society. Thai people live in a sexually diverse

society. However, homosexuals are likely to be religiously condemned and widely accepted.

2.2.6 Health profile

The Thai Ministry of Public Health (MoPH) is the main actor providing public healthcare services. The majority (70%) of healthcare facilities in Thailand are provided by the government (Ingun, Narkpaichit, & Boongerd, 2015). As Wibulpolprasert (2011) illustrated, the MoPH provides healthcare services according to geographical locations: villages, sub-districts, districts, provinces, regions and the capital, as seen in figure 4. Public healthcare services are also provided by Military (or Ministry of Defence), Ministry of Education for medical school hospitals, the Royal Thai Police, Department of Provincial Administration in Ministry of Interior, and Department of Health in Bangkok Metropolitan Administration. The services are not widely distributed as those provided by Ministry of Public Health.

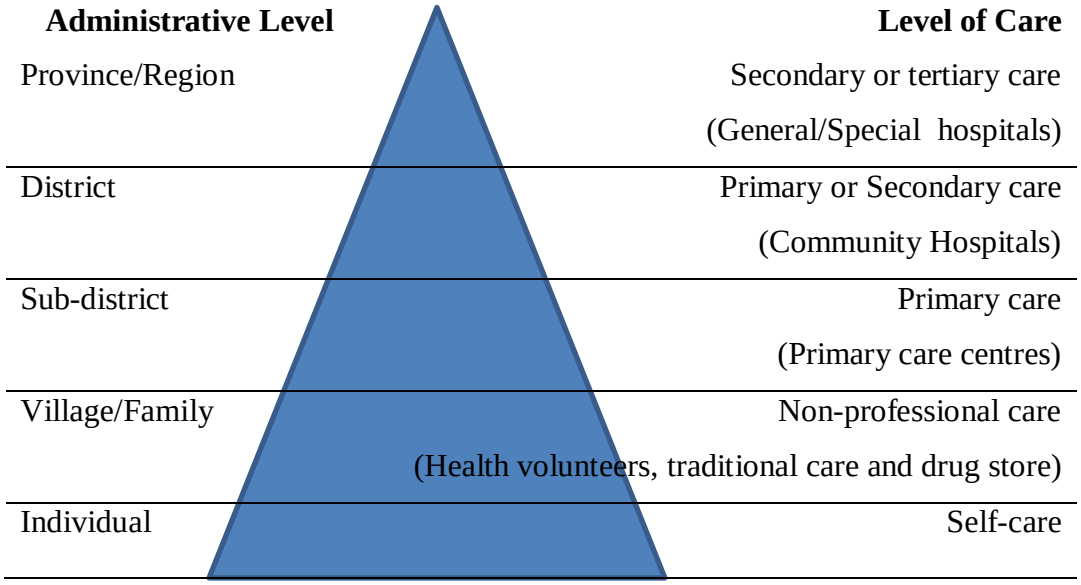

Figure 4: Five levels of health care system of Thailand
Sources: Sakunphanit (n.d.); Wibulpolprasert (2002)

Private sectors also provide healthcare services for Thais who can pay for their treatment and medication. These private healthcare facilities are mostly in urban areas. Private healthcare services include private hospitals, private clinics, community pharmacies and health-related businesses such as massages for health.

Alongside modern medicine, which operates in public and private hospitals or healthcare centres, a number of Thais prefer self-treatment prior to attending modern medicine services. Self-care is just as fundamental to the Thai healthcare system. Thai people have been encouraged by the Thai Government to control their health, as seen in the "Sufficiency Health System" section of the *Tenth National Social and Development Plan* (2007-2011). Suraratdecha, Saithanu, and Tangcharoensathien (2005) have showed that before trying modern medicine, 42% of Thai respondents commonly attempt self-care by purchasing medicine at pharmacies, taking local or traditional medicines and/or visiting traditional healers.

Since 2002, the Thai people's health was protected by one of three main health protection schemes. The Civil Servant Medical Benefit Scheme (CSMBS) was put in place for government (public) servants, pensioners and their dependents including spouses, parents and two children <20 years old. Second, the Health Insurance Scheme (HIS) was set up to provide for private businesses' employees. Third, the Universal Coverage Scheme (UCS) was established to support the remainder of the population, who were not protected by the two previously described schemes (Health Insurance System Research Office, 2012; World Bank, 2012). As of 2015, approximately 75% of the population in Thailand were covered by the UCS, 16% by the HIS and 9% by the CSMBS (Jongudomsuk et al., 2015).

Although most of the Thai population are still protected by these healthcare schemes today, inequality of access to healthcare services remains (World Bank, 2012). For instance, Thai people under the CSMBS can freely choose to be serviced by a healthcare provider of their convenience, whereas those who are protected by the HIS and UCS have specialised zoned governmental healthcare providers (Jongudomsuk et al., 2015). If those under HIS or UCS want to choose non-registered healthcare services, they must pay and cannot ask for reimbursement. Moreover, those holding UCS cover have to pay for the prescriptions of brand-name medicines outside the National Drug List of Thailand, while people holding the CSMBS policy can claim a refund on these items (Jongudomsuk et al., 2015).

After Thailand applied universal health coverage in 2002, mortality rates across all regions of Thailand declined from 1.2 in 2001 to 0.9 by 2014 (Aungkulanon, Tangcharoensathien, Shibuya, Bundhamcharoen, & Chongsuvivatwong, 2016). In 2014,

however, the foremost cause of death was from cardiovascular disease as seen in Figure 5 below:

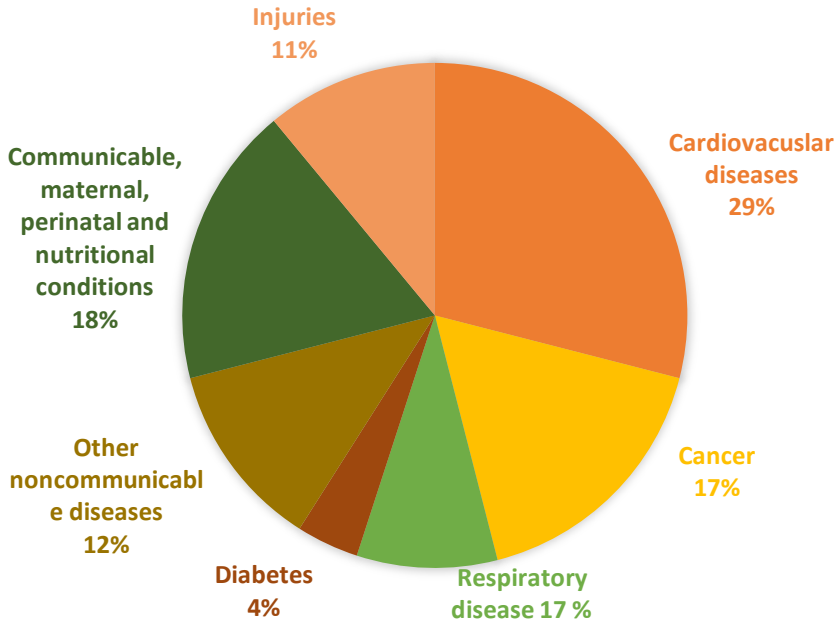

Figure 5: Causes of death among Thais
Source: World Health Organization (WHO, 2014c)

Concerning sexual and reproductive health, Thailand has reduced maternal deaths from 33.6 per 100, 000 births in 2007 to 31.8 in 2014 (Chandoevwit et al., 2016). Thailand has successfully implemented National Family Planning Programmes to tackle a rapid population growth since 1974. Total fertility rates have decreased from 2.1 in 1990, to 1.8 in 2009 and 1.5 in 2016 (WHO, 2016). Contraceptive prevalence rates among married females aged 15-49 have increased from 14.8 in 1970 to 74.5% in 1995, 78% in 2016 (Tangcharoensathien, Chaturachinda, & Im-em, 2015; UNFPA, 2016; WHO, 2016). Although Thailand has great success in increasing contraceptive use, Thai women reported unmet need for family planning as reported in table 5 and unmarried sexually active people still struggle to access effective contraceptive methods (WHO, 2016).

Beginning in the early to mid-1980s, people in Thailand were threatened by growing rates of HIV infections transferred through unprotected heterosexual intercourse (UNDP, 2004). In the early 1990s, the Thai Government implemented many programmes, including sex education, and also provided 100% condom programmes and healthcare services to tackle this pandemic (UNDP, 2004). Since then, Thailand

has successfully decreased HIV prevalence from 2% in 1996, 1.5% in 2003 to 1.1% in 2016 (Avert, 2017; World Bank, 2017b). In 2016, Thailand supported 450,000 out of 70 million people living with HIV, dealt with 6,400 new HIV infections that year, and provided 68% of adults living with HIV free access to antiretroviral treatment, with 86% of children living with HIV also being treated (Avert, 2017).

Table 4: Thailand's sexual and reproductive health (SRH) indicators (2016)

Health indicators	Reported results
Total fertility rate	1.5 children per woman
Adolescent pregnancy rate*	60 per thousand (age 15-19)
Contraceptive prevalence rate,	
All methods	78 %
modern methods	76%
Unmet need for family planning	6%
Proportion of demand satisfied	
All methods	93%
Modern methods	91%

Notes: despite the adolescent pregnancy rate (*), all of health indicators were collected from married or in-union aged 15–49 years
Source: United Nations Population Fund (2016)

Abortion has been an illegal act in Thailand. In article 305 of Thai Penal Code, abortion can be legal when approved by a medical practitioner on the following conditions. The pregnancy can be legally terminated when it endangers the mother's health or results from sexual offences such as rape. Only the first trimester of pregnancy is allowed to be terminated. However, abortion is still seen as an act which is against Buddha's teaching: destroying life or human being because Buddhists believe that life starts after fertilization. In Thailand, a number of females terminated their pregnancy legally and illegally. Warakamin, Boonthai, and Tangcharoensathien (2004) reviewed the case records of 787 public hospitals and interviewed 1,854 female patients who were admitted to hospital because of abortion complications. Approximately 45, 990 cases of admission were from complications of abortion. From this study, 71.5% of these abortions were spontaneous abortion and only 28.5% were the induced abortion. Among these induced abortions, 51% was from legal indications including maternal HIV

infection, Rubella, congenital anomaly, and socio-economic reasons including contraceptive failure.

2.3 Snapshot: Thai adolescents and their sexual and reproductive health

Adolescence is an important period of life in which a person moves from childhood to adulthood (WHO, 2015a). During this period, adolescents experience biological, psychological and social changes (McCarter, 2013). These changes, particularly social ones, have great impacts on teenagers' health and well-being (WHO, 2015a).

The age range describing adolescence is defined variously. According to the United Nations Children's Fund (2013a), adolescence refers to youth in the 10–19-year-old age range, and adolescents are subcategorised into two groups: these aged 10–14 years are "very young adolescents", or "early adolescents", and those aged 15–19 years are "later adolescents". Adolescents aged 15–19 years are also part of a group called "young people" (usually described as being 10–24 years old) and "youth" (15–24 years of age). Adolescents aged <18 years are considered to be children according to the Convention on the Rights of the Child (CRC) (UNICEF, 2013a).

Thai adolescents (or teenagers) aged from 15–19 years are the focus of the present study. Adolescents, particularly between the ages of 15–19 years, become independent of their parents, focus on peers, begin intimate relationships and develop their sexual identities (McCarter, 2013). During this period, adolescents are developing social, situational decision-making skills, and do not always fully understand all positive and negative outcomes of their actions (McCarter, 2013; World health Organization, 2015a). A great number of adolescents are vulnerable and likely to experiment with sex, alcohol and cigarettes (Bearinger, Sieving, Ferguson, & Sharma, 2007; WHO, 2015b)

Thai people have used many terms for referring to adolescents aged 15–19 years. The MoPH defines adolescents, or *wai roon*, as those from 10–19 years of age, and youth, or *yaw wa chon*, as young adults in the 15–24 year age bracket (MoPH, 2014). Adolescents under the age of 18 years, regardless of those who become legally mature persons through marriage, are also referred to as "children" or *dek* in the *Child Protection Act*, B.E. 2546 (2003) while the *Juvenile and Family Courts Act*, B.E. 2553 of Thailand defines children as those aged under 15 years and youth as those aged from 15–18 years.

2.3.1 Living as an adolescent boy and girl in Thai society

In Thailand, adolescent girls and boys are taught to behave differently according to their biological sex. Thai parents exert more control over girls' sexuality. At the age of 2–3 years, girls are taught to sit with their legs together, aiming to hide their genitals, although they are covered by clothes (Lyttleton, 2002). Girls are also taught that sex is dirty and shameful (Costa & Matzner, 2007). In contrast, boys are allowed to sit with the legs opened and do not have to worry about hiding their genitals. Until the age of four, boys can be naked, and they do not have to wear shorts or pants to cover their penises (Lyttleton, 2002).

Adolescent girls and boys are expected by their parents to be good children. According to Wichaiya (2013), adolescence is the period that teenagers are expected to be at school, concentrate on their study and abstain or ignore their sexual needs. Although Thai adolescents aged over 15 years old can legally engage in a sexual relationship, those who engage in a premarital sexual relationship are likely to be considered by their parents as irresponsible for their educational duties and bad sons/daughters (Wichaiya, 2013). Thai parents believed that adolescents are too young to be involved in sexual relationships and prefer their adolescent children to be abstinent until they graduate from universities and get a job (Wichaiya, 2013). For Thai parents, having sex during adolescence would be a big mistake (Vuttanont, 2010), and it has been seen as a behaviours against Thai-Isan culture ("Chaosainoi", 2008).

Although parents expect their teenage sons and daughters to concentrate on their studies equally, parents dictate the behaviour of adolescent boys and girls differently. Girls including those who live in Northeast of Thailand are supposed to avoid the touch of a man on her body, known in Thai as *rag* (love), *naun* (a colour of a female's skin), *sa-ngaun* (keep, look after) and *tua* (body); adolescent girls are supposed to keep their virginity until marriage ("Webmaster", 2019; Fongkaew et al., 2012; Thianthai, 2004). Girls should not talk about any sexual matters, look for information about sex or express their sexual desires (Ounjit, 2015; Thianthai, 2004). For boys, it is acceptable to express sexual appetite and to have sexual experiences as a rite of passage (Thianthai, 2004). Moreover, boys are actually expected to have sex with mutually agreeing partners, casual sex partners and sex workers to increase their sexual expertise (Thianthai, 2004).

While parents expect their children to be abstinent, young people themselves tend to consider sex and sexual relations as a natural instinct of all human beings, an expression of love and a necessary part of maintaining a relationship (Ounjit, 2011). Previous studies show that many young people in Thailand view premarital adolescent sexual relationships as normal (Fongkaew et al., 2012; Ounjit, 2011; Sridawruang, Pfeil, & Crozier, 2010; Vuttanont, Greenhalgh, Griffin, & Boynton, 2006). Cohabitation is also becoming normal in the younger generations. In one study, approximately one-third of university students reported they were cohabiting (Behera & Insomboon, 2014). Half (exactly 50%) of undergraduate students enrolled in one university in the Northeast of Thailand viewed premarital cohabitation as normal (Ounjit, 2015).

Such perceptions of sex and sexual relationships may lead a number of Thai adolescents to initiate a sexual relationship. In fact, one study showed young Thai people initiated sexual relationships at the average age of 13–15 years (UNICEF Thailand, 2016). Another study revealed that boys initiated sexual intercourse earlier than girls, at approximately age 12, whereas the average Thai girl initiated sexual relations at age 15 (Phuengsamran, Chamratrithirong, Guest, & VanLandingham, 2014). Commonly, boys' sexual curiosity and girls' expressions of love are self-reported as reasons for having sex (Hemachandra et al., 2012; A. Tangmunkongvorakul, Kane, & Wellings, 2005; Thianthai, 2004). In one study, it was found that approximately three out of four Thai adolescent girls engaged in sexual activities without coercion (Hemachandra et al., 2012; Roth et al., 2003).

Adolescent girls who engage in a premarital relationship, however, are more likely to be condemned than boys. Sridawruang, Crozier, and Pfeil (2010) reported that parents and adolescents considered premarital sexual relationships for male adolescents to be normal and to have no impacts on family reputation. In contrast, for girls, the study participants perceived engaging in premarital sex as a loss of virginity, which devalued the girl's personal worth, and caused the family shame and embarrassment (Sridawruang, Crozier, et al., 2010). Moreover, the family of the girl who engaged in a sexual relationship could also lose its reputation and standing, and the mother of the girl was likely to be blamed as the bad mother who taught her daughters badly (Sridawruang, Crozier, et al., 2010). Therefore, adults advise Thai girls not to have any intimate relationships with younger boys/men (Archavanitkul & Saekaoy, 2008). Also, in their relationships, if a girl/female starts discussing sex or contraceptives, she can be

judged by her boyfriend as a person who has a lot of sexual experience and is therefore promiscuous (Thianthai, 2004).

While adolescents in Thai society live with parental expectations to take responsibility for their studies, to get a job and to neglect the sexual needs, they view engaging in sexual relationships as normal. Although premarital sexual relationships and cohabitation has become acceptable for younger generations, sexually active girls are more likely to be oppressed by Thai society than sexually active boys.

2.3.2 Health status of Thai adolescents

Most adolescents around the world are healthy; however, global figures show that worldwide, 1.3 million adolescents died in 2012 from preventable or treatable causes (WHO, 2015b). The most common causes of mortality were unintentional injuries including road injuries and drowning, maternal causes, suicides and infectious diseases. For boys globally (particularly those aged 15–19 years), road injuries were the most common cause of death, but the negative consequences of pregnancy and unsafe abortion were the leading cause of death for girls in the same age group (WHO, 2017d).

In Thailand, similar to global figures, the leading cause of death for youth is from road accidents (Table 5). An adolescent boy is more likely to be at risk of death from road accidents than a female adolescent. Sexual and reproductive health problems are the second leading cause of death in Thai adolescents. In fact, in 2016, Thai youth died from HIV/AIDS at the mortality rate 0.8 for males and 0.5 for females (UNAIDS, 2017; WHO, 2017b). Approximately 9,600 young people aged 10–19 years were living with HIV, and 22% of them confronted HIV/AIDS-related discrimination at schools (UNICEF, 2015a). Moreover, new cases of HIV infection and other STDs are now increasing in this age group (UNICEF, 2014b).

Table 5: Health indicators of Thai youth in 2015

Health indicator	Males	Females
Mortality rates of the aged 15–29		
Road accidents	3.2	1.0
HIV/AIDS	0.8	0.5
Interpersonal violence	0.5	0.1
Safe-harm	0.4	0.4

Health indicator	Males	Females
Interpersonal violence	0.5	0.1
HIV prevalence rate		
Young people aged 15-24	0.4 (0.3–0.5)	0.3 (0.3–0.4)
New HIV infection (person)		
Young people aged 10-19	<1,000 (<500–1,200)	<1,000 (<500–1,100)
Young people aged 15-24	2,400 (1,400–3,300)	1,300 (1,000–1,600)

Source: UNAIDS (2017)

Although girls are less likely to be at risk of death from HIV/AIDs than boys, pregnancy is reported as the leading cause of hospital admissions for Thai adolescent girls aged 13–19 years (Areemit, Suphakunpinyo, Lumbiganon, Sutra, & Thepsuthammarat, 2012). The adolescent pregnancy rate of Thailand has risen from 47 to 60 per thousand in just 4 years (MoPH, 2012; UNFPA, 2016).

2.4 Adolescent pregnancy

Pregnancy during adolescence can place girls at increased risk of long-term health complications and death. Among the girls aged 15–19 years old, the childbearing and its complications are the second leading cause of their death (WHO, 2012a). In fact, adolescent pregnancy causes pregnant girls or adolescent mothers to have poor health and well-being. Adolescent girls aged 15–19 years also have a higher risk of mental health problems such as depression, compared to pregnant women of other age groups (Siegel & Brandon, 2014). Worldwide, adolescent girls who are pregnant often drop out of and rarely return to school, and it is likely that they will end up in low-paid work (WHO, 2012a). They are likely to struggle with social and financial problems and need additional social support, healthcare and child welfare assistance from their families, communities and states (Hoffman, 2006; WHO, 2012a).

Pregnancies during adolescence are even more complicated when those pregnancies are unwanted. Unwanted pregnancy puts a number of adolescent girls at risk of unsafe abortions. Approximately 3 million girls around the world have an unsafe abortion every year (WHO, 2014a). Many employ self-induced methods to terminate their

unwanted pregnancies before asking for help from others. They end unwanted pregnancies by jumping from the top of the stairs, taking traditional herbal solutions and applying toxic substances in the vaginal cavity (Grimes et al., 2006; Whittaker, 2002). In one recent study, 185 of 850 Thai participants reported that they had had an abortion experience or a partner who had had an abortion, and 25% of them took abortifacient agents from the black market for terminating their unwanted pregnancy (A. Tangmunkongvorakul et al., 2011).

Children born of adolescent mothers may suffer from poor health, may have lower birth weight and may be more likely to suffer death at or just after birth (WHO, 2012a). Moreover, children of adolescent mothers are likely to be neglected and abused (American Academy of Child and Adolescent Psychiatry, 2012).

Pregnancy out of wedlock has negative social consequences on adolescent girls and their parents. For instance, in a rural area of South Africa, male and female participants aged 17–30 years stated that premarital pregnancy meant the woman was likely to isolate herself from her friends to avoid unpleasant comments or stigma (Zwang & Garenne, 2008). Moreover, the parents were also condemned as bad and for failing to teach and control their daughters (Zwang & Garenne, 2008). In Thailand, Muangpin et al. (2010) confirmed that a girl who became pregnant before marriage would be socially condemned or labelled as naughty and promiscuous. She might also be ostracised by her own family or her partner's family (Muangpin et al., 2010). Moreover, parents of the pregnant girls were also reported as having suffered social pressure from their neighbours in the form of gossip (Sridawruang, Crozier, et al., 2010).

2.4.1 Magnitude of adolescent pregnancy

Adolescent pregnancy has been a global health problem for many years. Approximately 16 million adolescents aged 15–19 years around the world give birth each year (UNICEF, 2012b; WHO, 2012a). In 2015, the global adolescent birth rate is at 44 per 1000 female adolescents (World Bank, 2017a). The high rate of adolescent pregnancy has been observed in Sub-Sahara Africa countries such as in Niger with the highest rate of 201 per thousand and in Mali with the rate 174 ; in some countries in Latin American, i.e. Dominican Republic with the rate of 97 and Nicaragua with the rate of 88 ; and in Asia, e.g. Bangladesh with the rate 83, Nepal with the rate 71 and Yemen with the rate of 61 (World Bank, 2017a). Adolescents in ASEAN countries are also at risk of pregnancy. Adolescent birth rate of Laos PDR, Philippines, Cambodia and

Indonesia is 64, 63, 52 and 49 per thousand female adolescents aged 15–19 years (World Bank, 2017a).

Thailand has also faced adolescent pregnancy problems as many countries around the world. In Thailand, the adolescent pregnancy rate in Thailand is 60 per thousand in 2016, increasing from 54 per thousand in 2012 (MoPH Thailland, 2012; UNFPA, 2016) and approximately 200 adolescents give birth daily (Areemit, et al., 2012). Remarkably, 70% of adolescent pregnancies were reported by the pregnant girls as unplanned (Hemachandra et al., 2012).

2.4.2 Interventions for adolescent pregnancy in Thailand

Governmental and non-governmental organisations (NGOs) within Thailand have worked collectively and have employed various approaches to solving adolescent pregnancy issues. These approaches include creating relevant policies, providing SRH services, and delivering sexual and contraceptive knowledge.

Building policies.

Before 2008, health policies relied on politics and officials. The first National Health Assembly (NHA) was founded in 2008. Approximately 180 delegates from government agencies, the private sector and civil societies participated in this forum, with the purpose of pooling views and ascertaining the true needs of the Thai people for health and well-being (Treerutkuarkul, 2009). Concern about adolescent pregnancy at a national policy level was first raised as a national public health problems in this first NHA meeting (National Health Commission Office of Thailand, 2008).

After adolescent pregnancy issue was raised in the first NHA, adolescent pregnancy was integrated into the 11th National Social and Development Plan of Thailand (2012-2016). Five ministries including Ministry of Public Health, Ministry of Education, Ministry of Social Development and Human Security, Ministry of Labour and Ministry of Interior have been the main actors on this issue. In 2016, the *Prevention and Solution of the Adolescent Pregnancy Problem Act*, B.E. 2559 (2016) was launched to minimise adolescent pregnancy problems and to fulfil adolescents' sexual and reproductive rights. Adolescent pregnancy has remained a primary topic concern in the current 12th National Social and Development Plan of Thailand.

Providing sexual and reproducitve services.

Based on medical knowledge, Ministry of Public Health uses various strategies to solve adolescent pregnancy problems. Its strategies include building youth-friendly clinics, providing contraceptive services and providing legal abortion.

Youth-friendly clinics

The first youth-friendly health clinics (YFHCs) were set up in 24 provinces to tackle SRH problems (Poonkam, 2010). The YFHCs provide many health services including general health check-ups, health education, SRH counselling and testing, family planning services and contraceptive services (MoPH, n.d.). Currently, 835 hospitals nationwide provide YFHCs, but only 50% of them have obtained the minimum requirements for being rated as a good, youth-friendly clinic (MoPH, 2015).

In Khon Kaen City, the chosen study site for this research, a YFHC is located at the same location as the main provincial hospital of Khon Kaen. This YFHC provides services from the 5th level of the building from Monday–Friday, 8.30 a.m.–4.30 p.m. Adolescents are not required to register at reception when they want to access services. However, they must pass many patients waiting at reception before accessing the lift to the 5th level, and they must pass the reception desk of the health promotion department before reaching the unit.

At the Khon Kaen YFHC, teenagers can ask for free condoms with no limitations, but they need to write their name in a ledger in front of witnessing health officers. They can also access other contraceptive methods such as the intrauterine device (IUD), implants and injections. However, these three methods must be provided by a specialist from another department.

Contraceptive services

Apart from YFHCs, adolescents can access free condoms from hospitals, provincial public health offices, sub-district health promotion hospitals, NGOs, village health volunteers, and some school nursing units (UNICEF, 2015b). Those aged under 20 years can also access injectable methods and IUDs at primary care unit, district hospitals, provincial hospitals and regional hospitals without any medical cost (Pisitpaiboon, 2017).

In addition to government contraceptive services, Thai adolescents can access three contraceptive methods from private providers (UNICEF, 2015b). Without parental consent and without a medical prescription and, young people can buy emergency contraceptive pills (aka the "morning after pill"), normal contraceptive pills and condoms at any pharmacy or private clinic. In addition, all people in Thailand, including adolescents, can easily access condoms 24/7 at convenience stores located on almost every corner of every town, particularly in urban areas. However, many Thai adolescents reported embarrassment as further described in Section 3.2.3.

Abortion services

As mentioned in the "Health profile" section, abortion is considered illegal, except in cases where doctors diagnose pregnancy as harmful to an expecting mother's health or because of sexual offences. With parental consent and under doctors' supervision, adolescents can terminate their unwanted pregnancies by using public services. However, Thai adolescents still struggle to obtain safe abortion services. A. Tangmunkongvorakul et al. (2011) reported that half of 186 unmarried young study participants aged 17–20 years engaged in a self-attempted abortion by using illegal abortifacients, and one-third of pregnant respondents had an illegal abortion at private clinics or hospitals.

Delivering sexual and reproductive knowledge

In Thailand, sexual and reproductive information is delivered to young people in four ways: by integrating the topic into school curriculums, by word-of-mouth between friends, at public health exhibitions and on websites.

Integrating sex education into the curriculum

Today, the Ministry of Education (MoE) takes responsibility for providing sex education for students. Thai schools had already integrated sex education into curricula before adolescent pregnancy was raised as a national public health issue in 2008 but sex education was added into other classes such as sociology, health education, and life and society. Currently, sex education is taught in the subject of Health Education at the primary, secondary and vocational levels, both in formal and informal settings (Thaweesit & Bibmongkon, 2012). The content of education, including information about reproductive organs and contraception, is changed according to students' ages and educational levels (Thaweesit & Bibmongkon, 2012).

According to Thaweesit and Bibmongkon (2012), the MoE conservatively integrates negative messages about sex into curricula, such as "premarital sex is improper, and damages adolescents' health", and "condoms cannot 100% prevent AIDS". It does not provide for increasing adolescents' life skills, such as interpersonal and negotiation skills. While integrating knowledge into curricula, many sex education project managers follow the MoE lead and use a conservative approach to pass culturally based sexual messages to Thai adolescents (Thaweesit and Bibmongkon, 2012). These include the projects called *rak-naun-sa-haun-tau* (stay virtuous [my translation]), *waisai huajai sa-ard* (teenagers with pure minds [my translation]) and *ad praw wai kin wan* (wait for a good future [my translation]) (Thaweesit and Bibmongkon, 2012).

Working collectively with the MoE, the Programme for Appropriate Technology in Health (PATH), an NGO, has used contrasting, liberal techniques to create a new teaching method for sex education, and they have trained teachers to work with young people and to enhance the acceptance of sex education in Thai society (Thaweesit & Bibmongkon, 2012; UNICEF, 2014a). This approach uses activities such as games and case studies in group learning to positively increase adolescents' understanding of sexuality and its development, and to build adolescents' capacity to make informed decisions about their social behaviours (Thaweesit & Bibmongkon, 2012).

A number of Khon Kaen schools including one in this study were involved in the integrated sex education programme. Contraceptive information, sexual transmitted diseases information and sexual-related negotiation skills were delivered to students by trained teachers. Students spent two hours per week over about three to five weeks in their whole three-year course on this. These classes included activities such as games, role plays and simulation. Each semester, students also gain contraceptive information from two-hour sessions at a one-day exhibition provided by outside-school sex educators. There, condoms were freely distributed for those who participated in this one-day exhibition. In the other school in this study, students did not have integrated class-based sex education, but most of them gained contraceptive information from the integrated one-day exhibition about drug abuse and unwanted pregnancy prevention.

Friend-to-friend sex education

The Thai Ministry of Public Health (MoPH) launched programmes to promote adolescents' health and well-being holistically in 2002 (MoPH, 2008). The Department of Mental Health currently provides a training course for student representatives to peer

mentor other adolescent students at their schools (MoPH, 2008). In the training course, knowledge about SRH, including contraceptive information, is provided. Other adolescent issues, including drug addiction and HIV/AIDS, are also part of the training. Students dubbed this project the *moom paern jai wai roon* (friends' corner) (MoPH, 2008). The three main activities of this project include: 1) counselling and empowerment for vulnerable adolescents; 2) increasing life skills and knowledge, such as how to love during adolescence and safe dating; and 3) providing young adult extracurricular courses, such as dancing, singing and drawing (MoPH, 2008). Condoms and contraceptive pills are also provided at the "Friends' Corner" for those who want them (Saengsattarat, 2016). When adolescents' problems are uncovered by their peers, the trained peer mentors can refer problematic cases to teachers, and later to health professionals, for further support.

One of the participants in the current study was a student representative of the Friends' Corner project. He stated that, in addition to the three main activities sponsored by the project, he initiated a school performance for juniors at his school, and during the activity, he delivered knowledge he gained from the training. As a role model for this project, he showed junior students that he always carried condoms for unplanned, but safe, sex.

Exhibitions and campaigns at schools

At school, adolescents also have opportunities to join in many projects relating to SRH. The exhibition "Can Adolescents Get Pregnant?", for example, was organised on March 9th, 2017 at Kam Kaen Nakhon School by health professionals from Khon Kaen Hospital and the International Planned Parenthood Federation (IPPF) in Khon Kaen (Khon Kaen Hosptital, 2016). During this campaign, knowledge of SRH was delivered, and condoms were distributed to teenagers.

Many other internal school campaigns convey sexual and contraceptive messages. Thai Government-sponsored AIDS prevention campaigns, for example, aim to increase the knowledge and understanding of young people at school about HIV/AIDS and condom use to prevent spreading the infection. Condoms are distributed as a part of these school campaigns.

Online sex education

The Thai Government and NGOs have created websites to increases accessibility to SRH information. The Bureau of Reproductive Health, a part of the MoPH, provides an online handbook for young people, parents and health professionals who work in the area of SRH. The Thai Health Promotion Foundation also provides another link for young people: http://talkaboutsex.thaihealth.or.th/. An adolescent group on Facebook page https://www.facebook.com/3c4teen/ delivers information about SRH and rights for young people.

2.5 Chapter Summary

Adolescent pregnancy is an ongoing national public health concern for Thailand. The Thai Government and associated NGOs have been working collectively to address this problem since 2008. They have used various public health interventions, including delivering safe sex and contraceptive knowledge, and have provided contraceptive services to help vulnerable teenagers reduce the risk of pregnancy, as well as sexual transmitted diseases. For a decade, governmental and NGO agencies focused on adolescent pregnancy slightly slowing the rate of increase. However, hidden, deep-seated causes of adolescent pregnancy might not have been discovered or solved yet. Therefore, studies on adolescent pregnancy are crucial to promoting the health and well-being of Thai teenagers and their families, communities, the Thai nation as a whole and even other people around the world, because adolescent pregnancy is a worldwide concern.

In Thailand, to address adolescent pregnancy is challenging. Under the hierarchal and patriarchal social system, boys/men and girls/women undergo distinctive gender socialisation, and girls/women are likely to be suppressed. While young Thai generations see engaging in a sexual relationship as normal, and premarital sexual relationships as acceptable, their parents and the previous generations are unlikely to agree with that. A number of sexually active adolescents may live with imbalanced feelings of how to be a good child and how to be a modern teenager.

For sexually active adolescents to prevent unplanned pregnancy, apart from the abstinence method, contraceptive methods can be a good choice. In Chapter 3, I present a literature review on adolescent's contraceptive use in Thailand, and public

interventions to increase contraceptive use. In Chapter 3, I also illustrate the intricate process of adolescent decision making and how it affects contraceptive use.

CHAPTER 3. **Literature Reviews**

3.1 Chapter outline

This literature review chapter is divided into four main sections. The first section presents basic background information about contraceptive methods, global and national contraceptive use rates for adolescents, interventions used worldwide to increase contraceptive use and available methods of contraception. I include my views based on previous studies I have conducted, my thoughts about future contraceptive use, and the reasons why I think the actual decision-making process should be a main focus of government programmes aimed at decreasing adolescent pregnancies. The second section presents three critical decision-making factors and explores the significance of contraceptive decisions. The third section of Chapter 3 is a collation of all factors that affect contraceptive use decisions. The last section presents a summary of adolescents' sexual and reproductive rights as they pertain to the right to make decisions about contraceptive use. Gaps in knowledge are discussed in each section.

3.2 Contraceptives

Contraceptive methods are techniques or devices mostly used in family planning programmes by individuals or couples to control the number, spacing and timing of their children (WHO, 2014b). In the absence of effective contraceptive methods, unprotected sex has the potential to place adolescents, particularly those who are sexually active, at risk of unwanted pregnancy, unsafe abortion or other SRH problems (WHO, 2012a). Contraceptive use is therefore a significant determinant of adolescent pregnancy and future lives (WHO, 2012b).

3.2.1 Adolescents' contraceptive use

The global contraceptive use rate has increased; however, low rates of contraceptive use have been reported among adolescents. Global contraceptive use has increased from 55% in 1990 to 63% in 2011, and up again by 1% to 64% in 2013 (Alkema, Kantorova, Menozzi, & Biddlecom, 2013; United Nations, 2013b). Approximately 90% of women around the world have reported that they regularly use some kind of modern contraceptive method (UNFPA, 2013a). However, global contraceptive use among adolescents aged 15–19 years is relatively low at 21%, compared to 38% among those

aged 20–24 years, 52% among those aged 25–29 years and more than 60% among those aged 30–44 years (UNFPA, 2013). Studies have shown that adolescents aged 15-19 years have a lower rate of contraceptive use and a higher failure rate, compared to the aged 20-24 years (Blanc, Tsui, Croft, & Trevitt, 2009). Thai adolescents who are 15–19 years old also have low rates of contraceptive use. In Thailand, married or in-union females (aged 15–49 years) use contraceptives 79.3% of the time, whereas, married or in-union females in the 15–19-year age group use contraceptives only 75% of the time (MoPH, 2013).

Globally, low contraceptive use is more common in unmarried, sexually active adolescents (Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014). Approximately 25% of adolescents aged 15–19 around the world do not want to become pregnant, but they do not use contraceptives (UNFPA, 2013). Only 26.5%, 21.3% and 39.7% of unmarried, sexually active young women in India, the Philippines and Tanzania, respectively, use contraceptives (WHO, 2017a).

In Thailand, little is known about contraceptive use among unmarried, sexually active adolescents aged 15–19. Previous domestic studies have reported low rates, 30%–50%, of unmarried Thai youth (aged 17–25 years) using contraceptives (Jenkins et al., 2002; A. Tangmunkongvorakul et al., 2011). These two studies might suggest that unmarried, sexually active Thai adolescents aged 15–19 years old possibly have a low level of contraceptive use, compared to older and married or in-union women. Consequently, contraceptive use by unmarried, sexually active adolescents is the focus of the present study.

3.2.2 Common contraceptive choices for adolescents

Discounting vasectomy and female sterilisation, there are many contraceptive methods available to adolescents in Thailand. As shown in Appendix B, contraceptive methods can be divided in two groups. First, long-acting reversible contraception (LARC) methods are available to prevent unplanned pregnancy for a period of 3–10 years. Hormonal implants and intrauterine devices (IUDs) are included in this group. Second, short-acting reversible contraception (SARC) methods are viable for various use periods, from once per sexual encounter to several months at a time. Available SARC methods consist of hormone pills, male and female condoms, hormone patches, hormone injections, sponges, cervical caps, diaphragms and spermicides. Both of LARC and SARC are categorised by as modern contraceptive methods (WHO, 2014b).

Noticeably, among modern contraceptive methods, condoms are the only method that can provide users with dual benefits. Regardless of the fact that condoms can be broken or applied in the wrong way, they can prevent not only unwanted pregnancy but also sexually transmitted diseases (STDs) such as HIV/AIDS and gonorrhoea.

Apart from modern contraceptive methods, many traditional contraceptives are used in Thailand. According to the WHO (2014a), traditional contraceptive methods include withdrawal and periodic abstinence (rhythm). These two methods are considered less effective than others, however. Every year, approximately 20% of women using the early withdrawal method fall pregnant (US Planned Parenthood Federation, 2017). The periodic abstinence (rhythm) method suffers a 24% failure rate. Contraceptive methods and their success/failure rates are listed in Appendix B. Rates are calculated by the US Centers for Disease Control and Prevention (2013).

Most contraceptive methods are recommended for preventing fertilisation *before* sexual intercourse. Only emergency contraception (EC) is applied after sexual intercourse. Applied within 72 hours after unprotected sex, three EC options are available: 1) contraceptive pills (levonorgestrel or ulipristal acetate); 2) the Yuzpe method (combined oral contraceptive pills containing oestrogen (ethinylestradiol, 100–120 mcg) and progestin (levonorgestrel, 0.5–0.6 mg; or norgestrel, 1.0–1.2 mg); and 3) emergency copper intrauterine devices (WHO, 2014a). The first two options can be easily taken because they are in an edible form. In contrast, emergency copper IUDs need to be inserted into the vaginal cavity by trained doctors or nurses, and these devices can cause painful and heavy menstruation (NZ Family Planning, 2017).

Males have fewer contraceptive choices than females. Male-controlled methods include condoms and withdrawal methods (Fennell, 2011). Females' choices are many, and include female condoms, pills, injections, patches, caps, diaphragms, implants and IUDs. Although females have more contraceptive choices than males, not all of them are available or easily accessible. For example, some female-controlled methods, such as IUDs and hormonal injections, must be administrated by health-professionals located away from the privacy of home, at public healthcare facilities, where there are many witnesses.

Unmarried sexually active adolescents (aged 15–19 years) in various areas of the world choose different contraceptives. For instance, approximately 17%, 6% and 5% of

unmarried Filipino girls who use contraception regularly reported using withdrawal, condoms and pills, respectively (WHO, 2017a). In India, 13%, 7% and 3% of unmarried girls who used contraception reported using male condoms, withdrawal and periodic abstinence respectively (WHO, 2017a). In Thailand, no national survey of contraceptive-use survey of unmarried, sexually active adolescents has been conducted to date. Ministry of Public Health, Thailand (2013) reported that pills are widely used by female Thai adolescents. However, in this report, withdrawal and periodic abstinence are more commonly used by those aged 15–19 years, compared to those aged 30–49.

A. Tangmunkongvorakul et al. (2011) conducted a regional study of unmarried, sexually active young people aged 17–20 years and found that withdrawal was the most popular method as male condoms, followed by periodic abstinence and finally, pills. Although the A. Tangmunkongvorakul et al. (2011) study did not recruit the whole range of the young females aged 15–19 years, it nevertheless highlighted a low rate of effective contraceptive use by adolescents in Thailand.

In brief, less effective traditional methods, including withdrawal and periodic abstinence, are commonly used by adolescents including those in Thailand. Therefore, studies exploring Thai attitudes toward contraceptive use are required to illuminate the root causes of low use rates and to elucidate possible solutions for high adolescent pregnancy rates.

3.2.3 Interventions to increase contraceptive use and its accessibility

The World Health Organization (2012a) has proposed that lack of information about and accessibility to contraceptive methods as determinants of adolescent pregnancy problems worldwide. Building contraceptive knowledge through sex education and increasing accessibility to contraceptives are believed to increase contraceptive use and later, to reduce adolescent pregnancy.

Increased contraceptive knowledge through sex education

A number of adolescents around the world show insufficient knowledge about contraceptives. For instance, a cross-sectional survey study at three institutions in Canada and one institution in the US showed that 354 female participants aged 10–24 years had poor contraceptive knowledge and were often acting on misinformation about the side effects of hormone pills (Sokkary et al., 2013). In Australia, young males and

females aged 14–24 years reported having low knowledge about oral contraceptive pills, vaginal rings and IUDs, although they had more knowledge about condoms and withdrawal methods (Ritter, Dore, & McGeechan, 2015). In Thailand, a national survey by the Ministry of Education (2016) revealed that only 11%–30% of adolescent girl and boys aged 13–19 years knew how to use condoms, and only 19%–30% of them knew about the menstruation cycle and how to calculate safe times for having sexual intercourse.

Previous studies have illustrated that, despite high knowledge about condoms, a number of adolescents misunderstand contraceptive methods in general. Most of boys and girls aged 15-19 in Northern Madagascar believe that contraceptives caused infertility, cancer and the retention of bad blood in the woman's body (Klinger & Asgary, 2017). Undergraduate female students aged 18–24 years old in South-eastern USA perceived that the IUD could danger their physical body and their fertility (Berlan, 2017). In Thailand, many Thai people including adolescents believed that hormonal contraceptives cause infertility, cancer, bleeding and sexual dysfunction (Thai Health Promotion Foundation, 2012).

Sex education have been proposed as a strategy to increase knowledge about sex and contraception and then to solve adolescent pregnancy problems in many countries around the world (Baltag & Chandra-Mouli, 2014; Cornet, 2013). Providing new knowledge about sexual health and how to control reproduction is regarded by Thai authorities as a way of changing attitudes or beliefs, and as a way to help people make informed decisions (Naidoo & Wills, 2009).

Today, comprehensive sex education is believed to be a better approach than advocating an abstinence-only approach (Malone & Rodriguez, 2011). According to Alford (2001), comprehensive sex education provides various aspects about sex and sexual-related issues. Messages about sex and contraceptive methods are positively provided, and abstinence from sexual intercourse is seen as the most effective methods to prevent risks from engaging in sexual activities. Comprehensive sex education also adds sexual-related information about human development, interpersonal skills, sexual orientation and sexual expression. Abstinence-only programme employs fear tactics to deliver the negative messages about premarital sexual relationship as unacceptable behaviours and causes of negative physical, psychological and social consequences (Alford, 2001). Based on abstinence-only methods, condoms are discussed but in the light of the failure

of condom usage (Alford, 2001). Abstinence-only education is unlikely to consider the basic human rights of young people to access sexual and reproductive health information and services (Santelli, Ott, Lyon, Rogers, & Summers, 2006).

Many benefits have been realised after introducing comprehensive sex education. In China, an increase in contraceptive and condom use was reported after implementing a 20-month, comprehensive sex education programme with young male and female people age 15–24 years old in suburban areas of Shanghai (Wang, Hertog, Meier, Lou, & Gao, 2005). In Thailand, Sommart and Sota (2013) have noted, comprehensive sex education can increase not only adolescents' scores on contraceptive knowledge but can also develop positive attitudes towards sexuality. Moreover, comprehensive sex education can significantly decrease the frequency of sexual intercourse and can strengthen the intention to use condoms in secondary school students aged 13–18 years (Thato, Jenkins, & Dusitsin, 2008).

Barriers to delivering information through sex education at school, however, have been described in many countries including Thailand. In Spain, teachers have had little training to deliver sex education: only 12% of teachers were found to be trained to deliver the subject when they were in undergraduate courses, and less than 1% of them had training at the postgraduate levels (Martínez et al., 2012). In Thailand, teachers have no skills and no contraceptive knowledge to provide proper learning activities for students (MoE, 2016). Teachers feel uncomfortable when they deliver sexual and contraceptive information (Vuttanont et al., 2006). Moreover, young people have said that sexual and contraceptive information offered at specific educational levels does not match the level of curiosity and knowledge of that age group (Vuttanont, 2010).

Worldwide, parents also struggle to deliver sex education to their children. A study in Greece illustrated that delivering sex-related messages to children is not easy, although most parents do talk to their children about sex (Kirana, Nakopoulou, Akrita, & Papaharitou, 2007). Parents have reported embarrassment in engaging in such conversations (Stone, Ingham, & Gibbins, 2013). In Thailand, parents are likely to talk about physical changes and dating, but rarely discuss contraception (Rhucharoenpornpanich et al., 2012). Furthermore, sex education is expected to be the teachers' responsibility, not parents' (Sridawruang, Pfeil, et al., 2010).

For adolescents, the Internet can be an alternative way to obtain contraceptive information. A study in China, for example, has shown that adolescents in high schools who access sexual and reproductive information from the Internet get higher scores on tests about reproduction, contraception and STDs, compared to a control group (Lou, Zhao, Gao, & Shah, 2006). In Thailand, young people have indicated that the Internet is the first place they look for information, instead of teachers, parents or friends (Ministry of Education, 2016). Although the Internet can increase accessibility to contraceptive knowledge, adolescents in rural areas or lacking funds to pay for Internet services might not gain such benefits. Moreover, they could gain misconception about contraceptive from unreliable websites.

While many government agencies and NGOs have attempted to increase young people's knowledge on a variety of topics, increasing great knowledge does not guarantee that individuals will always use the knowledge to make the right decisions (Naidoo & Wills, 2009). For example, Ghanaian boys and girls aged 15-19 years had a low contraceptive use rate, although they showed a high level of understanding about contraception (Baku, 2012). In Nigeria, adolescents aged 10–19 years in the study had a high level of contraceptive knowledge but a low contraceptive use rate (Chimah, Lawoyin, Ilika, & Nnebue, 2016). A relatively recent study in Thailand echoed this trend: more than 80% of young people aged 12-21 years knew about the transitional period of adolescence, STDs and contraception, but over 50% of them still participated in sexual activities without condoms (Kaewchanta, Youchaiyen, Suwittayasiri, & Petchprapai, 2009).

Increased accessibility to effective contraception

A number of unmarried, sexually active adolescents around the world have unmet needs for contraception (Chandra-Mouli et al., 2014). Unmet need rates can indicate the gap between a demand of pregnancy prevention and a non-contraceptive behaviour. Approximately 48% of unmarried sexually active girls aged 15–19 in Tanzania and 64% of those in Zimbabwe have reported they want to prevent pregnancy but do not use any contraceptive methods. In Thailand, a potentially unmet need for contraception has been reported for the group of married or in-union adolescents aged 15–19 years (11.6%), compared to women aged 45–49 at 8.3% (Tangcharoensathien et al., 2015). This figure might also indicate a high rate of unmet needs among unmarried, sexually active girls aged 15–19. Unmet needs for contraception can mirror the external and

internal barriers teenagers face in accessing contraceptive services—a primary determinant of adolescent pregnancy rates (WHO, 2012b)

Barriers to accessing contraception in many countries include domestic laws and policies. In Senegal, a survey of women reported that health providers set the minimum age to access pills and the injections at 18 years, meaning younger women were unlikely to gain access to these two methods (Sidze et al., 2014). In the US, teenagers can access oral contraceptive pills by prescription only, and cannot access them as an over-the-counter (OTC) drug (Upadhya, Santelli, Raine-Bennett, Kottke, & Grossman, 2017). In Thailand, in contrast, law and policies are unlikely to affect access to contraceptive methods. Adolescents are eligible for contraceptive methods from Government healthcare providers under national healthcare schemes, and youth are able to buy contraceptive pills from pharmacies without prescriptions or parental consent.

Cost of contraceptive methods can be a barrier for adolescents in developed and developing countries to access effective means. For example, in US, 45% of adolescents aged 15-19 years old considered about the cost of ECPs (Mollen, Miller, Hayes, & Barg, 2013). In New Zealand, 10 key informants including midwifes, nurses and doctors reported that the cost of hormonal implants Jadelle was the biggest barrier for adolescents attempting to access LARC (Sandle & Tuohy, 2017). The UNICEF (2015b) stated that in Thailand, cost is a barrier for young people looking for effective, modern contraceptive methods.

Worldwide, social and group norms are reported as barriers seeking to access contraceptive services. Social norms discouraging premarital sexual relationships can hinder a number of young people in many countries from accessing contraceptive services. The top reason for adolescents in India, the Philippines, Albania and Tanzania not to use contraceptive methods is shame, because they are formally classified as “not married” (WHO, 2017a). It seems that people of unmarried status in these countries are expected to stay abstinent and not to use contraceptives. Similarly, in Thailand, adolescents are expected by adults to play the role of being a good child and a good student, and to neglect sexual needs; thus, adult health professionals may also see sexually active teenagers as “bad children”. In fact, one recent study reported that young people in Thailand are judged by health professionals (Tangmunkongvorakul et al., 2012). In fact, girls are expected not to seek information about sex and

contraceptives at all (UNICEF, 2015b). Thus, it seems that gender norms obstruct Thai girls from accessing information and services.

Providing adolescent-friendly healthcare services can increase the access to and the use of contraception (Chandra-Mouli et al., 2014). In US, many organizations such as NGOs Planned Parenthood, Title X and reproductive health-focused facilities have provided youth friendly services under the consideration of confidentiality and these services can increase provision of LARC among adolescents (Kavanaugh, Jerman, Ethier, & Moskosky, 2013). However, inconvenient opening hours was stated as a barrier to access these youth-friendly services (Kavanaugh et al., 2013). In Thailand, the Thai Government does provide adolescent-friendly services, but agencies still confront challenges in delivering services suitable for young people. Over nearly a decade, the Thai Government has provided youth-friendly clinics in hospitals and universities that deliver high-standard sexual and services specifically tailored to adolescent needs (UNICEF, 2015b; WHO, 2010). Key informants in a study of UNICEF (2015b) reported that only adolescents in urban areas can access such clinics. In addition, despite the many locations of youth-friendly urban clinics, health providers working at these places were reported as having no specific skills in working with adolescents (Auamkul, Koosmithi, & Jongvanich, 2012). When young people attended the clinics, they experienced judgement and stigma, they had no privacy and they gained insufficient information about contraceptives (Tangmunkongvorakul et al., 2012; UNICEF, 2015b).

3.2.4 Contraceptive key summary

Contraceptive methods can be an effective pregnancy prevention tool for sexually active Thai boys or girls. Sex education can be used to increase contraceptive use and to address adolescent pregnancy. Having great knowledge about sex and contraceptives, however, might not lead to informed decisions on contraceptive use. Building additional and improving existing youth-friendly services is necessary to increase access. All legal, economic and sociocultural barriers to contraceptive use must be eradicated in Thailand in order to address the adolescent pregnancy problem. The question remains whether or not these adolescents will decide to use contraception. Further studies about decision making and contraceptive use in Thailand are needed in order to increase understanding about this critical point *before* designing further youth-friendly service centres.

3.3 Decision making and contraceptive use

Decision making is vital for any individual's health and well-being, because it determines individuals' behaviours — both those decisions promoting and threatening their health. A decision on contraceptive use has potential long-term impacts on the lives of others, too.

Decision making on contraceptive use has been described as a dynamic process (Downey, Arteaga, Villaseñor, & Gomez, 2017). In the study of Downey et al. (2017), decision making on contraceptive use was described as a dynamic process of initiation, continuation and discontinuation in using a contraceptive product. Unmarried women in the 18–29-year age group in this study revisited their initial contraceptive decisions to better avoid unwanted pregnancies (Downey et al., 2017). Indeed, "contraceptive decision making is a journey, not a destination on a linear path" (Downey et al., 2017, p. 3).

Decision making on contraceptive use can also reflect a person's values, and personal values inform the final choice of method (Downey et al., 2017). For example, one 22-year-old participant in the Downey et al. (2017) decided to use oral contraceptive pills because she wanted to have freedom from unwarranted responsibilities in her relationship. A 23-year-old participant also related her emotional experiences with the failure of an IUD, which led her to choose abortion and to further consider IUDs as too invasive in the face of their ineffectiveness (Downey et al., 2017).

3.3.1 Adolescent decision making

In the current study, the term "decision making" as it applies to adolescents has three aspects: teenagers' decision making is 1) an immature physiological brain function, 2) a psychological and social-related process, and 3) a human right.

Decision making as an immature brain function

Adolescence is a transitional period in which young people learn and develop their social, situational and rational decision-making skills (McCarter, 2013). During this period, adolescents' brains are not fully developed yet, and therefore, their decision making can be affected by incomplete brain development (Crone, 2016).

It is well known that two main areas of adolescents' brains are still undergoing development. Crone (2016) has described one such area, the frontal lobe, which has a

crucial function for remembering what is right or wrong, responding to being rewarded or punished and regulating emotions. The second area still undergoing development is the somatic warning system for dangerous situations (Crone, 2016). When adolescents' brains are developing in the warning-system area, they seem to know how dangerous a situation is, but they do not feel the danger at an emotional level, and because they do not feel fear, they ignore the danger (Crone, 2016). Consequently, they become risk-takers, particularly when they want a potential reward (Crone, 2016).

Crone (2016) has defined decision making as a physiological function of the brain. However, it can be said that the brain function of remembering what is right or wrong becomes a cognitive ability to remember social values or norms — what a society accepts or assigns as right (good) or wrong (bad), which leads to consideration of rewards and punishments related to following or disregarding social guidelines. Therefore, decision making is unlikely to be only a physiological process but is also a socialisation process, as described in the following section.

Decision making as a psychosocial process

Janis and Mann (1979) described decision making as a psychological process. The process starts with examining goals and a wide range of choices. Decision makers then consider costs and risks relevant to the possible consequences after making decisions. Vigilant decision makers are likely to weigh up possible gains and losses affecting them and significant others (Janis & Mann, 1979). Moreover, the likelihood of gaining self and social approvals for a course of action are included in self-deliberations. Further information is probably needed to re-consider and to rank choices. After a decision is made, a course of action will be implemented (Janis & Mann, 1979). However, some people might not follow all of these steps. Janis and Mann (1979) have proposed that some people may reject the possibilities inherent in taking risks, and may therefore ignore the consequences of their choices. Some of them may even shift decision-making responsibility to others in order to escape conflicts (Janis & Mann, 1979).

While Janes and Mann (1979) have explained decision making as a psychological process, they have also indirectly stated that decision making is a process influenced by society. In the decision-making process, the decision maker is therefore preoccupied with various levels of consideration about the consequences of their actions on themselves and on the people surrounding them — generally speaking, their society.

Moreover, social approval for their behaviours after making a decision is of concern. Therefore, according to Janis and Mann (1979), decision making becomes not only a psychological process, but also a social commitment:

> "Decisions are socially committing because they require efforts at implementation of the decision maker is to fulfil his or her role in the community and maintain his public reputation as well as his self-image as a reasonably reliable person, p. 4."

Decision making as a human right

Despite being defined as a social, life and cognitive skill, decision making also refers to a basic human right. The right to make a decision in enshrined in global conventions. For instance, in preparing the *Convention on Elimination of All Forms of Discrimination against Women* (CEDAW), the right of decision making was officially proposed in the 1995 Beijing meeting. In Section G of the 1995 CEDAW, women were encouraged to participate equally in decision-making positions, on a par with men. State members of the UN must now provide and promote equal participation of women at all levels of governance. In the 1995 CEDAW declaration, the right to decide on SRH is explcitly stated in Paragraph 95 of "Section C: Women and Health". The UN's Committee on the Rights of The Child has urged its state members to ensure that adolescents have the right "to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to build life-skills, to acquire adequate and age-appropriate information, and to negotiate the health behaviour choices they make" (United Nations, 2003, p. 10).

In the present study, decision making has been described as a psychosocial process. Yet, it can also be considered as a basic human right for everyone in the world. However, we need to be aware of teenagers' immature brain development, which can affect their decision making and can cause them to make less vigilant decisions compared to adults.

3.3.2 Adolescents' decisions about contraception

A decision to use contraception may reduce female adolescents' health risks associated with unwanted pregnancy and its social and financial consequences. Reducing the chance of unwanted pregnancy during adolescence increases the quality of health and well-being of the next generation, while decreasing the chances of premature birth, low birth weight, low cognitive ability and child abuse and violence (Areemit, et al., 2012;

WHO, 2012a). United Nations Population Fund (2006) has emphasised that individuals' decisions about SRH, including contraceptive use, influence not only world population numbers but also the health and well-being of people around the world.

Many relatively recent qualitative and quantitative studies about decision making and contraception have been undertaken in countries such as the US, Nepal, Tanzania and Malaysia (Bangpan & Operario, 2014; Beaulieu et al., 2011; Daugherty, 2011; Merkh et al., 2009; Schuler et al., 2011; Subedi et al., 2013; Tong et al., 2014). The target group in more than half of those studies was the 18–49-year-old participant, however. Only a few studies have focused on adolescents aged 15–19 years, and fewer studies again have considered only adolescent female perspectives (Hemachandra et al., 2012; Nelson, 2009).

In Thailand, one recent study has brought to light concerns about adolescents' decisions regarding contraception. Hemachandra et al. (2012) investigated knowledge, attitudes and practices in married female adolescents aged 12–19 years. They found that contraceptive pills and condoms were the most common methods used to control birth, and that 60% of their female respondents were the main decision makers in charge of choosing either contraceptive pills, condoms, emergency pills or hormone injections. Although Hemachandra et al. (2012) found that female adolescents were the key decision makers in using a specific contraceptive method, the dynamics of decision making remained unexplored. In addition, no information about how the decisions were made to opt for alternative contraceptive choices, such as withdrawal or periodic abstinence, was gathered.

3.4 Factors influencing decisions about contraception

Several factors influence individuals' choices regarding contraceptive use (Commendador, 2003; Daley, 2014; Ogden, 2012). This section does not include analysis of two influencing factors previously described in this chapter: 1) lack of contraceptive knowledge and effective sex education; and 2) accessibility to effective contraceptive methods. In Section 3.4, I concentrate on other, psychosocial influencing factors, such as gender roles and expectations, and the influences of religious beliefs, partners, peer norms and parents' communications.

3.4.1 Religious beliefs

Religious beliefs influence some decisions on contraceptive use. Schenker and Rabenou (1993) have indicated that religious beliefs about the origins of life and reproduction affect global family planning programmes, including programmes aimed at increasing contraceptive use. For example, people of the Catholic faith accept only the abstinence method to control birth because they believe that children are a gift from God and that using contraceptives is against God's purpose (Schenker & Rabenou, 1993). For Muslims, using contraceptive methods depends on each country's policy. According to Farzaeh (2004), Muslims in some countries such as Iran, Turkey and Tunisia are allowed to use all methods, including tubal ligation and vasectomy. However, all of these methods are available to married Muslims only (Farzaeh, 2004).

Some parts of Buddha's teachings are related to sexual and reproductive behaviours. Practicing Thai Buddhists believe that reproduction is not the main duty of humanity, and that sexual needs are obstacles to reaching *Nirvana* (freedom of reincarnation). Regarding sexual and reproductive issues, Buddhists believe that life begins at fertilisation. Killing living creatures is a remarkably bad *karma* or sin (Srikanthan & Reid, 2008). Whittaker (2002) has illustrated that females feel extremely guilty about having an abortion, a remarkable sin in Buddhist teachings. This study, however, reports that there was disagreement among women participants about the identity of the sinner: some female participants stated that females committed a more serious sin than their partners when having an abortion, and others believed that males also committed a serious religious sin, because they were involved in the decision to have an abortion (Whittaker, 2002).

Buddhists in Thailand accept most contraceptive methods as long as they have no action after life is believed to begin, or after fertilisation (UK Family Planning Association, 2014). Indeed, most contraceptive methods aim to prevent pregnancy before fertilisation occurs. Only ECPs can affect the foetus after fertilisation. On many Thai websites such as Pantip, debates about whether emergency pills are abortifacient agents or not, are common. However, little is known about how Buddhism influences Thai adolescents' decisions about emergency contraceptive methods.

3.4.2 Gender roles and expectations

Gender roles and gender expectations can also affect contraceptive decisions. For example, in Tanzania, in one study of young married couples, men were described as

the dominant decision makers, because they were seen as the head of the family and as the responsible party for family finances (Schuler et al., 2011). Women in Tanzania were expected to be the caretakers of their husbands and children, and were expected to support the husband's decisions (Schuler et al., 2011). Tanzanian women were not able to use any contraceptive methods without the husband's permission (Schuler et al., 2011). The study of Schuler et al., 2011 has vividly illustrated the influence of gender roles on contraceptive decisions. However, unmarried women were not invited to participate in the study (Schuler et al., 2011).

In other countries, however, young unmarried women are expected to take responsibility for contraceptive use. In one US study, nearly all of the 22 unmarried couples (18–25 years old) sampled in the study agreed that the responsibility should be equally shared between the male and the female in a sexual relationship (Beaulieu et al., 2011). However, in practice, a decision to use emergency contraceptive pills was the female's responsibility (Beaulieu et al., 2011). A similar study in the UK also demonstrated that young women aged 16–20 years perceived that men viewed contraception as the woman's responsibility, while boys aged 14–18 cited it as a shared responsibility (Brown, 2014).

Little is known about how gender roles and expectations affect contraceptive decisions taken by unmarried, sexually active Thai adolescents. In the Hemachandra et al. (2012) study, 60% of 150 female adolescents aged 12–19 years used contraception and took a dominant role in decision making on contraceptive use. However, this study focused only on married women and did not illustrate how gender roles and expectations affected decisions; in fact, the fact that an unintended pregnancy might cause embarrassment as being a failure in making the right decision and in maintaining proper contraceptive use was not explored in the Hemachandra et al. (2012) study. In the Hemachandra et al. (2012) study, no explanations were given for failures in continuing contraceptive methods. When initial contraception was abandoned by participants, there were no further investigations about the influence of gender roles on choices (Hemachandra et al., 2012).

In Thailand, it seems that that females, either married or unmarried, are expected to take responsibility for contraception. Some time ago, Ford and Kittisukasthit (1994) conducted focus group discussions with unmarried females aged 18–25 years to explore 1) how gender influenced sexual behaviours, and 2) how the nature of sexual

expressions have changed over time. They found that contraceptive use was reported to be the female's responsibility and that women were expected to be good wives even though they were not married yet (Ford & Kittisukasthit, 1994). Although this study helps us understand gender roles and expectations about contraception in Thailand, it was conducted more than two decades ago, and is probably out of date with current social norms.

Further research is therefore needed to explore how gender roles and expectations can influence unmarried adolescents' decisions.

3.4.3 Peers and contraceptive decisions

Peers influence adolescent decision making about contraception via explicit approval and implicit suggestions (Commendador, 2003). Adolescents also tend to seek advice from and to imitate their friends' contraceptive behaviours (Ogden, 2012).

Although no studies have investigated peer influence on Thai adolescents' contraceptive use per se, friends do play an important role in Thai adolescent's decisions about condoms (Jenkins et al., 2002). Jenkins et al. (2002) distributed a questionnaire to 1,725 female and male teenagers who were studying at one vocational school in Northern Thailand. They found that peer norms influence the individual's intention to use condoms (Jenkins et al., 2002). This study did not investigate the influence of peers on decisions to use other types of contraceptive methods such as withdrawal, oral contraceptive pills or emergency pills; also, the respondents were from one school only (Jenkins et al., 2002). Thus, it is clear that broader research is required to clearly identify peer influences in different contexts.

3.4.4 Parents and contraceptive decisions

Parents influence adolescents' decisions about contraceptive use. In a systematic review of decisions made by adolescents in the US, parents were shown to have both positive and negative influences on their offspring (Daley, 2014). In contrast, Commendador (2010) has reported positive benefits to increased parent–child communication, which promoted initiation and consistency of condom use in that study. Thai parents also play a role in their children's decision making regarding sexuality. Recently, Bangpan and Operario (2014) conducted a qualitative study with 40 unmarried Thai females aged 18–25 years to develop an understanding about the influence of parents on teenagers' decisions. Their findings suggest that Thai

adolescents are influenced by their parents in making decisions about engaging in sexual activities. Nevertheless, the researchers found that the participants had their own authority to make decisions on sexual activities, and participants willingly accepted responsibility for their own behaviours (Bangpan & Operario, 2014). However, the Bangpan and Operario (2014) study did not explore the potential roles of parents and families in young people's decision making in depth; intriguingly, the study revealed that maintaining social harmony within families was a priority for young Thai participants.

3.4.5 Circumstances of intimate relationships

Previous studies have shown that contraceptive use can be influenced by relationship factors, partners' preferences for certain contraceptive methods and power dynamics in relationships (Commendador, 2003; Daley, 2014; Jenkins et al., 2002; Myo-Myo-Mon & Liabseetrakul, 2009; Oppenheim & Smith, 2000; Whittaker, 2002). These influences appear to be universal throughout the world.

Characteristics of a relationship

Characteristics of a relationship have a large influence on adolescents' decisions about contraception. In a casual sexual relationship, i.e. a one-night stand, young men aged 19–26 years in the US reported that they chose condoms because of their concerns about STDs and pregnancy issues (Raine et al., 2010). In a causal relationship with a higher trust, contraceptive methods such as condoms, withdrawal and pills were used to prevent pregnancy. In this study, participants reported that if the girl does not want to take the pills and the boy distrust that the girl is not taking any pills, the boy would choose condoms and take responsibility as the main decision makers. In a committing relationship, young men in this study reported having more conversation about contraception, reminding their partners to use methods and helping his partners to choose contraceptive methods at the clinic. In casual relationships with a higher degree of trust, mixed contraceptive methods such as condoms, withdrawal and pills were used; however, participants reported that if the young woman did not want to take the pill and the young man distrusted the fact that the woman was not "on" the pill, the young man would choose condoms and take responsibility as the main decision maker (Raine et al., 2010). In a committed relationship, young men reported having more conversations about contraception, remembered to remind their partners to use contraceptive methods and helped their partners choose contraceptive methods at the clinic (Raine et al., 2010).

In contrast, Wildsmith, Manlove, and Steward-Streng (2015) found that cohabiting couples were less likely to use condoms or other contraceptive methods, compared to dating couples. Also, with cohabiting couples, the more frequent sex was, the fewer times condoms were used (Wildsmith et al., 2015).

In Thailand, only one study has investigated to what extent the type of partnership influence the utilisation of condoms. According to Jenkins et al. (2002), 28.5% of 1,725 young males and females (aged 15–21 years) surveyed chose to use condoms with their casual partners, and only 8% of them refused condoms when they had sex with their steady partners. This study was limited in its approach, however, because other contraceptive methods were not part of the survey. In Thailand, no hard data about whether or not unmarried status can affect Thai adolescents' decisions exists, and this topic remained unexplored by Jenkins et al. (2002).

Maintaining social harmony in the relationship

Maintaining social harmony can influence individuals' decisions about SRH. Social harmony is embedded in Oriental cultures including Buddhists' beliefs. Buddhists believe that maintaining good relationships with surrounding people lead to peace, justice and social harmony (Chaudhry, 2015; Phillips, 2017). Social harmony concepts are used to prevent conflicts and to develop a balance between social groups such as children, parents and caregivers. Social harmony develops over time within relationships between a husband and a wife, parents and children, seniors and their juniors, individuals and social institutes, and ultimately, the whole of a society. Ha (2008) conducted a qualitative study with 25 married Vietnamese women on the importance of social harmony between women and their husbands. The participants asserted that maintaining family harmony resulted in women having less power in sexual relations and less say in negotiations about using contraceptives (Ha, 2008). In Thailand, this loss of power — whether it occurs in premarital and/or marital relationships — has never been formally reported.

Male and female preferences

Gender-based preferences for specific contraceptive methods can also influence decision making (Grady, Klepinger, Billy, & Cubbins, 2010). Oppenheim and Smith (2000) conducted a study to compare men's and women's preferences for contraceptives in five Asian countries: Pakistan, India, Malaysia, Thailand and the Philippines. They found that Pakistani males' preferences were adhered to by Pakistani

women. In contrast, Thai women's preferences, including Muslim Thai women in the southern region of Thailand, dominated. Unfortunately, however, neither of these studies focused on unmarried adolescents.

3.5 Sexual and reproductive health, rights and decision making

The UN adopted the *Universal Declaration on Human Rights* (UDHR) in 1948. Since then, laws framing human rights have determined how state governments treat their citizens and have suggested how people should treat one another, with equality and fairness the central tenet regardless of race, religion, language, location, ability, age, nation or colour (United Nations, 1948). Rights are inherited and belong to everyone in the world (UN, 1948). The UN member states have responsibilities to respect, protect, promote and fulfil their citizens' rights, including that of decision making, free from duress or undue influence (UN, 1948).

The right to make decisions about contraception was enshrined upheld by the UN International Conference on Population and Development (ICPD) in 1994, and the CEDAW *Beijing Declaration and Platform for Action*, 1995 (UN, 2009; UNFPA, 2004). Sexual and reproductive health rights (SRHR)

> " … rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (United Nations Population Fund, 1995, p. 46)".

According to the above definition of SRHR, individuals have the freedom to take three courses of action: 1) to decide freely; 2) to access the highest quality SRH services; and 3) to obtain information or education. However, in practice, individuals are more likely to protect, promote and fulfil their SRSH through two approaches: 1) by having access to SRH services; and 2) by improving their knowledge. Even today, after 20 years of ICPD implementation, it seems these two approaches exist without the actual freedom to decide (Barroso, 2014). In reality, the right to freely make decisions on contraceptive methods appears to be less than acceptable globally.

The right to make decision making on the number and spacing of children, to have contraceptive information, and to access contraceptive methods have also been of interest of the World Association for Sexual health (WAS), a multidisciplinary group of people working on human sexuality since 1997. In the 2014 WAS Declaration of Sexual Rights, the right to autonomy and body integrity is of concern: 'everyone has the right to control and decide freely on matters related to sexuality and their body, p.2" (WAS, 1999). This declaration defines that everyone has their rights to have the choice of sexual behaviours, practices, partners and relationship. Moreover, everyone living in this world also has the right to freedom of thought, opinions and expression regarding sexuality and with the consideration (WAS, 1999).

From UN and WAS arguments, it would seem that adolescents who are sexually active, whether they are married or not, should have basic human rights to freely make decisions about contraception, and to access information and effective contraceptive methods. Moreover, adolescents aged <18 years should have a right to be involved in making decisions about their own health (United Nations Human Rights [UNHR], 2017). According to the UN's 1989 Convention on the Rights of the Child, adolescents also have the right to form personal views and to express their views on all matters affecting them (UNHR, 2017).

Little practical attention from global communities has been paid to adolescents' rights to make decisions about SRH, however. In recent times, only one international organisation has advocated for the protection and promotion of the decision-making rights of adolescents: the IPPF has shown their intention to encourage adolescent girls to exercise their decision-making rights by introducing the "I Decide" campaign, launched in 2014 (UK IPPF, 2014). This organisation has suggested that adolescent girls should have the power to decide about their own lives, including SRH (UK IPPF, 2014). However, this "I Decide" campaign has been implemented in only a few countries such as Kenya, Gabon, Liberia, Madagascar and Mali (UK IPPF, 2014). Currently, the IPPF is promoting another campaign relating to decision-making rights, with the aim of encouraging world leaders to make SRH and rights an agenda item for their post-2015 global development goals.

Little is known about the effect of the global human rights agenda on individuals' desire or ability to exercise their rights to make informed decisions about SRH, unfortunately. In one US-based study, 51 adolescents participated in focus group discussions and

stated that they were not sure how to exercise their SRH rights in intimate relationships (Berglas, Angulo-Olaiz, Jerman, Desai, & Constantine, 2014). This study also found that the participants were not able to fully exercise the ultimate right to make decisions about contraception, because factors such as gender norms and gender expectations affected their choices (Berglas et al., 2014).

Thailand has adopted a number of international treaties concerning SRH, such as the UDHR in 1948, the CEDAW in 1985, the ICPD Programme of Action in 1994 and the Beijing Declaration and Platform of Action in 1995. After adopting these treaties, Thailand has shown progress in SRH programme implementation (Taweesit, 2010). In 1997, MoPH Thailand formed the committee to create the *draft of the Thailand Sexual and Reproductive Health Act* (Thai Healthy, 2014). In early 2000's, MoPH invited other four ministries to work collectively on the *draft of the Thailand Sexual and Reproductive Health Act* (Thai Healthy, 2014). United Nations (2011) reported that full sexual and reproductive rights have not been granted to citizens by the Thai Government as yet. Notably, during my data collection from October 2015 to January 2016, this *draft of the Thailand Sexual and Reproductive Health Act* had not approved yet.

In July 2016, Thai government turned the *draft of the Thailand Sexual and Reproductive Health Act* to the *Prevention and Solution of the Adolescent Pregnancy Problem Act*, B.E. 2559 (2016). The right to freely make decisions has been upheld by the *Prevention and Solution of the Adolescent Pregnancy Problem Act*, B.E. 2559 (2016). In section 5 of this Act, it says:

> "An adolescent has the right to make a decision by himself and has the right to information and knowledge, right to reproductive health service, right to confidentiality and privacy, and right to social welfare provision, that are equal and non-discriminative, and is entitled to any other rights for the purpose of this Act accurately, completely and adequately, p.3"

Although rights to make decisions are upheld by the Act, it does not clearly explain how adolescents' rights to make decisions about contraception can be protected and fulfilled by the Thai Government, social institutions and people living in Thai society. Apart from unclear definitions of the right to make decisions about SRH, little is explicit about

the impact of the global and national human rights agenda on Thai teenagers' desire or ability to exercise their rights to make informed decisions.

3.6 Chapter summary

Contraceptive methods are a crucial means for sexually active Thai adolescents to prevent unintended pregnancies, particularly those who are unmarried and are afraid of taboos about babies born out of wedlock. Unfortunately, Thai adolescents are not particularly proactive about using contraception.

The Thai Government has attempted to increase knowledge about reproductive health and accessibility to modern, effective contraceptive methods. However, studies show that in Thailand, a number of barriers to increasing knowledge about, and accessibility to, effective contraceptive methods exist. Moreover, overseas research shows that having knowledge about reproductive health does not guarantee wise choices. Even if barriers to accessing effective contraceptive methods are removed, modern contraceptive methods might, or might not, be chosen by Thai teenagers to prevent unplanned pregnancies. Therefore, further research is essential to increase understanding about how teenagers make their decisions.

It seems that numerous factors complicate choices made by sexually active young adults. These influencing factors include religious beliefs, gender roles and expectations, peers, parents and circumstances specific to intimate relationships. However, previous studies on influencing factors have never focused on unmarried, sexually active adolescents. Thus, influencing factors on the 15–19-year-old age group remain a mystery.

The global community considers decision making to be a basic human right. Thus, individuals, including adolescents, should have clear SRHR to access information on SRH, to access effective SRH services and to free make decisions to control birth. After 20 years of implementing the ICPD in Thailand, however, it remains unclear if adolescents' SRH needs and rights have been fulfilled.

CHAPTER 4. **Methodology**

4.1 Chapter outline

This research examined how Thai adolescents made their decisions about contraception and what factors and which circumstances influenced their decision making. The first section of Chapter Four presents the philosophies underpinning the choice of research methodology. The process of designing interviews and group discussions is illustrated in Section 4.3 and 4.4. The challenges in the research field: contacting the gatekeepers, training youth assistants, gaining access to school and managing research plans according to Thai teachers' suggestions are explored and presented in Section 4.5. Demographic data collection is presented in the fifth section, followed by an explanation of methodology underpinning data collection and data analysis. Subsequently, I discuss study rigour and limitations and address the ethics of working with young people immersed in Thai society.

Qualitative research can be considered a life research tool for the researcher. Learning gathered from field experiences can be invaluable in preparing and developing one to react positively in similar situations. Therefore, I include lessons I have learned after applying the qualitative approach to address my three distinct research questions. I present my reflections on the research process and how I responded to my participants in each situation. Hopefully, these reflections will provide insights into techniques other researchers, who aim to work with young people and/or on sensitive SRH topics, can use to their benefit.

4.2 Philosophical assumptions

Research paradigms or philosophical assumptions refer to the ways a researcher looks at the world, and the nature of the research (Creswell, 2014). Research paradigms shape the way researchers formulate their research questions, design their studies and choose the methods they use to gain and build new knowledge. Understanding of research paradigms is useful because it can aid academic enquiries by helping the researcher accommodate different viewpoints (Creswell, 2013). Understanding the concepts of research paradigms can also allow the researcher to reflect on how self-beliefs about a given topic affect the process of academic enquiry (Creswell, 2013).

A research paradigm includes a set of beliefs that researchers bring to a study. These beliefs consist of values and viewpoints about the nature of reality (ontology), what knowledge is (epistemology) and how researchers gain fresh knowledge (methodology). My ontological assumptions about the current research is that there are multiple socially constructed realities (Guba & Lincoln, 2004). This type of multi-faceted reality relies on how individuals perceive and make sense of their world and how they do this in relation to their circumstances of living (Lincoln, Lynham, & Denzin, 2011). I also believe that knowledge is subjective and socio-culturally constructed within a particular natural setting. Both researchers and the researched must have social interactions during the process of creating new knowledge, and the researcher–participant relationship cannot, therefore, be completely objective or separated from research results.

The present study is influenced by a combination of my research paradigms: feminist and constructivist. I used my constructivist lens to gain an understanding of multiple realities in the existing world, a goal I pursued by interpreting people's perceptions (Lincoln et al., 2011). Constructivists suppose that reality is socially constructed, and each person's realities are subjective and informed by their individual social attributes, social roles, norms, past and present experiences (Creswell, 2014). People's realities and interpretations are also the product of their life experiences within a specific social setting (Green and Thorogood, 2014; Lincoln et al., 2011). Therefore, individuals' life experiences and perspectives are constant sources of an individual's knowledge (Marshall & Rossman, 2011).

Within the feminist worldview of critique of power relations, I naturally aimed to raise the unheard voices of the oppressed and to advocate for political, socio-cultural and economic equality (Burns & Chantler, 2011; Liamputtong, 2013). Feminist researchers suppose that humans live in a power-imbalanced world and that social interactions contain am on-going dynamic of privilege for some and oppression for others (Lincoln et al., 2011). Oppression arises from prejudices concerning ethnicity, religions, age, socio-economic status and gender. According to feminists, world knowledge is gathered from women's and/or marginalised people's lived experiences (Liamputtong, 2013). In feminist research, the world knowledge comes from the unequal social interactions between the privileged and the oppressed in a given society (Lincoln et al., 2011). The main aim of feminist researchers is therefore to propose new knowledge and to apply this knowledge to change unfair social structure to benefit the oppressed

(Creswell, 2014; Lincoln et al., 2011). The oppressed include women, girls, adolescents, and those who have less power in a society (Liamputtong, 2007).

4.3 Research design

A qualitative approach was applied to increase understanding of the subjectively-constructed lived experiences of their research participants. As mentioned in Chapter Three: Literature Reviews, most of the previous studies on decision making on the contraceptive use of adolescents have been conducted quantitatively. I am concerned about limitations of the quantitative study in explaining dynamics of adolescents' decision making on contraceptive use in the situations and the place they live in.

According to Rossman and Rallis (2012), qualitative research is a good approach to use in the field to collect and collate what people see, feel, hear, taste and smell. Using qualitative methods allows a researcher to discern patterns in data gathered from individuals' related experiences and perceptions, and these patterns become information and knowledge (Rossman & Rallis, 2012). Qualitative approaches can reveal 1) the complex and unpredictable aspects of subjective phenomena, 2) webs of social interactions, and 3) the dynamics of the interesting circumstances in which the research participants live (Allsop, 2013; Braun & Clarke, 2013; Creswell, 2013; Curry, Nembhard, & Bradley, 2009). A number of researchers who hold constructivist or feminist paradigm namely Allen (2011), Campbell and Wasco (2000), Kabagenyi et al. (2014) and Liamputtong (2013) applied qualitative approach in their studies.

In terms of health, qualitative research facilitates public health researchers to better understand a specific health issue through the eyes of those most affected (Padgett, 2012). Understanding of participants' views and the reasons behind their behaviours benefits public health researchers, health professionals, health educators and policy/programme developers as they seek to develop programme initiatives and that suit their clientele (Green & Thorogood, 2014).

Qualitative research methodology is also a useful tool to explore sensitive topics including sexual and reproductive health issues (Braun & Clarke, 2013; Liamputtong, 2007). Since stories and experiences around sexual and reproductive practices often cause people discomfort when they are disclosed, these personal matters are usually kept private and secret. In order to delve deeply into such sensitive matters, the softer approach and variety of data collection methods that form the basis of qualitative

research methodology can encourage people to share their experiences (Braun & Clarke, 2013).

For the current study, the qualitative approach is particularly suitable because it allows the actual voices of marginalised people to be heard rather than just responding to some predetermined questionnaire items (Berg, 2007; Liamputtong, 2007; Silverman, 2013). Adolescents around the world including those living in Thailand are often vulnerable, their voices are often muted, and they are unable to express their viewpoints in the adult-dominated world (Liamputtong, 2007). Adolescents, in particular those who engage in activities frowned upon by society such as having sex at a young age, are likely to be excluded from their societies, and they are unable to talk openly about taboo sexual issues (Liamputtong, 2007).

Yong people's lived experiences have been explored by a number of researchers. Heath, Brooks, Cleaver, and Ireland (2009a) recently described young people as social actors with their own unique perspectives. In attempting to increase understanding of the world young people live in, researchers working with young people have found that adolescents are socialised differently in a given historical and cultural context during their transitional period of adolescence (Heath, Brooks, Cleaver, & Ireland, 2009b). Moreover, youth perspectives are also framed by specific adult-led policies and initiatives (Heath, et al., 2009a). Daugherty (2011) used the qualitative approach to find out how adolescent girls participate in decision making about emergency contraception. In Thailand, Bangpan and Operario (2014) also used a qualitative approach to explore the influence of family expectations on young people's sexual behaviours.

However, qualitative research has its own limits. Apart from being time-consuming, researchers using qualitative methods cannot make generalisations (Rossman & Rallis, 2012). Qualitative research is also subject to the influences of a researcher's personality (Rossman &Rallis, 2012). Because "the researcher is the means through which the study is conducted", his or her worldviews and personality can shape interactions between the researcher and the researched, data collection and the outcome of the entire qualitative project (Rossman & Rallis, 2012, p. 5). The qualitative research methodology also requires researchers to have good communication skills and to build trusting relationships with their subjects, which is not easy (Berg, 2007; Liamputtong, 2007). Researchers must also be active listeners, and they should be mindful of their own subjectivity (Smythe & Giddings, 2007).

4.4 Methods

Focus group discussions (FGDs) and in-depth interviews (IDIs) were employed in this current research. Focus group discussions were organised first, followed by in-depth, one-on-one interviews.

4.4.1 Focus group discussions (FGDs)

I chose FGDs because of the benefits. FGDs can net a wide range of viewpoints, suggestions and comments about the research topic (Guest, Namey, & Mitchell, 2013). Group dynamics and process can stimulate participants to express their opinions, experiences and feelings in a more relaxed atmosphere in which participants feel safe to share similar experiences, a scenario not replicated by IDIs where no sharing between participants can occur (Bernard, 2013; Guest et al., 2013; Liamputtong, 2013; Marshall & Rossman, 2011). This method has limitations in its ability to delve deeply into personal experiences and sensitive issues (Powell & Single, 1996). Personal characteristics such as shyness and fear of embarrassment may impede some participants from expressing their own experiences, particularly about sexual and reproductive issues (Liamputtong, 2013). However, I personally chose focus group discussions as a good initial pathway to gaining participants' trust before engaging in personal, one-on-one interviews.

I used the semi-structured interview schedule and vignette methods for FGDs. In Thailand, directly discussing sensitive subjects with adolescents is likely to be considered taboo, and cause discomfort. According to Edwards and Holland (2013), vignettes enhance participants' engagement in discussion of sensitive issues in a public setting. In addition, the method supports participants in controlling the amount of personal information they would like to share (Barter & Renold, 2000). In fact, commenting or sharing opinions about other peoples' experiences in vignettes is less threatening than talking about their own experiences directly (Barter & Renold, 2000). Barbour (2014) has stated that vignettes can also be used to elicit detailed and contextualised responses from participants in FGDs. By analysing adolescents' opinions during vignette sessions, researchers can hopefully anticipate how participants would behave in a real situation. However, no one can accurately predict how a participant would actually behave in a real situation (Polit & Beck, 2010).

Therefore, I based my vignette scenarios on adaptations from two different studies to make the vignettes more robust (Sridawruang, Pfeil, et al., 2010; Vuttanont, et al.,

2006). One study I used to construct my vignettes was conducted with Thai adolescents in Chiang Mai, a province in North of Thailand (Vuttanont et al., 2006) and the second was done in Udon Thani, a province in the North-eastern region (Sridawruang, Pfeil, et al., 2010). However, I found little information describing how these vignettes were developed and how effective they were. The vignette I used in the present research was a story of a teenage boy and girl aged 15-19 years old who were at school, started intimate relationship, and eventually had sex. Then, I asked my participants' opinions about contraceptive choices and relevant issues of the boy and the girl in the story. The vignette and semi-structured questions I raised were described in detail in Appendix A.

4.4.2 In-depth interviews (IDIs)

According to Braun and Clarke (2013), the private interview is a suitable method for answering experience-type and factor-type research questions. IDIs can be used to confidentially explore participants' experiences, perceptions, opinions, feelings and emotions, particularly about sensitive issues they would not ordinarily speak about (Braun & Clarke, 2013; Denscombe, 2010). Interviews, particularly those that are semi-structured rather than formal, are more flexible in words used to question subjects and in the order of question asked (Braun & Clarke, 2013). The flexibility of the interview formats and structures allows participants to feel comfortable in expressing their perspectives and sharing some of their innermost experiences (Braun & Clarke, 2013; Tod, 2006).

I designed face-to-face interviews for the current project although a telephone interview could have also been offered as an option if participants preferred to keep their physical distance to maintain confidentiality. Face-to-face interviews are more commonly used in qualitative research because direct contact helps researchers to probe and delve into hidden issues (Tod, 2006). During face-to-face interviews, researchers are able to capture participants' body language and make eye contact, which helps researchers respond appropriately, and therefore keep the interviewee relaxed (Guest et al., 2013). Although the telephone interview is useful to maintain anonymity and when geographical distance between researchers and the researched is an issue, building rapport is not easy on the telephone (Guest et al., 2013). Thus, I did not offer the option. I used the phone only to invite people to join my study.

The semi-structured interview schedule allowed me to select predetermined topics, but gave me the flexibility to ask open-ended questions and followed the participants' own

narratives (Polit & Beck, 2010). The semi-structured approach was also ideal in that it gave participants enough time to develop their ideas and to reply comprehensively (Denscombe, 2010). The approach was chosen to provide the requisite focus but to allow enough flexibility for interviews to be partly guided by participants' interests and responses (Denscombe, 2010).

4.5 Preparation Phase

Before going into the field and having direct interactions with participants, I conducted pre-research practices, contacted the gatekeepers, trained youth research assistants and adapted my research plan as suggested by the Thai school teachers I initially consulted. I then set up the first meeting with my participants. Section 4.5 describes my actions and learning as I completed these steps. In this section, I also highlight how preparation activities impacted data collection and research outcomes.

4.5.1 Conducting pre-research practices

Pre-research practices could help me to determine what would work and would not work before the commencement of full-fledged field research (Schreiber, 2008). My pre-research practices included conducting mock group discussions and mock in-depth interviews as expanded below.

I invited four Thai females (aged 15–19 years) from the Thai youth community in Auckland, New Zealand to participate in mock group discussions. After having mock discussions, the content and wording of the interview questions and group vignettes were discussed and modified to more youth-friendly utterances. For example, questions starting 'why' were changed to 'what reasons' instead. Names of two adolescents in the vignettes were suggested to change from 'Somchai' and 'Mali' to simply 'A' or 'B'. In the mock group discussions, I also tested my group-facilitating skills such as listening actively and balancing the influences of the dominant and the quiet.

I had mock interviews with my two supervisors and three Thai postgraduate students of Auckland University of Technology. From these five mock interviews, I learned to listen actively, probe and wait for the responses. I also learned to build relaxed atmosphere for in-depth interviews such as sitting next to the interviewee instead of opposite to the interviewee and having sense of humour.

4.5.2 Formulating initial contacts from overseas

Initial contact is a crucial part of the research process, and it requires much work (Feldman, Bell, & Berger, 2003). For the present study, I began seeking advice about Thailand-based youth counselling services and setting up a Thailand-based youth advisory group while I was still based in New Zealand.

I contacted the Head of Pharmacy of the Khon Kaen Centre via social media networks and informed her about my study. She informed the Head of the Friendly Youth Clinic in Khon Kean about my study, and the Head of the Friendly Youth Clinic in Khon Kean agreed to provide counselling services, as AUTEC suggested, for any study participants who felt discomfort during FGDs or IDIs, and who requested psychological support.

To gain advice about setting a youth advisory group and preparing youth research assistants for my study, I communicated with the Office of Human Development and Security in Khon Kaen to obtain details about qualified officers working with children and youth in the Khon Kaen area. My international call from New Zealand was transferred to a youth social worker (named Karea). She suggested to help by inviting local youths to help me facilitate FGDs and in case participants requested a same-sex or same-age facilitators.

4.5.3 Preparing a youth advisory group and training youth research assistants

Scholars who conduct research with adolescents have realised the importance of providing a safe space to fully participate in the research process. Adolescents can become active participants or co-researchers, and not simply the object of the investigation (Heath et al., 2009a; Jones, 2004). Adolescents can become personally involved in different stages of research, e.g. the research design, the development of research tools, data collection and data analysis, if invited to do so (Aggleton & Campbell, 2000; White & McDonnell, 1996; Wilkins, Bryans, Hetzel, Cutler, & Ellis, 2010). Such involvement of adolescents can increase the trustworthiness of qualitative studies because research findings based on greater participation from the research subjects better reflect participants' insights and stances (Coad & Evans, 2008; Shaw, Brady, & Davey, 2011).

I wished to involve adolescents in my research process including data collection and data analysis. Eight adolescents in the 16–22-year age group were invited by the social worker Karea and I to be in the local youth advisory group, as described in Appendix D.

I explained my study and ethics considerations and emphasised that I truly need their help in interpreting adolescents' terminology. I created closed a Facebook group to communicate, discuss and consult on any urgent issues. The social worker Karea was also included in this Facebook group. Mobile phone numbers of all young research assistants were collected in case of emergency.

I invited all of eight adolescents from the youth advisory group to assist me as a research assistant in FGDs and IDIs. However, only five of them accepted the invitation. I went through research procedures in details with these five youth interviewers, as recommended by Shaw et al. (2011). The rationale of study, research questions and scope of the project were explained and clarified. How to conduct qualitative research and techniques used in FGDs and IDIs were emphasised. The five adolescents were also asked to practice indicative questions. I underlined ethics considerations: respecting autonomy, keeping confidentiality, avoiding causation of harm and, in particular, preventing harm to participants.

4.5.4 Gaining access to schools

According to Feldman et al. (2003), gaining access to conduct original research is similar to the process of opening doors, which requires permission from multiple people. Without any direct connections to school directors or teachers, I had to walk through two such virtual doors (two groups of gatekeepers) before I reached my participants. The first group were those who had close relationships with me as colleagues or friends, but the second were not. Members of the first group helped me by contacting the second group of people including their connections, school teachers or school directors who could help me to reach my participants.

Three schools in urban Khon Kaen city in North-east of Thailand were approached. Two were upper secondary schools and one was a vocational college. In Thailand, after three years in a lower secondary school, students proceed either to further three years of secondary school or on to a three year vocational/technical college pathway. One secondary school refused politely to participate after my gatekeeper informed the school director about my research plan. My gatekeeper anticipated that this school director might have been concerned about the school's reputation because my research topic was sensitive. In this case, I never had a chance to explain the purpose of my study and the confidentiality protocols I had put in place to protect reputations. In contrast, at another secondary school, a female class teacher offered to introduce me to the school director

and presented my research procedures. The director allowed me access and asked the class teacher to assist me in introducing myself to potential student participants.

In the vocational college setting, I decided to walk in to the college when my connections were unavailable to introduce me to the college authority. I accidentally met a male school teacher in front of the college, introduced myself and informed him about my study. I was taken by him to inform the Deputy Director about my research. A class teacher in a department was assigned by the Deputy Director of the vocational college to help me approach and recruit students. Other four teachers in the same department vetted my intentions before I was allowed to introduce myself to students.

In both school settings, I was asked to provide the official letters for asking formal permission to conduct my study there. Although I had a working position in Sirindhorn College of Public Health in Khon Kaen, the official letters from my working place was refused. As I was also a PhD student sponsored by the Thai Government, official letters from the Office of Educational Affairs, Royal Thai Embassy in Australia was required instead. The official letters were obtained and delivered from Australia to these two institutions. The AUT ethics approval was also provided for the schools.

4.5.5 Obtaining advices from school teachers

I initially planned to conduct FGDs and IDIs out-of school during weekend or after school as AUTEC suggested to provide confidentiality and privacy for participants. I chose the Sirindhorn College of Public Health (Khon Kaen) and the seventh Health Centre of Khon Kaen because they had a private meeting room and a youth counselling unit.

Class teachers from both settings strongly suggested the research to be conducted during school time and on school premises. They reasoned that students could use my invitation to participate in the research as an opportunity or reason to leave home, hang out with friends and not come to the meeting for my study. If unexpected events such as accidents happened en route, I who had made the appointment would have to take responsibility. Research activities during school time meant that the schools were responsible.

Based on the teachers' experience in dealing with Thai students, I accepted their advice. However, to maintain privacy and confidentiality, I requested a private room in which to conduct focus group discussions and in-depth interviews. The class teacher of the

vocational college offered a small relatively private (curtained) room, and the class teacher of the upper secondary school suggested an available classroom. Regarding in-depth interviews, class teachers in both schools suggested keeping in contact with those who willing to participate, and then arranging interviews during school time and according to participants' requests, but only at school.

Consequently, I adapted my research plan. My plan to involve youth research assistants, who were also students, became even more challenging. I had to organise a timetable for youth research assistants and participants. Because of mismatch of the timetable between research assistants and participants, only one male discussion group was co-facilitated by a male research assistant. Fortunately, no participants asked for any same-sex or same-age interviewers for IDIs.

4.5.6 Initiating my introduction with adolescents

I first engaged with my potential participants by introducing myself and my study in front of the class. I explained about vignettes and the questions I was going to ask in the group discussions. I provided an information sheet (appendix A) and verbally underlined my ethics considerations, such as the right to leave the group without explanation and how confidentiality was being maintained. I also informed them about same-age and same-sex researchers. I left my contact details with them, as well as with class teachers.

4.6 Participants

4.6.1 Recruitment

Participants in the study were unmarried Thai adolescents, aged 15–19 years and recruited from an upper secondary school and a vocational college which located in an urban area of Khon Kaen City, the provincial capital of Khon Kaen Province in Northeast Thailand. The reason for recruiting only adolescents in school settings were that up to 80% of Thai male and female adolescents in this age group are enrolled in secondary school level schooling, i.e. upper secondary schools or lower vocational colleges (UNICEF, 2012a).

The data I needed for pursuing my first two research questions required conversations with sexually active adolescents. As Thai adolescents are not supposed to have sex before marriage, I was concerned that focusing only on sexually active adolescents could have caused participants to be at risk of being stigmatised. Consequently, I

needed to broaden my inclusion criteria to recruit any adolescents aged 15–19 years who had been thinking about contraception, regardless of sexual experiences. Thus, findings of this current study came from those who had had direct sexual experiences and those participants who were not sexually active at the time of the study.

4.6.2 Participants

A total of 38 adolescents aged 15–19 years, who had been considering using contraceptives, agreed to participate in the study. Of those 38, 29 joined one of the five single-gender discussion groups (Table 6). Those who participated in FGDs were subsequently invited to IDIs, and 11 participants responded positively. Nine participants did not attend group discussions, but agreed to in-depth interviews (Table 7). All participants were offered pseudonyms to maintain their confidentiality throughout this thesis.

Focus group discussions

At the vocational college site, students were approached by their teachers and me. There was no response. One boy and two girls suggested that I choose students for the study. I refused because I wanted them to be independently willing. The class teacher decided to choose, and told me that it was a characteristic of students at vocational colleges to hold back on making decisions. In contrast, in the upper secondary school, two groups of girls and two groups of boys showed willingness to participate in my study after I introduced myself and the research.

Apart from the girl group from the upper secondary school who suggested discussing the research topics in a coffee shop, each group discussion was conducted at school as school teachers suggested. In a separate room, the discussions began with a presentation of a short story about a teenaged couple aged 15–19 years, who had been in a sexual relationship and who wanted to prevent pregnancy. This story was used to stimulate discussion on adolescents' life, courtship and their lived experiences, without directly asking questions about sexual relationships and contraceptive use. When appropriate, each group was introduced to how they might use drawings, mind mapping and other methods to express their opinions and views.

Techniques for facilitating discussion in groups were selected and based on the nature of participants (Table 6). The ice-breaking or introductory period was the best period to learn about group behaviours. I found that inviting young people to introduce

themselves increased discomfort. Instead, asking young people who knew each other well already to introduce one another to me yielded a relaxed and fun atmosphere.

Other techniques were also employed to induce a friendly and relaxed atmosphere. Participants from the vocational college seemed quiet and did not want to explain. I decided to use paper and oil pastels, and invited them to work in pairs. I did not use paper and oil pastels with participants in the upper secondary school because they responded to my questions quickly and openly. I also saw that the young people from upper secondary school loved to tease each other and made jokes. Therefore, I decided to use my sense of humour to build trust and rapport. I also offered cold and fizzy drink as refreshment to calm my participants down from the hot weather in the afternoon which irritated some participants.

At the end of FGDs, I invited all of group members to participate in IDIs. I gave them my contact details, and my participants kindly left their mobile phone numbers with me for further contact. In addition, at the end of each session, I gave my participants small money (100 Baht or 4 NZD) as appreciation in an envelope. In the envelope, I had also placed a piece of paper on which I asked whether they had ever used contraception. To maintain confidentiality and to avoid unintentional judgement and bias on my part if some of my participants willingly participated in the next stage of my study, I asked them to write their answers, fold the paper twice, and put it in a box I provided. After a week, I called them to get their responses about having an interview.

Table 6: Demography of student discussion groups

Discussion groups	MG1	MG2	MG3	FG1	FG2
Participant names*	8 males:	6 males:	4 males**	8 females:	7 females:
	James, Allan, Gice, Boom, Orm, Ben, Noot, Baan	Koko, Kim, Fluk, Bass, Arom, Niwat	Allan, Gice, Boom, Orm	Fon, Tien, Num, Ney, Ying, Tey, Fern, Ice	Yim, Pew, Pang, Nug, Katang, Fang, Amie
Age (years)	16–19	17–18	16–19	17–18	17–18
Self-reported experiences on contraceptive use (persons)	Yes (6), No (2)	No (6)	Yes (4)	Yes (4), No (4)	Yes (1), No (6)
School location	Vocational college	Upper secondary school	Vocational college	Vocational college	Upper secondary school
Involvement of youth research assistant	Yes	No	No	No	No
Domestic guardians (persons)	Parents (7) Grandparents (1)	Parents (3) mother (1) Grandparents (1) Uncle (1)	Parents (3), Grandparents (1)	Parents(2) Boyfriend's parents (1) Mother (2) Grandparents (2) Dormitory (1)	Parents (4) Father (1) Mother (1) Grandparents (1)
Group recruitment	Class teacher selection	Voluntary	Voluntary and unplanned	Class teacher selection	Voluntary
Ice-breaking method	Self-introduction	Students introduced each other	None	Students introduced each other	Students introduced each other

Discussion groups	MG1	MG2	MG3	FG1	FG2
Materials used during discussions	Paper (drawing)	None	None	Paper (writing and drawing)	None
Place	A separate classroom (offered by class teacher)	A separate classroom (offered by class teacher)	A separate room in the college (group's decision)	A small classroom (offered by class teacher)	A separate room in a coffee shop (group's decision)
Date/time	Afternoon 5 Nov 2015	Morning 25 Nov 2015	Afternoon 1 Dec 2015	Morning 12 Nov 2015	Afternoon 10 Nov2015 Incomplete discussion 17 Nov 2015
Willingness to engage in in-depth interviews (number of group participants)	4	1	none	6	none

Abbreviation: MG = male group; FG = female group; **Recruited from MG1 (unplanned)

In-depth interviews

In-depth interviews occurred at a place in the school setting chosen by participants, and vetted by the researcher as a private and secure site. After greeting participants, I reminded them about confidentiality by providing an information sheet, see in Appendix A, and talking to them about their rights. I reminded them of their right to stop audio-recording or to leave the interviews at any time. The interviews lasted from 20–45 minutes. To build rapport with participants who had not attended the focus groups, I started in-depth interviews with general questions about subjects' experiences as teenagers in urban areas, and then followed the general discussion by asking semi-structured questions.

The snowball technique was also used to reach participants for in-depth interviews, but the technique was not successful in recruiting large numbers of participants.

Table 7: Participants in in-depth interviews

Participant name*	**Gender**	**Age** (years)	**Domestic guardians**	**Study location**	**Self-reported experiences of contraceptive use**	**Participated in focus group discussions**
Tey	Female	16	Parents	VC	N/A	Y (FG1)
James	Male	18	Father	VC	N	Y(MG1, MG3)
Allan	Male	18	Grandparents	VC	Y	Y(MG1, MG3)
Ice	Female	17	Parents	VC	Y	Y (FG1)
Tien	Female	17	Parents	VC	Y	Y (FG1)
Fon	Female	18	Boyfriend's parents	VC	Y	Y (FG1)
Ben	Male	18	Parents	VC	Y	Y (MG1)
Noot	Male	18	Parents	VC	Y	Y (MG1)
Ney	Female	17	Parents	VC	N/A	Y (FG1)
Num	Female	17	Parents	VC	Y	Y (FG1)
Mawin	Male	18	Parents	SS	N	N
Bee	Female	18	Grandparents	SS	N	N
Bew	Female	18	Parents	SS	Y	N
Honda	Gay	18	Parents	SS	N	N
Tong	Female	18	Parents	SS	N	N
Orm-am	Female	18	Parents	SS	N	N
Ong	Male	18	Parents	SS	Y	N
Max	Male	18	Parents	SS	N	N
Nat	Male	17	Parents	SS	N	N
Fluk	Male	18	Mother	SS	N	Y (MG2)

Abbreviation: Y= yes, N=No, and N/A= not applicable; VC = vocational college; SS = upper secondary school; MG = male group; FG = female group

4.7 Data collection and management

Data were collected between October 1st, 2015 and January 31st, 2016. The timeline for conducting the study and processing of data is shown in

Table 8: Study timeline and data collection

Sequences	2015			2016
	Oct	Nov	Dec	Jan
Gaining access	✓			
Training youth research assistant	✓			
Making arrangements for discussions/interviews	✓			
Conducting group discussions		✓	✓	
Conducting in-depth interviews		✓	✓	✓
Transcribing the data			✓	✓
Visit in person for thank giving to all gatekeepers				✓

All FGDs and IDIs were audio-recorded with the permission of participants. Participants were informed about how to stop the audio-recorder in case they were unwilling for certain parts of their interviews to be recorded. Writing and drawing were allowed by participants, to be used for the purposes of the current research only.

Audio recordings were transcribed verbatim in Thai, the birth language of the researcher. Being able to use my mother tongue helped me piece together the jigsaw of the Thai adolescents' social world and make sense of it. Because I am a bilingual researcher and also work as a casual translator for a company in New Zealand, I translated transcriptions into English. However, I also invited Thai adolescents who can speak and write in Thai and English from the Thai community in Auckland to re-check my transcriptions. I followed this protocol in recording all data, including drawings and written material.

4.8 Data analysis

4.8.1 Thematic analysis

I used the thematic analysis approach to analyse data. Thematic analysis is widely used in health research (Pope, Ziebland, & Mays, 2006) It is an accepted method used to

answer research questions by describing participants' social lives and their perspectives in their own voices (Green & Thorogood, 2014). Thematic analysis can be used across a broad range of theoretical frameworks including the constructivist and feminist paradigms that informed the current work (Braun & Clarke, 2006, 2014; Cook, 2012; Joffe, 2012; Tynan et al., 2013).

Thematic analysis helps researchers to categorise fragments of data collected from focus group discussions and in-depth interviews into meaningful themes (Braun & Clarke, 2006, 2014; Gibson & Brown, 2009; Green & Thorogood, 2014). During the process of thematic analysis, themes are generated according to the commonalities, differences, and relationships between each theme (Gibson & Brown, 2009). Thematic analysis can help researchers to organise complicated non-numerical data into easily understandable, clear, and credible information (Gibson & Brown, 2009). Such information can then be easily understood by non-academic communities such as health professionals, health programme developers, and policymakers (Braun & Clarke, 2006, 2014).

I followed Braun and Clark's six steps for conducting thematic analysis (Braun & Clarke, 2006):

Step 1: Data familiarisation

Braun and Clarke (2006) suggested three main activities should be undertaken to become familiar with raw data: 1) transcribe, 2) read and re-read, and 3) note down the main ideas. After completing a group discussion or in-depth interview, on the same day, I listened to the audio-recording, checked my field notes and reflected on the lessons I had learned. Then, when I transcribed voices into written words, I played the audio-recoding several times. I found that for each hour of audio, I had to spend at least 8 hours to transcribe it. To overcome eyesight issues, I transcribed voices on paper in handwriting before transferring to electronic format. Although typing initially seemed to be a waste of time, it actually helped with revision and formulation of ideas. I then recorded preliminary findings as per methodology proposed by Bazeley (2013), which allowed me the opportunity to look at transcriptions with fresh eyes.

Step 2: generating codes

I started coding line-by-line manually, and I worked on coding under the close supervision of my supervisors to ensure accuracy and quality (Braun & Clarke, 2006).

I highlighted excerpts and wrote codes in another column beside the transcriptions (Braun & Clarke, 2006). I created as many codes as possible, because these generated codes may have been of interest later, during analysis; I coded transcription extracts according to theme; and I worked with codes in a flexible manner, because one extract often fit more than one theme, while other extracts could not be coded because they did not fit any theme (Braun & Clarke, 2006). The NVivo 10 software package was used to analyse and link codes to transcribed extracts.

Step 3: Searching for potential themes

As Braun and Clarke (2006) recommended, at this step, I began analysing my codes, differentiated each code and grouped the similar codes under the same overarching themes. Within each participant's transcript, I compared and contrasted each code to clarify its meanings. Then, I follow the same step to check the similarity and difference of codes between cases and between two genders: boys and girls. Some codes became the main themes and sub-themes but some may be discarded (Braun & Clarke, 2006). I observed that there were unclassified themes from my data set, and (Braun & Clarke, 2006) suggested to set these unclassified themes as miscellaneous. In the end of this phase, I had candidate themes, sub-themes and relevant extracts of the data for each theme and sub-themes.

Step 4: Checking relations between themes

To further review and refine themes, I checked whether speech extracts were firmly aligned with the meanings attached to the theme I had assigned the extract to. At this stage, I combined similar candidate themes where extracts were similar, and broke some themes into two where speech extracts had different meanings (Braun & Clarke, 2006). I reviewed candidate themes separately by gender. After that, I compared gender-based themes with the whole dataset (interview transcriptions, writings and drawings) to check the relevance of each theme in the context of the whole dataset. Re-considering the dataset as a whole allowed the addition of new themes I had previously missed (Braun & Clarke, 2006).

Step 5: Defining and naming themes

After I reviewed and refined themes, I identified what each theme was about, including content and scope, and made sure themes told a story relevant to the research questions I sought to answer (Braun & Clarke, 2006). To increase study credibility, I enlisted the

help of my supervisors to generate codes, sub-themes and themes, and to define and name the themes that aligned best with the research questions.

Step 6: Producing the report

Before producing my final report, I checked that I had sufficient data to provide readers with a clear understanding of my research topic (Braun & Clarke, 2006). I also ensured that my thematic analysis answered the research questions I had proposed.

4.8.2 Drawing diagrams

I drew "mind map" diagrams to assist data analysis. I found that visual representations helped me make sense of how adolescents made decisions, what each stage of the decision process was, and what factors, people and experiences were relevant to how they eventually made choices about contraception. Examples of mind map diagrams are presented in Appendix F.

4.9 Rigour of the study

Qualitative researchers play crucial roles as a research tool in creating a new knowledge for the world. Their worldviews, professional experiences, demographical characteristics such as gender, social class and ethnicity, and even their personalities can have large impacts on their studies and on the novel ideas they and their participants co-create (Guba & Lincoln, 2004).

To mitigate such subjective influences and to increase the rigour of the present research, I used some widely accepted strategies suggested by Harvey and Land (2017). These strategies include the practice of reflexivity. To increase study transparency, I consciously practiced awareness of biases arising from my preconceived ideas at each step in the research process and during each social interaction with participants and others (Darawsheh, 2014). In addition, I provided a detailed description (known in thematic analysis as a "thick" description) about the context of the study. I also used two methods (focus group discussions and in-depth interviews) to collect data, and I recruited participants from two school settings, thus ensuring data were not limited by methodology or cultural context. Under the close supervision of two research supervisors experienced in thematic research, I scrutinised field data and generated a robust plan for analysis and dissemination to key stakeholders. To retain the unique voices of study participants, I transcribed the spoken word verbatim in Thai, and made sure my translations were vetted by Thai youth who were fluent in both languages and

were well-briefed about my research objectives. I also involved youth from the Thai community in Auckland, New Zealand and from the youth advisory group in Khon Kaen in checking that I had analysed data as per thematic analysis best practice guidelines (Coad & Evans, 2008; Shaw et al., 2011).

4.10 Ethical considerations

4.10.1 Ethics approval

This study was approved by the Auckland University of Technology Ethics Committees on 3 August 2015 with the reference number (AUTEC 15/225). I was concerned about Thai ethical consideration. I consulted the Head of the Ethics Committee of the Sirindhorn College of Public Health (Khon Kaen), Thailand about submitting an ethics application to the institution. However, AUTEC approval was acceptable to the Ethics Committee of Sirindhorn College, and there were no further requirements.

Researchers who recruit young people aged under 18 may need to acquire parents' or legal guardians' permission according to the national laws of each country (Green & Thorogood, 2014; Padgett, 2012). However, the Council for International Organizations of Medical Sciences (CIOMS) — an international organization jointly established by the WHO and the UNESCO — regulates exceptional cases according to the international ethics guidelines for biomedical research involving human subjects. To wit,

> In some jurisdictions, some individuals who are below the general age of consent are regarded as 'emancipated' or 'mature' minors and are authorized to consent without the agreement or even the awareness of their parents or guardians. They may be married or pregnant or be already parents or living independently. Some studies involve investigation of adolescents' beliefs and behaviour regarding sexuality or use of recreational drugs; other research addresses domestic violence or child abuse. For studies on these topics, ethical review committees may waive parental permission if, for example, parental knowledge of the subject matter may place the adolescents at some risk of questioning or even intimidation by their parents (Council for International Organizations of Medical Sciences, 2008, pp. 68-69).

The Forum for Ethical Review Committees in Thailand (FERCIT) takes the main responsibility for reviewing proposed health research to ensure it meets established ethics standards. According to the FERCIT, any research aiming to investigate adolescents' behaviours or beliefs regarding sexuality, drug abuse and child violence do

not require Thai researchers to obtain parental permission (FERCIT, 2012). Thus, I did not seek parental permission.

The FERCIT (2012) does not specify the need for institutional approval from school committees when a study is conducted at schools. In practice, however, I felt it was appropriate to obtain a verbal permission from the director or the deputy director of schools/colleges after I informed them about the purpose of my study, explained procedures and provided the Thai-version AUTEC approval.

4.10.2 Power imbalance in research

Because of the sensitive nature of the topics covered in the current study, the personal identity of the researcher could have influenced participants and study results. Feldman et al. (2003) has stated that personal and professional identities, such as gender and religion, are a salient issue for building rapport. Regarding Thai values, female adults are supposed to dress neatly in skirts, blouses and dresses. However, in order to catch my potential participants' attention and to minimise fears they may have had about taking part in my study, I decided not to dress in the way a normal Thai women would. I went to my research sites wearing a T-shirt, jeans, trainers and four earrings. With such an appearance, I hoped I would be perceived as a person who loves to break the rules and who does not follow Thai social norms. My potential participants might feel free to discuss about taboo issues. At the same time, I expressed that I was born in a previous generation and would like to talk with the young about their current social world. I usually used the term *pa* ("auntie" in the Thai language) instead of "I" or "a researcher", *loog* ("my children" in Thai) or *nu* (a pronoun used to address young people in Thailand) to relate to them as one who is in the same family. Sometimes, in group discussions, I spoke and repeated their rude or slang words to show that I accepted them as they were. This was an attempt to mitigate Thai hierarchal social power structures that would restrict open communication from younger to older authority figures. With this consideration on power imbalance, in this thesis, I decided to use my name "Sansanee" instead of "a researcher" in the quotes.

4.10.3 Doing no harm: observing participants' discomfort

The cultural principle of *kreng jai* may hinder Thai adolescent participants expressing their true feelings. *Kreng jai* refers to a consideration or a concern of the speaker to not make others feel awkward or embarrassed (Intachakra, 2012). Due to this cultural concept, the actor who mentions the word *kreng jai* or even who do not do so tends to

behave positively (socially desirably) towards others to not causes offense. Thai people who behave as such are likely to be considered as disrespectful people. They are likely to feel ashamed and worried about being judged as an unwise person. Therefore, Thais tend not to express their real feelings or ask directly for their actual needs. Some of my adolescent participants possibly felt *kreng jai* but dared not ask to leave the group discussions or in-depth interviews although they do not want to further engage in the study process. I was concerned about this cultural factor affecting the ability of participants to withdraw from this current study when they wish. Therefore, I attempted to observe non-verbal expressions showing discomfort.

I was aware of stigmatisation from talking about sexual-relate issues among participants in discussion groups. For example, in FG2, Fang openly shared her views on condoms, ECPs and withdrawal method. Then, Yim showed curiosity about Fang's sexuality and asked how Fang had such great knowledge about sex-related topics. I had to remind Yim that Fang had told the group that she read many books and blogs on the Internet. To observe covert signs of discomfort in in-depth interviews, I paced questions or talked off the subject if the participant showed evidence of embarrassment or anxiety. Then, I would end the interview earlier as appropriate without needing to complete the semi-structured questions. I felt that it was unlikely that participants who were uncomfortable would be willing to be interviewed further or would give candid answers.

4.11 My Reflections

Based on the constructivist paradigm, I believe that individuals including my participants and I have distinctive ways to perceive and interpret their world realities. Each must also create and co-create the social reality they inhabit. In my study, participants shared their perceptions, and at the same time, they became involved in co-constructing a new social reality framed by the experiences they had as participants.

In this section, I aim to reflect on what I achieved and what I learned. I start by describing my reflections on building rapport with participants and how that process affected the end result. Thereafter, I reflect on how my approach had to change to work with adolescents in this specific Thai setting. I was challenged to apply various flexible strategies with the main purpose of building a safe atmosphere for discussing and sharing views about sensitive subjects. Subsequently, I reflect on my views and

feelings, and how these could have affected my interactions with participants. Last but not least, I describe lessons I learned from the transcription process.

4.11.1 Building rapport as a process

I was concerned about working on a sensitive topic with adolescents because the subject matter could be viewed as taboo and personal. I conducted FGDs initially and in-depth interviews at a later stage. In group discussions, I had a great chance to introduce myself and my topic to my participants. I could also listen to current adolescents' life experiences, which were not part of the literature I had reviewed prior to taking my research into the field. Listening to such experiences helped me decipher current Thai adolescents' lived realities before I attempted to relate to participants one on one in an interview situation. I believe that nearly all participants from the vocational college could see that I had an open mind by the way I interacted during focus group discussions, which meant they were more willing to be interviewed alone. After they gave me their trust, personal stories including those about cohabitation, multiple sexual relationship and self-abortion flowed during interviews.

In one female discussion group, however, my plan of building rapports collapsed. Although I used the same strategies as I had before, not a single student showed any interest in participating in an interview. I thought about what had happened during that group discussions, and I realised that one participant may have set the tone for that group. She said in the group discussion, "Auntie Sansanee, I have had no sexual experiences. I do not think I have anything to tell you in in-depth interviews." I replied that I would like to talk with adolescents who had been considering about contraceptives and that I was not necessarily looking for teenagers who had had sexual experiences. She kept quiet for a while, but later she restated about having no sexual experiences. A week later, when I met all of them sitting together, I invited them to interviews again. The same girl kept mentioning in the group that she had had no sexual experiences and could not help me. I explained as I did in the previous meeting. From this situation, I learned that although focus group discussions can well help a researcher gain trust from participants before going further, the success of this strategy depends on participants' perceptions and other circumstances beyond the researcher's control.

4.11.2 Being flexible when working with young people

In this current study, I learned that researchers who work with adolescents should have a flexible communication mode to communicate with adolescents and be ready to the change of their research plan.

I found that mobile phone and Social Media was a fast communication mode for discussing with young people. As mentioned earlier, I invited eight Thai adolescents from Khon Kaen to help me finalise semi-structured questions, to provide their advice on working with young people and to assist in interpreting the meaning of what participants said (Kirby, 2004). After having a face-to-face meeting, I used mobile phones to make appointments with these young people individually. I created a closed group on Facebook to contact all of them collectively. During data analysis, I used this closed group on Facebook to further clarify raw data and the meanings of words the participants used in certain ways I might not have understood, such as *hai* (to give or allow) and *dai* (to gain or get). Such activities were conducted with due ethical consideration: discussion about participants' behaviours or narratives but did not mention participants' name. Eventually, this secret Facebook group was closed.

I have learned to be always ready to conduct unplanned group discussions and in-depth interviews. I formulated a research plan according to the Thai school term. Gatekeepers helped me to find suitable schools, but they could not give me the school calendar for each institution. At both school settings: the upper secondary school and the vocational college, group discussions and in-depth interviews were postponed by intervening school activities such as a sports week, extramural tutorials classes and urgent school business. For instance, in vocational college setting, the whole-day classes were cancelled because all of the school teachers had an unplanned and urgent meeting. In that morning, the class teacher announced to their students including my participants to have self-study and go home. With the urgency, the class teacher forgot about my research activities which I would conduct in the afternoon. Fortunately, he met me while I was there preparing the room for the afternoon discussions. The class teacher suggested me to conduct the group discussions in the morning, otherwise no students would participate in the discussions. I had to organise this unplanned group discussions in that morning and asked my participants came for koha in the next day. I learned to be ready and poised at all times to fit in my research where I could. My carry-on bag

was always filled with an audio-recorder, field notebooks, paper and coloured pencils, consent forms and koha envelopes.

I postponed a discussion group and have also learned to respect the particular situations that my participants are immersed in. For instance, I once set a time and date for a group discussion with the group agreement of the female participants from the upper secondary school. That day was during sports week. I hoped that participants would have time for me because they did not have to join any sports or parades. I met them in the canteen while they were working on their assignments. All of them were busy with their assignments and had not even had time to think about me. At that time, I felt disappointed and reviewed my research procedures. I worried about meeting research objectives on time. In the end, I was aware that students' work was as important as mine. It was I who had come to learn about their lives. These inner conversations calmed me down. I decided to sit next to them, talked to them about their assignments and helped them to paint their work. I enjoyed the moment we had together co-creating new perceptions. I found that the alteration to my plans was part of the beauty of undertaking qualitative research, decided to leave and told them that I would call them for a new meeting. On that day, I made no progress towards my research goals, but I did make progress in understanding adolescents' lives and facilitating research relationship.

4.11.3 Apply various strategies

In this current study, I used FGDs and IDIs to explore perceptions and experiences of adolescent in decision making about contraceptives. Within each method, I also applied various techniques.

Group discussion strategies

While I was in the field, I used various techniques to tease out participants' views. At the beginning of group discussions, I "broke the ice" by inviting group members to introduce themselves (Krueger & Casey, 2015). I had agreed beforehand with the participants that I would use this process, but they had known each other for at least 2 years, so inviting them to introduce themselves was only for my benefit, and was actually unnatural for them. Therefore, I realised that this technique, while it may suit groups of people unknown to one another, does not suit people who are already acquainted and who have formed relationships. I changed my strategy to break the ice by inviting them to introduce their friends in a positive way, by telling the wider group

about three good things they liked about that person. My new strategy worked well, because I could see teasing and laughing within the group.

The vignettes, used to provoke young people to share their perspectives, were not distant enough from some participants' life realities. In one female discussion group, participants felt that the story (vignette) seemed to be theirs, so they dared not discuss it openly. I recognised their discomfort, and I invited them to work in pairs to draw what was on their minds rather than speaking about it. Some complained about their drawing ability and felt relieved after I told them to write instead. During the drawing period, they talked to each other, teased and laughed. I also felt relaxed. I went from pair to pair to observe and chat.

Ranney et al. (2015) suggested offering food at the beginning of group discussions to ease participants into the sharing process. I did not start the discussions with food; rather, I put snack and drink in my basket and invited participants to select what they liked. Some of them— the group MG1 — used the opportunity to tease each other and to play fight for what they liked. After having snacks and drinks, male participants in MG1 talked more freely. They responded to my questions easily while they had their refreshments. I could not gain similar benefits with the other groups, however, because the mood was not the same, probably due to time pressures, and participants refused the snacks because they wanted to finish the discussions and go home.

Interview strategies

When I interviewed participants, I found that talking about irrelevant issues that interested them as a warm-up exercise decreased their initial discomfort. I accidentally found this when I talked to Mac, a male student from the upper secondary school. While Mac was sharing his experiences and his expectations for intimate relationships, I noticed he had a big scar. I asked him what had happened. Mac told me about a motorbike accident and his luck about the scar on his arm, not on his face. He nodded and laughed because I had just raised his main concern about his physical appearance. After sharing this story and a laugh, he looked happier about revealing his thoughts on the main topic, contraception.

I could not predict how a participant would react to other participants and to me as I mentioned in previous chapter about Yim's curiosity on Fang' sexuality. In MG3, Orm was bullied by others about his sexual behaviour. His friends told in the group that he

was in a sexual relationship with a teacher when he was in a lower secondary school. I decided not to probe because he smiled shyly, and immediately moved other group members to a new topic to protect Orm.

With this and other occurrences, I was challenged to build trust and to maintain a friendly, fun and relaxed environment for young people in such a short time. Little incidents like this could have had an effect on raw data, either on their own or as a cumulative effect, and student participants may not have even been conscious of the effect.

4.11.4 Negative impacts of positive feelings in an in-depth interview

I was aware of my own negative reactions when I heard some stories. I therefore prepared myself mentally for the worst experiences I might get from the field. I did not prepare for positive feelings which I found can also affect a researcher's responses to participants. For example, Ice, a female participant, paused frequently when I asked about her experiences with contraception. After I reacted positively to her story about getting free condoms, she paused less. I was amazed and thrown off topic because I had not observed any girls who had such a strong commitment to using condoms. This positive feeling pushed me into a negative situation, however. I did not know how I should react to Ice, who was so different, and I also forgot the semi-structured questions I had planned to ask. The conversation was frozen for a couple of minutes. I pretended to write notes while I considered what I should do next. My inner voice told me to tell her my true feelings. I told her I was astounded that she had such a strong commitment and had insisted on using condoms. I also told her that I wanted other female adolescents to insist on condoms the same way she did. She gave me a big smile. After that, she spoke openly about her boyfriend and contraception.

If I were in such a situation again, I would control my emotions, whether positive or negative, because unanticipated emotion can obstruct research and analysis. Although much scholarly advice has been given about dealing with negative feelings when listening to sad stories from participants, nothing has been written about how positive reactions can change the course of an interview. I would therefore suggest that novice researchers anticipate their positive reactions just as carefully. In my case, sincere admiration helped me overcome the conversation deadlock and positively affected Ice's responses to my questions, but the situation could just as easily have ended with a negative or neutral result.

4.11.5 The value of solo transcription

Transcribing could be a boring process for a number of researchers. In completing the transcription process, however, I found it very useful to review other stories participants told about their social world while I transcribed one story. The process also provoked me to consider participants' silences and to teach myself to be a better researcher.

Putting together mysterious pieces of a jigsaw

When I was doing my research, I could not concentrate on small hints all of the time. However, one day, I heard provocative whispers of one student in a small group discussion when I was transcribing. This whisper drove me to review a situation that had been troubling me in another light, and I could see the possibility that I had been stigmatised. The situation had evolved from a series of missed calls to my work mobile, which had been made by one male participant, Allan. Because the calls had been coming late at night, I originally thought they had come from my family who lived in New Zealand; the mobile service I used during the research displayed overseas numbers in the same way Thai mobile numbers were displayed. Eventually, I realised that the calls were from Allan. I took a call when I realised, as per Thai social mores that stipulate acknowledging the caller if you know the person, no matter who it is. Initially, Allan talked to me about his love with his girlfriend and his secret love with another young woman he had just met. He asked me what he should do. I did not answer, but I gave him questions to ask himself and ended the call. At that time, I thought something was on Allan's mind, but I did not know what it was. He did not mention the calls in front of his friends.

When I shared this unusual situation with a Thai colleague without mentioning my participants' name, she could not see the reason for Allan's calls, but her 18-year-old daughter said only girlfriends or boyfriends would make so many calls. The situation came to a head when I invited Gice (another male participant) to an interview, but Gice insisted on having the interview with his friends, which included Allan, Boom and Orm. During the discussion, Boom said that his ex-partner was older than he was and that she was the main decision maker. At that time, I was concentrating on Boom's discourse, and I did not hear Allan say that he used to have an older partner the same age as I was. I picked this statement up much later, when I replayed the audio-recording.

A picture popped up into my mind. I recognised the second day I went to introduce myself and my study to a lecturer in the vocational college. When I walked to the

lecturer with my gatekeeper, I heard a male adolescent in a big group ask me whether I wanted to "adopt" a young boy or not. Then, I thought it was a joke. The gatekeeper and I laughed.

I linked this situation of being asked to adapt a young boy and the calls from Allan with the transcription of his comments about having had sex with a woman exactly my age. I then saw that some of the young men at this school thought that having a sexual relationship with an older woman was normal. I wondered whether this was why Allan had been calling me only between 9–10 p.m. This situation frightened me although I still do not know the full truth behind Allan's behaviours. I was worried that there may have been a dark side in the scenario, where just talking about sex — even in a research context — might have provoked young people, because of my research interest, to see me as an older woman who wanted to have sex with a younger man.

After I put these mysterious jigsaws together and saw the possibility of being stigmatised, however, my mystery seemed to be disclosed. I was glad because I already had completed focus group discussions and in-depth interviews at the vocational college. I discussed with my gatekeeper about the behaviours of young people in the vocational college. She accepted that she also heard about the older Thai women who paid young men in the vocational college for sex.

From this situation, I learned three main lessons. First, a researcher who works in sensitive areas such as SRH may be labelled as promiscuous. Then, s/he might be at risk of being assaulted, or certainly propositioned. If I work with young people again in this type of research field, I will make sure that I have two mobile phone numbers, and I will not use the work number for my personal business. Moreover, the 18-year-old daughter of my colleague shared an interpretation of events that was useful, because young people are probably more correct in interpreting the behaviours of those who are in their age group. Lastly, I realised I should not overlook small things that happen during the day, such as the male voice in the large group asking me to adopt a young man. What happened that day was a hint about how some of the young men were reacting to my research questions, and if I had thought of this earlier, I may have been able to put a health and safety provision in place to protect myself and the participants better.

Discomfort can be recognised

I was provoked to consider the silences of participants when I was transcribing the audio-recording of one young woman, Tong. She informed me that she had had a boyfriend for 3 years but had never had sex. On the day of the interview, she came wearing a mask and told me that she had a cold. After I transcribed Tong's audio-recording, I found that I used less paper than for other participants who also spent 30 minutes at an interview. I listened to the audio-recoding again. Interestingly, I found that when I talked about other adolescents' experiences, Tong did not pause after my questions and sometimes answered them before I had finished asking. But when I asked about her life, Tong paused many times, and each pause was long.

Because of the nature of Tong's pauses, I became alert and reviewed other transcripts for similar pauses. I found that some pauses happened mid-sentence and others occurred after I had asked a question. In Tong's case, most of pauses occurred after I asked a question. These pauses probably indicated difficulty in answering a question, or discomfort. I tried to make sense her long pauses. I believe she might not have trusted me and felt uncomfortable sharing, so she had to think carefully before deciding which aspects to share. I felt disappointed that she might have made up her answers, but the mask reinforced my suspicions. However, I recognise in this situation that Tong had the right to share what she wanted to. I should respect her and accept the ways she shared her stories although her stories might distort my trustworthiness of my study.

Checking my consistency

While I transcribed, a realisation that I could have asked questions inconsistently slowly built. I felt disappointed in myself for being unable to probe efficiently. I then began checking whether I had used the same questions for every participant. I stopped the audio-recordings after a participant answered a question and wrote it down. Then, I compared the question I had asked with the question I had planned on asking. I found that most of the time, I had been true to plan. However, I had asked different questions on some occasions. I was concerned that this variation could have affected my results.

I collated transcriptions for which I had used different probes. I compared pre-, during and post-interview situations and found that two situations had altered the way I asked probe questions. The first was when I had two in-depth interviews on the same day. By the time I approached the second interview, I had had no settling in period for digesting information given by the previous participant. My brain was probably overwhelmed by

an information overload and could not concentrate on the second participant of the day. The second scenario occurred when I had joined in some school activities before I conducted in-depth interviews. These activities included reading books written in English and having a big meal about 30 minutes before conducting the interviews. I believe that these pre-interview activities might have dulled my concentration, thus negatively affecting the consistency of my probe questions. Although such situations might not happen regularly, I believe researchers should be aware of activities that can affect their probing and later, the validity of the data. Therefore, I have learned not to engage in such activities.

4.12 Chapter Summary

Based on the constructivist–feminist paradigm, the qualitative approach was employed in the current study to collect information about the perceptions and experiences of Thai adolescents about contraception. Gaining access to adolescents in a school setting depended on not only gatekeepers but also school teachers. Youth research assistants were trained to support the main researcher in case participants requested a younger or same-sex interviewer or moderator. However, a mismatch of timetables between youth research assistants and participants, and a lack of participant requests for same-sex youth research assistants, meant they were not needed.

In total, 38 Thai teenagers based in Khon Kaen participated in the study. Four single-gender discussion group, one unplanned discussion group and 20 face-to-face, in-depth private interviews were conducted. Audio-recordings were transcribed verbatim in Thai and translated into English by the principal researcher (a bilingual translator), and under the supervision of Thai adolescents from the Thai community in Auckland, New Zealand. Thematic analysis was used to process raw data.

With considerations on the rigour of the study, various strategies were applied in various stages of this study. Last but not least, ethical consideration on working with adolescents, on a sensitive topic and in a unique cultural environment is a central concern of this study.

Focus group discussions gained participants' trust. They willingly engaged in the next stage of the research, in-depth interviews. Time management was important for conducting the research, however, and complicated logistics meant youth research assistants were not included in most group discussions as planned. Various strategies

including vignettes, drawing, the provision of snacks and drinks and talking off the subject made participants feel comfortable and relaxed. Although transcribing was not challenging, it afforded a full analysis of possible causes for mistakes and offered potential solutions for future researchers conducting studies on sensitive topics.

In the next three chapters, I present interesting findings I collect from the field. Each chapter is an exploration of the research questions in series.

CHAPTER 5. Findings 1: How Contraceptive Decision are Made?

5.1 Chapter outline

Several themes emerged from my data analysis and I will discuss these in my three finding chapters: Chapter 5-7.

In this chapter, I present general experiences of being a teenager in urban Khon Kaen in the Section 5.2. This theme emerged from participants' narratives about their own life and other adolescents'. In Section 5.3, I demonstrate the themes on adolescents' views on sex and pregnancy. Participants' opinions about these matters are important, because knowing Thai adolescents' perception on sex and pregnancy can allow one to anticipate their tendency to engage in sexual relationships despite the risk of adolescent pregnancy. Interestingly, this section also shows various types of intimate relationships that adolescents in Khon Kaen City were engaged. The theme about contraceptive choices is disclosed in Section 5.3. A number of contraceptive methods are available in Thailand, but astonishingly the actual choices for adolescents are limited to only three methods, which are emphasised in this section. Last but not least, I found the most exciting themes explaining about how contraceptive choices of adolescents' were made, and it presents in Section 5.5. Most of contraceptive decisions were impromptu and happened just before each sexual intercourse. Unexpectedly, self-attempted abortion was revealed by a participant and that future contraceptive choices were likely to be made by parents at the time of teenagers' legal abortion which requires parental consent.

5.2 Being a teenager in Khon Kaen

To increase understanding about the lives of study participants in the particular context of the Thai-Issan culture as it is practiced in Khon Kaen, I present my data in 5 main subthemes.

5.2.1 The good student, the good child

As mentioned in "Chapter 2: The Thai Context", Thai parental expectation are that adolescents are expected to stay at school, study hard, pass their university entrance exams and register at a top public university or college. After graduation, they are

expected to get a well-paid job and to thereby gain financial independence from their parents. Then, they are supposed to contribute financially to their parents' and siblings' households. These expectations lead many young people to ponder their futures and their future responsibilities with some trepidation.

In Thai society, adolescents are considered as people who have bad *karma* when their behaviours distress their parents. The person with bad *karma* is one who does not obey their parents, the elders in the family or household rules. Bad behaviours including speaking to their elders in impolite language, refusing to help parents at home (particularly for young women), engaging in sexual relationships, taking drugs, smoking and consuming alcohol are all considered bad *karma*. Consequently, young people can avoid having bad *karma* by meeting parents' expectations.

Many participants in the current project mentioned their parents' expectations. Tong, for example, accepted that she had to study hard because of her parents' expectations:

> My parents want me to pass the entrance exam to study in [the] Faculty of Nursing, to be a nurse. I don't want to upset them.
>
> –Tong, female, upper secondary school, interview

Not only participants in this study but also other adolescents in Khon Kaen have to study hard. One participant shared her observation that teenagers are expected to be studious and later to pass a university entrance examination:

> If someone is a nerd, she or he must have extracurricular tutoring courses on the weekend. She or he would have no free time at home. After school and at night time, she or he has to do homework.
>
> –Bee, female, upper secondary school, interview

These expectations caused negative impacts on participants' health. Mac, a male participant, felt stressed from being expected to follow his older brother's journey of studying at Khon Kaen University and being awarded as a second-class honour student:

> At the moment, I felt confused. I felt confused only about my study. I am afraid of having no offers from any universities. Because my family pressures me, but [pause] maybe it is the way they encourage me, though.
>
> –Mac, male, upper secondary school, interview

5.2.2 Joining in extra–curricular activities

In addition to studying at school, young people also engaged in extracurricular activities such as sports. Schools regularly organise sport weeks. All of the students, including participants, were expected to participate in a kind of sport, cheerleading and parade. During sports week, interestingly, some participants of upper secondary school were allowed to opt out and do independent study at home.

Sports time can be very special, particularly for teenage boys. It is a time they can enjoy their friends' company, which I observed at the secondary school. Some young men chipped in their pocket money to buy a soccer ball. However, for adolescents who have financial problems, playing competitively as a professional footballer is done to earn money. In the current work, Ben reported playing football for wages. He got paid 300 baht (about 12 NZD) for each tournament and felt financially independent from his parents.

5.2.3 Claiming personal dependence and an identity

Many teenagers in Khon Kaen used motorbikes as their main vehicle. I observed more than 500 motorbikes parked in front of and behind the vocational college. When I went to see participants or school teachers, I saw many adolescents in the college uniform using motorbikes for hanging out before and after school, and even during breaks. Some of them smoked, ate their lunch or snacks, played with their phone and joked around near their motorbikes. At the upper secondary school, motorbikes were also used by many students, including participants, but motorbikes were not as common as for students in the vocational college.

As a convenient vehicle, motorbikes were used to access many places teenagers wanted to go without parents' surveillance. Using motorbikes may therefore reflect adolescents' bids for independence. Some participants stated freely that they used or would use motorbikes for going to contraceptive providers. Fon, a female participant from the vocational college, rode her motorbike to a primary health care unit close to her college with her friend to get free condoms. After she was refused service indirectly, she used her motorbike to go to another primary care unit. Ben, a male participant from the vocational college, found a new condom vending machine when he stopped his motorbike at a petrol station. He felt lucky because he had found a new place where he could buy condoms without observation. Mac, a male participant from the upper secondary school, told me that he would ride his motorbike to a primary care

unit to get free ones if he had to use condoms. He felt having a motorbike could help him to make a quick pass to observe the atmosphere at the primary care unit, and if it was crowded, then he could vanish just as quickly to avoid being stigmatised by people there.

Motorbikes are known to be used to express the identity of young people in Thailand. Their bids for freedom are reflected in the many Thai words used to describe the process. As "ESD" (not a real name) posted on www.oknation.nationtv.tv (2013), the term *'dek wan'* is used to described a group of young people who ride motorbikes with a loud noise: *wan wan*. *Dek wan* is mainly used to describe boys who ride a motorbike and wear very tight jeans, a black T-shirt and slippers. The term *skoy* is used to describe girls who sit on the motorbike behind and embrace *dek wan*. *Skoy* also have a unique look: short jeans, a very tight T-shirt, blazer or skivvy and slippers. In the current project, no participants identified themselves as *dek wan* or *skoy*, but nevertheless, using motorbikes seemed to define their social identities in some ways.

As mentioned in "Chapter 3: Literature Review", adolescents suffer many road accidents from riding motorbikes. In Thailand, only people aged >18 years can hold a driving license. Teenagers between 15 and 18 years of age can have a temporary driving license subject to limitations, such as smaller motorbike types. Their limited experience driving and potentially poor decision-making skills on the roads may be their downfall, because two participants in this study had had accidents. Mac, a male participant from the upper Secondary School, had ridden his motorbike from his village to school for 3 years. In 2014, Mac had a crash with a truck on the way home. Luckily, he suffered only a minor injury, but he still has a scar from this accident on his right arm. Tey, a female from the vocational college, also had had a road accident on the way home. Her motorbike hit another motorbike. She was unconscious and taken to a hospital, but survived intact.

5.2.4 Social networking

The Internet seemed to be the important part of adolescents' life in Khon Kaen City. Participants used the Internet for various purposes. For example, one female participant used the Internet for searching for new friends and "sneak-peeking" at other adolescents' stories. Two male participants played online games, were addicted to the games and failed their first year at college.

Four participants described the general scenario of Thai adolescents using Facebook or Line App to chat and to start new intimate relationships. One young man, for instance, started talking with his classmate via Facebook, and then agreed to start dating, although they were physically in the same class. He shared his reasons.

> During this era, teenagers would start by being a friend. Mostly, they knew each other via a social network such as Facebook. They might be in the same schools or different schools.
>
> –Nat, male, upper secondary school, interview

Tey, a female participant from the vocational college, chatted with many guys on the Internet. In an in-depth interview, Tey disclosed her personal life:

Tey:	I am a choosy one [laugh].
Sansanee:	So?
Tey:	I will chat via Facebook or Line App for a while. I have to see how he is first.
Sansanee:	Don't you?
Tey:	If he is the kind of person who is similar to me, I will say ok. [Pause] and if we get along well, are compatible. I will start this relationship.

Tien, a female participant from the vocational college, also shared a story of her close female friend (Mai). Mai started talking to guys on Facebook and Line App, and ended up having sex with the men she met on Internet dates:

> This friend, Mai, we lived in the same dormitory when I was in the first year [pause] the second semester. Mai loves to surf the Internet: Facebook and Line App. She loves to talk. When a man talks to her, she starts to play with that guy and ask that guy come to her dormitory [pause] and then have that kind of activity [having sex].
>
> –Tien, female, vocational college, interview

Two other young men from the vocational college also shared their Internet journeys. James, a male participant, used Facebook to regularly contact his girlfriend, who was in her internship at a governmental office in a neighbouring province. He explained that social networking made him feel close to his girlfriend.

One young male at the vocational college used social media to express his sexuality: Gice used a camera on his mobile phone to record his sexual activities, and his video

recording was shared on his Facebook page. Gice did not tell exactly why he took the video recording, but his mother had seen it on Facebook.

Focusing on sexual and reproductive health, from my observation, the Internet seemed to be a route leading young people to engage in intimate relationships — and potentially leading them to be at risk of unwanted pregnancy or other negative consequences.

5.2.5 Courtship and its diversity

During adolescence, some young people start a courtship. Most participants were involved in a romantic relationship with the opposite sex. They had various reasons for initiating a romantic relationship. One female participant wanted to be in an intimate relationship to imitate adults' behaviour.

> Being a teenager? Surely, teenagers want to have a boyfriend. When I am a teen, firstly I want to have a boyfriend since I was in Mattayom 1 [pause] I see many adults have lots of happiness when they are in a relationship. The older people, they live together. Kind of. They seem happy. I would like to be happy too. I would like to have an intimate relationship too. When I grew up, I started my intimate relationship.
>
> –Fon, female, vocational college, interview

Some female participants engaged in a romantic relationship for love, closeness and encouragement:

> I want to have an intimate relationship. I keep it for encouragement.
>
> –Fang, female, upper secondary school, FG2

> Having intimate relationship is good because sometimes I feel lonely. Being in an intimate relationship is::: sometimes [pause] sometimes it encourages us.
>
> –Ney, female, vocational college, interview

One female participant described educational benefits from having a romantic relationship. Tong started her intimate relationship when she was in Mattayom 3 (year 9). Her parents acknowledged her romantic relationship. However, only her mother talked with her boyfriend. Tong and her boyfriend spent their time together studying and helped each other doing homework.

> Sansanee: Tell me about your teenager's life.
> Tong: [Pause] Hmm [pause] I have a boyfriend [laugh].
> Sansanee: [Laugh] And then, my daughter?

Tong: Its' started when I was in Mattayom 3.
Sansanee: Wow, so long.
Tong: Keep the relationship. We help each other study.
Sansanee: How have you helped each other?
Tong: We have homework. [Pause] We help each other.

Like Tong, Nat had a 4-month relationship dating a girl under his parents' surveillance. He took his girlfriend to see his mother at home. However, this relationship did not last long. Nat ended this relationship and started a new one with another girl studying at the same school. Nat has not told his parents yet about this new, 1-month relationship. Nat spends his time on outdoor activities with his girlfriend.

> I am in a relationship with my girlfriend [pause] sometimes I go jogging with her. Sometimes, I spend time together at a shopping mall.
>
> –Nat, female, upper secondary school, interview

While a number of participants engaged in an intimate relationship with the opposite sex, some also engaged in romantic relationships with the same sex. According to a National Institute of Development Administration (NIDA) poll (2013), lesbian-gay-bisexual-transgender (LGBT) relationships have been accepted by many Thais because many LGBT unions are good, and do not harm other people. These types of relationships are also acceptable because the people involved are thought to be acting naturally, whereas attempting to form a heterosexual liaison would be a mismatch of the body and the soul (NIDA Poll, 2013).

The issue of same-sex relationships was mentioned in Female group number two (FG2). Fang and Yim disclosed that they both had had an intimate relationship with "*tomboys*" or "*tom*", or other young women who acted as the male. This information was disclosed after Yim showed her curiosity about Fang as someone who knew about sex. In Thailand, someone who knows about sex can be judged as the one who has had sexual experiences, and this person is then condemned as a "bad" person. At that time, I noticed Yim's curiosity about why Fang knew about sex and contraceptives. I considered that Yim's curiosity might harm Fang, and I reminded them that we were talking about the vignette. Hence, the revelation of being in a same-sex relationship could have been taken as a real experience or as a strategy of Fang's and Yim's to avoid being stigmatised by other group members.

Sansanee: Having sex makes them love each other more?
Fang: But I think someone might just want to try. And someone had already tried?
Yim: It seems that Fang has experienced it.
Sansanee: Hey, this is a story of A and B, A is a male and B is a female adolescent.
Fang: Oops, mine is female–female.
Yim: I am sorry, Mine is also female–female. So sorry, I have no experiences.

Two males also engaged in a same-sex relationship. In the male group number one (MG1) and in the male group number three (MG3), Orm was teased by his friends about having had sexual experiences with an older man. Unfortunately, Orm did not expand on anything and just smiled. I could not interpret his smile as an acceptance or rejection of being in a same-sex relationship. I decided not to probe Orm about his same-sex relationship because his smile might also be his embarrassment. Another adolescent boy from the upper secondary school (Honda) also was in a very short-term relationship with a man he met on the Internet. After chatting on the Internet for a while, Honda made an appointment to meet in person. A week after they met, however, Honda decided not to continue this relationship.

Sansanee: Have you had been in an intimate relationship?
Honda: Me? Hmm [pause] I was.
Sansanee: How about your relationship?
Honda: I talked with him about a week and then ended it. I am the kind of person who get easily bored.
Sansanee: Hmm?
Honda: Truly. Truly. [Pause] I had a chat and at one time I wanted to stop [pause] and then stopped.
Sansanee: Talking to each other for a week? Can you count this as being in a relationship?
Honda: Firstly, he and I agreed to be in a relationship. We spent only a week as I said. Then, the relationship started fading way. We kept up the chat, but it was not the same.
Sansanee: Is that a friend from the Internet or at school?
Honda: From the Internet.
Sansanee: You talked to each other on the Internet and then met in person?
Honda: [Pause] Yes.
Sansanee: How many teenagers start their relationships on the Internet?
Honda: Lots, especially the third sex.

5.3 Perceptions about sex and pregnancy

Perceptions about sex and pregnancy may influence decisions about engaging in a sexual relationship and using contraceptives. This sub-section explores perceptions as a holistic part of sexual and reproductive health. I acknowledge the diversity of sexual relationships I found. However, based on the focus of this study — which is adolescent pregnancy — sex and sexual relationships described in this section refer to heterosexual relations. Thereafter, sexual relationships are expanded to include other types. Finally, I present verbatim perceptions on adolescent pregnancy.

5.3.1 Sexual perception

Most of the male and female participants from the vocational college were sexually active, while only a few of participants from the upper secondary school engaged in sexual relations. Most of the participants from these two school settings, whether they were sexually active or not, expressed similar views that having sex during adolescence is *tammachat* (natural), *tamamda* or *pagati* (normal) and *raung saun tua* (personal business).

> All of the teenagers when they have a romantic relationship. They want to have sex. *tammachat* [natural] or *pagati* [normal].
>
> –Ong, male, upper secondary school, interview

> I think, nowadays, having sex is not strange.
>
> –Honda, male gay, Secondary School, interview

> Sex between my girlfriend and me is a secret [pause] it is the *raung saun tua* (a personal issue) and a secret between two of us.
>
> –Ben, male, vocational college, interview

> Whoever doesn't have sex is abnormal
>
> –Ying, female, vocational college, FG1

Some participants contended that sexual relationships were acceptable, but with the condition that those in such relationship had to avoid pregnancy.

> I think it ... in my view. It is normal for today's teenagers. Yes, they are in a relationship, go out together, it is impossible that they won't have any sexual activities. But it depends on whether they know how to protect themselves or not. If they don't know how to protect

> themselves, they may make a mistake [pregnancy]. We cannot stop them having sex. However, we cannot stop because it comes from love and fondness.
>
> –Bew, female, upper secondary school, interview

> It is normal as long as they [teenagers] know to protect themselves.
>
> –Bee, female, upper secondary school, interview

> I think teenagers are eligible to have sexual relationship if they prevent themselves from getting pregnant
>
> –Ben, male, vocational college, interview

Apart from seeing sex as an ordinary behaviour of teenagers in modern times, having sex was regarded as an important part of the identity and as an unavoidable component of an intimate relationship. Having sex thus appeared to be a normal feature that a female and a male in a relationship must go through with.

> If we are in an intimate relationship, one day, we would have sex anyway.
>
> –Bass, male, upper secondary school, MG2

> If I leave him, I cannot live without him. I am a female [pause] alone. In the later days, I must have sex.
>
> –Num, female, vocational college, interview

A few participants, even at the vocational college where sex was more common, contended that it was not normal for teens to have sex, however. They felt that adolescence was an improper time to engage in a sexual relationship.

> If we have sex during this period, what happens later, when we have to separate … It [having a relationship like this] is not as same as an adult when they have to engage, must marry. It is not the right time yet.
>
> –Tey, female, vocational college, interview

> I think it is too early to have sex [pause] because we didn't truly know about prevention.
>
> –Orm-am, female, upper secondary school, interview

> I think I and my ex-girlfriend both were too young to have sex.
>
> –Mac, male, upper secondary school, interview

> My parents told me not to have sex and to wait until I have a job. Now, it is not the right time
>
> –Ben, male, vocational college, interview

Some participants were quantitative in their assessment of what age was suitable. According to Orm, "the 15-year-old is too young to have sex, but for the 17-year-old, it is ok". Possibly, based on his definition, he did not touch his girlfriend, who was 15 years old, but accepted that he could have sex with senior females.

In FG1, while most of the participants agreed that having sex was normal, two of the group members disagreed. Num and Ney explained their ideas through a drawing by stating that "true love can wait". When I asked for clarification, however, they looked confused and hesitant to elaborate the meaning of "true love can wait" in front of their friends.

A similar situation occurred in MG2. One of the dominant participants agreed that sex was a natural human instinct, and that he accepted the premarital sexual relationship. In an in-depth interview, however, he indirectly pointed out that having sex during adolescence might not be suitable, and adolescents should consider pregnancy risks before having sex.

> If I was asked whether it is natural or not? Yes, it [sex] is a natural instinct of any human being. We are like that. We cannot stop our natural instinct. But as a human being, we also have our thoughts. We must know. Sometimes mistakes happen. We have to think about these. We have to think about our future that whether it is ok or not to have sex.
>
> –Fluk, male, upper secondary school, interview

A number of teenagers engaged in a sexual relationship because of following their sexual drive and curiosity, expressing their love and maintaining their intimate relationship. I observed that male and female participants had slightly different perceptions on the reasons for engaging in sexual intercourse. In male focus group discussions, for instance, reasons for becoming involved in sexual activities included following the sex drive, curiosity and having fun. In contrast, in two female discussion groups, reasons for having sex were related to the feeling of love, the expression of love and maintaining the intimate relationship.

Interestingly, young women in FG1 and FG2 also noted that lack of love and warmth from families could indirectly lead adolescents to have a sexual relationship.

> I think teenagers have sex because of their parents. Parents might not give them enough love and warmth. Is it relevant? I have never been with my parents. I didn't do that. It depends on each person.
>
> –Yim, female, upper secondary school, FG2

> I believe that if we have warmth from our family, nothing will happen.
>
> –Fon, female, vocational college, FG1

Imitating a friend was another reason cited for males engaging in sex. Mac, for example, was in a 9-month romantic relationship with a girl. There were no sexual activities during that period. He wanted to have sex with his girlfriend, but he was too shy to ask.

> I cannot do many things like having sex because I am not an adult. [pause] I just wanted to have sex as my friend did.
>
> –Mac, male, upper secondary school, interview

5.3.2 Different types of heterosexual relationships

With views that sex was normal or natural, most of the sexually active participants felt able to engage in relationships, most of which were heterosexual relationships. Such heterosexual relationships can be split into categories: single-partner relationships, multiple-partner relationships and one-night stand encounters.

Most participants had had a sexual relationship with one partner for a period of time. One young woman (Fon), for example, started a new relationship with a new boyfriend, and then ended up with her former boyfriend after living together with the second one for a year. Two males (Boom and Noot) from the vocational college reported that they were currently involved in sexual relationships, and that they used to be in such longer-term relationships with their ex-girlfriends.

One male participant, however, indicated that he had had two sexual partners in the same period.

> Gice: I had two at once.
> Sansanee: Wow. How could you manage?

Gice: They called me whenever they wanted. I had to save their number as Number 1 and Number 2.

No female participants reported engaging in multiple-partner sexual relationships. However, Tien, a young woman from the vocational college, knew one of her close friends had started sexual relationships with at least two boys she met on the Internet at the same time.

Sansanee: Tien, did you have any friend who got pregnant during adolescence?
Tien: Yes, a close friend.
Sansanee: Could you tell me her stories, please?
Tien: This friend, we used to live in the same dormitory when I was in the first year, the second semester. She loves to surf the Internet: Facebook and Line App. She loves to talk. When a man talks to her, she starts to play with that guy and ask that guy come to her dormitory.
Sansanee: And then, in a relationship?
Tien: No, that guy came to have a look but did not start a relationship. Then they both went out for dinner together [pause] and went out together.
Sansanee: And then, they had a baby?
Tien: She had lots of guys. I did not know who is who. She talked to this guy [pause] and another two guys. Talked to them for a couple of days and then moved to a new guy. Then, she got pregnant.

Two girls in FG2 described the one-night stand when talking about ECPs during vignette activities. None of the participants, however, had ever engaged in a one-night stand sexual relationship

Sansanee: Then do males know that female take emergency contraceptive pills?
Fang: Yes.
Sansanee: Depends on the males' responsibilities. If males pay attention enough, they will ask whether their girlfriends take emergency contraceptive pills or not. I see.
Yim: Some do not because it is only a one-night stand.
Fang: Some are not in a relationship but meet each other at the pub. Then [pause] they like each other [pause] and then go together. When they meet each other a night later, they do not know each other. It depends on each of them [pause] Hmm [pause] these days, it happens lots.

5.3.3 Perceptions about pregnancy

Most male and female participants said that pregnancy was *plad* (a mistake) and *panha* (a problem). These mistakes or problems could lead to punishment by their parents.

However, only a few participants mentioned the terms "mistake" and "problem" explicitly, *and* in relation to their own sexual activities.

> I think I and my ex-girlfriend both were too young to have sex. If we make a mistake, there will be big trouble.
>
> –Mac, male, upper secondary school, interview

> I used withdrawal, and then I was worried about pregnancy. I was afraid if::: a mistake [pregnancy] happened. I decided to buy emergency pills for my girlfriend.
>
> –Noot, male, vocational college, interview

> Normally, when teens have sex and then get pregnant. Right? Some of them go for abortion. [pause] That is the problem of teenagers.
>
> –Tey, female, vocational college, interview

In distinct contrast, one participant saw getting pregnant as normal for people of his age group (he was 18 years old).

> I don't think too much about this pregnancy issue. People around my house, people at my same age, they already have their baby. Those who are a couple years older than me [pause] have had their babies. In Ayutthaya [a province in Central region of Thailand], my cousins and other people at my same age have their babies. Only three to four people have not had babies.
>
> –Allan, male, vocational college, interview

Many participants acknowledged that adolescent pregnancy was the female's risk and problem.

> If I have a son, I will be worried about their death. If I have a daughter, I will be worried that she will have a baby.
>
> –Orm, male, vocational college, MG3

> If a girl has a baby, some men take responsibility. That will be good. But, some men don't. Then, the problems will belong to the girls.
>
> –Tey, female, vocational college, interview

Pregnancy was seen as shameful for young women. Participants felt that shame from pregnancy was more likely to have impacts on the female. Because of the obvious physical changes in the female adolescent's body, they seemed to be condemned, and

were the victim of the blame. The issue about shame was described by two female participants in FG2.

Sansanee:	Normally, how do Thai teens protect themselves from unwanted pregnancy?
Fang:	We have to be cautious.
Yim:	Girls will prevent pregnancy more than boys.
Fang:	Because girls will be the victim more than males. Hmm [pause] but some people do not think in this way.
Sansanee:	Nug, what do you think?
Nug:	Some people have sex for fun. Something like, some people heard from their friends about having sex. Then, they want to have fun and do not think about the consequences of having sex. That is some people.
Sansanee:	You said 'the victim'? Why?
Nug:	That is, the girl can have a baby but the boy cannot. The girl has to drop out of school, but the boy doesn't.
Yim:	The boy can still come to school without shame.

Many participants believed that pregnancy during adolescence led to *anakot dab* (a dark future). They felt that because adolescents are expected to finish their schooling, go to university and get a well-paid job, pregnancy during adolescence can distort the pathway to achieving this life goal, leaving them trapped in a dark future. Bass and Niwat, for example, stated these opinions in MG2.

Sansanee:	What makes you afraid?
Bass:	Pregnancy.
Niwat:	Consequences of pregnancy.
Sansanee:	The first fear is about pregnancy, and the second fear?
Bass:	Being scolded.
Niwat:	*Anakot dab* (a dark future).

The majority of participants were afraid of the negative consequences of unplanned pregnancy. However, one male participant described that consequences of pregnancy had fewer impacts on his life, compared to AIDS/HIV. For Gice, AIDS/HIV meant social discrimination and death. If he impregnated his girlfriend, he would have a chance to discuss or negotiate with his parents and the parents of his girlfriend about the future plan. Unplanned pregnancy was not as life-threatening.

Sansanee:	Do you have a hard time making a decision on contraceptive methods?
Gice:	Condoms, I have no reason for not using condoms. Currently, I am afraid. I am so much afraid.

Sansanee: Why are you afraid?
Gice: I attended a "Drug Abuse" workshop and then sex was added. A video showed about life after infection by HIV. And hvaing AIDS, kind of.
Sansanee: So, you are afraid of AIDS more than pregnancy then?
Gice: For pregnancy, we can chat. But for AIDS, it is hard to go to the community. Right, my friend Orm?

5.4 Contraceptive choices

Although various kinds of contraception are dispensed at public and private healthcare clinics, only three methods were mentioned by participants.

5.4.1 Condoms

When I asked the question about preventing pregnancy, the default answer from all of the participants was "condoms". In the current work, condoms — *tung yang* (rubber bags) or for short, *tung* (bags) — refer to male condoms. Only three girls mentioned female condoms. Therefore, throughout this section, the term "condom" refers to male condoms.

Condoms were seen as the most effective method. Most MG1 contributors, for example, felt safe when they used condoms. They often said, "I can die in peace when I use condoms". They also accepted that condoms can prevent STDs. However, some males in this discussion group mentioned that condoms were a barrier to reaching orgasm.

School teachers and exhibitions at school were the main sources of knowledge about condoms. In Health Education classes, teachers mainly taught their students about the reproductive system and its functions. Some contraceptive methods, such as condoms and contraceptive pills, were also introduced in these classes. Under the National Campaigns of "*Stop Teen Moms*", "*AIDS Prevention*" and "*To be Number One*", one-day exhibitions were generally organised in a school hall by health educators, staff from local community hospitals and primary care units. These one-day exhibitions included quest speakers, video presentations and question–answer sessions. Condoms were often given out for free to young people and as *koha* for coming to the exhibition or winning a game or a quiz.

Community pharmacists were also cited as a source of information about condoms. However, only a few participants mentioned that a pharmacist gave them further information about condoms.

> On that day, I went to a pharmacy with a female friend. She had diarrhoea. It was a late night. My friend and I took a motorbike to a pharmacist close to my friend dormitory. While I was waiting for the pharmacist, I found many types of condoms on the shelf [pause] and the prices. I was wondering about them. The age of pharmacist. [Pause]. I think she was very young. I asked her, the pharmacist, about the different types of condoms. She told both of us the details of each type of condoms. [Pause] Every type was on the shelf such as condoms with fruity flavours and fragrances such as strawberry, banana and smooth skin. Something like that.
>
> –Bew, female, upper secondary school, interview

Noot, a male participant, bought ECPs at a local pharmacy for his girlfriend. The pharmacist there suggested that he use condoms as the preventive method of choice instead of ECPs. The pharmacist told Noot about the advantages of using condoms to prevent STDs, and informed him about the risk of taking ECPs.

> The pharmacist told me about sex and how to prevent the dangers of unprotected sex. He advised me. He usually tells me to use condoms rather than emergency contraceptive pills. He said that emergency contraceptive pills also have dangers to my girlfriend's health.
>
> –Noot, male, upper secondary school, interview

5.4.2 Withdrawal method

When sex occurred without condoms, young male participants, with the agreement of their girlfriends, chose withdrawal to prevent unplanned pregnancy. The withdrawal method was locally known as *tag nock* (breaking outside) or *lang nock* (releasing outside), while the opposite term *tag nai* (breaking inside) or *lang nai* (releasing inside) refers to ejaculation inside the vagina. These words were expressed in conjunction with the terms *sod* (fresh) or *sod sai* (fresh insert), referring to "bareback" sex, or sex without condoms. In FG2, the term *tag nock* was explained.

> Fang: '*Tag nock'* means that when someone is having sex, then he doesn't use condoms or '*sod'*.
>
> Sansanee: Pardon? What do they call it? *Sod*?
>
> Fang: Yes, *sod*. But boys release [their semen] outside the vagina. When they feel close to getting to an orgasm, they will pull out.

While young females in FG2 discussed withdrawal methods openly, boys were shy to deliberate about their perceptions on withdrawal methods in their male-only discussion groups. Instead, four male youth including Allan, Noot, Boom and Ong disclosed their first-hand experiences in using the withdrawal method when they were interviewed alone. Allan's description was typical of the responses.

> If I am at that moment, I follow my sexual drive. Then, I *lang nock*. Nothing happens after I *lang nock*.
>
> –Allan, male, vocational college, interview

In the unplanned discussion group (MG3), Boom and Gice were more open about early withdrawal:

Boom:	No, if I have condoms, I will use condoms. If I don't have [them], I won't.
Gice:	Your standard, isn't it? Boom?
Boom:	Actually, I know whether I have condoms or not. My girlfriend will ask again.
Sansanee:	If you don't use condoms?
Boom:	I won't *lang nai*.

Because of their embarrassment, I decided not to probe deeply about how they learned to apply the early withdrawal method. However, I found that adolescents can learn about withdrawal from novels. Fang, a girl in FG2, said she knew about *tag nock* from reading a novel.

Interestingly, in a group discussion in which my participants and I discussed about withdrawal method, Fang was questioned by Yim about how she acquired such vast knowledge about sex and contraceptives including withdrawal method. In the discussions, Yim's questions seemed to have two meanings: 1) a direct meaning — where or how Fang gained the information, and 2) an indirect meaning — whether or not Fang had had sexual experiences. I was aware of the possible double meaning. Fang might also have understood the double meaning. In answering Yim's curiosity by saying she read such things in a book, Fang might have been deflecting the questions and any potential scrutiny by Yim or other group members, although in reality, Fang might have first learned about sex from her ex-boyfriend, her friends or the Internet.

Sansanee:	Apart from two methods, condoms and emergency contraceptive pills, is there anything else?
Yim:	Pardon?
Fang:	*Tag nock*, *tag nock* [withdrawal method].
Yim:	Fang, you seem like you know **EVERYTHING** [speaking loudly].
Fang:	I read lots of novels, do you know?
Yim:	What? Fang? You read lots of novels. Explain, explain.
Fang:	I am useful, aren't I? Reading novels.

5.4.3 Hormone pills and other contraceptives

Ya (medicine) *kum* (control) was also used when having sex without condoms, or when participants felt unsure about the effectiveness of early withdrawal. The term *yakum* was used for ECPs, or *yakum chugchern* (emergency contraceptive pills, ECPs). Females in FG2 suggested that ECPs were the best contraceptive method adolescents can get. Interestingly, young men in MG2 expressed negative views about males who knew their girlfriend was taking ECPs. They also perceived that the male in the relationship was seen having no responsibility or as being selfish because of having sex without condoms and indirectly pushing the female into having ECPs. The term *yakum* also referred to combined oral contraceptive pills (COC pills), which the users had to take daily to prevent unplanned pregnancies. At the time of the study, one girl and Noot's girlfriend took COC pills.

Fluk, a participant from the upper secondary school, noted in FGDs that at school no teachers or health educators had ever suggested young people should take ECPs. He underlined that Thai adolescents know about the ECPs and the uses of ECPs from their friends. Noot from the vocational college and Ong from the upper secondary school confirmed that they knew about ECPs from his male friends, whom they used to hang out with. Apart from sharing information about ECPs, Noot were requested by his male friends to go to a pharmacy to buy ECPs.

Websites were a common source of knowledge for participants. In Thailand, websites such as Pantip (https://pantip.com/tag/Website) have been in operation for more than 20 years. Initially, this website aimed to be a source of IT information for those who wanted to buy a new computer. Recently, Pantip becomes a source of information about sexual matters, too. One female participant in FG2 described Pantip as a site where today's adolescents could access various kinds of information, including tips about sexuality. Fang explained that sometimes teenage girls do not want to talk to

their friends because of fear of gossip. Therefore, Pantip was a safe place for the girls to post questions, invite discussion and ask for advice about contraception.

> On the Internet, sometimes, we shared our stories on the web board and wait for comments. For somebody who doesn't want their friends and parents know, they will go to the Pantip website. I think it's good, various comments are there. We can choose comments we like.
>
> –Fang, female, upper secondary school, FG2

Other contraceptives mentioned were hormone implants (*yafang tai pewnang*), IUDs (*huang*) and hormonal injections (*yacheet*). None of the participants had had first-hand experiences in using these methods at the time of the study.

Thus, my findings show that although numerous contraceptive choices are ostensibly available in Thailand, adolescents are likely to choose condoms, the early withdrawal method or ECPs.

5.5 How contraceptive choices are made

From my data, it was clear that four types of decisions about contraception were being made. First, the decision could be made before initiating a sexual relationship. Second, a decision could be made just before each sexual encounter. Third, a choice could be made after having an abortion. Finally, a decision could be made when one or both sexual partners were drunk. The diagram of contraceptive decision making process is presented below.

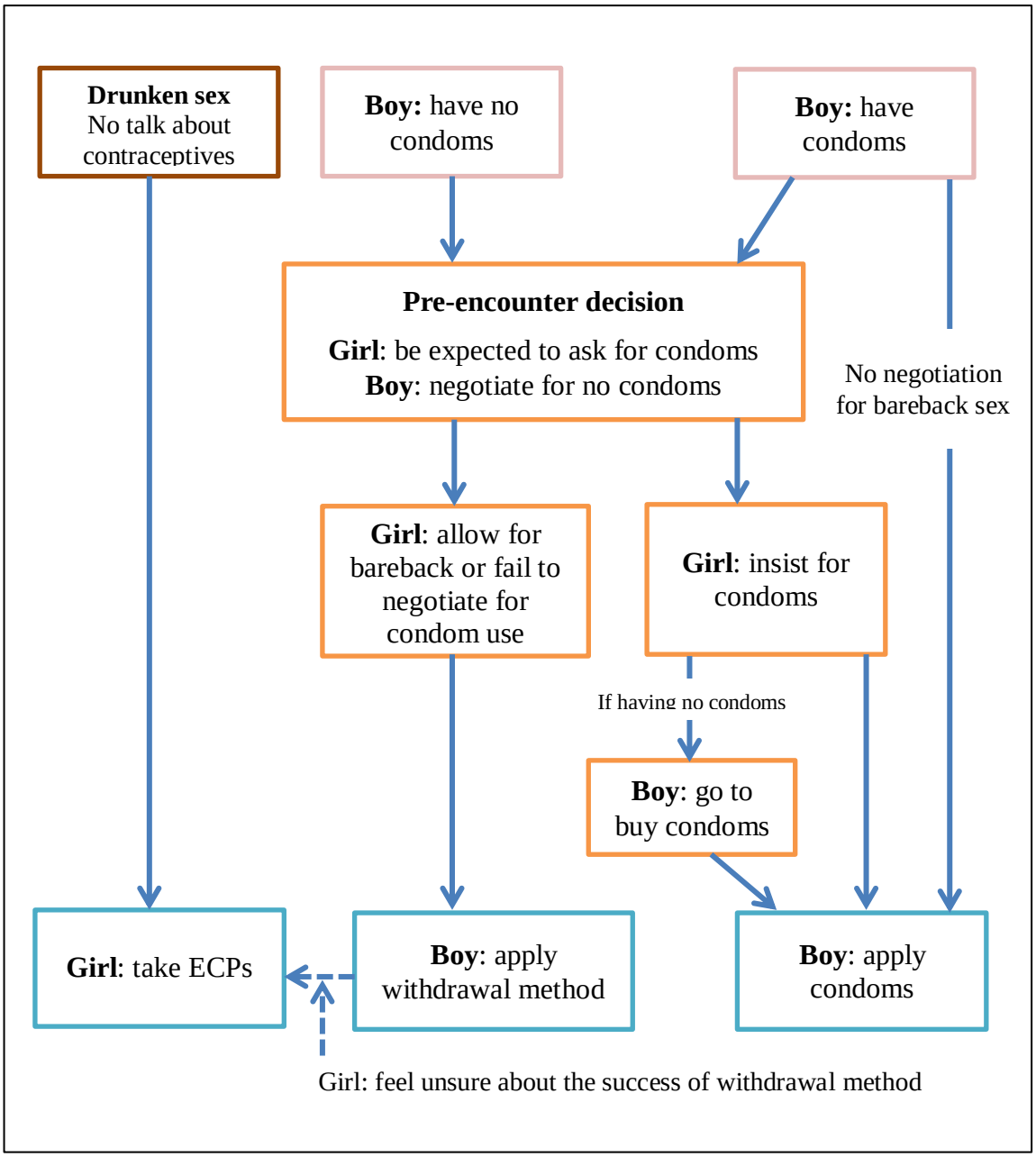

Figure 6: Contraceptive decision making process

5.5.1 Pre-intimacy decisions

Only one sexually active girl from the upper secondary school reported that contraceptive methods were decided before initiating a sexual relationship, although her sexual activities were always unplanned. Bew started her intimate relationship with her boyfriend in 2014. Both she and her partner considered the negative impacts of

unplanned pregnancy on their education, their immaturity in the face of parenthood and potential future financial difficulties if they were to have a child. Bew said,

> If I were to have a baby, I would have no money to look after the baby. My boyfriend also said that he was not ready to be a father yet.

Because of these concerns, Bew and her boyfriend set their rule as "no condoms, no sex". They were both responsible for making sure they had enough condoms. They bought condoms or collected free condoms from their friends. Sometimes, they had to buy condoms. Since initiating a sexual relationship, Bew and her boyfriend have kept this commitment, and Bew's boyfriend had never asked for unprotected sex.

5.5.2 Pre-encounter decisions

Apart from Bew, none of the participants had had a conversation about contraceptives before engaging in sexual relations. Instead, the conversation about contraceptive methods was likely to occur just before each session of sexual intercourse. Four sexually active participants stated that the discussion about contraceptives might or might not happen at all. They said that "it depend[ed] on situations", and "it depend[ed] on how many times I h[ad] sex". Therefore, decision making was not planned, but was dynamic according to the circumstances. Both genders were likely to be caught in "big uncertainty" in deciding about contraceptives.

Despite one girl living with her boyfriend, all of the sexually active participants had lived or were currently living with their parents. Two participants reported sexual activities occurred when parents and other family members were not around. Two male participants said that they had had to manage their time during school days to go to their girlfriend's dormitory or to their friends' dormitory, have sex there and came home on time. This could imply that these young people could not predict when sex would happen, nor could they predict for how long they would be able to enjoy their sexual activities. Their sex was therefore likely to be "spur of the moment". With such uncertainty, contraceptive decisions were messy.

This study also found that the male and the female in a sexual relationship have different roles in the decision process.

Boys as the responsible party for condoms

Young men in MG2 explained that condoms were a male-dependent contraceptive method and that pills were a female-dependent choice. They perceived it as normal that each gender had a gender-specific method: the young man carried condoms and the young woman carried pills.

Niwat:	It's easy to carry condoms. But for boys.
Sansanee:	What's it like?
Fluk:	It's normal for boys carrying condoms, it's strange if a boy carries pills.
Sansanee:	If a girl carries condoms?
Bass:	It's like a boy carrying pills, strange.
Niwat:	In school exhibitions, health educators suggested boys carry condoms, not pill.
Fluk:	If a girl carries condoms, it is like, *ran* [promiscuous]. Is she *ran* [promiscuous]?
Niwat:	She looks like **being ready** [speaking loudly] to have sex.

Most of sexually active boys in this study took the main responsibility for seeking for free condoms or buying condoms. For example, Allan, a sexually active male participant from the vocational college, believed that females were not expected to carry condoms or pills. He had never asked his girlfriend to prepare condoms.

Tey, a non-sexually active girl, also agreed boys should seek for free condoms or buy condoms. She confirmed that she would not have sex if her boyfriend did not bring condoms. From Tey's perspective, it could imply that girls were not expected to carry condoms. However, four female participants including Orm-am (non-sexually active), Bew (sexually active), Tien (sexually active) and Fon (sexually active) did not see that carrying condoms was only the male's responsibility. They had similar and positive views on females who carried condoms. They contested that "it's good for the girls to carry condoms, because they know to protect themselves". Surprisingly, sexually active girls in this study such as Fon and Bew helped their boyfriends seeking free condoms.

Girls initiate talk about condoms

Most of the participants explained that before having sexual intercourse the girl was likely to be the first person who spoke about contraceptives, particularly condoms. For example, Gice explained in MG3.

Sansanee: Between the boy and the girl in a relationship, who will be the first one who thinks about condoms and talks about condom first?
Gice: Females.
Sansanee: Why?
Noot: Perhaps, they are afraid of getting pregnant, and they are also afraid of diseases.

Like Gice, Fang and Yim, FG2 participants, expressed the role of the female as the initiator.

Sansanee: Normally, how do Thai teenagers protect themselves from unwanted pregnancy?
Fang: Girls have to be more conscious.
Yim: The girls will be more concerned about preventing pregnancy than the boys.

Only one MG3 participant (Gice) explained that, after his girlfriends had talked about condoms, he followed their requests to use condoms without any hesitation. He had always applied condoms with his two former girlfriends.

Gice: I stopped my relationship three years ago.
Sansanee: Had you ever asked for no condoms?
Gice: No, I was afraid of pregnancy.
Sansanee: So, you had to follow your girlfriends' wishes?
Gice: I had to follow [them]. If I didn't follow [them], I wouldn't have had sex with them.
Sansanee: Have you ever begged?
Gice: I haven't. If she said something, I had to follow that thing.
Orm: Girlfriends could force their boyfriends.
Gice: Girls are so fierce, and they can scold their boyfriends.

It seemed that young male participants witnessed females asking for condoms, and then felt that it was the responsibility of the female. Then, they expected the female to perform as the initiator. Boom, a male participant in MG3, had been conditioned to accept condoms as the status quo.

Actually, I know whether I have condoms or not before going to see her. I don't have to talk anything. In that situation, my girlfriend will ask me again about condoms.

Boys prefer not to use condoms

Many sexually active male adolescents tried to negotiate with their girlfriends for no condoms. The reasons for "riding bareback" included the lack of sexual pleasure when wearing *tung*. After the male won the negotiation, the withdrawal method was likely to be agreed upon as the contraceptive method of choice.

> I told her I had no condoms, but actually, I had condoms in my pocket. I asked her for no condoms. It's hard to reach that point [orgasm] with condoms. Hmm [pause] we had sex. That's it … But I couldn't have *tag nai*, I had *tag nock* (withdrawal).
>
> – Allan, male, vocational college, interview

Boom explained further during MG3 discussions.

Sansanee:	From what I have heard from you say, you seem to listen to your girlfriends.
Allan:	Yes, you guys don't have a brave heart.
Sansanee:	Boom, how about you? Is it hard to make a decision?
Boom:	No, if I have condoms, I will use condoms. If I have no condoms, I won't use condoms.
Gice:	Your rule, isn't it? Boom?
Boom:	Actually, I know whether I have condoms or not before going to see her. I don't have to say anything. My girlfriend will ask me again about condoms.
Sansanee:	If you don't have condoms?
Boom:	I won't release inside.

One participant (Yim) in FG2 also shared a story of her close friend, who was very submissive and could not say "no" to her boyfriend. Although the withdrawal method was used, her close friend was still afraid of an unplanned pregnancy.

Sansanee:	What did they normally use?
Yim:	Condoms.
Sansanee:	Did they buy condoms for themselves?
Yim:	Yes, they did.
Fang:	But my friend did not use condoms.
Sansanee:	What did they do?
Yim:	*Tag nock* [withdrawal method]
Sansanee:	Weren't they afraid?
Yim:	My friend was afraid. She told me that in the first sexual session they used condoms, the second session, yes for condoms. The third [pause] yes. But the fourth, they did not use condoms.

One girl (Ice) reported using condoms every time she had sex. She formed the rule "no condoms, no sex". Although she was very strict with this rule, she accepted that her boyfriend used to negotiate with her about not using condoms in order to enhance his sexual pleasure. She refused, and argued that "as much as I love my boyfriend, I have to think of my future". She convinced him to consider his future and to weigh up the risks and benefits between sexual pleasure and a good future. Finally, her boyfriend agreed to use condoms.

Girls may allow for no condoms

Allan, a male participant, also shared his story that sometimes his ex-girlfriend allowed him to have sex without condoms and did not even ask about withdrawal methods. He felt he had to be sure of her decision by asking her again.

Allan:	With my ex, sometimes she asked me not to use condoms. Really, Auntie [Sansanee]. With my ex, I followed her demands. Sometimes, females ask for no condoms. She said that I didn't have to use condoms.
Sansanee:	What did you do then, Allan?
Allan:	I then followed her. But I asked her again: really, no condoms? In case, she was just kidding me. Then, she said yes. Alright, Auntie [Sansanee]? I said yes too.

Although Allan was allowed to have sex without condoms, he did not know whether or not his girlfriend used other methods such as periodic abstinence or ECPs. He said bashfully that sometimes he did not use condoms, and sometime he did not even withdraw early.

One male participant said that if his girlfriend willingly allowed unprotected sex, he would opt for unprotected sex without any hesitation. Then, ECPs were likely to be the next choice.

Sansanee:	James, if you are in a situation in which you are going to have sex with your girlfriend, then you realise that you have no condoms. What are you going to do?
James:	I will ride a motorbike to a 24-hr convenience store and buy condoms if she won't let me have sex without condoms. But if she lets me have sex without condoms, I will follow my feelings. Then, talking after having sex. [Pause] I will go to buy emergency contraceptive pills.

I found that the ECPs were most likely to be used when female youth were worried about bareback sex and the failure of early withdrawal.

> I used *tag nock* at that time, but she was still worried that I couldn't get it right. Her face told me so. I rode my motorbike to a pharmacy and bought a box of emergency pills for her.
>
> –Noot, male, vocational college, interview

When adolescent participants had unprotected sex, feelings of relief would arise after the female sexual partner menstruated, or after a negative pregnancy test result. However, it seemed to me that they were likely to be caught in this anxious loop again and again.

5.5.3 Contraceptive decision after having abortion

Stories about abortion emerged unexpectedly. Abortion was viewed as a strategy to prevent unplanned pregnancies, but it involved loss of sexual and reproductive health and rights. Participants changed the way they made contraceptive decisions after abortion in two different ways.

Abortion with parental permission

Participants related stories that a decision was often made by parents, instead of adolescents, when unwanted pregnancy was acknowledged by the mother and father, and later, terminated legally. Subsequently, parents were likely to ask their adolescent children to use hormone implants. No participants in this study had ever been in such a situation, but two female participants were witnesses to friends or cousins who had been forced to abort and thereby lost their contraceptive decision-making authority.

Tien, a female participant, told a story of her friend who had had sex with at least two young men she met on the Internet. Tien's friend (Mai) felt unsure who the father of her baby was, and she came to Tien for advice. Tien decided to talk to her mother. Tien's mother conveyed the message to Mai's mother. Then, Mai was sent to a youth-friendly clinic for a legal abortion. This abortion was not the first abortion for Mai, and her mother knew this truth. To prevent another pregnancy, a 5-year hormonal implant was chosen for her. This decision was made by her parents.

Orm-am also shared a similar story of parents being in charge. The truth about her cousin's pregnancy was disclosed when Orm-am's aunt found that the household usage of sanitary pads had decreased. A subsequent discussion about pregnancy out of wedlock between parents of the two teenagers was organised. Abortion was the final

decision of the two families, because the two youth were considered as too young to have a family. After the abortion, the young woman's mother took her to a doctor for a hormone implant to prevent the recurrence of unplanned pregnancies.

Secret abortion

Tien, a young woman from the vocational college, had once self-attempted abortion by mixing five sachets of *tum jai* (containing 650 mg of aspirin per sachet) and vodka. This attempt nearly cost her life. She was admitted to an emergency unit because of severe bleeding. After her hospitalisation, she did not decide on a LARC method such as hormone implants, IUDs or contraceptive pills. Male condoms remained her choice. However, she stated that her fear of the bleeding from the technique for abortion led her to convince her boyfriend to use male condoms.

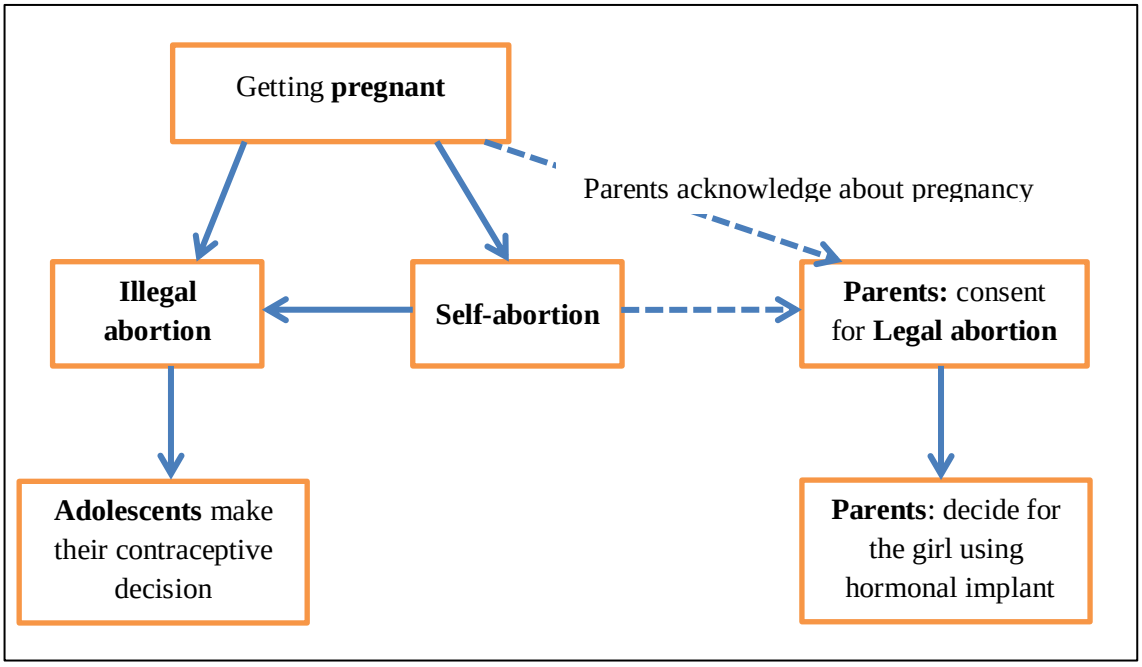

Figure 7: Contraceptive decision after having abortion

5.5.4 Contraceptive decisions after drunken sex

Having sex when drunk meant no conversation about contraceptives occurred, according to study participants. In such instances, as two participants revealed in this study, the female was expected to take responsibility. Emergency pills appeared to be the only choice.

Ben, a male studying at the vocational college, said that alcoholic drinks could increase his sexual drive. Once, he got drunk and rode his motorbike to his girlfriend's place.

After having unprotected sex with her, Ben came home and slept at his house. A day after that, he realised that his girlfriend had not had any ECPs. He started worrying. He told his girlfriend to take ECPs as quickly as possible.

Another story was from Bee, a female participant studying at the upper secondary school. Bee did not experience drunken sex directly, but she related a story from her 16-year-old female cousin, Dang. Dang engaged in unprotected sex when she was drunk. Dang was afraid of getting pregnant and of being judged as a bad person by her mother who also got pregnant during adolescence. She asked a "lady boy" friend, who was unlikely to suspect when buying hormonal pills, to go to the pharmacy and buy ECPs for her.

In brief, decisions about contraceptives appeared be consistent when the couple discussed the issue before starting a sexual relationship, and when both of them had a strong commitment to use the chosen method. When one or both were drunk, no conversation about contraceptive use occurred. In such a situation, the female was likely to take ECPs. The decision was likely be very complex, however, when no discussion before initiating sexual activities occurred. In these cases, when negotiations just before sex were entered into, the genders took on various roles in initiating a talk about condoms, negotiating for condoms or for no condoms, and in taking responsibility after having sex without protection.

5.6 Chapter Summary

Although adolescents in this study understood Thai traditional parental expectations to be good children, and to take responsibility for their studies, go to university and get well-paid jobs, they were also striving for modern style independence, a separate social identity and intimate relationships.

A sexual relationship was considered acceptable to most participants, as long as pregnancy did not result. Generally, pregnancy was seen as a mistake or problem resulting in punishment and a dark future. Most participants also thought pregnancy was the females' risk and shame. However, one male saw pregnancy as normal for his age group (he was 18 years old) and not as a life-threatening condition.

Despite some participants making contraceptive decisions before initiating sexual relationships, most choices adolescents made appeared to be impromptu and psychosocially dependent. Decisions were likely to happen just before sexual

intercourse. Condoms were well known as a method in preventing unplanned pregnancies, and were likely to be chosen in preference to other methods. However, negotiations to have unprotected sex were often initiated by sexually active young men. Instead of condoms, withdrawal was likely to be used when the female lost the negotiation round. Emergency pills were sometimes used in case early withdrawal failed, or participants were worried it had failed.

In situations involving alcohol, there was no communication about contraceptives and emergency contraceptive pills were the contraceptive of choice. The young woman was likely to be expected to take responsibility.

These adolescents revealed that once pregnancy out of wedlock was discovered they had no authority over whether pregnancy was terminated. Parents were then in charge as the main decision makers and also over the future contraceptive choices. Hormone implants, a long acting reversible contraceptive method, were the parents' contraceptive of choice for preventing another pregnancy.

CHAPTER 6. **Findings 2: Influencing Factors on Contraceptive Decisions**

6.1 Chapter outline

I address what factors influence Thai adolescents' decisions on contraceptive use in this chapter. Several themes emerged from my data analysis. I found that some of the themes were commonly mentioned by both genders, but other some were found among male-only and female-only groups. The major factor, which mentioned by both genders, was fear of negative consequences of pregnancy. This factor was later divided into two subthemes according to the underlying reasons for this fear, as expanded in Section 6.2: Gender-neutral factors. In this section, three other common factors also emerged. Only one factor of girls' negotiation skills was identified by the researcher independently of the participants. Two significant themes were noted by the young men I interviewed. So, I separately placed these two themes in Section 6.3: Male-specific factors. The last section (6.4: Female-specific factors) shows the cultural considerations of the young women participants, as they described how decisions about contraceptives and contraceptive use were made, in their own words. Unexpectedly, complicated factors affected one girl who co-habituated with her boyfriend. As shown in Table 9, all of themes and subthemes I will illustrate in this chapter are summarised.

Table 9: Factors influencing contraceptive decisions mentioned by participants

Influencing factors	The boys	The girls
Fear of the negative consequences of pregnancy:		
Burdening parents	✓	✓
Being punished	✓	✓
Knowledge about contraceptives	✓	✓
Accessibility to and affordability of contraceptives	✓	✓
Female negotiation skills	✓	✓
Female seniority	✓	×
Fear of HIV/AIDS	✓	×

Influencing factors	The boys	The girls
Fear of being in social and financial difficulties	×	✓
Fear of being unable to fulfil cultural expectations	×	✓
Cohabitation	×	✓

6.2 Gender-neutral factors

Gender-neutral factors evident in the data analysis were 1) the fear of negative consequences from unplanned pregnancies; 2) existing knowledge about contraceptives; 3) accessibility to and affordability of contraceptives; and 4) females' negotiation skills.

6.2.1 The fear of negative consequences from unplanned pregnancies

Most participants agreed that fear of pregnancy led Thai adolescents from both genders to take action to prevent pregnancies. I was interested in the fact that many methods including abortion could be applied to prevent unplanned pregnancies. However, interviews and focus group discussions revealed that only three contraceptive methods were used. Findings showed that some young people opted immediately for condoms and that some females chose contraceptive pills instead of using condoms. From the data analysis, fear of pregnancy can be categorised into two subthemes according to causes of the fear, presented below.

Burdening parents

Most study participants were financially dependent on their parents. They reported that their parents would be the ones who would have to give them financial support to raise a baby if the female got pregnant. In MG1, for example, Orm emphasised that a baby would impose a big financial burden on his parents.

> Orm: If [our girlfriends got pregnant], we couldn't continue our studies. Really, we want a [good] future. We would have to drop out of school to look after our baby.
>
> Youth research assistant: Why wouldn't you ask your parents to look after your baby instead and come back to school?
>
> Orm: Asking that would make my parents get into more troubles. They would be very tired from looking after the baby.

Two female participants, including Bee (a non-sexually active young woman) and Bew (a sexually active participant), shared their similar views.

> No jobs, no money. [Adolescents who have a baby] have nothing to raise their babies. Finally, they will go back to parents. In order to [pause] But doing this will make parents in difficulties again. Instead of looking after parents, these teenagers become a burden … more and more.
>
> –Bee, female, upper secondary school, interview

> That is, we. We are young, aren't we? If we got pregnant. [pause] We would burden our parents more than usual. We heap more burdens on our parents. Parents would have to look after us. They would have to look after our children too.
>
> –Bew, female, upper secondary school, interview

Having punishment

None of female participants had had first-hand experience of being punished after getting pregnant out of wedlock, but many of them had learnt about punishments meted out after the event from their friends or other surrounding them. Two sexually active female youths, Tien and Fon, reported that their female friends were hit and scolded by parents after disclosing their status. Both of them expressed fear of punishment, and motivated by that fear, they had been using condoms and contraceptive pills.

Some male participants also expressed fear of being punished by parents because of impregnating a girlfriend. Fear of punishment pushed a number of young people to use ECPs, despite the health risks.

Bass:	If we make a mistake [having sex without condoms], we have to buy [emergency contraceptive pills]. We have to think about our reason [pause] and our fear.
Sansanee:	What makes you afraid?
Bass:	Pregnancy.
Fluk:	The effects of pregnancy.
Sansanee:	The first fear is pregnancy and the second fear is?
Bass:	Being scolded.

6.2.2 Knowledge about contraceptives

All participants knew that condoms can prevent unplanned pregnancies and STDs. Tien, for example, once visited a one-day exhibition, "Stop Teen Moms", where health educators told her and her friends to use condoms to prevent unplanned pregnancies, and taught them to put condoms on a penis model.

> I remember how to wear condoms [laugh]. First, I have to do this [Tien pretended to pick a pack of condoms and tear]. Then, tear the plastic package and then hold here [a corner of the package]. [Laugh].
> –Tein, female, vocational college, interviews

However, it was clear from the data analysis that great knowledge about condoms did not guarantee that adolescents would use them consistently during sexual intercourse. Two sexually active male participants considered their financial situation before buying condoms, although they knew about the benefits.

> Before I went to my girlfriend I knew whether I had condoms or not. If I had no condom, I would not use condoms with her.
> –Boom, male, vocational college, MG3

> If I had no money to buy condoms, I would not use condoms.
> –Noot, male, vocational college, interview

All the teenagers I spoke to acknowledged the potentially high failure rate of withdrawal method. Although they knew that condoms were more effective than withdrawal, knowledge about failures of the pull-out method did not stop them from having unprotected sex.

> Some people used hormonal injection because *tag nock* [withdrawal method] cannot give 100% prevention.
> –Orm, male, vocational college, MG3

> If I use *tag nock* [withdrawal method], liquid [semen] might come out unintentionally and I didn't know about when it came out. Then, I will impregnate my girlfriend. But, I still use *tag nock*.
> –Boom, male, vocational college, MG1

> If I am in a romantic mood, I follow my sexual instincts. I have had sex without condoms. I released [semen] outside. Nothing has happened so far.
> –Allan, male, vocational college, MG1

Only one female participant questioned the effectiveness of the withdrawal method. Ice always insisted her boyfriend use condoms.

> If he doesn't listen to me [to use condoms]. But [pause] he has to obey. *Tag nock* [withdrawal method] is not safe.
>
> –Ice, female, vocational college, interview

Noot (a male) knew the dangers of early withdrawal, and he worried about his failure to use condoms. He went to a pharmacist and bought ECPs for his girlfriend after unprotected sex.

> After we had sex [pause] for a while it was ok, on the same day. Then, I was afraid and more afraid. It::: If a mistake happened. I thought about that, then I went to buy emergency contraceptive pills for my girlfriend.
>
> –Noot, male, vocational college, interview

Most of young people in this study had indicated some knowledge about the effectiveness of contraceptive pills. Clearly, misinformation about contraceptive pills also influenced them. Many female participants believed "the pill" could cause infertility and having twins. Fear of these misinformed side effects of birth control pills surfaced in an FG1 dialogue.

Sansanee:	When they have sex, what kinds of methods they use to prevent unwanted pregnancy?
Fang:	Condoms, the easiest.
Yim:	Then, emergency contraceptive pills.
Fang:	Yes, emergency contraceptive pills
Yim:	Yes, leave it about 6 hours or 12 hours and take another tablet. My friend told me that she left it about 6 or 12 hours before taking another tablet.
Fang:	Twelve hours.
Yim:	It is the best preventive method.
Fang:	But it is dangerous. Taking these tables probably lead to infertility.
Yim:	Every contraceptive pill has this kind of effect?
Fang:	No.
Yim:	Frightening, then we will get twin. Those who have sexual relationship should protect themselves by not using emergency contraceptive pills.

Surprisingly, this misinformation about the adverse effects of birth control pills led one female participant to use condoms consistently.

> I won't take hormone contraceptive pills. I heard that. I don't know if it is correct or not. That is, if we take these pills for a long time. There will be drug residues in our body. These residues could make us

> infertile. I decided not to take these pills and to insist on condoms.
> –Ice, female, vocational college, interview

Only a male participant considered about contraceptive pills. He believed that contraceptive pills would endanger his girlfriend and other females who took the pills. However, he could not specify what he meant. He suggested that men should take responsibility to use condoms because, in Thai society, men are taught to protect women.

> Ask females to have pills? They [pills] are not good things … they endanger females if females have to take them over a long period. Males should use condoms to prevent unplanned pregnancies. Males [pause] we are gentlemen.
> –Fluk, male, upper secondary school, interview

In this study, misconceptions about contraceptive pills affected adolescents and caused them enough angst that in some cases, they might choose not to use hormone-based pills to prevent unwanted pregnancy. However, when particular adolescents were frightened of the supposed adverse effects of the pill, they were likely to choose condoms, which gave them the added advantage of protection from STDs.

6.2.3 Accessibility, affordability and quality of condoms

Contraceptive uptake by young people can be affected by accessibility, affordability and the quality of the item. As noted by participants in Chapter Five, "How Contraceptive Decisions are Made", it was far more acceptable for males to carry condoms than for young women to be seen with them. In fact, in the current project, the accessibility, affordability and quality of condoms affected male adolescents far more than the female.

The accessibility of free condoms

In addition to school exhibitions and the health education campaigns, Thai teenagers in Khon Kaen could get free condoms at school and at many other locations. In this study, condoms were provided by the school nursing units at both the upper secondary school and the vocational college. Surprisingly, none of participants from these two settings mentioned the availability of condoms at their schools. They might have known but ignored the source. Or, they might not have known about the provision of free condoms by the school nursing unit.

At the time of the study, free condoms were also available from government health care clinics including primary care units and hospitals. The opening hours of these services were normally between 8.30 a.m. and 4.30 p.m. Monday to Friday, similar to school hours. Therefore, the majority of young people who studied at school were unable to freely access these services.

Koko: At the primacy care unit, condoms are cheapest. Because they are **free** [speaking loudly].
All of participants laughed.
Fluk: As a box of condoms [100 condoms], as a package. One box of condoms can be used for a year.
Sansanee: Condoms at the primacy care unit are free?
Fluk: Yes, **free** [speaking loudly]. But then there are the opening hours. But some teenagers choose to go there. I think teenager won't generally go.

Mac, a male participant from the upper secondary school, reported that Thai adolescents had to sign on the reporting documents when they asked for free condoms at government healthcare services. He anticipated such action might hinder young people to go there for free condoms.

No sexually active male participants had ever gone to ask for free condoms at a primary care unit. Only one sexually active female participant, Fon, had once gone to ask for free condoms at a primary care unit close to her college. She and her friend went there during her lunch break. Fon was refused by a health practitioner because, apparently, the staffs were going to have lunch.

Fon: I told her [the staff member] that I had come for free condoms. She told me that this primary care unit had run out of condoms, no condoms. Kind of. She told me again '**no condoms**' [speaking loudly] and reasoned that the health practitioners would have to have lunch. Then, she asked me to go to another place.
Sansanee: So, they ran out of condoms and asked you go to another place?
Fon: I saw many patients waiting there. I thought, why they have lunch while all the patients were waiting there? Kind of [pause] I thought she didn't want to give me condoms. [Pause] And then, she stared at my face. She repeated that there are no condoms and it was nearly lunch time. She added that I should not come for condoms at the lunch time and asked me to go to another place.
Sansanee: Hmm. And then?

Fon: She drew a map for me. She used a big size of paper but she drew only a small map for me. I followed the map but I could not find any of the places she suggested I should go. [Laugh]. The paper is as big as this [opened her arms wide] but the map was very small [Fon used her thumb and index to show how small it was].

The cost and quality of condoms

The price of condoms can be a significant issue for many male participants. Interestingly, only a few females expressed their concern about the price. Fang, a female participant in FG2, described the expectation that males would buy the condoms — "males will go to buy condoms". Allan reiterated in in-depth interview that "it's not good to ask my girlfriend to buy or carry condoms".

Most participants said that condoms were expensive for young people, particularly when they had to buy condoms from 24-hour convenience stores. A box of three condoms cost about 30–50 baht (1–2 NZD). Ben, a male participant, mentioned in a discussion group that it would have been much more affordable if the cost of a box of condoms at convenience stores had been about 30 baht or less.

One male from vocational college and two female participants from the upper secondary school noted that condoms sold at pharmacies were cheaper. Therefore, a pharmacy was the first choice supplier for them and their sexually active friends.

Noot: Um … They [condoms] are not expensive when you buy them from drug stores. Forty baht per box [three pieces].
Sansanee: I saw 70 baht for a box [three condoms] at 7Eleven.
Noot: [the price of condoms] depend on each store. But at the drug store I went to buy condoms, they were 40 baht and 60 baht a box.

The cheapest condoms could be purchased from condom vending machines, but the quality was poor. Most male participants mentioned in FGDs that condoms from a vending machine were the cheapest, at 10 baht per box (three pieces). However, they complained about insufficient vending machines and unanticipated variation in condom sizes. Poor quality rubber was easily the biggest complaint, because the young men were afraid that such low-quality condoms could be easily broken.

The price of condoms obviously influenced Noot to choose the withdrawal method.

Noot:	Sometimes I have no money. I won't buy condoms.
Sansanee:	You mean that you won't buy condoms at a drug store?
Noot:	No, I meant I won't buy condoms from any drug or convenience stores.
Sansanee:	What will you do if you really want to have sex?
Noot:	I won't use condoms. [Pause] I will use *lang nock* [withdrawal method] instead. Sometimes I feel worried that I cannot pull out in time.

Although most participants agreed about the high cost of condoms, one sexually active male participant, Ong, saw the price of condoms as reasonable. He bought condoms for himself and ECPs for his girlfriend. Ong shared his views in group dialogues.

Sansanee:	Ong, can I asked you directly? It [the question] may be too sensitive. If you don't want to answer, that's fine. What kind of contraceptive methods do you use to prevent unwanted pregnancy?
Ong:	I used condoms and emergency contraceptive pills.
Sansanee:	You used condoms [pause] when do you use emergency contraceptive pills?
Ong:	After I had sex.
Sansanee:	But you had already use condoms?
Ong:	Yes, but I asked her to take pills, too.
Sansanee:	In this case, you have to pay for two things, condoms and pills?
Ong:	[Ong nodded].
Sansanee:	You paid for two methods.
Ong:	They were not expensive. One was 50 baht. All together was 100 baht.

6.2.4 Female negotiation

In the current work, the female became the critical factor in the choice to use or not to use condoms. The negotiation skills of the female in convincing her boyfriend or in insisting on condoms were regarded by participants as a key influencing factor. None of the participants *directly* described females' negotiation skills as an influencing factor. I was made indirectly aware of this influencing factor when I was conducting in-depth interviews with three female participants, and again in MG3. Three female participants from the vocational college shared their experiences or perceptions on sexual negotiation. I found that they negotiated with their boyfriends by using two main "scare tactics".

Scare tactic one: concern on their future

Ice, a sexually active teenager studying at the vocational college, always used condoms when she had sexual encounters with her boyfriend. Sometimes, she was asked by her boyfriend to have unprotected sex. She started the negotiation with a question. She asked her boyfriend to weigh up his desire for sexual pleasure and the negative consequences of pregnancy on their futures.

> I told my boyfriend that [pause] choose! That [sexual pleasure] and your future!! The whole of your life? I asked him like this.
>
> –Ice, female, vocational college, interview

Scare tactic two: concern for bodily integrity

As discussed in the "Thai sexual culture" section in "Chapter Two: The Thai Context", the term *dai sia gan* and *sia tua* can imply that, in a sexual relationship, women/girls are likely to "lose" their bodies to men/boys. No young women I spoke to used the terms *dia sia gan* or *sia tua*. However, the term *hai* (give or allow), and the negative from, *mai hai* (to not give, or not allow) were used by female participants. Although there is no literal explanation for using *hai* in the context of having sex, *hai* in this sense could refer to the young woman allowing her boyfriend to use her body for his sexual pleasure. Ice talked about her bodily integrity and used the term *mai hai* (to not allow, not give) to condition her boyfriend to use condoms.

> If you asked me whether he used to request unprotected sex, my answer is that yes, he used to request no condoms. But I *mai hai* [didn't allow] [paused] If he had no condoms, we had no sex.
>
> –Ice, female, vocational college, interview

Surprisingly, a non-sexually active girl (Tey) would say *mai hai* if she was asked to engage in unprotected sex.

> I won't *hai* (let) him, kind of, do anything with me [my body] if he has no condoms and doesn't use condoms.
>
> –Tey, female, vocational college, interview

In this study, one female considered her bodily integrity and used this point to negotiate with her boyfriend to use condoms. Tien had once self-attempted abortion. This attempt nearly caused her to die. Tien reminded her boyfriend about the incident and asked him to use condoms.

> He knew about my abortion self-attempt and my admission [to hospital, because of bleeding from talking 5 sachets of aspirin and a half glass of vodka]. He knew. [Pause] He was worried, and then he used condoms.
>
> –Tein, female, vocational college, interview

Some male participants indirectly described negotiations. In MG3, Gice and Orm would not talk directly about negotiating with their girlfriends. However, similar to the other females who described their negotiations, Gice's girlfriend and Orm's girlfriend used ownership of their own bodies to negotiate with Gice and Orm to apply condoms.

> I had to follow her [to use condoms]. If I wouldn't follow her, she would *mai hai* [not allow] me to have sex with her.
>
> –Gice, male, vocational college, interview

> Sometimes, I asked for no condoms. But [pause] she didn't agree. She *mai hai* [didn't allow] to have sex with her. Then, I had to use condoms.
>
> –Orm, male, vocational college, interview

In brief, four key influencing factors commonly shared by male and female participants were: 1) fear of the negative consequences of pregnancy; 2) knowledge about contraceptives; 3) the quality, accessibility and affordability of condoms; and 4) the negotiation skills of the female. In next session, male-specific factors will be presented.

6.3 Male-specific factors

Apart from influencing factors that affected both genders (see "Gender-neutral factors"), males had other considerations when they made their contraceptive choices. These influencing factors included seniority of the female in a relationship — directly related to female negotiation skills — and fear of HIV/AIDs infections.

6.3.1 Seniority of the female

Life with older girlfriends was unexpectedly mentioned by four males in MG3. Two used to have sexual relationships with older sexual partners. Only one of them (Boom) was fully aware of the effect of having an older girlfriend on the way a decision was made about contraception. Boom would fulfil his girlfriend's request to use condoms without argument. Boom reasoned that his girlfriend was older than him. Therefore, he had to listen to her.

Sansanee: Older girlfriends? How's that?
Gice: Um [pause] Boom, tell Auntie Sansanee about your experience.
Boom: I talked with her [my girlfriend] first. If she told me to use condoms, I would use condoms.
Sansanee: That means she would be the one making the decision?
Boom: Yes. But, I asked for no condoms first. If she didn't let me having sex without condoms, I would go to buy condoms at a convenience store. [I was] lazy.
Sansanee: Why?
Boom: I don't know. She was in the higher class. She was older. We had to obey ***phi*** [the senior person].

Boom did not explain further how he behaved with *phi* [the senior person]. According to Thai culture, as mentioned in "Chapter Two: The Thai Context", Boom's behaviour seems to imply that he felt he had to show his respect to his older girlfriend by obeying her.

Other sexually active boys (Noot, Ben and Ong) also had older girlfriends. Noot and Ben said that they were more likely to listen to and follow the ideas of their girlfriends. According to their experiences, older girlfriends were more likely to give advice about using condoms, to pay for ECPs and were likely to know more about contraceptive pills.

> Condoms, I would be a condom seeker. But the older girlfriend [pause] or [emergency contraceptive] pills, [pause] she would buy them. She paid for them herself. But with a younger one, [pause] sometimes I had to pay.
>
> –Ben, male, vocational college, interview

> Comparing between older and young girlfriends, the older one knows more about how to prevent unwanted pregnancies and diseases. She suggested to me to use condoms while the younger one said nothing about prevention.
>
> –Noot, male, vocational college, interview

Ong, a sexually active participant studying at the upper secondary school, had a girlfriend who was only one year older than him. He observed that having an older girlfriend had no impacts on his ability to make the decision about contraception. Unfortunately, he was unable or unwilling to explain further. Possibly, the one-year age difference was too small to have an impact on negotiations.

Sansanee:	How about having an older girlfriend and contraceptive use?
Ong:	Contraceptive use?
Sansanee:	I heard from someone else that he had to obey his older girlfriend to use condoms because his older girlfriend advised him to do so. How about your situation?
Ong:	Um [pause] Um, I don't think the age difference affected me. She was only one-year older than me.

Interestingly, although many sexually active male participants in this study were older than their girlfriends, they had no concern about their own seniority in making decisions about contraception.

6.3.2 HIV/AIDS infections

Successful interventions have reduced the annual new HIV infection rate in Thailand from 143,000 in 1991 to 10,853 in 2010 (WHO, 2017c). While the general infection rate is decreasing, the number of *young people* who live with HIV/AIDS is not. Approximately 9,600 adolescents in Thailand are living with HIV/AIDS, and 22% of them have confronted HIV/AIDS-related social discrimination (UNICEF, 2015a).

However, in the current research, only one male confirmed that his fear of HIV infection led him to use condoms. Gice learned from a drug abuse campaign about the consequences of HIV infection. He explained that, to him, HIV/AIDS was a matter of life and death, and unbearable social stigma and discrimination. Because of his fear, Gice used condoms every time he had sex. He also used condoms because of the fear of impregnating his girlfriends. Compared to death from HIV/AIDS, for him, however, impregnating a girl was a much less critical issue. Thus, he gained the dual benefits of HIV/AIDS/STD prevention and pregnancy prevention.

6.4 Female-specific factors

Contraceptive decisions made by young Khon Kaen women were also affected by gender-specific considerations. These influencing factors included fear of physiological and socio-economic difficulties; fear of being unable to complete cultural expectations as the firstborn daughter; and complicating factors arising from cohabitation.

6.4.1 Fear of being in social and financial difficulties

Of particular interest, many female participants believed that pregnancy was particularly hard for adolescent mothers. In contrast, none of the male participants contemplated the

difficulties of being an adolescent father. In a female group, Yim and Fang expressed their beliefs about being at a disadvantage: "girls get pregnant but boys cannot get pregnant". Pregnancies were believed to place a greater burden on the adolescent mother than on the adolescent father. The woman was seen as the one who carried through the pregnancy and endured the pain of labour, and who dropped out of school to look after her baby at home. These burdens were perceived as not being shared by males.

The financial burden of looking after a young infant was the most serious concern to the young women I interviewed. Fon, who had been sexually active, had learned from four of her close friends and a cousin. She acknowledged that pregnancies could cause difficulties to teen mothers who were financially dependent on their parents or on the parents of their husbands. Fon also talked at length about the burden of motherhood, which in her eyes involved constantly looking after a young infant, being sleep deprived and feeling exhausted.

> My friends kept on complaining about not having money because they didn't work. They had no idea about how to raise children without money. I am afraid of being in this difficult situation. My cousin also got pregnant when she was 14. She gave birth to a baby girl. I asked her about her life after she had the baby. At night time she could not get enough sleep because her baby cried all night long. I think it would be exhausting [local language].
>
> –Fon, female, vocational college, interview

Num, a sexually active female participant, recalled how badly her female friends were treated by local villagers. She did not want to be in such a situation. She did not want to be in a situation where she had to raise her baby on her own without any help from the father of her baby. Num questioned males' fidelity and willingness to take responsibility as teen fathers.

> Num: I heard some boys say that if they had a baby they would raise the baby. Sometimes [pause] I think boys only say this to gain trust from his girlfriend [pause], but in reality, they wouldn't accept that responsibility. I have seen this in many cases.
>
> Sansanee: Where did you see it?
>
> Num: In my village, many boys impregnated their girlfriend. Then, they started a new relationship with a new girl. I saw many people surrounding me be like this. I am

afraid [pause], so I always insist that my boyfriend uses condoms.

This description shows a fear of a lack of involvement by male adolescents in looking after a baby and a lack of companionship between male and female adolescent parents. Fear of being in social and financial difficulties on their own affected some female adolescents, who then felt they must insist on some kind of contraceptive method.

6.4.2 Fear of an inability to fulfil culture expectations

In interviews, Ice and Num described what their parents expected them to do as the oldest daughter in the family, and the responsibilities that they had to accept in looking after their parents and siblings. Being a firstborn female child was reason enough for Ice and Num to insist on condoms for pregnancy prevention. Interestingly, such views were not shared by male participants who were also the firstborn children, namely James, Allan, Orm and Nat.

As shown in the interview notes below, Ice believed that pregnancy during her adolescence could stop her from fulfilling her responsibilities as a firstborn daughter.

Sansanee: Apart from seeing your friend having a baby, do your parents influence you?
Ice: Parents?
Sansanee: Have your parents said anything about a girl getting pregnant out of the wedlock?
Ice: There have been no words from my dad and my mom. But [pause] How could I explain? I think if I got pregnant during this time [pause] I would [pause] I am the first child of my family. Do you know? My mom [pause] would [pause] kind of. I think I should not have a baby.
Sansanee: You are the eldest aren't you? Being the eldest what had been expected from you?
Ice: I think [pause] I must look after my mother, and my sister is very young, only 5 years old.

Like Ice, Num also believed that any unplanned pregnancy during adolescence would make it very hard to fulfil her duty as the eldest daughter. She recognised the expectations from her parents to finish her studies, get a job and look after her parents and two brothers. Num, thus, forced her boyfriend to use condoms.

Num: If I got pregnant, I would have to drop out of school. Kind of.

Sansanee: Drop out of school?
Num: That is, [stay] at home [pause] I am the eldest [pause] My parents have a lot of expectations of me [pause] to look after them and my two younger brothers. So, I am afraid of getting pregnant.

Thus, cultural expectations can lead firstborn females to opt for more effective contraceptive methods, such as condoms, to prevent an unwanted pregnancy. Although daughters, whether they are the firstborn or are not the firstborn, are expected to look after their parents and/or siblings, in this study, only the firstborn females I spoke to underscored the importance of being the firstborn daughter, a situation that drove them to insist on condoms to prevent unplanned pregnancies.

6.4.3 Cohabitation as a complicating factor

Most participants lived with their parents or their extended family, and premarital cohabitation was unusual among those aged 15–19 years old. Cohabitation was mentioned unexpectedly in in-depth interviews by Fon, a female participant, and Noot, a male participant, both recruited from the vocational college. Because Noot did not explain his experience with cohabitation, only Fon's stories can be shared.

The story of Fon illustrates the complexity of decision making about contraception during cohabitation. After moving in together, Fon had to consider her boyfriend's preferences. Fon did not analyse why she had to follow her boyfriend's decisions. Yet, by living together, Fon might have considered herself as a Thai wife. According to Thai culture, a good Thai wife should obey the husband and fulfil his needs and expectations, so she might avoid the natural conflicts involved in living together. However, Fon did not mention this. Instead, Fon said the frequency of sexual intercourse increased and could happen at any time. Fon ended up taking daily contraceptive pills although she had developed some kind of allergy to a type of these contraceptive pills. However, male preference could override cohabitation as the primary influence on decisions, as can be seen by Fon' story of moving in with a second man.

Fon's story

Fon was the only child in her family. Her mother passed away when she was 10 years old. Her life after that was spent mainly with her grandmother. Fon rarely spent time with her father because he travelled around the Northeast of Thailand on business.

She wanted to have a courtship because she thought that she would be happier being a lover. Fon started her courtship with a young man called Mo when she was 15 years of age. Mo was 2 years older than Fon, and he dropped out of school. Fon and Mo decided to live together. When Fon's father found out, he stopped sending money to Fon and stopped paying for her tuition fees. Fon had to drop out of school, and she worked as a sales assistant at a street market to make a living.

Fon took contraceptive pills every day to prevent an unwanted pregnancy. Fon decided to use contraceptive pills because Mo disliked condoms. Emergency contraceptive pills did not suit her because ECPs could be taken only twice a month. Moreover, Fon had an allergy to ECPs. Contraceptive pills were the only choice for Fon.

Fon had tried different regimens of contraceptive pills. She started with a 5-baht regimen. These 5-baht regimens usually include two high-dose oestrogen and progesterone tablets. Her body reacted adversely to the high-dose hormone pills. She had a swollen face and a skin rash. Finally, she found the appropriate regimen, namely PREME, a pseudonym of a low-dose hormone regimen: cyproterone acetate 2 mg, ethinylestradiol 0.035 mg. However, she had to pay more for this regimen, a high price, about 25 times higher than the first pill she had taken. Mo never asked or offered to pay for the pills.

Fon often forgot to take the pills. She was afraid of getting pregnant. When she forgot to take the pills, she decided to take a double dose the following day. Although taking double doses might have affected her health, Fon believed that it was better to take the risk.

Fon had to work very hard to support herself and to pay for the contraceptives. She earned very little. She knew she would have earned more if she had obtained a higher educational qualification. She decided to talk with Mo about going back to study. Mo was unhappy with her decision and warned her that he would finish their relationship if Fon went back to study. Fon broke up with her

boyfriend and went back home. Luckily, Fon's father was willing to pay for Fon's tuition again if she wanted to study. Fon was sent to live with her father's mother, and she took the bus to school to study.

After Fon went back to her college, she started a new sexual relationship with her classmate Pong. One day, her grandmother found out that Fon had slept with Pong at her house. Her grandmother was furious and asked Pong's parents to arrange an engagement. Fon's friends heard about her circumstances and blamed her. After the engagement, Fon moved to live with Pong and Pong's parents. Fon and Pong continued their studies. Fon mentioned that Pong was very future-focused and did not want to have a baby before completing his degree. Condoms had been the main contraceptive method they used. Unfortunately, Fon never mentioned who decided on condom use and who paid for the condoms.

In brief, cohabitation played a crucial role in decision making about contraceptives. From Fon's story, the decision to use condoms — whether it was made by her or by Pong — might have been influenced by her past allergic reaction to contraceptive pills, her boyfriend's preference, money constraints, and/or poor drug adherence.

It is clear from interviews and group discussions that girls' contraceptive decision were influenced by their fear of being in social and financial difficulties, and that of being unable to fulfil cultural expectations as the firstborn daughter. Although only one young woman spoke about living together, female adolescents cohabiting with their boyfriends may have to take responsibility, and their decisions could be affected by health and their boyfriends' contraceptive preferences.

6.5 Chapter Summary

Numerous factors appear to influence Thai-Isan adolescents' decisions about contraception. For both genders, the major theme was clearly the fear of consequences of pregnancy such as upsetting parental expectations and its impact on their own lives. Very surprisingly, fear of HIV infection was not a major motivation for contraceptive use; only one boy mentioned this and not one girl.

Contraceptive knowledge also affected the usage. Most participants knew that condoms could prevent pregnancies, but frequently, they ignored freely available condoms.

Although these young adolescents ignored freely accessible condoms, they applied early withdrawal as a method to prevent pregnancies. Previous experiences with early withdrawal failures, or the fear of future failure, led many young people to opt for ECPs.

Physical and economical access to condoms also influenced Khon Kaen adolescents' choices. Price and quality of condoms were of concern when these young people had to pay for them. School student "unfriendly" opening hours of healthcare providers supplying free condoms were mentioned as inappropriate (community health centres open from 8 am to 4pm weekday only). Social barriers were also large. Embarrassment at engaging with health centres, pharmacy and convenience store staff hinder young people in accessing and using condoms – free or for sale.

Females' negotiation skills were seen as an influencing factor when condom use was being negotiated. Concerns about their future careers and their rights to decide about their own bodies led some young women to negotiate with their boyfriends to use condoms and to insist when the boyfriend begged to "ride bareback".

For the males, contraceptive decisions were likely to strongly influenced by an older girlfriend. Younger men would follow their older girlfriend's wishes to apply condoms.

For the female teenagers, fear of physiological and socio-economic difficulties, and fear of being unable to live up to cultural expectations, were paramount concerns that led them to insist to some kind of contraceptive method. However, complicating factors in cohabiting with a man appeared to alter the trajectory of one participant's decisions.

CHAPTER 7. Findings 3: Adolescents' Expectations and Needs

7.1 Chapter outline

In this chapter, I address Thai-Isan adolescents' expectations and needs on contraceptives and sexual and reproductive health. Several themes and subthemes commonly arose from both gender groups: male and female participants. I discuss these themes in the "Commonly held expectations" section. In this section, five subthemes are categorised according to whom adolescents expected from, including parents, family members, teachers and the grown-up in their society including neighbours, community pharmacists and other health practitioners. Adolescents' expectations are presented in the feature of 1) understanding and supports, 2) talking with family members, 3) having no judgement but encouragement, 4) maintaining privacy and confidentiality, and 5) having a good communication skill. Notably, responses of all females and most of male adolescents fell into this first group. However, a number of what I have called "male-specific" responses was voiced, and I present those in the second section of the chapter. Having a sharing and warning system for adolescents to increase awareness of using contraception was emerged in a male discussion group.

In the last section of this chapter, I present Thai-Isan adolescents' expectations and understandings on sexual and reproductive health (SRH). Because of the sensitive nature of the questions, I used drawing as an alternative way to approach group discussions. In group discussions, I first asked, "Have you heard about *sit-thi anamai chareanpan* (sexual and reproductive health and rights, SRHR)?" The immediate response I got from everyone was a blank face. Probably, it was the first time any of them had heard this term. In focus group discussion of the male number one (MG1), the male number two (MG2) and the female number one (FG1), further discussions had to wait until I briefly described the definition of SRHR: the right to access sexual and reproductive health services, obtain sex education and to freely make decisions about sexual and reproductive health. Unfortunately, because of time constraints and the consequent postponing of the second round of group discussions, I had no response from FG2. In MG1 and MG2, because I did not get many responses from participants, I

decided to use drawings first to help participants express their perceptions. To get an idea of what students were thinking, I asked them to draw their answers to the following question: "What do Thai adolescents expect or want from Thai society regarding SRH?"

With much laughing and teasing, five pictures were produced in the male groups, and four pictures were drawn by the females (Appendix C shows all drawings). Two representative pictures are shown in Figures 6 and 7, one drawn by a male and another one drawn by a female. I chose these two pictures because they best reflected most of the adolescents' expectations and needs. I added translations near each element of the picture.

The drawings showed similarities and differences between genders, as depicted in Table 10. Pictures of condoms could be seen in the pictures drawn by adolescent males and females, while "the pill" and emergency contraceptive pills (ECPs) featured in most females' drawings.

Their drawings illustrated that these young people also wanted love and understanding, which females illustrated as a gesture of heart but which males wrote in words. Sexual morals were included in the pictures created by both genders, but they were more likely to be seen in females' drawings, where sexual morals elucidated visually included depictions of abstinence, pre-planning before intercourse, use of condoms for safe sex, the negative consequences of sex and anti-abortion messages. In contrast, male sexual themes depicted were of men using condoms for safe sex and being proud to carry condoms.

Pictures from adolescent females were more likely to contain social interactions with key figures in their social environment: parents, boyfriends, friends and healthcare services, while pictures drawn by male youths concentrated on them alone. Most males' drawings featured a single man standing in the middle of the picture.

Drawing was a good strategy to facilitate a relaxed atmosphere for discussing sensitive topics. It also suited participants who were reserved, shy or quiet, or who were visual rather than verbal communicators. I took into account the limitations of drawings, however: social values/norms and sex itself (including early withdrawal) cannot easily be captured by drawings that are socially acceptable, as pointed out by participants in MG2.

Figure 8: A drawing of two female participants from FGDs

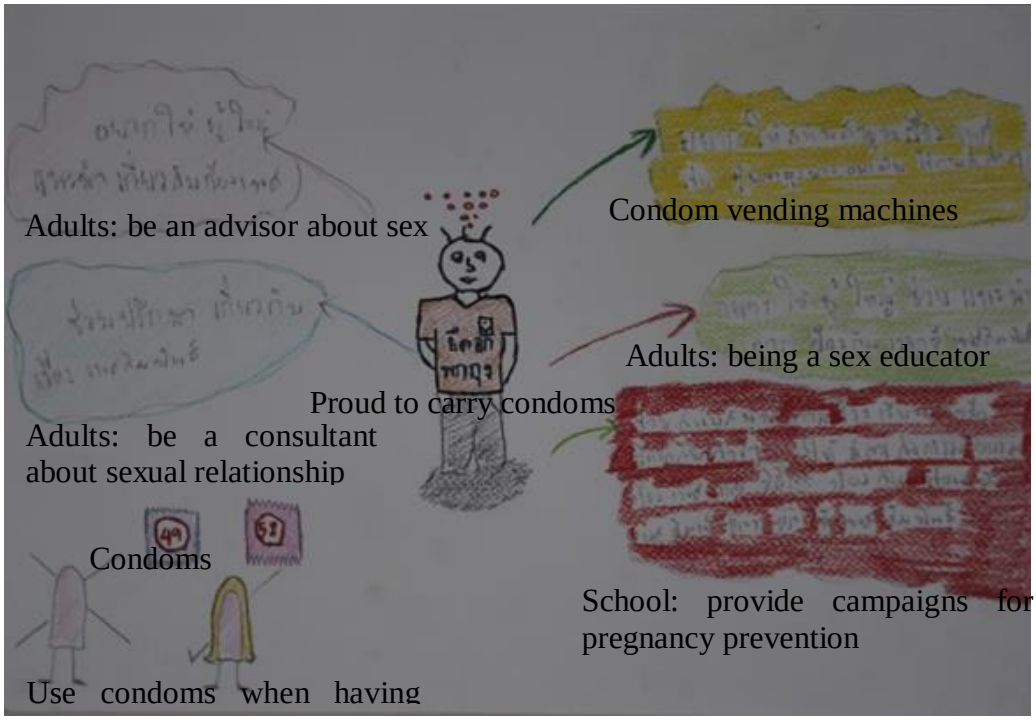

Figure 9: A drawing of two male participants from FGDs

Table 10: Summary of adolescents' expressions in drawings

Details in the drawings	Female drawings (F)				Male drawings (M)				
	F1	F2	F3	F4	M5	M6	M7	M8	M9
Expectations of parents/adults									
• Love, care and understanding			✓			✓	✓	✓	✓
• Being a consultant/ adviser	✓		✓		✓				✓
Expectations of a sexual partner									
• Intimate relationship and love	✓	✓	✓	✓				✓	
Expectations of friends									
• Being a consultant			✓						
Contraceptive services									
• At a primary care unit	✓	✓	✓	✓					
• Condom vending machines			✓						
• Youth-friendly clinics		✓							
Pregnancy prevention campaigns			✓	✓					
Contraceptive methods									
• Condoms	✓	✓	✓	✓	✓	✓			✓
• ECPs	✓	✓	✓						
• Contraceptive pills	✓	✓	✓	✓					

Details in the drawings	Female drawings (F)				Male drawings (M)				
	F1	F2	F3	F4	M5	M6	M7	M8	M9
Moral beliefs about sex									
• Proud to carry condoms					✓				
• True love can wait		✓	✓						
• Think before having sex		✓	✓						
• No abortion		✓		✓					
• Use condoms for safe sex		✓	✓	✓	✓	✓			
• Sex negatives: can bring a baby and STDs	✓	✓	✓						
Miscellaneous									
• Freedom and privacy						✓	✓	✓	
• Good futures		✓	✓						✓

Notes. Ticks show themes that appeared in each person's drawing. The numbering system (F1, F2, etc.) refers to pairs of participants. In a pair of male, two pictures were produced.
Abbreviations. F, female; M, male.

7.2 Commonly held expectations

Commonly held expectations and needs included the need for understanding and support from adults; more open conversations about sexual relationships with same-sex parents or older siblings; having privacy and confidentiality; and health professionals with good communication and interpersonal skills.

7.2.1 Requesting understanding and support from adults

Most participants wanted adults including parents, neighbours, nurses and community pharmacists to understand the realities of the modern adolescent's life and how sex is a part of it. Participants of both genders expressed the wish that grown-ups could talk openly with them about the realities of living in the modern world and how sexual needs were part of being a teenager. They wanted their elders to give them contraceptive advice. Bew (sexually active) and Fluk (non-sexually active), for example, were clear that advice was better than punishment.

> I want Thai parents to understand the world of young people. Parents should be able to talk to young people about everything. I don't want them to inhibit young people from having intimate relationships. Actually, they can't stop it. Young people will continue to have girlfriends or boyfriends. They will have an intimate relationship [pause] and have sex. I think young people want to talk to parents [pause] consult them [pause] sort of.
>
> –Bew, female, upper secondary school, interview

> Parents should give advice and explanations. Don't speak and make young people feel that they did something wrong and later decide to take a bad action such as forcing an abortion.
>
> –Fluk, male, upper secondary school, MG2

Many participants wished, if an unplanned pregnancy occurred, that their parents would be empathetic and would help them to solve the issue. They did not want to be scolded and ostracised from the family. Both non-sexually active and sexually active participants were consistent in expressing this view.

> Help solve the problem [pause] not to blame us.
>
> –Bee, female (non-sexually active), secondary school, interview

> I want adults to be more accepting when unplanned pregnancies happen. I want adults to arrange for an engagement or marriage according to Thai culture. If there is no engagement, young people will fail to follow *jareet prapaynee* [social norm].
>
> –Mac, male (non-sexually active), secondary school, interview

> If [I get pregnant], I want my parents to understand what has already happened, help to solve the problem [unplanned pregnancy] and help me to let it go by starting a new life together. If the problem hasn't happened yet, I want my parents to give advice on how to prevent an unwanted pregnancy and how to have safe sex.
>
> –Num, female (sexually active), vocational college, interview

One female sexually active participant (Ice) was criticised by her neighbours for having a boyfriend at a young age and for going out with her friends at night. Her neighbours scolded her and said that Ice would get pregnant out of wedlock. Ice discussed this gossip with her mother, and she also insisted on condoms when she had sex with her boyfriend. She wished her neighbours would hold their tongues and stop judging her. Ice explained angrily and at length.

> Um [pause] I love nightlife and to spend my time with my friends and my boyfriend. My neighbours had been very critical of me and have said that I would soon have a baby out of the wedlock. I want my neighbours and other adults not to look at young people who love to go for a night out [pause]. They are not going to have sex or do something bad or bring a baby back home. Young people have their own way to [prevent or solve a problem].
>
> –Ice, female (sexually active), vocational college, interview

Bee, however, was very empathetic with adults' negative reactions. She said it was important for young people to understand the reason behind adults' reactions.

> I just want to [pause] I want adults to understand young people. Some parents don't understand young people. Some people in society don't understand either. They look at these young people negatively. I just want Thai society to accept [pause] and understand who they are**.** For young people [pause], young people should understand adults too. When adults scold you [young people], you should understand that these adults are worried about you.
>
> –Bee, female (non-sexually active), secondary school, interview

Besides expressing a need for understanding and support from parents and neighbours, two females and one male emphasised the importance of the community pharmacist,

whom they felt should be aware of the sexuality of adolescents, encourage these young people to use contraceptives and give contraceptive information to them. Community pharmacists were expected to be professional, friendly and non-judgemental. Fang, Orm-am, and Fluk were united in these views.

> Yes, pharmacists should give us information and [pause] not blame us. They should be the person who has the most understanding. A female teenager wrote on a website that she went to a pharmacist for emergency contraceptive pills. She was scolded by the pharmacist.
> –Fang, female, upper secondary school, interview

> Teenagers want to talk to a pharmacist who uses nice words. If the pharmacist speaks badly to us, we won't go there again.
> –Orm-am, female, upper secondary school, interview

> [Pharmacists] should give us information and encouragement. Kind of [pause] we made a mistake already. We want somebody to help us to think. [Pause] We want to come back to be a good person. I don't want to talk to the person who repeats my pain, my mistakes.
> –Fluk, male, upper secondary school, interview

In MG2, Bass was also concerned that gender and the age of the pharmacist might affect young people's decisions to access contraceptives. Bass believed that young people would prefer to talk to the middle-aged pharmacist and respect him/her as a knowledgeable person. Moreover, Bass believed that male adolescents would like to talk to same-sex pharmacists.

> At a pharmacy, pharmacists should be middle-age males [pause] better than female [pause] or anybody who can give us advises. I don't want a female pharmacist. Male adolescents, in general, will be too shy to talk to a female pharmacist.
> –Bass, male, upper secondary school, interview

In brief, participants wanted adults including parents, neighbours and community pharmacists to understand the sexuality of today's Thai-Isan adolescents. They wanted parents and pharmacists to provide information on sexual health and contraceptive options. Youths also wanted their parents to be empathetic, forgiving and supporting of them when unplanned pregnancies did occur.

7.2.2 Talking with the same-sex family members

Participants also wished to have conversations or discussions with their parents about sexual relationships and contraceptives.

> [I want parents] not to scold me before giving suggestions. Kind of. [Parents should be] open-minded to talk with their children and to discuss.
>
> –Fang, female, upper secondary school, FG2

> Parents should be brave enough to talk more about anything about sexual health and contraceptives with their children [pause] about the sexual relationship and how to prevent an unwanted pregnancy. My parents already talked with me about this. My dad talked to me about these issues lots. My dad told me to use condoms. My mum told me not to have sex and asked me and my girlfriend to focus on our study.
>
> –Mawin, male, upper secondary school, interview

Four young women and one young man said that if they had had unprotected sex or if an unplanned pregnancy happened, they would like to discuss it with their same-sex parent. Ice, Tong, Fon and Fern felt more comfortable discussing issues with a parent of the same gender.

> Young people want parents to accept when unplanned pregnancy happens [pause] I want my mum's advice. I want to talk to my mum more than to dad.
>
> –Ice, female, vocational college, interview

> If I have sex accidentally, I want to talk to my mum. Because mum was once a teenager too. [Pause]. I want to talk to her because having sex is normal, and I want to find the ways to prevent an unwanted pregnancy such as taking *yacum chugchern* [ECPs].
>
> –Tong, female, upper secondary school, interview

> Fern: Mum, we want to talk to mum about our sexuality.
> Sansanee: Why mum?
> Fern: Too embarrassed to talk to dad.
> Fon: Because dad is **A MALE** [speaking loudly].
>
> –Fern and Fon, females, vocational college, FG1

> I want my dad to advise me about sexual relationship and pregnancy prevention.
>
> –Noot, male, vocational college, interview

One male teenager also mentioned that he preferred talking about his friendships and intimate relationships with his older brother.

> But, for me, I want to talk to my brother more than my parents. My bro often asks me how I am, how about my relationship with my friends and my girlfriend. With my bro, I can talk about everything. He is like a handbook on how to live a life.
>
> –Mawin, male, upper secondary school, interview

From Mawin's account, it was hard to know whether young people were more likely to talk about sex-related issues with same-sex siblings or not. Mawin had only one older brother and did not have any sisters. Stories of Mawin with his brother provoked me to check my conversation with Gice (a male participant in two group discussions, MG1 and MG3) about his sister. Gice told me that he and his older sister chatted about safe sex. However, the conversation between the siblings came after his mother found a video on Facebook of Gice and his girlfriend having sex. His mother might have asked his sister, as a messenger, to tell him about using condoms. His sister brought free condoms from her office to Gice. It seems that talking with his sister was a one-way communication from either his mother or sister, and had not originated from Gice.

7.2.3 Having no judgement but encouragement

Many participants asked adults for non-judgemental acceptance of young people's behaviours. Young people were afraid of being judged if they were to carry condoms, buy condoms/ECPs or ask for free condoms. They wanted adults to be empathetic and to recognise that young people want to prevent themselves from becoming involved in unplanned pregnancies and from contracting STDs.

> Young people don't want to be judged when they go to buy condoms or contraceptive pills. Actually, they want to prevent [accident] themselves, and they are not lustful.
>
> –Allan, male, vocational college, MG3

> When young people go to ask for free condoms, I want adults to see this as normal for young people [to use condoms when having sex].
>
> –Ice, female, vocational college, interview

Two male participants believed that adults should support the young to have safe sex. They said that when young people are seeking, buying or asking for free contraceptive methods, adults ought to know that young people are being responsible in controlling their fertility.

> I want my parents, and my grandparents, to let me have a girlfriend and to say to me that [pause] if I have sex, use something to prevent. [Pause]. When I go to buy condoms, I want other people to look at me in a good way [pause] I want them to say 'good to know you are using preventive methods when having sex'.
>
> –Ben, male, vocational college, interview

> I want Thai parents to say: if you have sex, you have to use prevention.
>
> –Honda, male gay, upper secondary school, interview

7.2.4 Maintaining privacy and confidentiality

Teenagers wanted condom vending machine placed where they could buy condoms privately. At primary care units, they also wanted to be given privacy when asking for free condoms. In addition to privacy, the teenagers I spoke to wanted confidentiality assurances from their teachers when they asked for condoms or contraceptive information. Their voices are presented in the following three sections.

Privacy at condoms self-services

Many male and female participants agreed that young people need more discreet condom self-service options. For young people, condom vending machines were seen as places where they could buy condoms discreetly. Condom vending machines were discussed in MG1, MG2 and FG1.

> Teenagers will first go to condom vending machines if we have enough machines.
>
> –Arom, male, upper secondary school, MG2

Bew and Nat suggested more vending machines should be located in places where young people love to socialise such as food courts or canteens.

> I think [pause] teenagers want [condom vending machines]. For example, at some primary care units, there are condoms vending

> machines. That is, we don't have to go to a person to ask for free condoms. That is, we don't have to be shy about asking for free condoms [pause] putting coins in a machine. [Pause]. We can do for ourselves. Kind of [pause] health professionals won't stare at our faces and think about what we are going to do with the condoms. Kind of.
>
> –Bew, female, upper secondary school, interview

> Yesterday, I talked to Vitoon, a friend of mine [about condom vending machines]. We thought we needed more vending machines because [pause] in case young people don't dare to buy condoms [pause] because lots of people are in the store. Young people can access condoms comfortably.
>
> –Nat, male, upper secondary school, interview

Two participants preferred to have condom vending machines in public toilets.

> If I put a coin in a vending machine of a male public restroom, other people won't see me. It's ok if other men or boys see me buying condoms because we are men.
>
> –Mac, male, upper secondary school, interview

> Put condom machines in school toilets or public toilets. It is more likely to be private if they are put separately in female and male toilets.If we put the machine in front of male and female toilet, everybody can see us when we are putting coins in the machine.
>
> –Num, female, vocational college, interview

Interestingly, one male participant, Noot disagreed with putting condom vending machines somewhere at school.

> Young people will destroy the machine for free condoms if it is at school.
>
> – Noot, male, vocational college, MG1

Privacy at primary care units

Two male youths talked during in-depth interviews about asking for free condoms at a primary health care unit, although neither of them had ever done so.

> Teenagers want to go and ask for free condoms at a quiet place. Primary care units [pause] seem quiet because there will be a health practitioner as a condom giver and teenagers as a receiver. [pause] But If I go there and see a lot of people there, I won't go inside and

ask for condoms. I will ride my motorbike back home.
–Mac, male, upper secondary school, interview

Three female adolescents mentioned the need for "a place for teenagers" relatively close to school.

I want a place for only adolescents. [Pause] not far from schools. Somewhere we can easily go. If we have a problem, we can go and ask for help. Comfortable [pause] we don't have to feel afraid.
–Fon, female, vocational college, interview

Confidentiality and privacy at school

A few participants questioned confidentiality when accessing contraceptives at school. Nat, a male participant, was not convinced he could trust school authorities to protect his identity if he asked for free condoms.

Some teachers asked me to go to them and promised that they would not tell any other teachers or students. But [pause] sometimes [pause] Um [pause] kind of [pause]. What happens then? Teachers told us that they would not say anything when we asked you for free condoms. In reality, [pause] teachers mention it to other teachers. That is [pause] sometimes young people are afraid. [Pause]. They are also afraid of teachers doing such things.
–Nat, male, upper secondary school, interview

Because Nat disbelieved that teachers could keep his and his friends' identities confidential, he felt that teachers should distribute condoms to all of the students in his classroom and not only to those who were sexually active and wanted condoms. Nat felt that mass distribution would enforce confidentiality.

Distributing condoms to a specific person would negatively spot the person. That person might be seen as suspicious or be teased by other students. Nobody, including teacher, would know who actually uses the condoms if condoms were distributed to everybody.
–Nat, male, upper secondary school, interview

In in-depth interviews, a female participant from the upper secondary school agreed with distributing condoms to all students to prevent stigmatisation of sexually active persons by other students. Tong recalled a situation when she was at a school exhibition.

> At the exhibition, condoms were given as a reward to those who provided the right answer to a question. Health educators came and gave us free condoms without us asking for them. Lots of students there got condoms, and nobody was different.
>
> – Tong, female, upper secondary school, interview

Another young man felt that condoms should be regularly distributed in the classroom, which would help some teenagers who were shy or afraid.

> Teachers who teach health education subject don't give students condoms. Nothing is distributed. They had just told us how to prevent pregnancy [pause] sometimes young people are too shy to ask for more information they want to know or for free condoms. If teachers distribute condoms in our classrooms, young people will have condoms to prevent mistakes themselves and [pause] don't have to be embarrassed to ask for free condoms.
>
> –Nat, male, upper secondary school, interview

Privacy and confidentiality are extremely important for young people who want to access contraceptives. Regular distribution of condoms in classrooms or at school exhibitions were seen as strategies that could protect some young people's privacy, as were strategically located vending machines.

Noticeably, Nat's narrative was touching not only condom distribution but also the a fundamental problem with health education. The important issues on the difference between health education and the reality of social, behavioural, emotional and embarrassment factors involved in accessing them to healthcare centres, health worker, 7Eleven and so on. There is the difference between having knowledge and behaviour.

7.2.5 Good communication and health practitioners

Apart from the quality of SRH services, personalities and presentation were described by participants as important in the delivery of services. Only three young women in this study had had direct encounters with a nurse at a local primary healthcare unit.

At her first visit, Fon met a middle-aged nurse, and she was appraised as *ying Thai jai gla* (a brave Thai lady) who came to collect free condoms. This middle-age nurse talked to her nicely and made her feel at ease. At the second visit, she met a young female nurse, who talked with no smile and a flat intonation.

> I want to see the same auntie who works there. She was an auntie aged around your age, Auntie Sansanee, [laugh] about 40. She spoke nicely

> with a nice smile. She told me to come back for free condoms again. She said that I am a *ying Thai jai gla* [a brave Thai lady] because few Thai females ask for free condoms. On another day, I went there again. I expected to see that auntie. But [pause] I found another female health professional. She stared at me and spoke to me with bad intonation. It seemed like she didn't want to talk to me. She had a grumpy face [pause] no smiles at all.
>
> –Fon, female, vocational college, interview

Ben had never asked for free condoms at a primary care unit. When he wanted free condoms, he asked his friends to go to the primary care unit instead. He heard from his friends about uncomfortable feelings when that young man asked for free condoms. The discomfort of Ben's friend arose from a health professional who stared at his friend, smiled and said nothing. The smile and stare with no words seemed to make Ben's friend feel insecure about asking for free condoms.

> My friend told me that the health professional looked at his face and smiled when he went for free condoms. He felt like [pause] this health practitioner wanted to know what he was going to do with these condoms [pause] curious.
>
> –Ben, male, vocational college, interview

Young people had different experiences with health professionals at different local primary care units. Unanimously, however, they expected a warm, non-judgmental welcome. Staff behaviours with personal connotations increased the discomfort of the adolescents I spoke to, who later did not feel able to access contraceptive methods.

7.3 Male-specific perceptions

This section presents viewpoints collected from male adolescents regarding their expectations and needs for sexual and reproductive health and rights. It is divided into two sub-sections, "Sharing and warning systems" (Section 7.3.1) and "Adapting social values and norms" (Section 7.3.2).

7.3.1 Sharing and warning systems

During adolescence, friends have a great influence their peers. I found that adolescent boys formed a group that shared the same recreational interests, such as football or playing computer games. Stories of sexual relationships were shared openly among some of them. When I invited Gice to have an interview, he wanted his other three friends to be with him because his friends knew everything about him, including his

sexual relationships. He refused to have an interview alone, but insisted on having his friends for a group chat.

According to Bew (a sexually active female participant), contemporary teenage females also talked with their friends about their sexual relationships. This represents a generational transition in openness of discussing about sexual behaviours. Such behaviours of sharing sexual relationship stories were rarely seen in my (researcher's) generation. In past generation, I have heard grown-up males in Thai society had talked behind their girlfriends' backs. Females rarely talked about their sexual relationships with their friends. Bew and her friends had, however, discussed their sexual relationships when she was in her last year studying at the SS. "We talked about everything in our sexual relationships", confirmed Bew. "Friends should warn friends to carry condoms and to use condoms when they have sex", suggested one heterosexual male participant (Nut). This sentiment was echoed by Honda, a gay male participant. None of the female participants ever mentioned this point, either in interview or group discussions. In contrast, both Nat and Honda expected their friends to share contraceptive information or to remind them or other friends about carrying condoms, like a type of warning system.

> Friends are the people closest to adolescents. We should choose to be with good friends and to motivate each other to do good things. We cannot tell when we will engage in a sexual relationship. We should tell each other to carry condoms all the time.
>
> –Nut, male, upper secondary school, interview

> Friends should warn friends [pause] say something about contraceptive methods [Pause] say but not teach [pause] tell friends to have protected sex. A friend of mine said to another friend who had had a sexual relationship that if a mistake happens, you will be in trouble. Take condoms.
>
> –Honda, gay, upper secondary school, interview

It appears from participants' shared stories that in modern times, friends dare to share their personal stories, including those of sexual relationships, with their friends. In the current project, however, only male youths wanted their friends to talk openly with them about having safe sex by reminding each other to carry condoms. Females did not appear to share the same need for a friendly warning system, although such a need could exist or could be fulfilled by a similar strategy.

7.3.2 Adapt social values or social norms

Ka ni-yom and *jareet prapaynee* were mentioned in one male discussion group (MG2). *Ka ni-yom* literally means "social values". *Jareet prapaynee* can be translated as "social norms", which refers to standards or patterns of appropriate behaviour assigned by Thai society; Thai people are expected to behave according to these social roles and according to their status in the social hierarchy. In MG2, *jareet prapaynee* was called *jareet* by Fluk, but as *kot kaow* (old rules) by Bass.

Again reflecting transitional process and different values between generations, Bass and Fluk were concerned that some social norms and values could hinder Thai adolescents in accessing effective contraceptive methods including condoms. Bass recalled an old social rule about sexual behaviours, which he said meant adolescents were too young to have sex and to access condoms in adults' eyes.

> *Kot kaow* is *jareet*. I kind of [pause] please [adults] don't see it [having sex] as wrong or strange. Really, it is natural. Some adults see it as a bad thing and look down on young people as too young to have sex. They might think young people are too young but dare to buy condoms and have sex. It is like *jareet* [a social norm]. Based on Thai culture, we should not do that.
>
> –Bass, male, upper secondary school, MG2

Fluk said that young people who carried or bought condoms were seen as bad. These young people felt ashamed after being stigmatised.

> In our country, there are social values such as *ragnaun sngaun tua* [to love and preserve your young and feminine body and self]. It is like a *jareet prapaynee* of our country. For sexual issues … sexual issues seem to be *mai dee ngam* [not good] since a previous era. If we go to buy something [condoms], we would feel ashamed of ourselves.
>
> –Fluk, male, upper secondary school, MG2

Participants in MG2 agreed that Thai society should change its social values and norms, but not all existing social values and norms. They did not specify which social norms and values needed to change.

> Sansanee: Do you mean throw away the old rules?
> Bass: No no … adapt some of them.
> FlukN: Like building a house… we change it from the olden days of using wooden walls to concrete ones… here we are not pulling down the whole house, but we strengthen

> the house by replacing the wooden walls with concrete ones making it like a new one…

7.4 Human rights and SRH

7.4.1 The right to freedom of expression

I did not ask teenagers about whether they had heard about SRHR in some group discussions, but when I did, most of the participants went quiet and could not define the term *sit-thi anamai chareanpan* (SRHR). *Sit-thi* literally means "a right" or "rights", and *anamai chareanpan* refers to "sexual and reproductive rights". In MG1, Ben, a male participant, attempted to make a guess at the term *sit-thi* as "a basic right we should or should not have". However, he was unable to elaborate or to give details about his version of SRHR. Although I used leading questions, such as how about SRH services or contraceptive services, students were unsure about my meaning. None of them spoke about their own *sit-thi anamai chareanpan*. However, *sit-thi* as it related to older adults was described. In MG2, Fluk explained that younger people were expected to respect their elders by refraining from arguing with older adults. Fluk believed young people who argued could be seen as bad people.

> Based on Thai culture, we cannot argue with adults. For the elders, explanations of young people seem to be disrespectful arguments. Having an argument with adults leads young people to be judged as hvaing 'bad manners'. We still have this kind of social norm. … We still have social norms like this [pause] between adults and adolescents. Explaining by young people is:::.
>
> –Fluk, Male, upper secondary school, MG2

Fluk thought that arguing with or talking to adults could increase understanding between adults and adolescents. At the same time, Fluk believed the social norms for young people to never question adults could obstruct young people to from doing this. Fluk strongly advocated young people to have the right to talk, explain or argue.

> *Jareet prapaynee*, yes. Actually, adults should allow young people to speak their minds. We live in a democratic country. Everybody has their own right to their own opinion. So, young people should be able to exercise their right to speak too.
>
> –Fluk, male, upper secondary school, MG2

Niwat agreed with Fluk, and added that young Thai people wanted to explain to tell the adults how they felt.

> Buying condoms, asking for free condoms, or carrying condoms is for prevention and not a bad person.
>
> –Niwat, male, upper secondary school, MG2

Niwat's argument provoked me to consider adolescents' sexual and reproductive rights to have access to safe, effective, affordable and acceptable methods to regulate their fertility. I reflected that their accessibility to contraceptive methods could be obstructed by fear of social condemnation or stigmatisation accentuated by rigid social norms.

7.5 Chapter summary

Findings from drawings and transcripts suggest that male and female participants wanted Thai adults including parents, neighbours and community pharmacists to be more empathetic and understanding of their sexual needs and their reality. Young people wanted their parents to be more ready and willing to talk with their children about sexual relationships and how to practice safe sex. Young people were advanced in transition than parents. They also wanted Thai adults to encourage young people to use contraceptives and not to judge when young people asked for or bought condoms.

Male and female participants wanted healthcare providers and school teachers to protect their privacy and confidentiality. They opted for regular, mass distribution of condoms. More condom vending machines placed in socially acceptable public places — to reduce social embarrassment barriers — were also recommended.

Male participants, in particular, wanted their peers to remind each other to practice safe sex and to carry condoms at all times. They also asked Thai society to change social values/norms that hinder young people from accessing effective contraceptive methods. They advocated exercising their right to express their views freely. They considered that two-way communication between adults and young people could help promote more freedom for young people to live their lives according to their own realities.

CHAPTER 8. **Discussions**

8.1 Chapter outline

This study investigated Thai-Isan adolescents' understanding of contraceptive practices in preventing unintended pregnancy, and to raise adolescents' voices regarding sexual and reproductive health issues in Thailand. It aimed to address three research questions 1) how Thai adolescents make contraceptive decisions, 2) what factors influence their contraceptive choices, and 3) what Thai adolescents need or expect regarding sexual and reproductive health and rights. Participants provided rich data on sexuality and contraceptive decisions of Thai adolescents as outlined below.

8.2 Summary of the findings

A large number of these school-age participants admitted being sexually active, most vocational college participants but only 10% of upper secondary school participants. Sexual relationships during adolescence were acceptable with pregnancy seen as a mistake or problem and a major cause of having a "dark future". Such a mistake or problem could result in punishment for Thai adolescents because of breaking parental expectation for good children to follow their parents' expectations e.g. taking responsibility for their studies, going to university and later having a well-paid job. Pregnancy incurred higher social and lifestyle shame, for females. Interestingly, one male participant saw pregnancy as normal for the age 18 and not as a life-threatening condition.

Because Young Thai-Isan adolescents were afraid of negative consequences of pregnancy for themselves (being scolded and punished) and their parents (putting burdens of looking after a new family member, baby), they chose some kinds of contraceptive methods to prevent unwanted pregnancy. Very interestingly, only one participant always reported using condoms because of possibly contracting HIV/AIDS. Most contraceptive choices adolescents made appeared to be impromptu and situationally dependent, and were made just before sexual intercourse. Condoms were the most well-known method in preventing pregnancy and STDs, but were not always used. Inconvenient opening hours of healthcare services where free condoms were

offered, lack of confidentiality and sense of embarrassment and cost of condoms were all likely barriers restricting use.

Male adolescents were likely to try to negotiate for bareback sex. Adolescent girls concerned about their future career, social and financial difficulties from having a baby, their bodily integrity and their cultural expectation as first daughter were likely to resist their boyfriend and insist on condoms. Adolescent boys were likely to follow their own older girlfriends' request: using condoms. When female adolescents were unable to negotiate and insist on condoms or willingly allow their boyfriend having unprotected sex, withdrawal method was likely to be the choice. Some adolescents who were concerned about the failure of withdrawal method would later seek emergency contraceptive pills. Such emergency pills were also taken after having drunken sex, and the girls were expected by their boyfriends to know about this emergency contraception and take responsibility for seeking emergency contraceptive pills.

Typically, in this study, Thai adolescents aged 15-19 years old live with their parents. However, one girl admitted to cohabitation with her current and an ex-boyfriend. Her contraceptive choices were influenced by many factors including male preference for condoms, medical history (allergy to hormonal pills) and financial status at the time.

When pregnancy out-of-wedlock occurred, parents would take over as the main decision maker on future contraceptive use of adolescents, as well as on terminating the unwanted pregnancy. At this time, a long acting reversible contraception including hormonal implant was typically chosen by adolescents' parents as the main contraceptive choice.

Most participants agreed that Thai adolescents confronted significant social embarrassment barriers to access free contraceptive methods when interacting with staff at government healthcare services and even when they bought contraceptives from private businesses such as convenience stores. They requested understanding and support from parents and people surrounding them regarding their lifestyle and when they had unprotected sex and unintended pregnancy. More open talk about sex and contraception between young people and adults was also requested from participants in this study. At healthcare services or school nursing units, increased privacy and confidentiality were needed. Mass distributions of condoms at school exhibitions or class rooms were suggested to eradicate social stigmatization of individuals having to

seek and carry condoms when engaging in a sexual relationship. My adolescent participants also suggested more condom vending machines where they could access condoms discreetly e.g. in toilets in shopping malls, petrol stations and healthcare centres.

Need for changes in social values and norms was seen, particularly by male participants. For example, traditional social values and norms of respecting and not disagreeing with adults conflict with carrying condoms seen as a bad behaviour. These factors hinder Thai adolescents open discussion about sex and contraceptive choices with their parents or other Thai adults.

8.3 Discussions on the main findings

8.3.1 Being sexually active

Most adolescent participants in this study, whether they were sexually active or not, considered premarital sex during adolescence was normal as reported in previous studies (Fongkaew et al., 2012; Ounjit, 2011, 2015; Sridawruang, Pfel, &Crozier, 2010; Vuttanont, Greenhalgh, &Boynton, 2006). Such acceptance of premarital sexual relationships shows a transitional change between this current generation and previous generations including my own (researcher's) generation and my participants' parents' generations. Surprisingly, I found that female adolescents willingly and openly shared personal information of their sexual relationship and contraceptive use while previously only males in my generation did that.

While most participants from the two school settings accepted sex as normal, prevalence of their sexual activity was dissimilar. Most participants from the vocational college reported engaging in sexual relationships while only 10% from upper secondary school did, as reported in other Thai research (Ministry of Public Health, 2016). These findings clearly reflected the different lifestyles of adolescents from these two school settings although they have similar views on premarital sex. Thus, perceptions of premarital sex as normal might not the only reason for these young people engage in sexual relationships. Young people studying in vocational college might have lower parental expectations and academic achievement than those from the upper secondary school who anticipated proceeding to university or other tertiary education. Low parental expectations, academic achievement and work/life ambitious may lead more adolescents from the vocational college to engage in sexual relationship than those from

the upper secondary school. The live time consequences of unintended pregnancy could be considered less severe for those, particularly males, from the vocational college.

8.3.2 Knowledge on contraceptive methods

All participants were well-informed about condoms as an effective contraceptive method for preventing pregnancy and HIV infection, similar to other findings of Ministry of Education of Thailand (MoE, 2016). Participants were also aware of how condoms performed versus withdrawal method. Both male and female adolescents gained their knowledge about condoms not from their parents but teachers, exhibitions at schools, peers and the Internet, as previously reported by Chirawatkul et al. (2012). Community pharmacists were again largely affirmed as a source of contraceptive knowledge for adolescents in the Thai Ministry of Education study (2016).

Apart from acknowledging the dual benefit of condoms in protecting against both pregnancy and sexual transmitted diseases, most participants also knew where they could get condoms cheap or free. I found similar findings to previous studies that the cost of contraceptives, particularly condoms at 24-hour convenience stores, approximately 60-90 Thai Baht (2-4 NZD), mattered very much to many unmarried, sexually active adolescents in Khon Kaen (Mollen et al., 2013; Sandle & Tuohy, 2017; United Nations Children's Fund, 2015b). In this study, participants recognised that condoms in pharmacy costed them less than those in convenience stores and the cheapest ones were from vending machines. Thus, financial accessibility to contraceptive methods remains a barrier to many Thai adolescents who are still financially dependent on their parents, or at least, ones living in Khon Kaen. In terms of free condoms, limited opening hours of government healthcare services (from 8.30 a.m.–4.30 p.m. only in weekday) clashing with school hours and no access on weekends were also considered barriers for adolescents to collect free condoms.

Participants, particularly young men, were likely to take risky decisions to have sex without condoms (although many times they had condoms in their pockets) and choose the withdrawal method to prevent pregnancy. Such risk taking might stem from the immature state of adolescents' brains, which cannot recognise right and wrong choices, and which ignore danger signals (Crone, 2016). However, passion of moment and reduced pleasure from "non-bareback" might be important factors influencing more than their decision making, cognitive functioning at that time.

Apart from having information about condoms, Thai adolescents had inadequate knowledge about other effective contraceptive methods. Concurring with other overseas studies (Klinger & Asgary, 2017; Küçük, Aksu, & Sezer, 2012), many participants in the present project had misconceptions about possible infertility resulting from using "the pill". This might reflect what is taught at schools, which is often insufficient information for adolescents to use in the real world (Vuttanont, 2010). A male participant underlined that "last chance" contraceptives, including ECPs, were never mentioned by teachers or health educators at school exhibitions. Instead, information about ECPs was accessed on the grapevine and passed from one friend to another, or was found by surfing the Internet.

I found that the gender of educators could be a crucial element for delivering sexual and contraceptive information. Youths would have appreciated it if they could have learned to have safe sex from same-sex parent, teachers, or older siblings. The gender of teachers was emphasised by female participants to be a barrier in delivering knowledge to the girls e.g. they preferred female teacher, not male teacher, for sex education. Those participants who had had direct contact with community pharmacists would have liked to talk to a same-sex pharmacist about contraception.

The current research confirmed that having good knowledge about contraception could not guarantee that adolescents would choose to use contraceptive methods (Baku, 2012; Chimah et al., 2016; Kaewchanta et al., 2009). Indeed, adolescents who had sex while they were drunk or were caught up in the sexual moment were unlikely to apply condoms, although they knew the benefits well enough (Brown, 2014). In this present study, withdrawal method was recognised as a method with a higher failure rate than condoms. However, most sexually active males were more likely to take a risk by choosing, with their girlfriend's agreement, to use this risky method. The withdrawal method was commonly chosen in this study as also found in an earlier study by A. Tangmunkongvorakul et al. (2011).

8.3.3 Gendered expectation and contraceptive decisions

In previously published literature, researchers found that an overriding fear of pregnancy can provoke unmarried and married teenagers (aged 15–24 years) in Uganda to use contraceptive methods (Nalwadda, Mirembe, Byamugisha, & Faxelid, 2010). The current research similarly found that fear of pregnancy was the main reason for

unmarried sexually active Thai adolescents of the same age group to choose some kind of contraceptive method to prevent unplanned pregnancies.

Adolescent pregnancy was viewed by both Thai male and female participants in this current study as a fault or a huge mistake as also previously reported by adolescent girls in a study of Sa-ngiamsak (2016). Parental expectations are for Thai adolescents to be at school and not engage in sexual relationships (Wichaiya, 2013). Even those who are not at school, particularly girls, are expected to remain chaste, and to earn an income and look after their parents by providing funds directly and by paying bills, sentiments expressed by my participants who engaged with me in discussions (Sa-ngiamsak, 2016). Moreover, Thai sons and daughters are assigned social roles by their religion (Buddhism) to show their gratitude (Lyttleton, 2002) and to pay back a debt of gratitude for their care and upbringing to their parents (Liamputtong et al., 2004). Pregnancy during adolescence therefore increases parents' financial, emotional and social burdens from looking after the new-born family member. It is also hard for the affected couple, who have a baby to provide for, to pay back their parents the debt of gratitude for their upbringing. My research further found that Thai teenagers' fear of burdening their parents motivated them to consider, but not always use, contraceptives. Mixture of religious and Isan cultural fear of being punished by parents and society at large could be a unique conundrum teenagers spoke about as a reason for sexually active Khon Kaen boys and girls to prevent unwanted pregnancy.

Similar to a Thai study conducted by Sridawruang, Crozier, et al. (2010), pregnancy during adolescence in the current research was considered as a shaming factor for young women and their families more than it was for the young men and their families. Participants felt that female adolescents were condemned as naughty and promiscuous when they had babies out of wedlock as reported by Muangpin et al. (2010). Physical changes to the girls' bodies as they advanced through pregnancy were considered to be evidence of bad behaviour. After having a baby, participants said young women were expected to take on a new social and Isan cultural role as a mother. Thai mothers, no matter how young, were expected to feed their babies and to save money for their families (Liamputtong et al., 2004). Fear of being unable to fulfil these roles was cited by female participants as the single greatest influencing factor that drove them to consider their contraceptive choices.

From this study, Thai adolescents could be seen as spending adolescence juggling two sets of conflicting beliefs: 1) sex and pregnancy during adolescence are not good in any way according to their parental expectations and Thai cultural culture, and 2) having sex is normal and acceptable according to contemporary adolescent values and culture. To resolve this conflict, some adolescents might decide to be "good" by avoiding sex. Some might decide to engage in sexual activities, but would still like to be a seen as good sons or daughters. Or, they might conceal their sexual relationships and use various strategies to prevent unplanned pregnancies. As similar to Janis and Mann's (1979) position, participants in the current study did consider and weigh up benefits and negative consequences on their self and others. Although my work focused on pregnancy prevention via contraceptive use, adolescents might use other methods to deal with their internal conflict and to satisfy their needs without so much risk, such as engaging in oral sex, mutual masturbation and anal sex to avoid unwanted pregnancies. These choices, although valid and an integral part of the adolescent matrix, were beyond the scope of my project.

Hierarchal social systems, gender roles and contraceptive decisions

Unexpectedly, I found that hierarchal social systems could increase "messiness" or complexity in decision making, making many decisions dysfunctional. Its influences were felt via the patriarchy and seniority systems, common social constructs throughout Thailand.

The patriarchal and gender role effect

In Thai Buddhist society, girls are considered inferior to boys at birth as they cannot bring supreme merit to their parents by becoming a monk. Sexual expression and expectations are that girls are not supposed to be sexually active although it is more acceptable for boys. Evidence of the negative effects of these patriarchal beliefs/values were illustrated in participants' perceptions, what roles they expected to have to perform in society but were ill equipped for, and the actual actions they took when faced with making decisions about contraception.

Downey et al. (2017) found that contraceptive decision making was non-linear and relational. In the current work, this finding was confirmed: the decisions of unmarried, sexually active young men and women were complex, and choices about contraceptive method relied on interactions between the two sexual partners and the circumstances in

which they found themselves. Gender roles influence the contraceptive decisions of many couples in a non-rational way (Schuler et al., 2011). In Thailand, the patriarchal system has assigned social roles to males/boys that make them superior to females/girls, which meant unmarried, sexually active participants from both the upper secondary school and the vocational college demonstrated distinctive gendered roles in their decisions during different stages of the decision-making process. The decision-making processes included providing condoms, initiating conversations about condoms, negotiating for condom use and selecting withdrawal method or ECPs if the female lost the negotiations. Notably, two of these contraceptive methods (condoms and early withdrawal) are male-controlled methods.

I found that Thai adolescent males were expected by their girlfriends to be condom seekers: asking for free condoms or buying condoms. Thai adolescent male's role in preparing condoms has not been reported in any previous studies conducted in Thailand, but a similar scenario was reported by 20 adolescent girls aged 14–19 years in the Upper East region of Ghana (Krugu, Mevissen, Prinsen, & Ruiter, 2016). Such a gender separation might arise from the idea that condoms are a male-dependent method and therefore are a male's responsibility (Fennell, 2011). Moreover, in a patriarchal society of Thailand, it is more accepted that men should engage in sexual activities, and buying plus carrying condoms can be seen as a sign of manhood, an idea male participants also expressed in their focus group drawings (Sridawruang, Crozier, et al., 2010).

Poor social accessibility to condoms was problematic for male youths in Khon Kaen, frustrating their ability to fulfil their expected role as the providers of contraception. Concurrent with other published literature, adolescent participants in the present work who accessed free condoms at public healthcare units, and those who bought condoms from the private sector, were likely to be negatively judged by healthcare professionals and others, such as neighbours (Arundee, Natrujirote, Kayee, & Phungphak, 2016; Tangmunkongvorakul et al., 2012). A general lack of privacy and confidentiality were also difficult barriers to overcome, as in other studies (Arundee et al., 2016; Tangmunkongvorakul et al., 2012; Upadhya et al., 2017; World Health Organization, 2012b). To increase accessibility, participants strongly suggested that health professionals, who provide sexual and reproductive health services for adolescents should work to remove these social barriers, work with good communication skills,

understand adolescents' sexuality and encourage young people to use condoms and other contraceptive methods. A major barrier to accessing free government provided condoms in government health centres is the need to sign off receipt of condoms for health service administrative reporting services. This adds privacy, confidentiality factors when many adolescents already feel embarrassed.

Social attitudes on males providing condoms might be changing. I recently found that although Thai females were not supposed to prepare or carry condoms, some female participants in this current study helped their boyfriends by going to primary care units for free condoms or, if necessary, bought condoms themselves.

Just like females in Latin America and the Caribbean, Thai female adolescents in Khon Kaen were expected to initiate talk about condom use (Pulerwitz & Dworkin, 2006). In Thailand, social stigmas associated with adolescent pregnancy, which disadvantage women considerably more than men, probably also pushed the female to begin the conversation. It seemed that young men expected and waited for the female to start the conversation, perhaps a learned behaviour engrained by gender role plays carried out years before the sexual act occurred. Certainly, a lack of discussion about condoms before having sex was interpreted by the male participants in the current research as permission for having unprotected sex.

An additional conflict situation arose from patriarchal beliefs. While young women were expected by their boyfriends to initiate a talk about condoms, the female was also expected to be a "good girl" and was not supposed to talk about sex-related issues or to engage in sex (Ounjit, 2015; Thianthai, 2004). Thus, some females, especially inexperienced ones, did not initiate a conversation, probably because they were afraid of being judged, while the expectant male interpreted this silence as permission to "ride bareback". These opposed gendered values and interpretations can be seen as critical failure points at which decisions are made to engage in unprotected sex. Globally, sexually active male youths are likely to negotiate for no condoms (Arundee et al., 2016), which I found to be true, even though Khon Kaen youths were educated to understand the dual benefits of wearing condoms to prevent pregnancy and STDs.

Unexpectedly, I found that a minority of females who were concerned about their right to decide about their own body, or were conscious that they had this right, used their authority to successfully negotiate for protected sex. Interestingly, the moral

consideration of fulfilling their roles as firstborn Thai-Isan daughters drove two young females in this position to always insist on condoms despite repeated negotiations.

A previous study reported that withdrawal is commonly used by Thai adolescents and by adolescents in other countries (Liddon, Olsen, Carter, & Hatfield-Timajchy, 2016; A. Tangmunkongvorakul et al., 2011; World Health Organization, Western Pacific Regions, 2014). However, little is known about the circumstances in which withdrawal method is chosen as the main contraceptive method. My results, new to the field, show that withdrawal method is the second choice for females when negotiations to use condoms have failed or when females allowed their boyfriends to use it, but "pulling out" is the first choice for males, to avoid pleasure desensitisation caused by condoms.

Women were the main decision makers about ECPs when they felt uncertain about their partner's likely success in using withdrawal method. Contradictory to a study by Daugherty (2011), I found that young males in this current study did not initiate conversations about ECPs, nor did they join in the decision-making process. Interestingly, male participants related that after their partner made the decision, they would ride their motorbike to a pharmacy, avoid talking to the pharmacists and buy the ECPs on behalf of their girlfriends. Thus, in a roundabout way, some of them took partial responsibility. However, these young men expected their girlfriends to know about ECPs and to talk to a pharmacist about the morning after pills.

An Isan cultural concept of being good wives could influence contraceptive decisions of couples. Unexpectedly, one female I interviewed reported two different experiences of living with a previous and a current boyfriend. When cohabiting, she considered her boyfriend's preferences. The decisions to use condoms were shifted to contraceptive pills when the relationship developed from casual dating to steady commitment as reported in previous studies (Brown, 2014; Daugherty, 2011; Raine et al., 2010). I believe that living together might have provoked the female partner to take on the social role of the "wife" who was expected to take responsibility for contraception, as Ford and Kittisukasthit (1994) found when they investigated adolescent cohabitation in Thailand. This participant took the main responsibility without any complaints. Asking for condoms might have shown no trust in him. She might have caused conflict as a good Asian wife is expected to maintain family harmony and to avoid conflicts in her relationship (Ha, 2008). She decided to take the pills although she had allergy to many types of contraceptive pills. She also paid for the pills herself. Curiously, she did not

mention about a long acting reversible contraception such as intrauterine devices or hormonal implants. It could reflect poor contraceptive knowledge and inaccessibility for unmarried sexually active Thai adolescents to access the long acting reversible contraceptives at sexual and reproductive health services.

The seniority effect when attaching with the girls

Young people in Thailand have been taught to respect adults and their elders (*phi*), as traditionally adults are perceived as having more experience, knowledge and social power to make decisions (Lyttleton, 2002). In previous research, however, no scholars have documented how such a seniority system can influence adolescents when they are faced with making choices about contraception. My results suggest that in fact, social concerns about respecting elders did play a role for these Khon Kaen teenagers. Younger boyfriends obeyed their older girlfriends' requests to use condoms. So, the social power inherent in being older was attached to senior females, thus increasing their power in the relationship. However, if the male did not feel that the age gap was an issue, he did not obey the female's wishes, as in the case where a 1-year gap could have been construed as minimal enough to warrant ignoring.

8.3.4 The shift of contraceptive decisions

Contraceptive decisions of unmarried sexually active Thai adolescents occurred between couples. The decisions can be categorised in two groups according to whether or not couples had conversation about contraceptive before initiating their sexual relationship. Conversations between couples shape eventual decisions about contraceptive use worldwide, as seen in a study of unmarried young people (Widman, Welsh, McNulty, & Little, 2006). The participants I interviewed were quiet on this topic, but only one female reported that she and her boyfriend had talked about contraceptive methods before their first sexual encounter. Concerns about parenthood and other negative consequences that could affect their future careers led both individuals to choose condoms as the only safe method available, and they used condoms consistently thereafter. No negotiation for unprotected sex occurred in this case; both were strongly committed to their futures. However, most sexually active Thai adolescents in this study reported that no conversations about contraceptives had occurred before they slept together. Instead, the conversation occurred just before each round of sexual intercourse, and various circumstances before each round therefore affected the outcome.

Contraceptive decision-making was taken over by adolescents' parents when unwanted pregnancy was terminated. Very little scholarly effort has been devoted to investigating how contraceptive decisions are made after a young adolescent (aged 15–19 years) has an abortion. Previous studies have illustrated that abortion led women in France and New Zealand to choose a long acting reversible contraceptive (LARC) method thereafter, such as intrauterine device (IUDs) or implants (Hallander, 2016; Moreau et al., 2010). Consistent with this current study, a long-acting reversible contraceptive method was likely to be used by unmarried sexually active adolescents after abortion. However, the decision to use a LARC method was not made by adolescents themselves after parents had consented to legal abortion. Instead, parents made the decision. Hormone implants were likely to be chosen for their daughter to prevent the recurrence of an unplanned pregnancy. The IUDs was not described as a choice by the participants involved in the current research.

Interestingly, after having abortion without parental awareness such as self-attempted abortion, adolescent couples were still the final decision maker on their contraception. One young woman I interviewed had a self-attempted abortion that led to hospitalisation. Her concern thereafter did not cause her to opt for a LARC method; instead, she negotiated with her boyfriend to use condoms. This young female's decision to select condoms and to neglect LARC options might mean young people perceive barriers to using LARC or to accessing information about the methods available in Thailand, but these barriers were not part of the conversation.

8.3.5 Sexual and reproductive health and rights have not fulfilled yet.

Adolescents' sexual and reproductive health and rights (SRHR) have still not been fulfilled in Thailand after more than 20 years of ICPD implementation (Barroso, 2014). Findings from the current research confirmed that the needs of teenagers on sexual and reproductive health remain unmet, and are exacerbated by the high cost of condoms, social barriers to contraceptive services provided by government health facilities and the private sector, youth-user unfriendly youth clinics and the inadequate number of condom vending machines and contraceptive knowledge. In addition, it seems that young people as a group do not know how to exercise their SRHR to using contraceptives they would like to use (Berglas et al., 2014). No participant taking part in the Khon Kaen study acknowledged their SRHR or understood the phrase "sexual and reproductive health and rights". In saying this, three participating females

unconsciously exercised their rights to bodily integrity by successfully negotiating with their boyfriends to use condoms.

Participants also requested for their human rights. Thai adolescents' demands that adults refrain from judging them could indicate that the concepts of human rights international organisations have introduced to Thailand in the form of the UNHR (1948), CEDAW (1985) and CRC (1992) have failed to have any impact on how Thai society operates. In the traditional hierarchical adult-dominant society of Thailand, I found that the Khon Kaen adolescents had little space to express their opinions about sexual matters. Lack of communication about contraceptives and SRHR could increase misunderstandings between adolescents and the previous generations. Without open discussions between the two parties, it is certainly clear that so-called youth-friendly SRH initiatives cannot be effective, because underlying attitudes will influence how services are provided, as when one participant was refused service at a government unit by a female health worker. Embedded social attitudes could also reinforce social barriers youth encounter when trying to find an effective contraceptive method (Tangmunkongvorakul et al., 2012). Males in one focus group suggested Thai society should change to reject out-of-date social values that obstruct young people from accessing services that fulfil their needs, as Barroso (2014) also suggested.

8.4 Summary

Participants from two secondary schooling settings, whether they were sexually active or not, considered premarital sex normal and natural. However, more participants from vocational college than the upper secondary school engaged in sexual relationship. The different numbers of adolescents engaging sex probably reflects different lifestyles and aspirations in the same adolescent generation in those different environments and, perhaps, different parental expectation.

Fear of negative consequences on/from parents was the major factor leading to contraceptive considerations. Being well-informed about condoms does not mean condoms would always be used for pregnancy prevention. A riskier contraceptive method (withdrawal method) was the final choice when the girl lost negotiation for protected sex or when the girl agreed not to use condoms. Misinformation about the pill and IUDs left adolescents without LARC options. Although they were able to buy condoms at 24-hour convenience stores, costs, quality and availability, and social conditions were still issues. Free condoms are provided at public health facilities, but

adolescents faced social, privacy and confidentiality barriers in accessing these as well as inconvenient clinic opening hours mostly in school hours and no weekend hours.

Thai adolescents' sexual decision making was impromptu. The patriarchal social system and gender expectations led both genders to take action, and a female's superior negotiation skills and consideration for her own body could gain outcomes in her favour. Young women who had social power from being older (*phi*) indirectly forced younger men to use condoms. Cohabitation meant the couple relied on male preferences, and the female was likely to take responsibility in fulfilling his wishes. For the one adolescent couple who achieved serious conversation about contraceptive methods before initiating sex, consistent contraceptive use was reported. Being drunk led to unprotected sex. Contraceptive decision making was shifted to parents once an unplanned pregnancy was discovered.

CHAPTER 9. **Conclusions and Recommendations**

9.1 Chapter outline

In this current study, contraceptive decisions of Thai adolescents were impromptu and situationally dependent on various influencing factors. Unique findings of this study were unexpectedly emerged and freshly added to the contemporary knowledge for the world, as described in Section 9.2. These unique contributions include knowledge not only about contraceptive decisions but also about research methodology: for working with young people.

Based on findings of this study, I provide recommendations, in Section 9.5, for researchers who passionately work with young people in the areas of contraceptives and/or sexual and reproductive health and rights. For health professionals and policy/programme makers, in the later section, I also propose a holistic public health approach to encourage young people in giving their voices to develop youth-friendly sexual and reproductive health services and to fulfil their sexual and reproductive rights. I end this chapter and, surely, this thesis with my final reflection and my hope to help young people having a secure place to express their true need in this adult-dominated world.

9.2 Contributions to the knowledge

This study illustrates the complexities of contraceptive decisions made by unmarried, sexually active Thai adolescents aged 15–19, a time period in which their decision-making skills have not yet fully developed. Most published studies to date have concentrated on other age groups and/or on married subjects. Thus, the findings from this study can add new knowledge to the wider body of sexual and reproductive health (SRH) literature.

It is clear that gender roles impact contraceptive decisions and the condom-seeking behaviours of unmarried, sexually active adolescents. It is also clear that adolescents bound by gender roles make decisions that can be problematic for their futures. The current research also increases understanding about decisions made in Buddhist societies, meaning that it is also as relevance as a case study for adolescents living in

similar Buddhist-dominated countries such as Cambodia and the Lao People's Democratic Republic, or for those who are nurtured in families who adhere to the Buddhist faith but who live in other countries.

The current work also confirms that sexual and reproductive health and rights (SRHR) for adolescents is still poorly developed in Thailand, and as such, is governed by traditional patriarchal social norms such as deferring to elders which does not support human rights concepts. In this particular case study, Khon Kaen adolescents' SRHR to access effective contraceptive methods and to obtain contraceptive knowledge needs to be more respected, protected and fulfilled by adults. Therefore, Thailand and other UN signatories around the world should re-evaluate their implementation of UN human rights treaties to make sure that adolescents' human rights are actually part of how their societies operate in everyday life. Supporting an investment in SRHR in Thailand means overcoming barriers imposed by religion and patriarchal constructs, implementing a holistic approach to SRH and providing public health interventions *acceptable and accessible to teenagers* to address the teen pregnancy potential.

This study also adds to existing knowledge of youth-friendly qualitative approaches used by researchers worldwide to explore sensitive, confidential topics. Recommendations to researchers undertaking like endeavours include:

- *Changing group discussion formats*. Avoid asking youth to introduce themselves to the researcher to break the ice. Motivate them to describe the best characteristics of their friends, which sets a positive, natural tone for group discussions.
- *Being yourself, a researcher with a unique identity*. In my case, I was an "auntie" from a previous generation, but I was not a rule follower. This had its benefits and its dangers, which must be taken into account when thinking about identity.
- *Including adolescents in the research process as much as possible*. For example, during data analysis, adolescent research assistants can help interpret meaning and feelings behind the words used by same-age participants, because they understand the teen lexicon.
- *Being flexible at all times*. Contemporary teenagers have exhausting timetables and responsibilities other than participating in research e.g. after school and

weekend tutoring, and their schedules are similar to busy adults', subject to changes beyond their control.

- *Appling a gamut of techniques to make teens feel comfortable*. Most of teenagers have never been involved in research, and they learn using different styles. Therefore, different activities, such as drawing and writing, should be part of the mixed techniques researchers use to stimulate conversation about sensitive topics.
- *Taking the heat off the question.* A dogged approach to asking key questions yields less than candid responses. Teens prefer to jump between off-topic conversations they initiate and key questions, which keeps them relaxed.
- *End conversations gently when discomfort arises*. Be alert to the signs, such as long pauses or slow responses.

9.3 Significant findings recap

Apart from one couple's decision, made before initiating their sexual relationship, most adolescents' decisions were impromptu and were likely to occur spontaneously, just before intercourse. This repeated scenario caused angst afterwards for the participants, highlighted relationship inequalities and put participants at risk.

Fear of negative consequences, including burdening their parents and of being punished, led sexually active Thai adolescents to make attempts to prevent pregnancy, but often with less than accurate information. Respecting the decisions of older girlfriends and fear of HIV/AIDS for only one participant were the only factors that led young men to practice safe sex. For women, their imbalance of power in heterosexual relationships put them at risk, especially when cohabitation enforced patriarchal social constructs. Only fear of being in social and financial difficulties, and especially the fear of being unable to fulfil cultural expectations as a firstborn daughter, led to females exercising power in a relationship. Being older facilitated females taking control. In this case study, female leadership meant the ability to control fertility safely, and power meant having SRHR, which young women otherwise did not have.

Risks to females unable to exercise their rights included pregnancy, stigmatisation when their condition was revealed, and abdication of all rights to make a decision when parents took control and forced an abortion. The ability of female teens to make decisions was further eroded when parents, post abortion, chose LARC to prevent the recurrence of an unplanned pregnancy. Secret abortion, however, allowed one female

to enforce her own decisions in a subsequent relationship, which may indicate why young women worldwide continue to seek often illegal, and sometimes dangerous, methods to terminate pregnancies in secret.

In Thailand, SRHR for adolescents remains an unfulfilled theory. Adolescents still have insufficient knowledge about contraception and confront social barriers to accessing modern methods, sometimes enforced by the prejudicial judgements made by adults who are supposed to provide SRH impartially. Other rights of adolescents, such as the right to express their views, remain suppressed by social norms that are at odds with natural instincts. Adolescents involved in this research unilaterally expressed a need for understanding from adults and older siblings. They also asked for adults — their parents, teachers and community pharmacists — to be their sources of knowledge about sex and contraceptive use. In reality, though, they felt that their rights to confidential treatment and privacy were eroded when they attempted to access SRH. Like teenagers around the world, Khon Kaen adolescents suggested a review of rigid traditional social beliefs in a bid to build bridges of understanding with the adults who had judged them.

9.4 Limitations of the study

This study provides insight of adolescents' perceptions and experiences on the contraceptive decision and their demand for fulfilling their sexual and reproductive health and rights. However, this study has some limitations as expanded below:

9.4.1 Other means of preventing unplanned pregnancy

The primary purpose of this study was to explore unplanned pregnancy in Thai adolescents, their choices of contraceptive methods and how they made these choices. However, within the diverse society that is Thailand, adolescents might decide to avoid unplanned pregnancies by escaping heterosexual relationships to various degrees. This could involve entering into same-sex relationships, or simply avoiding vaginal penetration by limiting sexual practices to oral sex, mutual masturbation and anal sex. However, investigating these practices was beyond the scope of this research.

9.4.2 Participants

This study selectively recruited adolescents who were attending either two Thai secondary schooling options, but potentially, up to 20% of available recruits in Thailand are adolescents living and working outside of the school system (UNICEF, 2013b) .

School participants are more likely to have been exposed to sex education, compared to those who are in other environments.

Some participants in this study were first chosen by school teachers, making the teacher the "editor", because teachers' choices were subject to their personal opinions. Potentially, they selected the best class and the best students from the best classes. This selection of participants by class teachers could have biased the results, because the students were not volunteers. In addition, the choices were not random.

In this study, vocational college class teachers asked the students to attend the group discussion, so groups included adolescents who were not close friends. At the upper secondary school, on the other hand, the teacher had no involvement in group formation. Groups consisted of adolescents who were already close to each other. The differing group makeups probably affected information sharing. To counter-balance a skewed selection process, initial recruitment criteria were broad: adolescents were recruited regardless of socio-economic status, sexual experiences or sexual orientation.

9.4.3 Location of the study

Findings from this study present the perceptions and experience of a group of adolescents who live in Khon Kaen, or at least a subset of teenagers from the region,. Although the sample size was small, most people in Khon Kaen have been socialised by Thai Isan or Lao-like cultural background. Therefore, results probably cannot be fully extrapolated to adolescents of other cultural backgrounds who live in the capital city Bangkok, Northern, the Southern region of Thailand or even other provinces in North-eastern Thailand, where there is Khmer and other cultural influences.

Furthermore, this research was focused on adolescents aged 15–19 years, who lived or studied in urban areas. In urban areas, young people might have more freedom to hang out with their friends at shopping malls, share their knowledge and learn from their more cosmopolitan surroundings. Theoretically, they have easy access to 24-hour convenience stores or pharmacies. In the rural areas, adolescents at the same age are likely to be under closer parental supervision, and find it even harder to access condoms and other contraceptive methods due to less access to healthcare services and convenience stores. Thus, this study is limited in its ability to be used as a case study representative of other regions in Thailand.

In reflecting on these limitations, however, extrapolation may be warranted to a degree, because many of the results agreed with conclusions drawn by other youth researchers not only in Thailand, but worldwide. The replicated results were across a wide range of factors, making generalisability more feasible.

9.4.4 Research aids

Participants in this study were offered access to youth research assistants and/or same-sex facilitators. Some participants stated that they were more comfortable talking about sex and contraceptive use with adults of the same sex. However, they did not ask for same-sex researchers or research assistants directly. Yet, they may have been too shy to request this option, and unfortunately, the youth services became unavailable at times due to schedule clashes. Whether youth assistants would have facilitated or stifled conversations remains an unknown.

9.4.5 Time limitation and the boredom of adolescents

I spent four months in the field. The first month was spent seeking schools and introducing the study. Data was collected after that. In the second month, five discussion groups were completed, and a few in-depth interviews were started. In-depth interviews were conducted until the end of the third month. In the fourth month, I found that adolescents who were in group discussions (in both school settings) were not inclined to attend interviews. They might have gotten too familiar with me and had no curiosity to satisfy. Overall, although research objectives were met, lack of time presented a significant challenge.

9.5 Recommendation for further research

This study found that adolescents' contraceptive decisions were complex and uncoordinated. They all had different experiences, and found themselves in a variety of situations. Such complexity, mirrored by their differing accounts, has shown that further research is essential to expand this case, or pilot, study. A larger sample size would be beneficial. Specific suggestions for further researcher are presented in sections 9.5.1–9.5.5.

9.5.1 Focusing on other means of pregnancy prevention

There are various means to prevent unplanned pregnancies, and not all of these were explored in this project. Abstinence or not engaging in sexual activities could be the first means to prevent the unthinkable, and this option was not discussed. Also, as

noted in section 9.3, same-sex relationship or no-penetration heterosexual relationships were not within the terms of reference. Further, large-scale studies on adolescents' SRH is needed to increase understanding if their sexual behaviours.

9.5.2 Focusing on social belief/values and decision making

In this study, I found that hierarchical social beliefs/values defined adolescents' decisions. In fact, these social beliefs/values silently control Thai society. Some people might be able to make sense of these social norms and live freely away from or according to the rules imposed by others. However, others might not be able to live their lives according to such patriarchal social values. It would be invaluable to investigate the social norms governing modern Thai society, how individuals deal with them, and there transitioning over time in the context of SRHR. No published documents on Thai social beliefs influencing Thai sexual and contraceptive behaviours exist, so such an investigation would be a seminal work.

9.5.3 Recruiting a wide range of participants

Although many studies on adolescent pregnancy have focused on young women, this study recruited males as well. However, only a small sample was recruited, and these subjects came from only two schools. In future, to expand the representativeness of study results, researchers could invite:

- adolescents from other settings such as those practicing other religions, those attending informal schools and teen members of Internet communities,
- adolescents from rural areas, and
- adolescents living together as sexual partners.

Moreover, recruiting only sexually active adolescents to the study may help researchers to clarify decision making as reported first hand, rather than relying on secondary accounts of witnessed events, or events where gossip is the main descriptor.

9.5.4 Avoiding face-to-face interactions

This study involved face-to-face invitations and was based on personal interactions with participants. Sexual and contraceptive topics are very personal issues and are normally discussed only with close confidants although in this study participants appeared to relax "into" very frank and open communication with the researcher. Because face-to-face interactions contain an element of pressure when intimate topics are discussed, telephone-based interviews could be a choice used to avoid embarrassment and to

facilitate disclosure. Regarding working with vulnerable populations, telephone-based conversations could also be more suitable for guarding participants' confidentiality and privacy.

9.5.5 Conducting research with a new research design

This study utilised a qualitative approach based on thematic analysis. Data were analysed and categorised according to themes. To a degree, whole lived experiences were compromised and could not be captured. For example, I found that some participants had more than one reason to make a decision, but their stories had to be cut into pieces to fit suitable themes. Further research using a different design may be advisable to enhance understanding. For instance, phenomenology could be used as an alternative approach.

9.6 Recommendation for policy/programme makers

I agree with Oringanje et al. (2009), , who proposed two side-by-side public health interventions (increasing sex education and accessibility to SRH services) to address the adolescent pregnancy issue. However, my findings also suggest that holistic approaches are required, and that these must be managed according the perspective of the teenager and their SRHR. Therefore, I advocate two main approaches for Thailand (sections 9.6.1 and 9.6.2).

9.6.1 The morals-cultural based approach

In the patriarchal society that defines Thailand, young females are more likely to be condemned as bad children than male youths when an unwanted pregnancy is discovered (Sridawruang, Crozier, et al., 2010). As same as other Thai women, these girls are also expected to be a good mother (Liamputtong et al., 2004). Yet, pregnancy could not happen without a male involved, so Thais as a responsible society should encourage males to 1) start the conversation about protected sex; 2) use an effective, male-controlled contraceptive method; and 3) protect women from the risks of pregnancy/STDs and condemnation. These ethical principles should be transferred to males via gender equality socialisation. These moral concepts can be taught by parents, teachers, government health officials, and through social and traditional media. I believe that Thai adults whose social positions have put them in high places as leaders at national and local levels should be proactive in building these concepts around their own households and those of wider Thai society.

9.6.2 Human rights-based approach to health

Thailand ratified the UDHR in 1948, CEDAW in 1985 and CRC in 1992. According to these international human rights treaties, the Government of Thailand is the main actor to respect, protect and fulfil the rights of all people in Thailand, including adolescents. However, study results suggest that the Thai Government needs to work much harder to implement these treaties. Four basic rights are discussed in sections below.

The right to express their opinion

The first focus of this study was on adolescents' SRHR. However, participants in this study urged Thai adults and Thai society at large to respect, protect and fulfil their rights. Consideration of such rights could help the sexually active adolescents create better futures for themselves (UNs, 2017). Giving a space to adolescents to express their own views in public, particularly on carrying condoms or buying condoms, could help adults in the positions of policymakers or health providers to recognise the unmet needs of adolescents for SRH services.

Adolescents should be respected, protected and fulfilled in their rights as a human, as documented in Article 19 of *Universal Declaration of Human Rights* (1948): "Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers." Article 13 of the *Convention on the Rights of the Child* (1989) reinforces these concepts.

> The child [including teenager] shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

The right to information

Adolescents should have their sexual and reproductive rights to access information on contraception. Sexual and reproductive rights were clearly defined in the International Conference on Population and Development (ICPD) in 1994 and in the Beijing Declarations of Platform for actions in 1995. Sexual and reproductive rights refer to

> These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and *to have the information and means to do so* [emphasis mine] , and the right to attain the highest standard of

> sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (United Nations Population Fund, 1995, p. 46)

However, giving information or delivering sex education, findings of this study suggest conjugating gender-based concepts. Thus, girls should be educated by female educators: parents, female teachers and female pharmacists. Similar gendered educators should be available for boys. Then, the government and policy/programme makers could provide same-sex health educators to deliver gender-tailored SRH programmes. Additionally, in the sexually diverse society of Thailand, delivering suitable sex education for the lesbian-gay-bisexual-transgender (LGBTs) should also be addressed.

As seen from the small hints revealed in this study, knowledge about contraception does not predicate prudence. To promote prudence in choosing effective contraceptive methods, policy makers and SRH programme facilitators should consider additional public health interventions, an approach that includes more than hard information/facts about physiological and behavioural elements of sexual relations. This study suggests using a morals-culture based approach in which education includes cultural, religious, gender power relations issues that influence women's risk of pregnancy and its currently gendered outcomes.

The right to sexual and reproductive health services

Adolescents should have their sexual and reproductive rights to obtain the highest standard of sexual and reproductive rights as mentioned in the International Conference on Population and Development (ICPD) in 1994 and in the Beijing Declarations of Platform for actions in 1995.

In Thailand, public and private health sectors including primary care units, schools and community pharmacies should provide consistently available youth-friendly services in places and times teenagers can use them. Youth-friendly services should, in turn, be defined by strict confidentiality and privacy codes. Health providers or educators should have good verbal and non-verbal communication skills and should be open-minded and free of bias.

Condom vending machines should be placed in private but accessible locations in places adolescents frequent, such as toilets in shopping malls, healthcare centres,

entertainment centres, petrol station and bars. The cost of condoms should be subsidised, and quality should be controlled to a high standard.

The right to bodily integrity

To fulfil adolescents' rights might take time, because changing behaviours and cultural beliefs is difficult. As part of consciously changing social values, I believe health advocates should encourage women to recognise their bodily integrity rightd. The findings of this study confirm that female teens who exercised their right to control their own bodies were the most successful advocates for safe sex.

9.6.3 Summary of recommendation for policy/programme makers

Holistic approach including morals-cultural based, rights-based and gender-based approach should be implemented to advocate Thai adolescents to make prudent decisions about contraceptives, to increase contraceptive use and to address adolescent pregnancy, a national public health problem.

9.7 Final reflection

The questions I had had when I was working at a community pharmacy in Thailand long ago were answered by this research. I found that before sexually active Thai adolescents came to the pharmacy, they confronted many types of fear. They tried to get condoms, but were hindered by social, financial and physical barriers despite the supposedly wide availability of condoms. I found that teenagers often fought an internal battle with their sex drive, which was about the enhanced pleasure of "riding bareback". Unfortunately, male sex drive put the onus on young women to insist on condoms, which they could not do in many cases as the male's inferior in Thai hierarchy. I saw this pattern of behaviour repeated again and again.

The qualitative approach helped me to actively listen to participants and to respect their right to control the information they delivered to me, a stranger. Qualitative methods also gave the power to participants to lead the conversation and to divert it according to their interests and comfort levels. Unexpected stories, such as those of cohabitation and cultural expectations on the firstborn daughter, emerged by using this approach.

Morals-culture based, rights-based and gender-based public health approaches are suggested to encourage gender equality between the sexes in making informed decisions about contraception. Based on these findings, I, as a community pharmacist, believe that pharmacists particularly those are working long hours in community settings could

be given relevant training and skills and the main role to be one of the key providers of contraceptive information to adolescents. The community pharmacist can play a key role in encouraging adolescents to safe sex practice. Pharmacists in other parts of Thai health care services, such as provincial hospitals and community hospitals could provide 24-hour hotline or special services for young people who need urgent contraceptive information and services. Moreover, pharmacists could involve and work collectively with other health workers, adolescents' parents, school teachers, people in community, community leaders, and governmental and non-governmental organisations in moving forward the Prevent and Solution of the Adolescent Pregnancy Act, B.E. 2559 (2016). My hope is that Thailand can emerge into a future where young, sexually active populations are not at risk of the physical and mental health complications that arise from adolescent pregnancy, as well as HIV/AIDS and other sexual transmitted diseases. Then, and only then, they can enjoy growing up, enjoy their sexuality without fear and work uninterrupted to obtain their goals for the future.

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Appendices

Appendix A: Ethic considerations

a. Ethics approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

30 June 2017

Sari Andajani
Faculty of Health and Environmental Sciences

Dear Sari

Ethics Application: **15/225 Perception of Thai adolescents on contraceptive use and influencing factors.**

On 3 August 2015 you were advised that your ethics application was approved.

I would like to remind you, that it was a condition of this approval that you submit to AUTEC the following:

- A brief annual progress report using the EA2 Research Progress Report / Amendment Form, available at http://www.aut.ac.nz/researchethics/forms, or
- A brief Completion Report about the project using the EA3 from, which is available online through http://www.aut.ac.nz/researchethics/forms. This report is to be submitted either when the approval expires on 3 August 2018 or when the project is completed;

It is also a condition of approval that AUTEC is notified if the research did not proceed or any adverse events occurring during the research. If there has been any alteration to the research, (including changes to any documents provided to participants) then AUTEC approval must be sought using the EA2 form.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please contact us at ethics@aut.ac.nz.

Yours sincerely

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: ch.sansanee@gmail.com

b. Patient information sheet for focus group discussion

Participant Information Sheet

(Focus group discussions)

Date Information Sheet Produced:

dd mmmm yyyy

Project Title

Thai adolescents' perception on contraceptive use and influencing factors

An Invitation

Hello, I am Sansanee, a PhD student in school of Public Health and Psychosocial Studies, Auckland University of Technology, New Zealand. I would like to invite you to participate in my study. This study is a fulfilled requirement of my doctoral degree. It aims to increase understanding of Thai adolescents' experiences of decision making on contraceptive use and its influencing factors. This study also aims to raise adolescents' voices concerning sexual and reproductive health and rights.

I will be the main researcher of this study and under supervision of Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop. However, I will provide the research assistants in the case of that you require for same-sex or same-age group facilitators. Participating in this study is voluntary. Therefore, you can withdraw or leave this study at any time prior to completion of data collection and without giving me any explanation. Although this study may directly not benefit you, the findings of this study could benefit to other unmarried sexually active Thai adolescents who are silently confronting sexual and reproductive health problems and at high risk of unwanted pregnancy.

What is the purpose of this research?

The main purpose of my research originates from the adolescent pregnancy problems in Thailand. Thailand has confronted with the adolescent pregnancy problem since 2008. After the Thai government has provided a number of sexual and reproductive health intervention to tackle this problem, the adolescent pregnancy remains. Low contraceptive use rates of Thai adolescents, particularly among those aged 15-19 years old, have been reported. Up to 50% of sexually active adolescents reported that they use some kind of contraceptive methods. Approximately, 90% of them reported that they used traditional methods such as withdrawal methods at most of the time although they can access free and effective contraceptive methods from youth-friendly clinics and can purchase condoms and contraceptive pills with low price at pharmacy and convenience stores. There is little known about how Thai adolescents make decisions on contraceptive use. Therefore, this study aims to explore the three main areas: (1) how do Thai adolescents aged 15-19 years old make decisions about contraceptive use? (2) What factors influence their decision making? (3) What are Thai adolescents' needs and expectations from Thai society regarding sexual and reproductive health and rights?

This study is a requirement to fulfil my PhD qualification which is sponsored by the Thai government. The results of this study will be disseminated in the features of the PhD thesis, papers for conferences and for publishing in academic journals.

How was I identified and why am I being invited to participate in this research?

You are being asked to take part in my study because according to studies Thai adolescents aged 15-19 are at risk of sexual and reproductive health problems and are likely to reject contraceptive use. In order to increase understanding of Thai adolescents' behaviours and to raise their voices concerning sexual and reproductive health including contraceptive use, you are being invited to participate in focus group discussions.

Your experiences, perception, and perspectives you are going to share here will benefit to Thai adolescents not only nowadays but also in the future because this data will help sexual and reproductive health programme developers or policy makers provide the suitable programmes tailored to Thai adolescents.

What will happen in this research?

After you accept my invitation to participated in my study, you will be invited to discuss and share idea about stories of a young sexually active couple and other Thai adolescents' behaviours. There are two sessions of focus group discussion and you will spend up to 60 minutes for each session. You will be able to choose activities such as drawing or mind-mapping to present your experiences, perceptions, and perspectives about Thai adolescents' behaviours. You can also select to work in pairs first and then to work as a group. The indicative questions for the first session are (1) how do Thai adolescents make decision making on contraceptive use? (2) What factors affect their decision making? In the end of the first session, we will summarise and present our ideas to each other in our group. Here, if anybody has further ideas or comments, we can discuss again.

In the second session, you will be able to choose activities such as drawing or mind-mapping to present your expectations and needs regarding sexual and reproductive health and rights in Thailand. You can also select to work in pair firsts and then to work as a group. The indicative question for the second session is (1) what are Thai adolescents' expectations and needs regarding sexual and reproductive health and rights? In the end of session, we will group and rank our expectations and our needs.

During focus group discussions, you can withdraw at any time you want and without giving me any explanation or permission. However, information you have shared will be used in this group and without naming who said it.

What are the discomforts and risks?

During focus group discussions, we may feel discomfort and embarrassed from talking about sexual practices and how Thai adolescent use contraceptive methods to prevent pregnancy. Additionally, you may feel insecure to be a victim of stigmatization and judgement by other participants from holding great knowledge about sex and contraceptive use.

During focus group discussion, you may feel discomfort from my activities such as note taking or taking a photograph during working in pairs or with your small group.

How will these discomforts and risks be alleviated?

In order to minimise these feeling: discomforts, embarrassed, and insecure, we will brainstorm what we can help each other and which activities we should use for focus group discussions. We may work in pairs or in a small group before presenting our ideas to our group. Please do not hesitate to tell me what you would like to do. Please do not forget that what you share here is our group's ideas, not only you because personal identity will be kept confidentially.

Moreover, you can reject to answer or share your experiences, perceptions, and perspectives if you feel uncomfortable to do that. You can also ask to stop the audio-recording and leave the discussions any time you want.

Regarding note taking and taking a picture, if you feel discomfort and insecure please do not hesitate to ask me to stop note-taking or other activities. I am appreciated to do that. All photographs I take will be checked by you and your group in which pictures you are happy or unhappy to publish. I will take pictures of your creative or artistic work. I will not take any picture of you and others in our group.

Counselling services will be provided for you without any cost. If you need psychological supports or further information about contraception, please contact me. I will ask a health counsellor to give you advices and supports.

What are the benefits?

This study will offer a friendly place that you can share your experiences, perceptions, and perspectives regarding social disapproval issues of sexual and reproductive health including contraceptive use. Your sharing will also benefit to other Thai adolescents after your voices have been heard and used as evidence to improve youth-friendly sexual and reproductive health programmes.

How will my privacy be protected?

All information we have share in our group will be keep confidentially. You real name will not be required and identified in the finding reports. All nicknames used here will be changed again during transcription process.

Transcription will be sent to you via email. If you do not want to receive this transcription, you can choose not to do that. The data of our group discussion can be accessed by me and my supervisors, Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop. Computer files will be accessed only from three of us.

After coding and generating themes for the whole data gathered from four focus group discussions, this interpretation will be send to the local advisory group for checking trustworthiness of the data analysis. Six members of the local youth advisory group will treat the data under the confidentiality agreement: keep confidentiality and anonymity.

What are the costs of participating in this research?

You do not need to spend any expense of participating in this research but instead I will provide travelling costs and refreshment to appreciate your time.

What opportunity do I have to consider this invitation?

I will spend one week for considering this invitation. If you have any enquiries or need further information about this study, please do not hesitate to text or mail me.

How do I agree to participate in this research?

After you decide to participate in focus group discussions, I will pass the consent form to you. In consent form, you need to read and sign in order to make sure that you understand about this research, as well as your rights including privacy and confidentiality.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on the results of this study via email even though we summarise our experiences, perceptions, and perspectives when we were in the process of focus group discussion. However, you have options to reject to receive the results.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Sari Adajani, sari.andajani@aut.ac.nz, 064 9921 9999 ext 7738

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz , 0064 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Sansanee Chanthasukh, ch.sansanee@gmail.com and Facebook account: Brave archer

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

เอกสารแนะนำงานวิจัย

สำหรับผู้เข้าร่วมงานวิจัยในกระบวนการอภิปรายกลุ่ม

(Participant information sheet for focus group discussions)

วันที่ออกเอกสาร คือ

วันที่ เดือน พ.ศ. ๒๕๕๘

ชื่อโครงการ

การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

คำกล่าวเชิญ

สวัสดีนะคะทุกๆท่าน ขอแทนตัวเองว่าป้าอิ๊นะคะ ป้าอิ๊ชื่อศันสนีย์ จันทสุขนะคะ ตอนนี้เป็นนักเรียนปริญญาเอกของโรงเรียนสาธารณสุขและจิตวิทยาสังคม จากเอยูที (Auckland University of Technology) ที่ประเทศนิวซีแลนด์ ป้าอิ๊อยากเชิญเด็กวัยรุ่นไทยอายุ 15-19 ปี มาร่วมในงานวิจัยโครงการนี้ค่ะ ดประสงค์ของงานวิจัยโครงการนี้ เพื่อเพิ่มพูนความเข้าใจประสบการณ์ชีวิตและมุมมองของวัยรุ่นโดยเฉพาะอย่างยิ่งเกี่ยวกับเรื่องการตัดสินใจในการใช้วิธีคุมกำเนิด เพื่อป้องกันการตั้งครรภ์ไม่พึงประสงค์ รวมถึงปัจจัยที่มีผลต่อการตัดสินใจนั้นๆ นอกจากนี้ งานวิจัยนี้ยังมุ่งที่จะรวบรวมสิ่งจำเป็นและสิ่งที่วัยรุ่นต้องการที่เกี่ยวกับอนามัยเจริญพันธุ์และสิทธิอนามัยเจริญพันธุ์

ป้าอิ๊จะเป็นนักวิจัยหลักสำหรับโครงการนี้ โครงการนี้ดำเนินการภายใต้การดูแลของอาจารย์ที่ปรึกษาสองท่าน คือ Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop แต่อย่างไรก็ตาม การวิจัยนี้อาจจะมีผู้ช่วยนักวิจัยท่านอื่นมาร่วมด้วยถ้าผู้เข้าร่วมวิจัยคือหนูๆวัยรุ่นที่จะเข้าร่วมวิจัยต้องการผู้ร่วมกระบวนการกลุ่มที่มีอายุใกล้เคียงกันหรือเพศเดียวกัน การเข้าร่วมงานวิจัยครั้งนี้เป็นการเข้าร่วมกิจกรรมโดยความสมัครใจ ดังนั้น วัยรุ่นที่เข้าร่วมในงานวิจัยครั้งนี้จะสามารถยกเลิกการเข้าร่วมได้ทุกเวลาเมื่อพวกเขาต้องการไม่ว่าจะเป็นก่อนหรือหลังการให้ข้อมูลและโดยไม่ต้องให้เหตุผลว่าทำไมถึงยกเลิก แม้ว่าการศึกษาครั้งนี้ไม่ได้มีประโยชน์โดยตรงกับหนูๆวัยรุ่นที่เข้าร่วมในการศึกษาครั้งนี้ แต่การร่วมแสดงความคิดเห็นและประสบการณ์ครั้งนี้อาจจะมีประโยชน์สำหรับวัยรุ่นคนอื่นๆที่กำลังเผชิญปัญหาด้านอนามัยเจริญพันธุ์อย่างโดดเดี่ยวและไม่กล้าเอ่ยปากบอกใคร และยังมีประโยชน์ต่อกลุ่มเด็กๆวัยรุ่นที่มีความเสี่ยงที่จะตั้งครรภ์ไม่พึงประสงค์

เป้าหมายของการศึกษาครั้งนี้

งานวิจัยครั้งนี้มีต้นกำเนิดมาจากปัญหาการตั้งครรภ์ไม่พึงประสงค์ในกลุ่มวัยรุ่นที่มีมาตั้งแต่ปีพ.ศ. 2551 รัฐบาลไทยได้ใช้หลากหลายวิธีในการแก้ไขปัญหาการตั้งครรภ์ไม่พึงประสงค์ในกลุ่มเด็กวัยรุ่น แต่จนถึงปัจจุบัน ปัญหาการตั้งครรภ์ไม่พึงประสงค์ในวัยรุ่นยังคุกรุ่น จากการศึกษาที่ผ่านมาพบว่า วัยรุ่นไทยโดยเฉพาะกลุ่มอายุ 15-19 ปี มีอัตราการใช้วิธีการคุมกำเนิดที่ค่อนข้างต่ำ มีประมาณ 50% ของเด็กวัยรุ่นที่มีเพศสัมพันธุ์ใช้วิธีการคุมกำเนิดที่มี

ประสิทธิภาพ นอกจากนี้ ประมาณ 90% ของเขาเหล่านั้น ยังใช้วิธีการหลั่งภายนอก ทั้งๆ ที่ยาคุมกำเนิดและถุงยางอนามัยมีขายด้วยราคาย่อมเยาและสามารถซื้อได้จากรนสะดวกซื้อ แต่อย่างไรก็ตาม ยังไม่มีการศึกษาใดที่ศึกษาลึกถึงรายละเอียดเกี่ยวการตัดสินใจในการใช้วิธีการคุมกำเนิดในกลุ่มวัยรุ่น ดังนั้น การศึกษานี้มีเป้าหมายหลักเพื่อตอบคำถาม 3 ประการดังนี้ คือ (1) วัยรุ่นเขาตัดสินใจในการใช้วิธีการคุมกำเนิดอย่างไร (2) ปัจจัยใดที่มีอิทธิพลต่อการตัดสินใจของเขา (3) เด็กๆวัยรุ่นเขาคาดหวังหรือต้องการอะไรจากสังคมไทย โดยเฉพาะด้านอนามัยสืบพันธุ์และสิทธิอนามัยสืบพันธุ์การศึกษานี้เป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกของป้าอี๊ผู้วิจัยหลัก ผู้วิจัยหลักได้รับทุนการศึกษาจากประเทศไทยให้ทำการศึกษาเรื่องการตัดใจในการใช้วิธีคุมกำเนิดในกลุ่มวัยรุ่น15-19 ปี ผลของการศึกษาเหล่านี้จะนำเสนอเป็นรูปเล่มวิทยานิพนธ์ บทความในการประชุมวิชาการและวารสารวิชาการ เพื่อเพิ่มพูนความรู้และความเข้าใจเกี่ยวกับสุขภาพของวัยรุ่นต่อไป

ผู้วิจัยหลักระบุผู้เข้าร่วมวิจัยและมีวิธีการเชิญผู้เข้าร่วมวิจัยอย่างไร

ผู้วิจัยหลักจะดำเนินการเชิญหนูเข้าร่วมงานวิจัยโครงการนี้ เพราะวัยรุ่นอยู่ในกลุ่มช่วงอายุเดียวกันกับวัยรุ่นที่เป็นกลุ่มอายุที่มีความเสี่ยงทางสุขภาพด้านอนามัยเจริญพันธุ์และมีแนวโน้มที่จะปฏิเสธการใช้วิธีการคุมกำเนิดเพื่อการป้องกันความเสี่ยงนั้น

การศึกษาประสบการณ์ การรับรู้และมุมมองของวัยรุ่นกลุ่มนี้จึงจะยังประโยชน์เพื่อการพัฒนานโยบายและโปรแกรมการส่งเสริมสุขภาพด้านอนามัยเจริญพันธุ์ให้แก่ตัววัยรุ่นในปัจจุบันและในอนาคตตามความต้องการที่แท้จริงและเหมาะสมกับวัยรุ่นไทย

อะไรจะเกิดขึ้นบ้างในการวิจัยครั้งนี้

หลังจากที่หนูวัยรุ่นตอบรับคำเชิญการเข้าร่วมวิจัย หนูจะมีกิจกรรมอภิปรายและแสดงความคิดเห็นเกี่ยวกับเรื่องของเด็กวัยรุ่นสองคน และเด็กวัยรุ่นไทยทั่วๆไปในเรื่องพฤติกรรมของพวกเขา กิจกรรมกลุ่มจะมีสองครั้ง แต่ละครั้งใช้เวลาไม่เกิน 60 นาที สมาชิกในกลุ่มจะช่วยกันตัดสินใจว่าเราจะทำกิจกรรมใดเพื่อตอบคำถามเช่น วาดภาพหรือเขียนผังความคิด เราอาจจะจับคู่ช่วยกันคิดก่อน แล้วค่อยรวมเป็นความคิดกลุ่มในภายหลัง คำถามที่จะใช้ในกระบวนการกลุ่มครั้งที่ 1 คือ (1) วัยรุ่นเขาตัดสินใจในการใช้วิธีการคุมกำเนิดอย่างไร (2) ปัจจัยใดที่มีอิทธิพลต่อการตัดสินใจของเขา ในตอนท้ายของกิจกรรมกลุ่มเราจะรวบรวมสิ่งที่เราระดมความคิดกัน และถ้ามีใครที่จะเสนอความคิดเพิ่มเติมเราจะอภิปรายร่วมกันอีกครั้งตอนท้ายนี้

กระบวนการกลุ่มครั้งที่ 2 ก็จะคล้ายกับครั้งแรก คือ สมาชิกในกลุ่มสามารถเลือกกิจกรรมที่อยากทำ เพื่อระดมความคิดเห็นเกี่ยวกับเรื่องเด็กๆวัยรุ่นเขาคาดหวังหรือต้องการอะไรจากสังคมไทย โดยเฉพาะด้านอนามัยสืบพันธุ์และสิทธิอนามัยสืบพันธุ์ ในตอนท้ายของกระบวนการกลุ่มครั้งนี้ เราจะรวบรวมแนวความคิดทั้งหมด และจัดอันดับความสำคัญว่าวัยรุ่นไทยต้องการอะไรก่อนหลัง

ระหว่างการทำกิจกรรมกลุ่ม หนูสามารถยกเลิกการร่วมกิจกรรมกลุ่มได้ทุกเวลาและโดยไม่จำเป็นต้องอธิบายเหตุผล แต่ข้อความหรือกิจกรรมที่หนูได้ร่วมแสดงความคิดเห็นไปแล้วจะยังใช้เพื่อการศึกษาต่อไปเพราะเราไม่ได้ระบุว่าใครพูดอะไร

อะไรที่จะทำให้รู้สึกไม่สะดวกใจและเป็นความเสี่ยง

ระหว่างกิจกรรมกลุ่ม หนูอาจจะไม่สะดวกใจ เขินอายและไม่ไว้ใจที่จะพูดคุยเรื่องเกี่ยวกับพฤติกรรมทางเพศและวิธีใช้การคุมกำเนิดเพื่อการป้องกันการตั้งครรภ์ไม่พึงประสงค์ นอกจากนี้หนูอาจจะรู้สึกไม่ปลอดภัย เพราะเกรงว่าจะโดนคนอื่นๆว่าหนูรู้ดีในเรื่องพฤติกรรมทางเพศและวิธีคุมกำเนิด

หนูอาจจะรู้สึกไม่วางใจเมื่อเห็นผู้วิจัยหลักคือ ป้าอิ๊ จดข้อมูลที่หนูพูดคุยออกมา หรือการบันทึกภาพ

จะแก้ไขการรู้สึกไม่สะดวกใจและความเสี่ยงนั้นอย่างไร

เพื่อป้องกันไม่ให้หนูรู้สึกไม่สะดวกใจ เขินอายและไม่วางใจที่จะพูดคุยเรื่องนี้ สมาชิกในกลุ่มเราจะมาระดมความคิดว่าเราจะทำยังไง และใช้กิจกรรมใดในกระบวนการกลุ่ม เราอาจจะทำงานเป็นคู่หรือกลุ่มเล็กๆก่อนแล้วค่อยมารวมความคิดในกลุ่มใหญ่ และ อย่าลืมนะคะ การระดมความคิดครั้งนี้เป็นความคิดของกลุ่ม เป็นผลงานของกลุ่ม ไม่ใช่ของเราคนเดียวค่ะ และป้าอิ๊ไม่ได้ระบุเขียนไปว่าใครพูดว่าอะไร และเราจะไม่ใช้ชื่อจริงในการนำเสนอข้อมูลใดๆ ทั้งสิ้น

นอกจากนี้เพื่อลดความรู้สึกเหล่านั้น ถ้าหนูไม่สบายใจที่จะตอบหรือแสดงความคิดเห็นหนูสามารถทำได้นะคะ หรือถ้าไม่อยากให้ป้าอิ๊จดหรือบันทึกเสียง หนูสามารถบอกได้ทันทีเลยนะคะ และภาพถ่ายนั้น ป้าอิ๊จะนำมาให้หนูและเพื่อนๆในกลุ่มดูก่อนว่า ภาพไหนจะอนุญาตหรือไม่อนุญาตให้เผยแพร่

บริการให้คำปรึกษามีบริการฟรี ถ้าหนูรู้สึกไม่สบายใจระหว่างการทำกิจกรรมกลุ่ม อยากคุยกับผู้ให้คำปรึกษา หนูสามารถไปคุยกับผู้ให้คำปรึกษาได้เลยนะคะ เดี๋ยวป้าอิ๊จะติดต่อประสานงานให้ ถ้าหนูๆ ท่านใดต้องการข้อมูลความรู้เกี่ยกับการคุมกำเนิดเพิ่มเติมหนูสามารถไปได้เช่นกันค่ะ แจ้งความประสงค์ป้าอิ๊เลยนะคะ

ประโยชน์ของการศึกษานี้คืออะไร

ประโยชน์โดยตรงต่อผู้เข้าร่วมในงานวิจัยโครงการนี้คือ ผู้ร่วมวิจัยจะมีโอกาสแสดงความคิดเห็นและประสบการณ์ในประเด็นที่สังคมไทยเห็นว่าเป็นประเด็นที่เด็กวัยรุ่นมิควรพูดหรือแสดงออก ป้าอิ๊ผู้วิจัยหลักได้เตรียมสถานที่ที่ปลอดภัยที่หนูๆสามารถแสดงความคิดเห็นได้อย่างเป็นตัวของตัวเอง ข้อมูลเหล่านั้นจะถูกเก็บไว้เป็นความลับและไม่เปิดเผยชื่อผู้แสดงความคิดเห็น เสียงของวัยรุ่นไทยที่ได้รวบรวมในรายงานผลการศึกษาโครงการนี้ จะเป็นประโยชน์ในการพัฒนานโยบายและโปรแกรมส่งเสริมสุขภาวะอนามัยเจริญพันธ์และสิทธิอนามัยเจริญพันธุ์ของวัยรุ่นโดยรวมต่อไป

ความเป็นส่วนตัวของผู้เข้าร่วมการศึกษาจะได้รับการดูแลปกป้องอย่างไร

ทุกๆข้อมูลที่หนู วัยรุ่นผู้เข้าร่วมในงานวิจัยครั้งนี้ จะได้รับการเก็บปกปิดเป็นความลับและไม่มีการระบุชื่อที่แท้จริงของผู้ให้ข้อมูล ชื่อที่ใช้ที่นี่จะเป็นชื่อเล่น และหลังจากการถอดบันทึกเสียงการทำกระบวนการกลุ่มแล้ว ป้าอิ๊ผู้วิจัยหลักจะทำการเปลี่ยนแปลงอีกครั้งสำหรับการรายงานผลการศึกษา

บทสนทนาที่ถอดจากการบันทึกระหว่างกระบวนการกลุ่มจะถูกส่งไปยังหนูๆ วัยรุ่นผู้เข้าร่วมในงานวิจัยทางอีเมลล์เพื่อตรวจความความถูกต้อง บทสนทนาเหล่านี้และไฟล์ที่เกี่ยวข้องจะมีเพียงป้าอิ๊ผู้วิจัยหลักและอาจารย์ที่ปรึกษา Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop เท่านั้นที่สามารถเข้าถึงข้อมูลเหล่านี้ได้

ระหว่างการวิเคราะห์ข้อมูลจากกระบวนการกลุ่มจำนวนสี่กลุ่ม ประเด็นหลักที่ได้จากกากรวิเคราะห์จะถูกส่งไปยังคณะที่ปรึกษาท้องถิ่นที่จังหวัดขอนแก่น คณะที่ปรึกษานี้จะประกอบด้วยวัยรุ่นจำนวน 6 ท่านที่ผ่านการทำข้อตกลงในการรักษาข้อมูลเป็นความลับของงานวิจัยว่าจะไม่นำไปเปิดเผยพูดคุยต่อผู้ใดทั้งสิ้นยกเว้นผู้วิจัยหลักคือป้าอิ๊ คณะที่ปรึกษานี้จะทำหน้าที่ตรวจสอบข้อมูลที่ผ่านการวิเคราะห์จากผู้วิจัยหลักว่ามีความน่าเชื่อถือหรือไม่ และเป็นเสียงจากวัยรุ่นไทยจริงหรือไม่ ก่อนการรายงานผลการศึกษา

ค่าใช้จ่ายในการเข้าร่วมการศึกษาครั้งนี้คืออะไร

การเข้าร่วมงานวิจัยครั้งนี้ไม่มีค่าใช้จ่ายใดๆทั้งสิ้น เพื่อเป็นการแสดงความขอบคุณที่หนูๆวัยรุ่นเข้าร่วมกิจกรรมนั้น ทางป้าอิ๊ได้เตรียมค่าเดินทางสำหรับหนูๆวัยรุ่นแต่ละท่าน และจัดเตรียมอาหารของว่างระหว่างการเข้าร่วมกิจกรรม

จะสามารถใช้เวลาที่ใช้การพิจารณาคำเชิญเพื่อเข้าร่วมงานวิจัยครั้งนี้ได้นานเท่าใด

ทางผู้วิจัยหลัก(ป้าอิ๊)จะใช้เวลาประมาณ 1 สัปดาห์ในการรอการตอบรับคำเชิญเข้าร่วมงานวิจัยนี้ ถ้าหนูๆวัยรุ่นท่านใดมีข้อข้องใจซักถามเพิ่มเติมเกี่ยวกับงานวิจัยโครงการนี้ กรุณาติดต่อผู้วิจัยหลักคือป้าอิ๊ได้ตามที่ระบุข้างท้ายเอกสารนี้ เมื่อหนูๆวัยรุ่นตัดสินใจที่จะเข้าร่วมการวิจัยครั้งนี้ หนูๆวัยรุ่นจะได้รับเอกสารและลงชื่อแสดงความยินยอมที่จะเข้าร่วมการวิจัยในเอกสารแสดงความยินยอมดังกล่าว ในเอกสารนี้จัดทำเพื่อเป็นการยืนยันว่าหนูๆวัยรุ่นทุกๆท่านรับทราบและเข้าใจเกี่ยวกับงานวิจัยโครงการนี้ รวมทั้งสิทธิที่จะได้รับในฐานะการเป็นผู้เข้าร่วมงานวิจัยในด้านการรักษาความลับและความเป็นส่วนตัวของหนูๆเอง

ผู้เข้าร่วมการศึกษาจะได้รับผลการศึกษาของงานวิจัยนี้ไหม

ผู้เข้าร่วมการศึกษา(หนูๆวัยรุ่น)ในโครงการวิจัยครั้งนี้จะได้รับรายงานการศึกษานี้แม้ว่าในกระบวนการกลุ่มจะมีการสรุปใจความสำคัญจากประสบการณ์ การรับรู้และมุมมองของผู้เข้าร่วมวิจัยวัยรุ่นแล้วก็ตาม อย่างไรก็ตามหนูสามารถเลือกที่จะรับหรือไม่รับรายงานดังกล่าวได้โดยระบุในเอกสารแสดงความยินยอมเข้าร่วมงานวิจัย

ถ้ามีข้อสงสัยหรือข้อข้องใจใดๆ จะทำอย่างไร

ข้อสงสัยและข้อข้องใจใดๆ เกี่ยวกับลักษณะของงานวิจัยนี้ กรุณาติดต่อ อาจารย์ที่ปรึกษาหลักของงานวิจัยในครั้งนี้คือDr Sari Andajani, อีเมลล์ sari.andajani@aut.ac.nz โทร 064 9921 9999 ต่อ 7738

ข้อสงสัยและข้อข้องใจใดๆ เกี่ยวกับกระบวนการของงานวิจัยนี้ กรุณาติดต่อ เลขาธิการหลักของคณะกรรมการจริยธรรมการวิจัยของ Auckland University of Technology คือ Kate O'Connor อีเมลล์ ethics@aut.ac.nz ,โทร 064 921 9999 ต่อ 6038.

ใครที่ผู้เข้าร่วมการศึกษาสามารถติดต่อเพื่อขอข้อมูลเพิ่มเติม

รายละเอียดการติดต่อผู้วิจัยหลัก คือ ป้าอี๊ ศันสนีย์ จันทสุข ch.sansanee@gmail.com หรือ Facebook account: Brave archer

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

c. Patient information sheet for in-depth interviews

Participant Information Sheet

(In-depth interviews)

Languages: copies of this information sheet are in English and Thai

Date Information Sheet Produced:

19 May 2015

Project Title

Thai adolescents' perception on contraceptive use and influencing factors

An Invitation

Hello everybody, I am Sansanee, a PhD student in school of Public Health and Psychosocial Studies, Auckland University of Technology, New Zealand. I would like to invite you to participate in my study. This study is a fulfilled requirement of my doctoral degree. It aims to increase understanding of Thai adolescents' experiences of decision making on contraceptive use and its influencing factors. This study also aims to raise adolescents' voices concerning sexual and reproductive health and rights.

I will be the main researcher of this study and under supervision of Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop. However, I will provide the research assistants in the case of that you require for same-sex or same-age interviewers. Participating in this study is voluntary; therefore, you can withdraw or leave this study at any time prior to completion of data collection and without any explanation. Although this study may directly not benefit you, the findings of this study could benefit to other unmarried sexually active Thai adolescents who are silently confronting sexual and reproductive health problems and at high risk of unwanted pregnancy.

What is the purpose of this research?

The main purpose of my research originates from the adolescent pregnancy problems in Thailand. Thailand has confronted with the adolescent pregnancy problem since 2008. After the Thai government has provided a number of sexual and reproductive health intervention to tackle this problem, the adolescent pregnancy remains. Low contraceptive use rates of Thai adolescents, particularly among those aged 15-19 years old, have been reported. Up to 50% of sexually active adolescents reported that they use some kind of contraceptive methods. Approximately, 90% of them reported that they used traditional methods such as withdrawal methods at most of the time although they can access free and effective contraceptive methods from youth-friendly clinics and can purchase condoms and contraceptive pills with low price at pharmacy and convenience stores. There is little known about how Thai adolescents make decisions on contraceptive use. Therefore, this study aims to explore the three main areas: (1) how do Thai adolescents aged 15-19 years old make decisions about contraceptive use? (2) What factors influence their decision making? (3) What are Thai adolescents' needs and expectations from Thai society regarding sexual and reproductive health and rights?

This study is a requirement to fulfil my PhD qualification which is sponsored by the Thai government. The results of this study will be disseminated in the features of the PhD thesis, papers for conferences, and articles for publishing in academic journals.

How was I identified and why am I being invited to participate in this research?

You are being asked to take part in this study because according to studies Thai adolescents aged 15-19 years are at risk of sexual and reproductive health problems and are likely to reject contraceptive use. In order to increase understanding of Thai adolescents' behaviours and to raise their voices concerning sexual and reproductive health including contraceptive use, you are being invited to involve in-depth interviews.

Your experiences, perception, and perspectives you are going to share here will benefit to Thai adolescents not only nowadays but also in the future because this data will help sexual and reproductive health programme developers or policy makers provide the suitable programmes tailored to Thai adolescents.

What will happen in this research?

After you accept my invitation to participated in my study, you will be invited to share your experiences, perceptions, and perspectives on the issue of decision making on contraceptive use. The three indicative questions are (1) how do you make decisions on contraceptive? (2) what factors influence your decisions? and (3) what you expect and need from Thai society concerning sexual and reproductive health and rights?

During interviews, you can reject to answer any enquiries you do not want to answer. You can withdraw at any time you want before and after data collection and without any explanation. Here, you can use your anonymous nickname for this interview.

After I collect whole data set, I will transcribe conversation I have with you and then send back to you for validity checking. After that, your anonymous name will be changed again for data analysis. Coding and generating themes will be done by me. Then, this interpretation will be sent to the local youth advisory group for checking that is from adolescents' stances. The final report of the study will be sent to you if you require.

What are the discomforts and risks?

During in-depth interviews, we may feel discomfort and embarrassed from talking about sexual practices and contraceptive methods you used for pregnancy prevention. You may also feel discomfort from my activities such as note taking.

How will these discomforts and risks be alleviated?

In order to minimise these feeling: discomforts, embarrassed, and insecure, you can reject to answer what you feel unhappy or uncomfortable to response. You can also ask me to stop the audio-recording and leave the interviews any time you want.

Regarding note taking, if you feel discomfort and insecure please do not hesitate to ask me to stop note-taking or other activities. I am appreciated to do that.

Counselling services will be provided for you without any cost. If you need psychological supports or further information about contraception, please do not hesitate to tell me. I will ask a health counsellor to give you advices and supports.

What are the benefits?

This study will offer a friendly place that you can share your experiences, perceptions, and perspectives regarding social disapproval issues of sexual and reproductive health including contraceptive use. Your sharing will also benefit to other Thai adolescents after your voices have been heard and used as evidence to improve youth-friendly sexual and reproductive health programmes.

How will my privacy be protected?

All information we have share here will be keep confidentially and anonymously. Please use your anonymous nickname here. All nicknames used here will be changed again after transcription process.

Transcription will be sent to you via email. If you do not want to receive this transcription, you can choose not to do that. The data of our group discussion can be accessed by me and my supervisors, Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop. Computer files will be accessed only from three of us.

During data analysis, the data interpretation will be send to the local advisory group for checking trustworthiness of the data analysis. Six members of the local youth advisory group will treat the data under the confidentiality agreement: keep confidentiality and anonymity.

What are the costs of participating in this research?

You do not need to spend any expense of participating in this research but instead I will provide travelling costs and refreshment to appreciate your time and your kind sharing.

What opportunity do I have to consider this invitation?

I will spend one week for considering this invitation. If you have any enquiries or need further information about this study, please do not hesitate to text or mail me.

How do I agree to participate in this research?

After you decide to participate in in-depth interviews, I will pass the consent form to you. In consent form, you need to read and sign in order to make sure that you understand about this research, as well as your rights including privacy and confidentiality.

Will I receive feedback on the results of this research?

Yes, you will receive feedback on the results of this study via email even However, you have options to reject to receive the results.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Sari Adajani, sari.andajani@aut.ac.nz, 0064 9921 9999 ext 7738*.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 0064 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Sansanee Chanthasukh, ch.sansanee@gmail.com and Facebook account: Brave archer

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

เอกสารแนะนำงานวิจัย

สำหรับผู้เข้าร่วมงานวิจัยในการสัมภาษณ์เชิงลึก

(Participant information sheet for in-depth interviews)

Languages:copies of this information sheet are in English and Thai

วันที่ออกเอกสาร คือ

วันที่ เดือน พ.ศ. ๒๕๕๘

ชื่อโครงการ

การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

คำกล่าวเชิญ

สวัสดีนะคะทุกๆท่าน ขอแทนตัวเองว่าป้าอิ๊นะคะ ป้าอิ๊ชื่อศันสนีย์ จันทสุขนะคะ ตอนนี้เป็นนักเรียนปริญญาเอกของโรงเรียนสาธารณสุขและจิตวิทยาสังคม จากเอยูที (Auckland University of Technology)ที่ประเทศนิวซีแลนด์ ป้าอิ๊อยากเชิญเด็กวัยรุ่นไทยอายุ 15-19 ปี มาร่วมในงานวิจัยโครงการนี้ค่ะ จุดประสงค์ของงานวิจัยโครงการนี้ เพื่อเพิ่มพูนความเข้าใจประสบการณ์ชีวิตและมุมมองของวัยรุ่น โดยเฉพาะอย่างยิ่งเกี่ยวกับเรื่องการตัดสินใจในการใช้วิธีคุมกำเนิดเพื่อป้องกันการตั้งครรภ์ไม่พึงประสงค์ รวมถึงปัจจัยที่มีผลต่อการตัดสินใจนั้นๆ นอกจากนี้ งานวิจัยนี้ยังมุ่งที่จะรวบรวมสิ่งจำเป็นและสิ่งที่วัยรุ่นต้องการที่เกี่ยวกับอนามัยเจริญพันธุ์และสิทธิอนามัยเจริญพันธุ์

ป้าอิ๊จะเป็นนักวิจัยหลักสำหรับโครงการนี้ โครงการนี้ดำเนินการภายใต้การดูแลของอาจารย์ที่ปรึกษาสองท่าน คือ Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop แต่อย่างไรก็ตาม การวิจัยนี้อาจจะมีผู้ช่วยนักวิจัยท่านอื่นมาร่วมด้วยถ้าผู้เข้าร่วมวิจัยคือหนูๆวัยรุ่นที่จะเข้าร่วมวิจัยต้องการผู้ร่วมกระบวนการกลุ่มที่มีอายุใกล้เคียงกันหรือเพศเดียวกัน การเข้าร่วมงานวิจัยครั้งนี้เป็นการเข้าร่วมกิจกรรมโดยความสมัครใจ ดังนั้น วัยรุ่นที่เข้าร่วมในงานวิจัยครั้งนี้จะสามารถยกเลิกการเข้าร่วมได้ทุกเวลาเมื่อพวกเขาต้องการไม่ว่าจะเป็นก่อนหรือหลังการให้ข้อมูลและโดยไม่ต้องให้เหตุผลว่าทำไมถึงยกเลิก แม้ว่าการศึกษาครั้งนี้ไม่ได้มีประโยชน์โดยตรงกับหนูๆวัยรุ่นที่เข้าร่วมในการศึกษาครั้งนี้ แต่การร่วมแสดงความคิดเห็นและประสบการณ์ครั้งนี้อาจจะมีประโยชน์สำหรับวัยรุ่นคนอื่นๆที่กำลังเผชิญปัญหาด้านอนามัยเจริญพันธุ์อย่างโดดเดี่ยวและไม่กล้าเอ่ยปากบอกใคร และยังมีประโยชน์ต่อกลุ่มเด็กๆวัยรุ่นที่มีความเสี่ยงที่จะตั้งครรภ์ไม่พึงประสงค์

เป้าหมายของการศึกษาครั้งนี้

งานวิจัยครั้งนี้มีต้นกำเนิดมาจากปัญหาการตั้งครรภ์ไม่พึงประสงค์ในกลุ่มวัยรุ่นที่มีมาตั้งแต่ปีพ.ศ. 2551 รัฐบาลไทยได้ใช้หลากหลายวิธีในการแก้ไขปัญหาการตั้งครรภ์ไม่พึงประสงค์ในกลุ่มเด็กวัยรุ่น แต่จนถึงปัจจุบัน ปัญหา

การตั้งครรภ์ไม่พึงประสงค์ในวัยรุ่นยังคุกรุ่น จากการศึกษาที่ผ่านมาพบว่า วัยรุ่นไทยโดยเฉพาะกลุ่มอายุ 15-19 ปี มีอัตราการใช้วิธีการคุมกำเนิดที่ค่อนข้างต่ำ มีประมาณ 50% ของเด็กวัยรุ่นที่มีเพศสัมพันธุ์ใช้วิธีการคุมกำเนิดที่มีประสิทธิภาพ นอกจากนี้ ประมาณ 90% ของเขาเหล่านั้น ยังใช้วิธีการหลั่งภายนอก ทั้งๆ ที่ยาคุมกำเนิดและถุงยางอนามัยมีขายด้วยราคาย่อมเยาและสามารถซื้อได้จากรนสะดวกซื้อ แต่อย่างไรก็ตาม ยังไม่มีการศึกษาใดที่ศึกษาลึกถึงรายละเอียดเกี่ยวการตัดสินใจในการใช้วิธีการคุมกำเนิดในกลุ่มวัยรุ่น ดังนั้น การศึกษานี้มีเป้าหมายหลักเพื่อตอบคำถาม 3 ประการดังนี้ คือ (1) วัยรุ่นเขาตัดสินใจในการใช้วิธีการคุมกำเนิดอย่างไร (2) ปัจจัยใดที่มีอิทธิพลต่อการตัดสินใจของเขา (3) เด็กๆวัยรุ่นเขาคาดหวังหรือต้องการอะไรจากสังคมไทย โดยเฉพาะด้านอนามัยสืบพันธุ์และสิทธิอนามัยสืบพันธุ์

การศึกษานี้เป็นส่วนหนึ่งของการศึกษาในระดับปริญญาเอกของป้าอิ๊ผู้วิจัยหลัก ผู้วิจัยหลักได้รับทุนการศึกษาจากประเทศไทยให้ทำการศึกษาเรื่องการตัดใจในการใช้วิธีคุมกำเนิดในกลุ่มวัยรุ่น15-19 ปี ผลของการศึกษาเหล่านี้จะนำเสนอเป็นรูปเล่มวิทยานิพนธ์ บทความในการประชุมวิชาการและวารสารวิชาการ เพื่อเพิ่มพูนความรู้และความเข้าใจเกี่ยวกับสุขภาพของวัยรุ่นต่อไป

ผู้วิจัยหลักระบุผู้เข้าร่วมวิจัยและมีวิธีการเชิญผู้เข้าร่วมวิจัยอย่างไร

ผู้วิจัยหลักจะดำเนินการเชิญวัยรุ่นอายุ 15-19 ปี เข้าร่วมงานวิจัยโครงการนี้ เพราะวัยรุ่นอายุ อายุ 15-19 ปี เป็นกลุ่มอายุที่มีความเสี่ยงทางสุขภาพด้านอนามัยเจริญพันธุ์และมีแนวโน้มที่จะปฏิเสธการใช้วิธีการคุมกำเนิดเพื่อการป้องกันความเสี่ยงนั้น

การศึกษาประสบการณ์ การรับรู้และมุมมองของวัยรุ่นกลุ่มนี้จึงจะยังประโยชน์เพื่อการพัฒนานโยบายและโปรแกรมการส่งเสริมสุขภาพด้านอนามัยเจริญพันธุ์ให้แก่ตัววัยรุ่นในปัจจุบันและในอนาคตตามความต้องการที่แท้จริงและเหมาะสมกับวัยรุ่นไทย

อะไรจะเกิดขึ้นบ้างในการวิจัยครั้งนี้

หลังจากที่หนูวัยรุ่นตอบรับคำเชิญการเข้าร่วมวิจัย หนูและป้าอิ๊จะคุยกันว่าเราจะเจอคุยกันแบบไหน หรือที่ไหน ใช้เวลาไม่เกิน 60 นาที คำถามที่จะถาม (1) หนูมีวิธีตัดสินใจในการใช้วิธีการคุมกำเนิดอย่างไร (2) ปัจจัยใดที่มีอิทธิพลต่อการตัดสินใจของหนู และ (3) หนูคาดหวังหรือต้องการอะไรจากสังคมไทย โดยเฉพาะด้านอนามัยสืบพันธุ์และสิทธิอนามัยสืบพันธุ์

ระหว่างการสัมภาษณ์เชิงลึก หนูสามารถใช้ชื่อเล่นสมมุติในการให้ข้อมูล หนูสามารถยกเลิกการร่วมกิจกรรมกลุ่มได้ทุกเวลา และโดยไม่จำเป็นต้องอธิบายเหตุผล

หลังจากการพูดคุยข้อมูลเหล่านี้ บทสนทนาระหว่างหนูและป้าอิ๊จะถูกถอดออกมาเพื่อการวิเคราะห์ข้อมูล ชื่อสมมุติที่หนูตั้งจะถูกเปลี่ยนอีกครั้ง ก่อนการวิเคราะห์ข้อมูล หลังจากนั้นข้อมูลที่ป้าอิ๊วอเคราะห์จะส่งไปยังคณะที่ปรึกษาท้องถิ่นเพื่อตรวจสอบว่า การวิเคราะห์ของป้านั้นมีความน่าเชื่อถือหรือไม่และออกมาจากเสียงของวัยรุ่นไทยหรือไม่

อะไรที่จะทำให้รู้สึกไม่สะดวกใจและเป็นความเสี่ยง

หนูอาจจะไม่สะดวกใจ เขินอายและไม่ไว้ใจที่จะพูดคุยเรื่องเกี่ยวกับพฤติกรรมทางเพศและวิธีใช้การคุมกำเนิดเพื่อการป้องกันการตั้งครรภ์ไม่พึงประสงค์ นอกจากนี้หนูอาจจะรู้สึกไม่ปลอดภัย เพราะเกรงว่าจะโดนคนอื่นๆว่าหนูรู้ดีในเรื่องพฤติกรรมทางเพศและวิธีคุมกำเนิด

หนูอาจจะรู้สึกไม่วางใจเมื่อเห็นผู้วิจัยหลักคือ ป้าอิ๊ จดข้อมูลที่หนูพูดคุยออกมา

จะแก้ไขการรู้สึกไม่สะดวกใจและความเสี่ยงนั้นอย่างไร

เพื่อป้องกันไม่ให้หนูรู้สึกไม่สะดวกใจ เขินอายและไม่วางใจที่จะพูดคุยเรื่องนี้ ถ้าหนูไม่สบายใจที่จะตอบหรือแสดงความคิดเห็นหนูสามารถทำได้นะคะ หรือถ้าไม่อยากให้ป้าอิ๊จดหรือบันทึกเสียง หนูสามารถบอกได้ทันทีเลยนะคะ บริการให้คำปรึกษามีบริการฟรี ถ้าหนูรู้สึกไม่สบายใจระหว่างการสัมภาษณ์และอยากคุยกับผู้ให้คำปรึกษา หนูสามารถไปคุยกับผู้ให้คำปรึกษาได้ฟรีนะคะ เดี๋ยวป้าอิ๊จะติดต่อประสานงานให้ ถ้าหนูๆ ท่านใดต้องการข้อมูลความรู้เกี่ยกับการคุมกำเนิดเพิ่มเติมหนูสามารถไปได้เช่นกันค่ะ แจ้งความประสงค์ กับป้าอิ๊ได้ทันที

ประโยชน์ของการศึกษานี้คืออะไร

ประโยชน์โดยตรงต่อผู้เข้าร่วมในงานวิจัยโครงการนี้คือ ผู้ร่วมวิจัยจะมีโอกาสแสดงความคิดเห็นและประสบการณ์ในประเด็นที่สังคมไทยเห็นว่าเป็นประเด็นที่เด็กวัยรุ่นมิควรพูดหรือแสดงออก ป้าอิ๊ผู้วิจัยหลักได้เตรียมสถานที่ที่ปลอดภัยที่หนูๆสามารถแสดงความคิดเห็นและประสบการณ์ได้อย่างเป็นตัวของตัวเอง ข้อมูลเหล่านั้นจะถูกเก็บไว้เป็นความลับและไม่เปิดเผยชื่อผู้แสดงความคิดเห็น

เสียงของวัยรุ่นไทยที่ได้รวบรวมในรายงานผลการศึกษาโครงการนี้ จะเป็นประโยชน์ในการพัฒนานโยบายและโปรแกรมส่งเสริมสุขภาวะอนามัยเจริญพันธ์และสิทธิอนามัยเจริญพันธุ์ของวัยรุ่นโดยรวมต่อไป

ความเป็นส่วนตัวของผู้เข้าร่วมการศึกษาจะได้รับการดูแลปกป้องอย่างไร

ทุกๆข้อมูลที่หนูๆวัยรุ่นผู้เข้าร่วมในงานวิจัยครั้งนี้ จะได้รับการเก็บปกปิดเป็นความลับและไม่มีการระบุชื่อที่แท้จริงของผู้ให้ข้อมูล ชื่อที่ใช้ที่นี่จะเป็นชื่อเล่นสมมุติ และหลังจากการถอดบันทึกเสียงการสัมภาษณ์เชิงลึกแล้ว ป้าอิ๊ผู้วิจัยหลักจะทำการเปลี่ยนแปลงอีกครั้งสำหรับการรายงานผลการศึกษา

บทสนทนาที่ถอดจากการบันทึกระหว่างการสัมภาษณ์จะถูกส่งไปยังหนูๆผู้เข้าร่วมในงานวิจัยทางอีเมลล์เพื่อตรวจความความถูกต้อง บทสนทนาเหล่านี้และไฟล์ที่เกี่ยวข้องจะมีเพียงป้าอิ๊ผู้วิจัยหลักและอาจารย์ที่ปรึกษา Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop เท่านั้นที่สามารถเข้าถึงข้อมูลเหล่านี้ได้ ไฟล์ข้อมูลจะมีรหัสลับเพื่อป้องกันการเข้าถึงข้อมูล เอกสารเหล่านี้จะเก็บไว้ในตู้และห้องที่มีการล็อคอย่างแน่นหนาที่ Auckland University of Technology, New Zealand และจะถูกทำลายตามระยะเวลาที่คณะกรรมการจริยธรรมกำหนด

ระหว่างการวิเคราะห์ข้อมูลจากสัมภาษณ์เชิงลึกจากผู้ร่วมเข้าวิจัย ประเด็นหลักที่ได้จากกากรวิเคราะห์จะถูกส่งไปยังคณะที่ปรึกษาท้องถิ่นที่จังหวัดขอนแก่น คณะที่ปรึกษานี้จะประกอบด้วยวัยรุ่นจำนวน 6 ท่านที่ผ่านการทำข้อตกลงในการรักษาข้อมูลเป็นความลับของงานวิจัยว่าจะไม่นำไปเปิดเผยพูดคุยต่อผู้ใดทั้งสิ้นยกเว้นผู้วิจัยหลักคือป้าอิ๊ คณะที่ปรึกษานี้จะทำหน้าที่ตรวจสอบข้อมูลที่ผ่านการวิเคราะห์จากผู้วิจัยหลักว่ามีความน่าเชื่อถือหรือไม่ และว่าเป็นเสียงจากวัยรุ่นไทยจริงหรือไม่ ก่อนการรายงานผลการศึกษา

ค่าใช้จ่ายในการเข้าร่วมการศึกษาครั้งนี้คืออะไร

การเข้าร่วมงานวิจัยครั้งนี้ไม่มีค่าใช้จ่ายใดๆทั้งสิ้น เพื่อเป็นการแสดงความขอบคุณที่หนูๆวัยรุ่นเข้าร่วมกิจกรรมนั้น ทางป้าอิ๊ได้เตรียมค่าเดินทางสำหรับหนูๆวัยรุ่นแต่ละท่าน

ท่านจะสามารถใช้เวลาที่ใช้การพิจารณาคำเชิญเพื่อเข้าร่วมงานวิจัยครั้งนี้ได้นานเท่าใด

ทางผู้วิจัยหลัก(ป้าอิ๊)จะใช้เวลาประมาณ 1 สัปดาห์ในการรอการตอบรับคำเชิญเข้าร่วมงานวิจัยนี้ ถ้าหนูๆวัยรุ่นท่านใดมีข้อข้องใจซักถามเพิ่มเติมเกี่ยวกับงานวิจัยโครงการนี้ กรุณาติดต่อผู้วิจัยหลักคือป้าอิ๊ได้ตามที่ระบุข้างท้ายเอกสารนี้

เมื่อหนูๆวัยรุ่นตัดสินใจที่จะเข้าร่วมการวิจัยครั้งนี้ หนูๆวัยรุ่นจะได้รับเอกสารและลงชื่อแสดงความยินยอมที่จะเข้าร่วมการวิจัยในเอกสารแสดงความยินยอมดังกล่าว ในเอกสารนี้จัดทำเพื่อเป็นการยืนยันว่าหนูๆวัยรุ่นทุกๆท่านรับทราบและเข้าใจเกี่ยวกับงานวิจัยโครงการนี้ รวมทั้งสิทธิที่จะได้รับในฐานะการเป็นผู้เข้าร่วมงานวิจัยในด้านการรักษาความลับและความเป็นส่วนตัวของหนูๆเอง

ผู้เข้าร่วมการศึกษาจะได้รับผลการศึกษาของงานวิจัยนี้ไหม

ผู้เข้าร่วมการศึกษา(หนูๆวัยรุ่น)ในโครงการวิจัยครั้งนี้จะได้รับรายงานการศึกษานี้ อย่างไรก็ตามหนูสามารถเลือกที่จะรับหรือไม่รับรายงานดังกล่าวได้โดยระบุในเอกสารแสดงความยินยอมเข้าร่วมงานวิจัย

ถ้ามีข้อสงสัยหรือข้อข้องใจใดๆ จะทำอย่างไร

ข้อสงสัยและข้อข้องใจใดๆ เกี่ยวกับลักษณะของงานวิจัยนี้ กรุณาติดต่อ อาจารย์ที่ปรึกษาหลักของงานวิจัยในครั้งนี้ Dr Sari Adajani, sari.andajani@aut.ac.nz, โทร 064 9921 9999 ต่อ 7738

ข้อสงสัยและข้อข้องใจใดๆ เกี่ยวกับกระบวนการของงานวิจัยนี้ กรุณาติดต่อ เลขาธิการหลักของคณะกรรมการจริยธรรมการวิจัยของ Auckland University of Technology คือ Kate O'Connor, ethics@aut.ac.nz ,โทร 064 921 9999 ต่อ 6038.

ใครที่ผู้เข้าร่วมการศึกษาสามารถติดต่อเพื่อขอข้อมูลเพิ่มเติม

รายละเอียดการติดต่อผู้วิจัยหลัก คือ

ป้าอิ๊ ศันสนีย์ จันทสุข ch.sansanee@gmail.com หรือ Facebook account: Brave archer

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

d. Consent form for focus group discussions

Consent Form

For use when focus group discussions are involved.

Project title: Perception of Thai adolescents on contraceptive use and decision making

Project Supervisor: Dr Sari Andajani, Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed. However, I can ask to stop taking notes and recording my conversation.
- ○ I understand that a creative artistic, and other visual recording produced from this study including photograph of creative and artistic work will be taken and used for academic purposes only.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

……..

……..

Date: ……

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

เอกสารแสดงความยินยอมเข้าร่วมงานวิจัย

สำหรับกระบวนการอภิปรายกลุ่ม

(Consent form for focus group discussion)

ชื่อโครงการ: การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

อาจารย์ที่ปรึกษา: Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop

ผู้วิจัย: ศันสนีย์ จันทสุข

- ○ ข้าพเจ้าได้อ่านรายละเอียดและเข้าใจถึงรายละเอียดของงานวิจัยนี้จากเอกสารแนะนำการวิจัยลงวันที่ เดือน พ.ศ. ๒๕๕๘
- ○ ผู้วิจัยได้เปิดโอกาสให้ข้าพเจ้าได้สอบถาม และตอบคำถามที่ข้าพเจ้าสงสัยเกี่ยวกับงานวิจัยนี้
- ○ ข้าพเจ้าจักปกปิดความลับของข้อมูลและความเป็นตัวตนของผู้เข้าร่วมวิจัยท่านอื่นๆที่มาร่วมในกิจกรรมการอภิปรายกลุ่มไว้เป็นความลับ และ ไม่นำไปเปิดเผยที่ใดๆ ทั้งสิ้น
- ○ ข้าพเจ้ารับทราบว่า ผู้วิจัยจะทำการจดบันทึกระหว่างการสัมภาษณ์ และ ใช้เครื่องบันทึกเสียงระหว่างการสัมภาษณ์ แต่ข้าพเจ้าสามารถขอระงับการบันทึกอย่างใดอย่างหนึ่งหรือทั้งสองอย่างเมื่อข้าพเจ้ารู้สึกไม่สะดวกใจที่จะให้ข้อมูลเหล่านั้นถูกบันทึกด้วยวิธีการใดการหนึ่ง
- ○ ข้าพเจ้ารับทราบและยินยอมให้มีการ นำผลงานต่างๆจากกระบวนการกลุ่ม รวมถึงการถ่ายถาพผลงนเหล่านั้น เช่น งานทางศิลปะ เพื่อการรายงานผลการศึกษาและ เพื่อประโยชน์ทางการศึกษา
- ○ ข้าพเจ้ามีสิทธิ์ที่จะยกเลิกการเข้าร่วมงานวิจัยครั้งนี้ทุกเมื่อไม่ว่าจะเป็นก่อนหรือหลังการเก็บข้อมูลไปแล้ว และสามารถขอข้อมูลที่ข้าพเจ้าเคยให้กับผู้วิจัยหลัก โดยไม่เสียสิทธิ์ประโยชน์ใดๆ ก็ตาม
- ○ ถ้าข้าพเจ้ายกเลิกคำยินยอมในการเข้าร่วมงานวิจัย ข้อมูลต่างๆทั้งที่อยู่ในรูปเอกสารและไฟล์อีเลกโทรนิกส์จะต้องมีการดำเนินการทำลายอย่างสิ้นซาก
- ○ ข้าพเจ้ายินยอมขอเข้าร่วมงานวิจัยครั้งนี้ด้วยความเต็มใจ
- ○ ข้าพเจ้าต้องการได้รับสำเนาผลการศึกษาในครั้งนี้: ใช่○ ไม่ใช่○

ลายเซ็นผู้ยินยอม: .....

ชื่อสมมติที่ใช้ในงานวิจัยครั้งนี้: .....

อีเมล หรือ ชื่อบัญชีเฟสบุค หรือ ชื่อบัญชีไลน์ (ถ้ามี):

.....

ลงวันที่ .....เดือน ..... พ.ศ. ๒๕๕๘

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

e. Consent form for in-depth interviews

Consent Form

For use when **interviews** are involved.

Project title: Perception of Thai adolescents on contraceptive use and decision making

Project Supervisor: Dr Sari Andajani, Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed. However, I can ask them not to note and record my conversation.
- ○ I understand that anonymous nickname will be used during the interviews and will be changed again by the primary researcher for the final report.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive and check the accuracy of transcription (please tick one): Yes○ No○
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: .....……

Participant's name: .....……

Participant's Contact Details (if appropriate):

……..

……..

Date: ……

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

เอกสารแสดงความยินยอมเข้าร่วมงานวิจัย

สำหรับการสัมภาษณ์เชิงลึก

(Consent form for in-depth interviews)

ชื่อโครงการ: การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

อาจารย์ที่ปรึกษา: Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop

ผู้วิจัย: ศันสนีย์ จันทสุข

- ○ ข้าพเจ้าได้อ่านรายละเอียดและเข้าใจถึงรายละเอียดของงานวิจัยนี้จากเอกสารแนะนำการวิจัยลงวันที่ เดือน พ.ศ. ๒๕๕๘
- ○ ผู้วิจัยได้เปิดโอกาสให้ข้าพเจ้าได้สอบถาม และตอบคำถามที่ข้าพเจ้าสงสัยเกี่ยวกับงานวิจัยนี้
- ○ ข้าพเจ้ารับทราบและยินยอมให้ผู้วิจัยจะทำการจดบันทึกระหว่างการสัมภาษณ์ และ ใช้เครื่องบันทึกเสียงระหว่างการสัมภาษณ์ และข้าพเจ้าสามารถขอระงับการบันทึกอย่างใดอย่างหนึ่ง หรือทั้งสองอย่าง
- ○ ข้าพเจ้ารับทราบเรื่อง การใช้ชื่อสมมุติแทนชื่อจริง และหลังจากที่เอกสารบทสนทนาส่งกลับมาเพื่อให้ข้าพเจ้าตรวจสอบความถูกต้องในเนื้อหา ชื่อสมมติของข้าพเจ้าจักได้รับการเปลี่ยนแปลงอีกครั้งโดยผู้วิจัยหลักในการนำเสนอผลการศึกษาวิจัยในครั้งนี้
- ○ ข้าพเจ้ามีสิทธิ์ที่จะยกเลิกการเข้าร่วมงานวิจัยครั้งนี้ทุกเมื่อไม่ว่าจะเป็นก่อนหรือหลังการเก็บข้อมูลไปแล้ว และสามารถขอข้อมูลที่ข้าพเจ้าเคยให้กับผู้วิจัยหลัก โดยไม่เสียสิทธิ์ประโยชน์ใดๆ ก็ตาม
- ○ ถ้าข้าพเจ้ายกเลิกคำยินยอมในการเข้าร่วมงานวิจัย ข้อมูลต่างๆทั้งที่อยู่ในรูปเอกสารและไฟล์อิเลกโทรนิกจะต้องมีการดำเนินการทำลายอย่างสิ้นซาก
- ○ ข้าพเจ้ายินยอมขอเข้าร่วมงานวิจัยครั้งนี้ด้วยความเต็มใจ
- ○ ข้าพเจ้าต้องการได้เอกสารและตรวจสอบเอกสารการถอดความจากการสัมภาษณ์ในครั้งนี้: ใช่○ ไม่ใช่○
- ○ ข้าพเจ้าต้องการได้รับสำเนาผลการศึกษาในครั้งนี้: ใช่○ ไม่ใช่○

ลายเซ็นผู้ยินยอม: .....

ชื่อสมมติที่ใช้ในงานวิจัยครั้งนี้: .....

อีเมล หรือ ชื่อบัญชีเฟสบุค หรือ ชื่อบัญชีไลน์ (ถ้ามี):

.....

ลงวันที่ .....เดือน ..... พ.ศ. ๒๕๕๘

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

f. Indicative questions and vignettes

Indicative questions and vignettes

*__Note:__ these indicative questions and vignettes will be consulted with the youth advisory group in Khon Kaen, Thailand

Project title: Perception of Thai adolescents on contraceptive use and their decision making

Project Supervisor: Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

Indicative questions and vignettes for focus group discussions

VIGNETTES

Scenario one: Man and Mali are teenagers at the same age as you and studying at a local school/college. They have just started an intimate relationship. They begin holding hands, hug and kiss. They end up with having sexual activities.

Scenario two: They have regularly sexual activities.

To warm-up the focus group discussion, these questions will be used:

- What do you think is happening in this story?
- Do you know if any similar situations happen in our community these days?
- Does this Man and Mali's story reflect the todays' Thai adolescents?
- When reading those two scenarios what came up in your mind?
- What sorts of questions do you have in mind?
-

INDICATIVE QUESTION 1: HOW THAI ADOLESCENT MAKE DECISIONS ABOUT CONTRACEPTIVES?

INDICATIVE QUESTION 2: HOW DO THAI ADOLESCENTS PREVENT PREGNANCY?

Probing questions:

- What will happen to Man and Mali if they don't use contraceptives?
- What happen then?
- What will be the main reason why adolescents use contraceptives?
- Why?
- Are they likely to use contraceptives?
- Why?
- If supposedly they use contraceptives, what are they likely to use?
- Why?
- Who would decide what contraceptive to use?
- Do you think Man and Mali will think of different or same contraceptives?
- Why?
- What happen if they disagree on contraceptive use?
- Who will have a stronger say then?
- Who will make main decision maker?
- Why?

- Who would buy those contraceptives?
- Why?
- Who would pay for those contraceptives?
- Why?
- How do they know about which contraceptives to use?

INDICATIVE QUESTION 3: WHAT FACTORS INFLUENCE MAN AND MALI DECISION ON CONTRACEPTIVE USE

Probing questions:

- What do they need to consider when choosing a contraceptive? [influencing factors]
- Why?
- What factors are likely to be influencing their decision?
- Why?
- Can you give specific examples?
- Can you give me the 5 or 10 most influencing factors?
- Could you please rank them for me?
- Why did you come up with that ranking?

INDICATIVE QUESTION 4: WHAT SORTS OF REPRODUCTIVE AND SEXUAL HEALTH SERVICES DO ADOLESCENTS NEED?

Probing questions:

- Have you heard of any reproductive and sexual health services in your area?
- Where are they?
- What do they offer?
- What sort of services that would work for Man and Mali?
- Why?
- Could you give me specific examples?
- How about contraceptive services for adolescents?
- What a good service should look like?
- What criteria should they have?
- Do you think if those services exist, adolescents will use it?
- For sure? Why?
- If you could, is there anything you would like to change?
- What the ideal youth-friendly reproductive services shall look like?
- How we can start making those changes?
- Who can help?
- Why?
- Please prioritise (rank) of your needs and aspiration for good reproductive services for adolescents.
- Why did you rank it that way?

INDICATIVE QUESTION 5: HOW CAN WE BEST FULFILL THE REPRODUCTIVE RIGHTS OF ADOLESCENTS?

Probing questions:

- Have you heard …. About sexual and reproductive rights?
- When did you hear about this? Where? Who told you?
- If they have not heard about it, then the following definition will be given "reproductive rights is defined as the xxxxx '

- In your own word what would you call it?
- What do you think the best way to fulfil adolescents' reproductive rights?
- What rights should be prioritized?
- Why?
- Could you rank them?
- Why did you come up with that ranking system?

The session will be close by asking participants to give feedback

- Is there anything you want to add?
- Is there anything else you want to clarify?
- What feelings do you have after this session?
- Do you have any feedback to this group discussion?

Indicative questions for in-depth interviews

Welcoming remark: thanks for agreeing to participate in this interview.

Opening questions:

- What did you get from that group discussion?
- Do have anything to add?
-

INDICATIVE QUESTION 1: HOW DO THAI ADOLESCENTS MAKE DECISIONS ABOUT CONTRACEPTIVES?

INDICATIVE QUESTION 2: HOW DO THAI ADOLESCENTS PREVENT PREGNANCY?

INDICATIVE QUESTION 3: WHAT FACTORS INFLUENCE YOUR DECISIONS?

Probing questions:

- Have you ever in a situation when you consider using a contraceptive?
- Please tell me more about it
- What happened?
- Did you finally get a contraceptive device or method?
- What was it?
- Have you been using just that type of contraceptives? Of have you tried other methods?
- What are they?
- How often do you use contraceptives?
- Who keep them?
- Who has been the main decision maker?
- Why?
- Who went to buy it?
- Who paid for it?
- What happened if you had different opinions?
- Who/what influenced your decision?
- Please give me specific examples?
- How strong was it influencing your decision?
- Why?

INDICATIVE QUESTION 3: WHAT ARE YOUR EXPECTATIONS?

Probing questions:

- Where do you (or your boyfriend/ girlfriend) usually go and get your contraceptives (mention the name)?
- Do you use other services as well?
- Please give me examples
- Do you like it?
- Why?
- Do they meet your need?
- Why?
- What an ideal service should look like?

In the group discussion we discussed a bit about adolescents' sexual and reproductive rights

- Do you remember it?
- Have you heard about it before?
- Where? When? Who told you?
- What did you think, when you heard about it?
- Do you think those services available are already meeting your needs?
- Are they respecting your rights (e.g. right to obtain information, to access sexual and reproductive health services, and to be treated with respect and with no discriminations)?
- How it can be improved?
- If you could, who would you like to change it?

Concluding questions:

- Is there anything else you want to tell me?
- Anything else you want to clarify?
- What do you feel?

g. Researcher safety protocol

Researcher Safety Protocol

Project title: Perception of Thai adolescents on contraceptive use and decision making

Project Supervisor: Dr Sari Andajani and Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

- Sansanee, the primary researcher, will go to Khon Kean, Thailand to conduct her fieldwork. She is a Thai student holding a NZ student visa. Her Student visa allows the multiple entries during the duration of the student visa's travel condition.
- Sansanee will use her NZ mobile phone number 022 187 9753 via global roaming during round trips between Khon Kaen, Thailand and Auckland, New Zealand. After she gets her new local number, she will inform this new mobile phone number to her supervisors in New Zealand. She will check the mobile phone coverage the areas she will have focus group discussions and in-depth interviews. She will take her mobile phone to every focus group discussion and in-depth interview. Skype and email will be used once a week to communicate with her supervisors.
- Her health insurance covers working overseas. She also has the National Health Insurance of Thailand because she is in governmental position as a pharmacist.
- She will stay in a house which Sirindhorn College of Public Health provides for their staff. It locates at 90/1 Anamai Road, Nai-Muaeng Sub-district, Muaeng District, Khon Kaen 40000 Thailand. Landline: 0066 043 221741
- Sansanee will discuss and share her timetable and the location of focus group discussions and in-depth interviews with her supervisors in New Zealand and her colleagues in Sirindhorn College of Public Health (Khon Kaen), Thailand. These are her two colleagues:

  Dr Pennapa Sriring
  166/16 Pimanchon Soi 23, Kaentumpracharat Road
  Nai-Muaeng Sub-district, Muaeng Distict
  Khon Kaen 40000 Thailand
  Landline: +66 043 11282
  Mobile: +66 900 254985 or +66 83 051 1545
  Email: pensriring@gmail.com or Facebook ID: Sriring Pennapa

  Kanchana Jatupan
  166/86 Pimanchon Soi 29, Kaentumpracharat Road
  Nai-Muaeng Sub-district, Muaeng Distict
  Khon Kaen 40000 Thailand
  Landline: +66 043 911303
  Mobile: +66 896 208590
  Email: freebird102515@gmail.com or Facebook ID: Chrishmish Vco

h. Confidential agreement for research assistants

Confidentiality Agreement

For an intermediary or research assistant

Project title: Perception of Thai adolescents on contraceptive use and decision making

Project Supervisor: Dr Sari Andajani, Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

- ○ I understand that all the material I will be asked to record is confidential.
- ○ I understand that the contents of the Consent Forms, audio-recording, or interview notes can only be discussed with the researchers.
- ○ I will not keep any copies of the information nor allow third parties access to them.

Intermediary's signature: .....

Intermediary's name: .....

Intermediary's Contact Details (if appropriate):

……..

……..

……..

……..

Date: …./…../……

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

ข้อตกลงการรักษาความลับโครงการวิจัย

(Confidentiality agreement for research assistants)

สำหรับ ผู้ช่วยนักวิจัย

ชื่อโครงการ: การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

อาจารย์ที่ปรึกษา: Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop

ผู้วิจัย: นางศันสนีย์ จันทสุข

○ ข้าพเจ้ารับทราบว่า ข้อมูลของผู้เข้าร่วมวิจัย และเอกสารต่างๆที่เกี่ยวข้องกับงานวิจัยนี้ ล้วนเป็นความลับ

○ ข้าพเจ้ารับทราบว่า ข้อมูลและรายละเอียดในเอกสารยินยอมเข้าร่วมในงานวิจัย ไฟล์ข้อมูลบันทึกเสียง สมุดบันทึกการสัมภาษณ์ รวมถึงเอกสารต่างๆที่เป็นผลผลิตจากการสัมภาษณ์และกระบวนการกลุ่มนั้น ไม่สามารถนำไปเปิดเผยและพูดคุยปรึกษากับผู้อื่นได้ ยกเว้นกับผู้วิจัยหลักเท่านั้น

○ ข้าพเจ้าจักไม่ทำการสำเนาเอกสารใดๆ และ ไม่อนุญาตให้ผู้ใดสามารถเข้าถึงเอกสารเหล่านี้ได้

ลายเซ็นผู้ยินยอม: .....

ชื่อสมมติที่ใช้ในงานวิจัยครั้งนี้: .....

อีเมล หรือ ชื่อบัญชีเฟสบุค หรือ ชื่อบัญชีไลน์ (ถ้ามี):

.....

ลงวันที่ .....เดือน ..... พ.ศ. ๒๕๕๘

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

i. Confidential agreement for the local advisory group

Confidentiality Agreement

For members of the local advisory group in Khon Kean, Thailand

Project title: Perception of Thai adolescents on contraceptive use and decision making

Project Supervisor: Dr Sari Andajani, Professor Peggy Fairbairn-Dunlop

Researcher: Sansanee Chanthasukh

- ○ I understand that all the material I will be asked to comment is confidential.
- ○ I understand that the contents of data analysis including coding and theme generating can only be discussed with the researchers.
- ○ I will not keep any copies of the information nor allow third parties access to them.

Signature: .....……

Name: .....……

Contact Details (if appropriate):

……..

……..

……..

……..

Date: …./…../……

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

ข้อตกลงการรักษาความลับโครงการวิจัย

(Confidentiality agreement for member of the local advisory group)

สำหรับ สมาชิกของกลุ่มที่ปรึกษางานวิจัยในกลุ่มวัยรุ่นจังหวัดขอนแก่น

ชื่อโครงการ: การรับรู้ของวัยรุ่นไทยในการตัดสินใจการใช้วิธีการคุมกำเนิด

อาจารย์ที่ปรึกษา: Dr Sari Andajani และ Professor Peggy Fairbairn-Dunlop

ผู้วิจัย: นางศันสนีย์ จันทสุข

- ○ ข้าพเจ้ารับทราบว่า ข้อมูลของผู้เข้าร่วมวิจัย และเอกสารต่างๆที่เกี่ยวข้องกับงานวิจัยนี้ ล้วนเป็นความลับ
- ○ ข้าพเจ้ารับทราบว่า ข้อมูลและรายละเอียดเอกสารต่างๆที่ได้จากการสัมภาษณ์และกระบวนการกลุ่มที่นำมาเสนอต่อกลุ่มที่ปรึกษางาวิจัยในวัยรุ่นจังหวัดขอนแก่นเพื่อการสรุปประเด็นหลักนั้น ไม่สามารถนำไปเปิดเผยและพูดคุยปรึกษากับผู้อื่นได้ ยกเว้นกับผู้วิจัยหลักเท่านั้น
- ○ ข้าพเจ้าจักไม่ทำการสำเนาเอกสารใดๆ และ ไม่อนุญาตให้ผู้ใดสามารถเข้าถึงเอกสารเหล่านี้ได้

ลายเซ็นผู้ยินยอม: .....

ชื่อสมมติที่ใช้ในงานวิจัยครั้งนี้: .....

อีเมล หรือ ชื่อบัญชีเฟสบุค หรือ ชื่อบัญชีไลน์ (ถ้ามี):

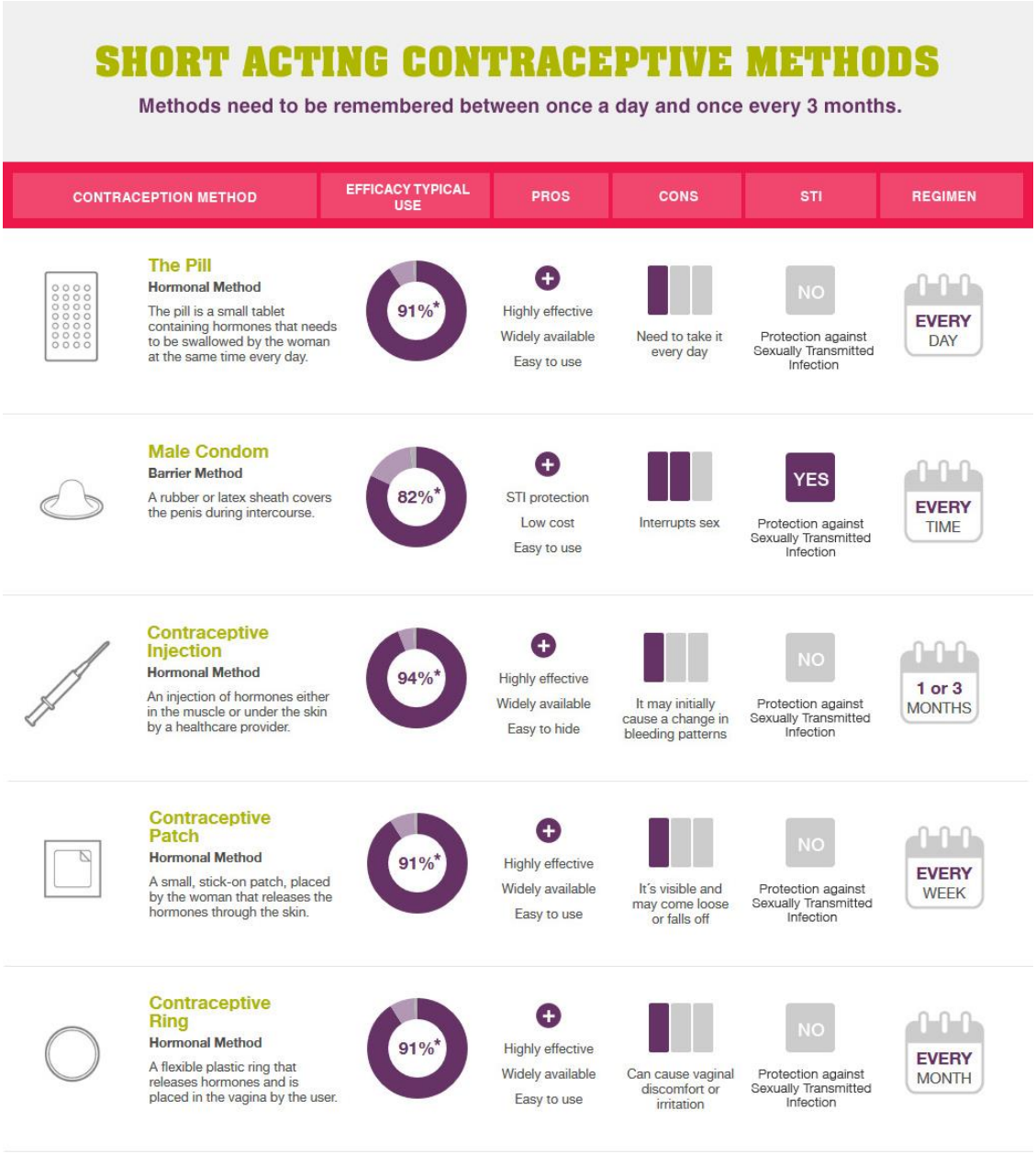
.....

ลงวันที่ .....เดือน ..... พ.ศ. ๒๕๕๘

Approved by the Auckland University of Technology Ethics Committee on *3 August 2015*, AUTEC Reference number *15/225*.

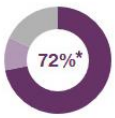
Appendix B: Contraceptive information

(Retrieved on 30 September 2017 from https://www.your-life.com/en/contraception-methods/#methods-)



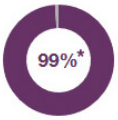
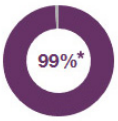
SHORT ACTING CONTRACEPTIVE METHODS

Methods need to be remembered between once a day and once every 3 months.

CONTRACEPTION METHOD	EFFICACY TYPICAL USE	PROS	CONS	STI	REGIMEN
 **Female Condom** **Barrier Method** A rubber or latex sheath that covers the vagina during intercourse.		STI protection Hormone free Low cost	Interrupts sex and low reliability	YES Protection against Sexually Transmitted Infection	
 **Diaphragm** **Barrier Method** A small dome that is placed over the entrance to the womb by the woman to stop sperm from entering.		Low cost Hormone free Widely available	Interrupts sex	NO Protection against Sexually Transmitted Infection	
 **Cervical Cap** **Barrier Method** A small cap that is placed over the entrance to the womb by the woman to stop sperm from entering.		Low cost Hormone free Widely available	Interrupts sex	NO Protection against Sexually Transmitted Infection	
 **Sponge** **Barrier Method** A small disk-shaped sponge that is placed over the entrance to the womb by the woman to stop sperm from entering.		Low cost Hormone free	Interrupts sex and low reliability	NO Protection against Sexually Transmitted Infection	
 **Spermicides** **Chemical Method** Any cream, foam, gel or other liquid that prevents sperm from moving freely.		Low cost Hormone free Widely available	Interrupts sex and low reliability	NO Protection against Sexually Transmitted Infection	

LONG ACTING REVERSIBLE METHODS

Methods need to be placed every 3 to 10 years.

CONTRACEPTION METHOD	EFFICACY TYPICAL USE	PROS	CONS	STI	REGIMEN
 **Intrauterine Device - IUD** **Intrauterine Method** A T-shaped device containing copper that is put into the uterus by a healthcare provider.	 99%*	Highly effective Long-acting reversible Easy to hide	 May cause heavier bleedings or crampings	NO Protection against Sexually Transmitted Infection	 <5-10 YEARS
 **Contraceptive Implant** **Hormonal Method** Small hormone releasing silicone rods put under the skin by a healthcare provider.	 99%*	Highly effective Long-acting reversible Easy to hide	 It may initially cause a change in bleeding patterns	NO Protection against Sexually Transmitted Infection	 <3-5 YEARS
 **Intrauterine System - IUS** **Intrauterine Method** Small, hormone releasing T-shaped device put in the uterus by a healthcare provider.	 99%*	Highly effective Long-acting reversible Easy to hide	 May cause changes in menstrual bleeding pattern	NO Protection against Sexually Transmitted Infection	 <3-5 YEARS

Legend

Efficacy with typical use:
*Where there is a risk of inappropriate application, inconsistent use or just plain human error.

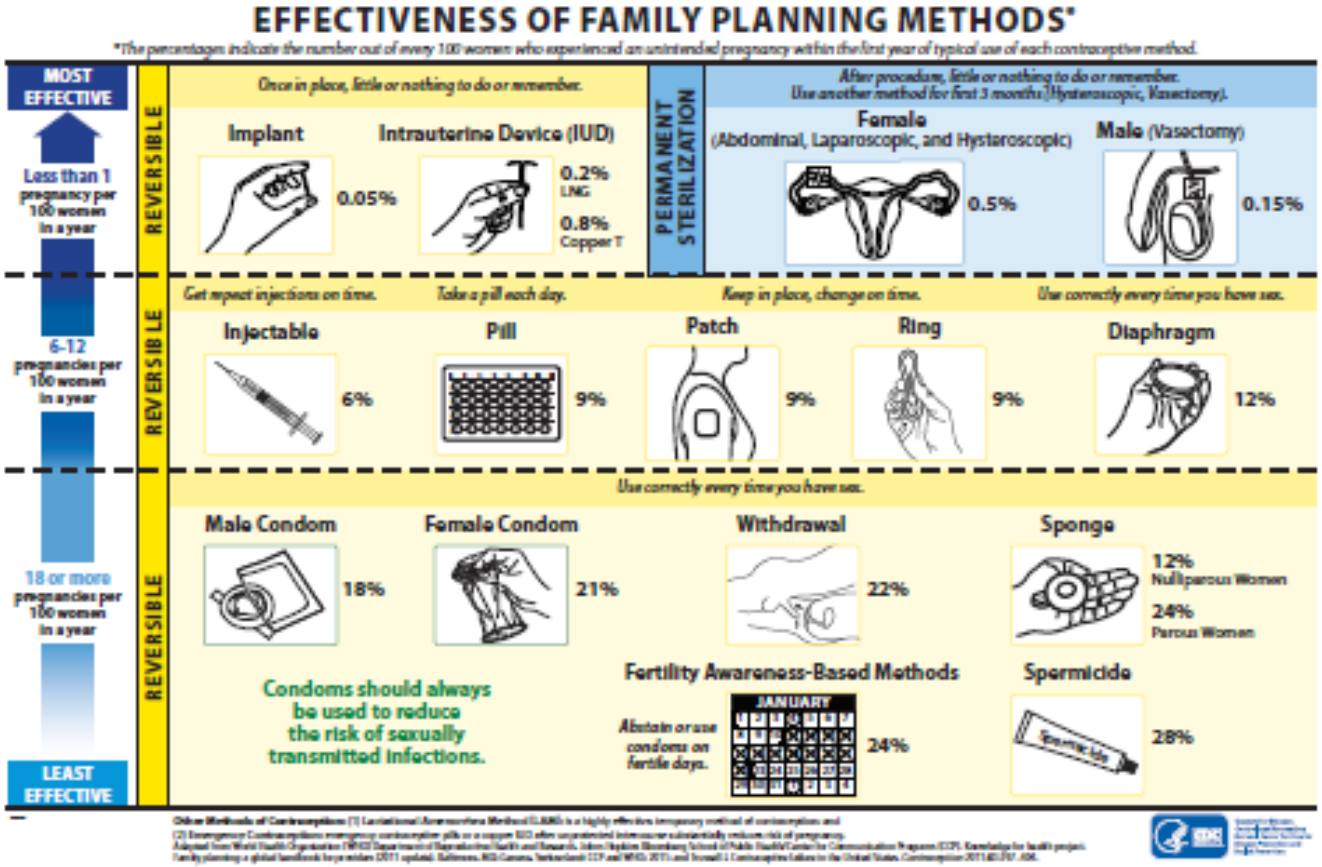
Efficacy with correct use:
When used with 100% accuracy, not relying on self-administration and used exactly according to instruction.

There are more than 15 different contraceptive methods available, all of which vary with regards to efficacy, usage, benefits and disadvantages. Discover all you need to know about each of the other contraceptive methods available to you.

For finding the best contraceptive method that suits you and your current lifestyle take the quiz "Which contraception is right for me?" at your-life.com or ask your healthcare provider.

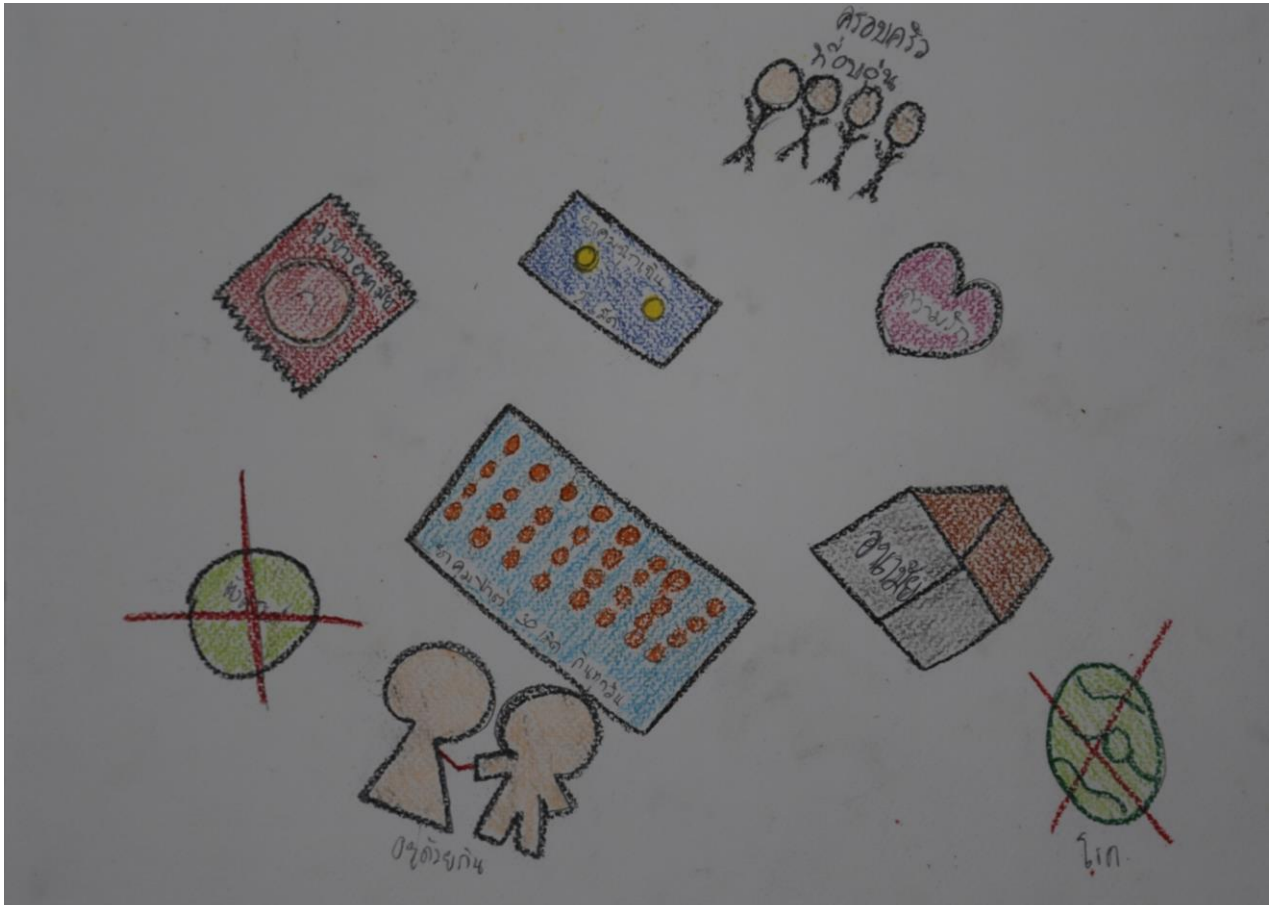
B.2 Effectiveness of Contraceptive methods

(Retrieved on 1 October 2017, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Family-Planning-Methods-2014.pdf)



Appendix C: Drawing from focus group discussions

Picture 1F

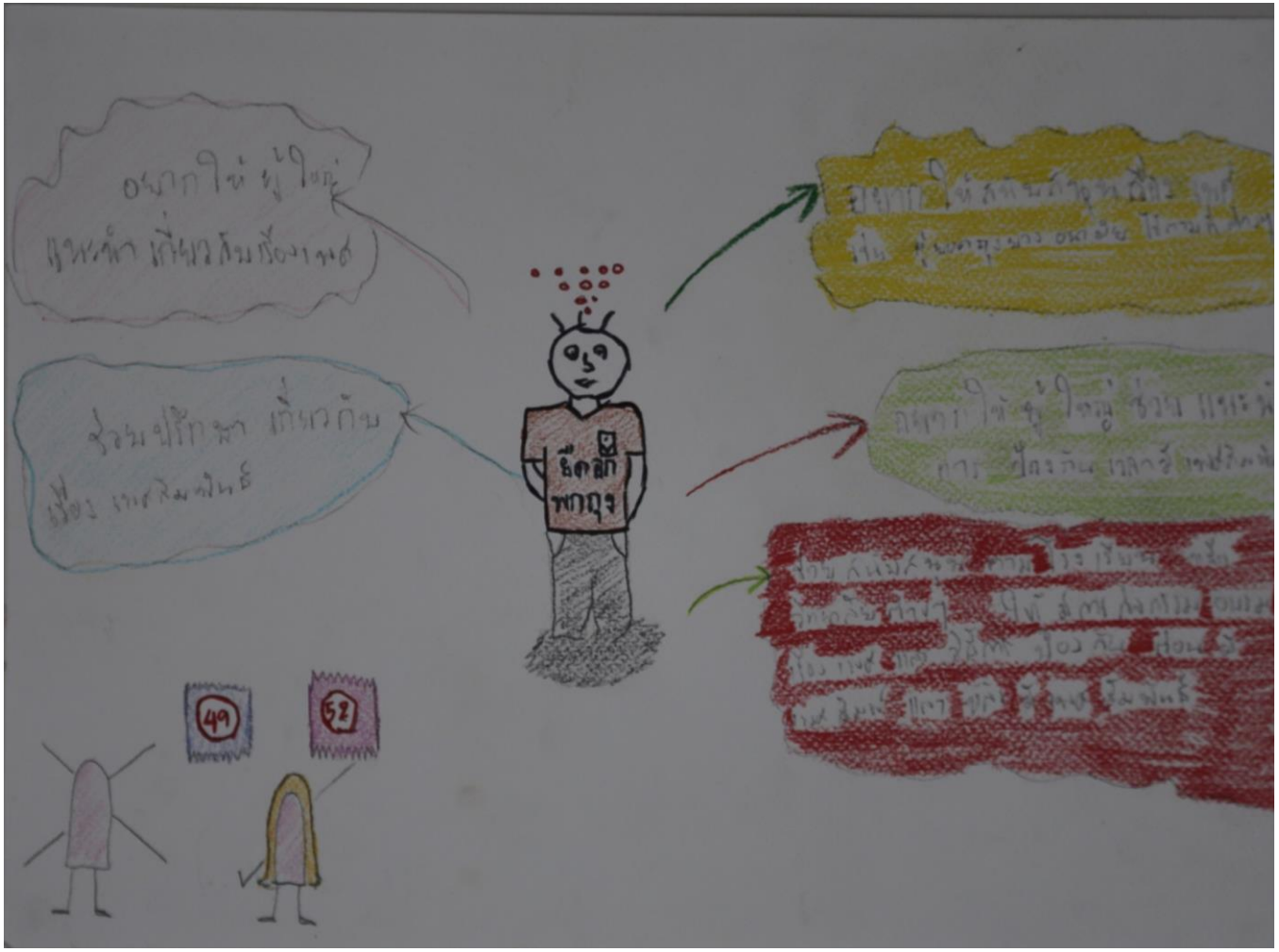


Picture 2 (Female)

Picture 3 (Female)

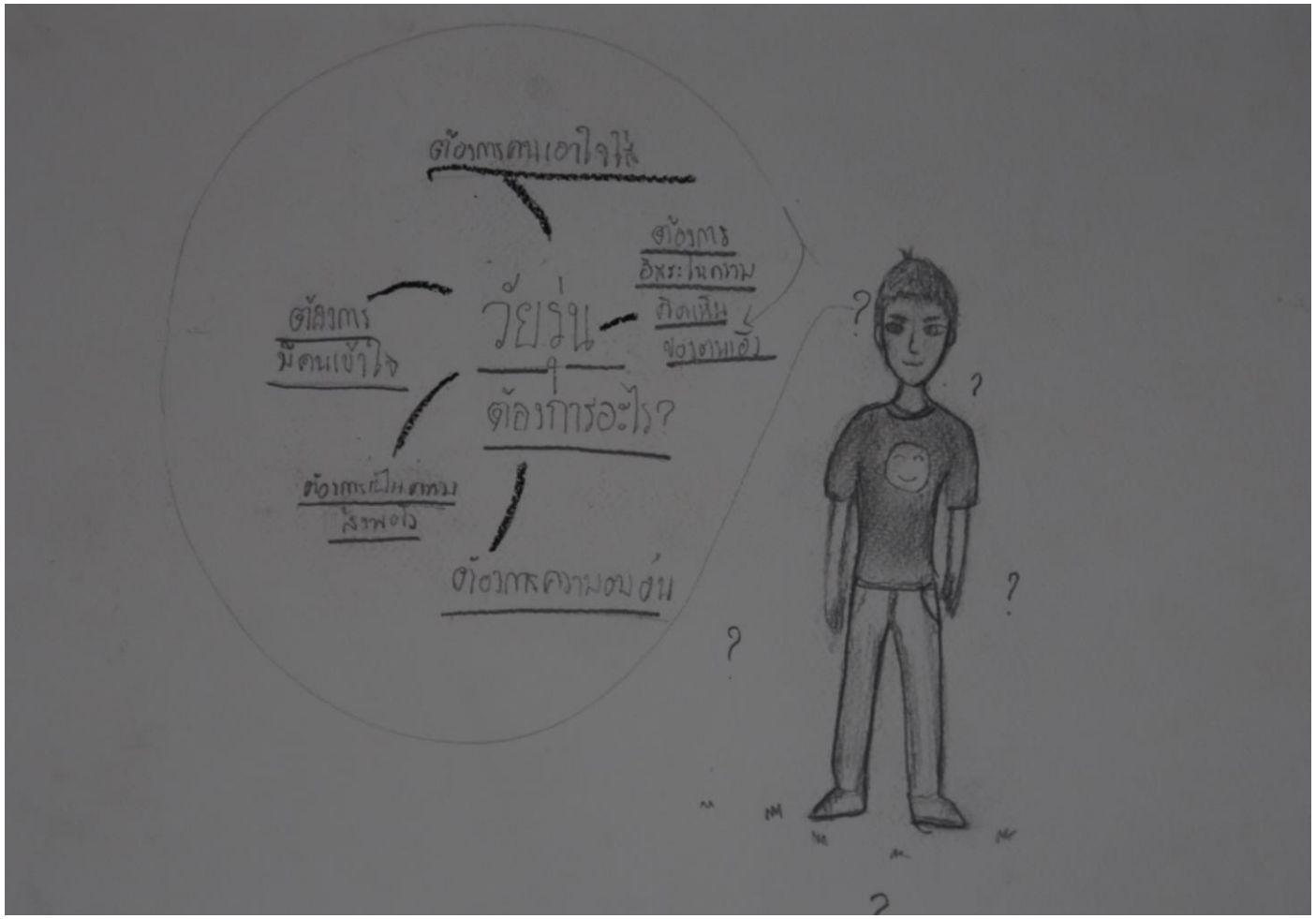
Picture 4(Female)

Picture 5 (Male)

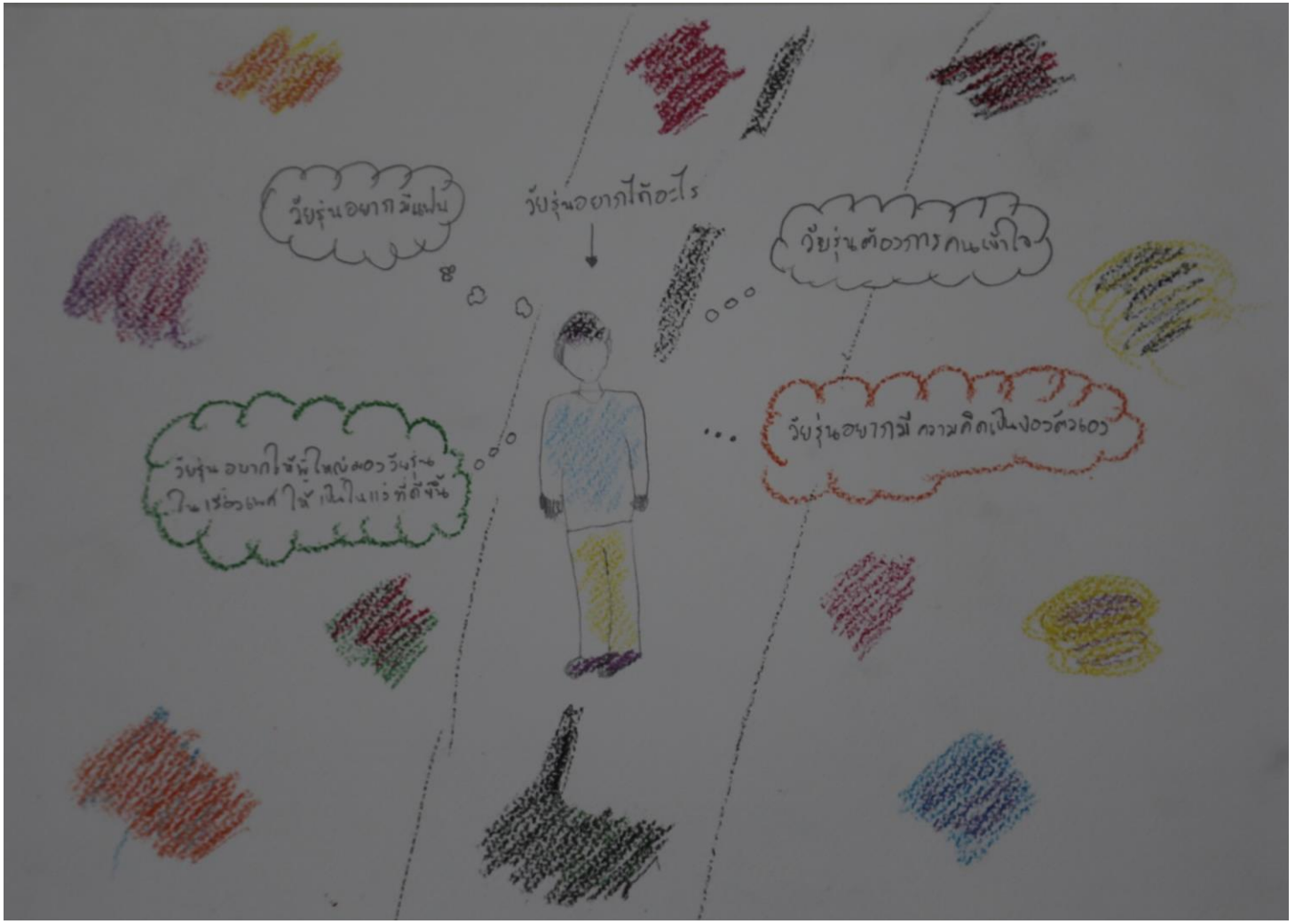


Picture 6(Male)

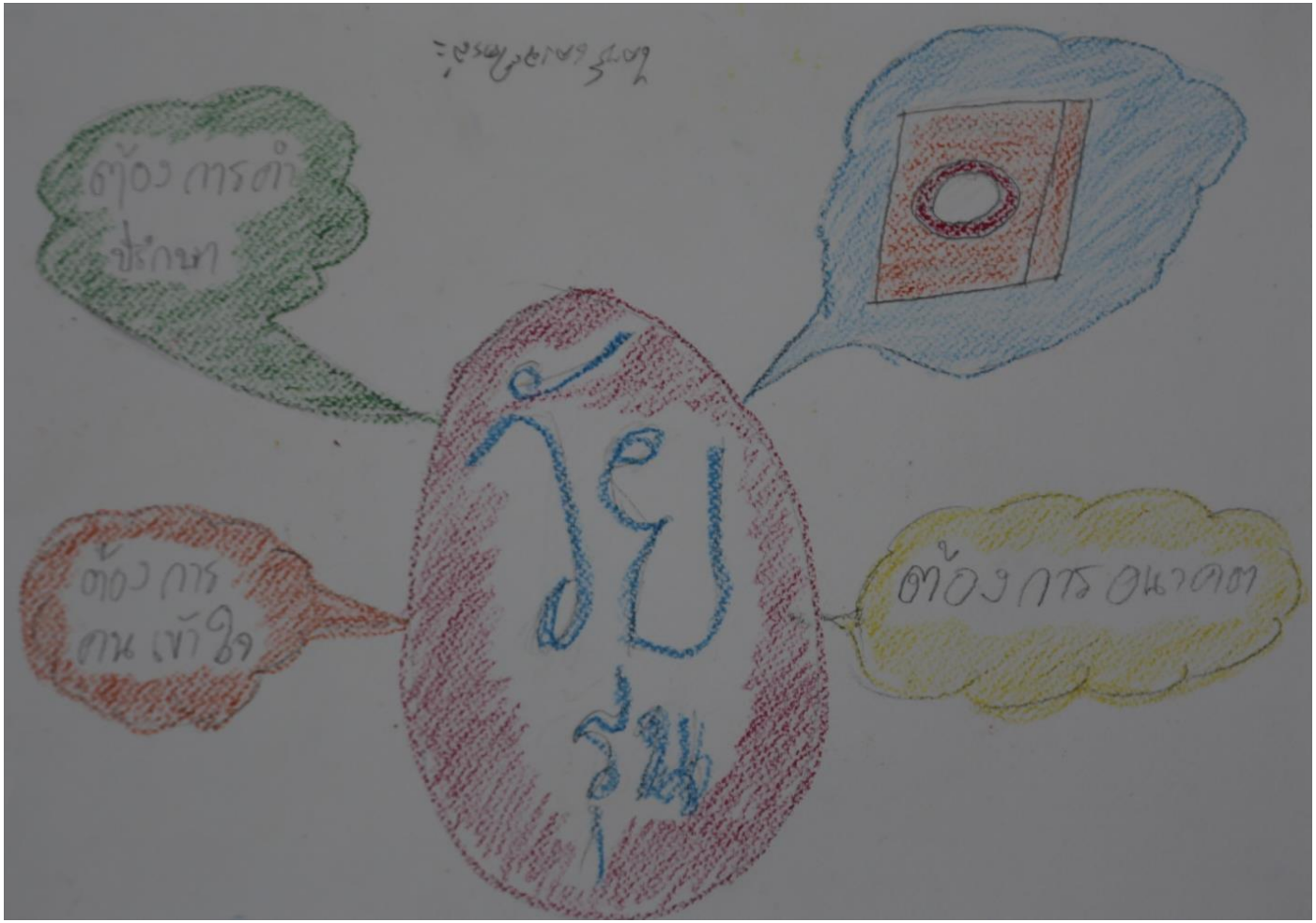
Picture 7 (Male)



Picture 8 (Male)



Picture 9 (Male)



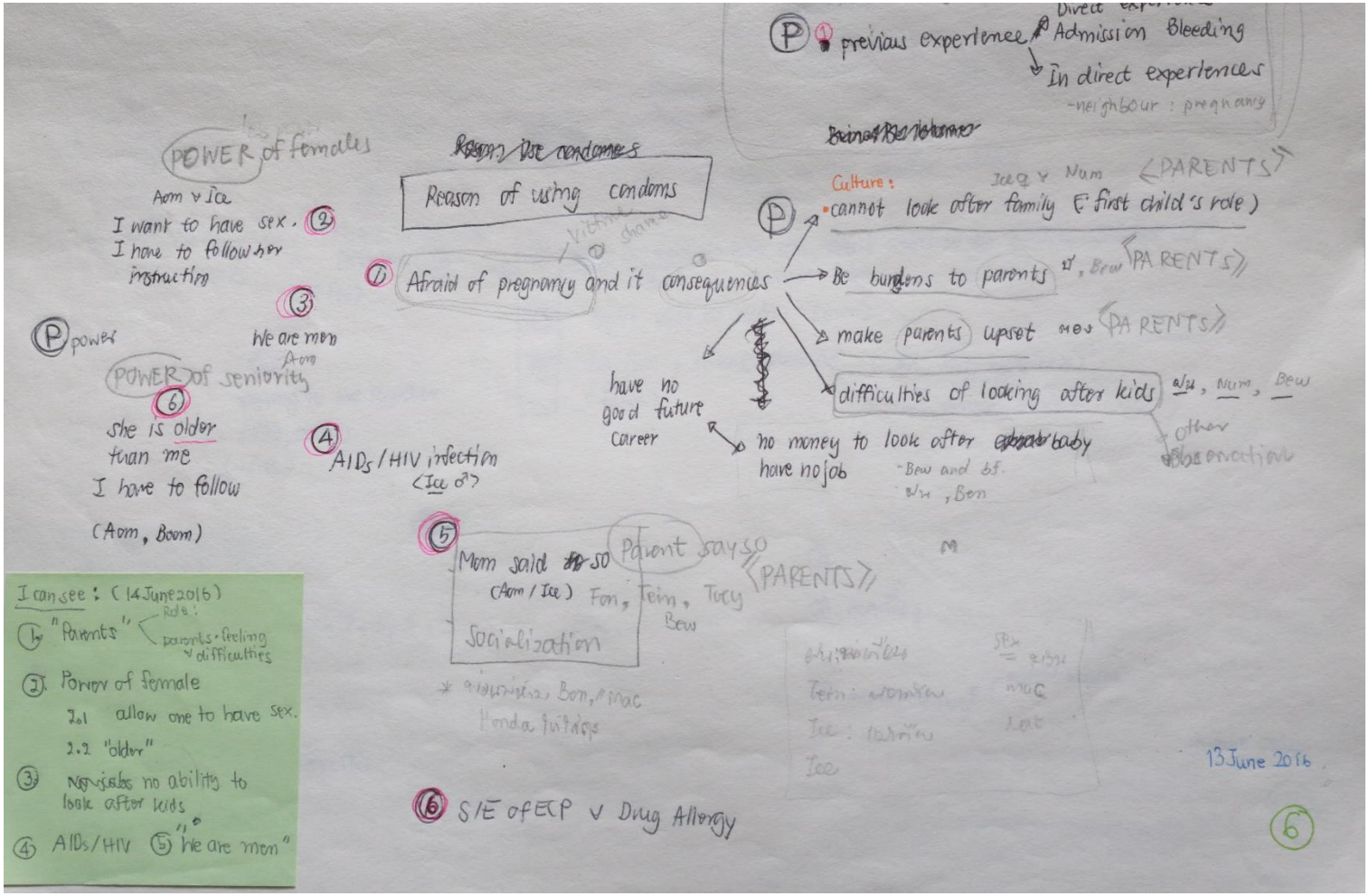
Appendix D: Demographical data of youth research assistants

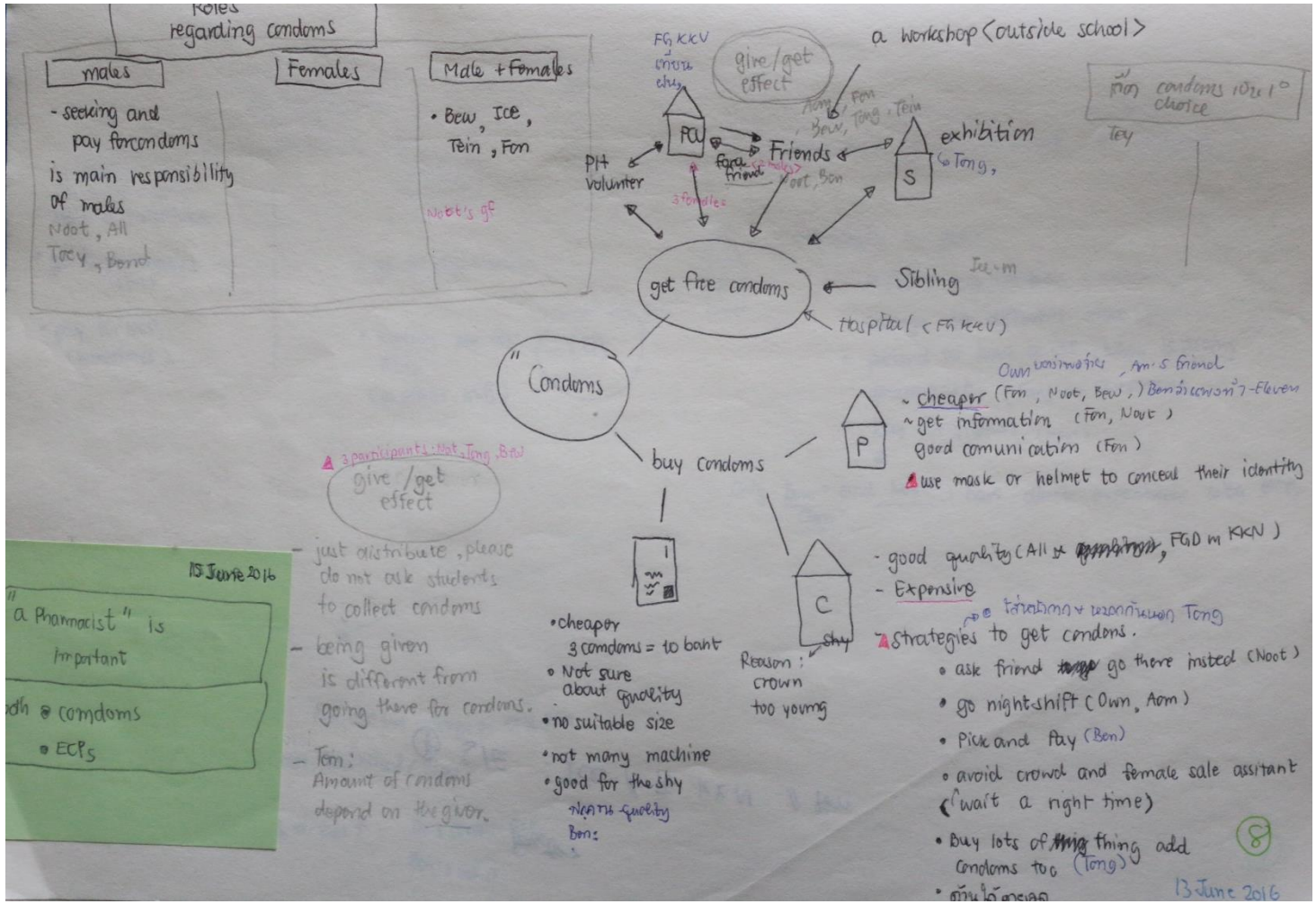
Name	age	Gender	Education	Experiences of working with adolescent	Attendance of training	
					1st	2nd
Tae	22	Male	University	Yes	✓	✓
Jorm	21	female	University	Yes	✓	×
Ping	20	male	University	Yes	✓	×
Turk	18	male	University	Yes	✓	✓
Yord	18	male	University	Yes	✓	✓
Da	18	female	University	Yes	✓	✓
Tan	18	female	University	Yes	✓	×
Not	16	male	Secondary school	No	✓	×

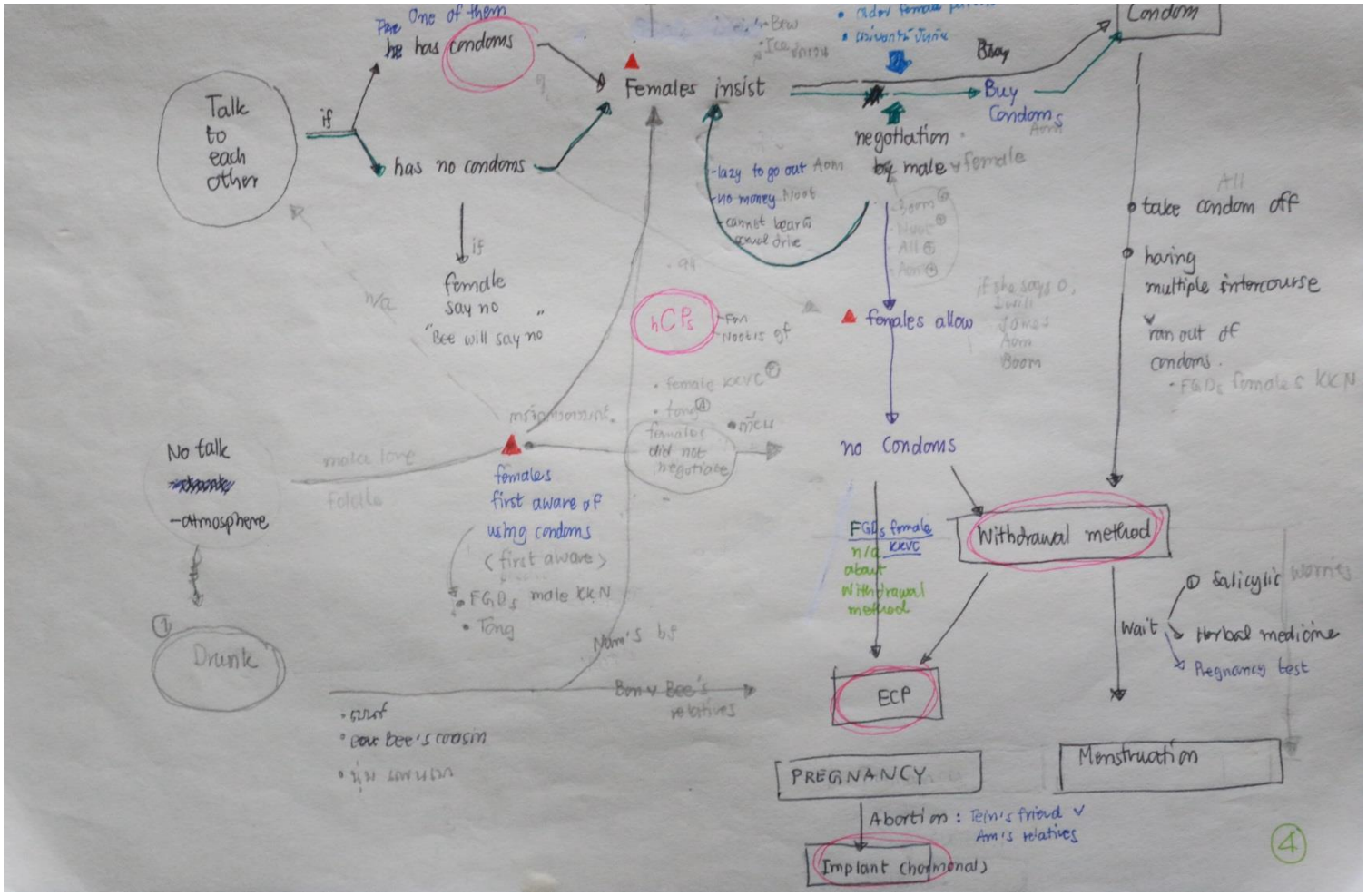
Appendix E: An example of thematic analysis

Participants' quotes	Codes	Concepts (sub-themes)	Themes
"Um … I love nightlife and spend my time with my friends and my boyfriend. My neighbours had been very critical of me and said that I would soon have a baby out of the wedlock. I want my neighbours and other adults not to look at young people who love to go for a night out … they are not going to have sex or do something bad or bring a baby back home. Young people have their own way to [prevent or solve a problem]" –Ice, female, in-depth interview, vocational college	-Nightlife -Friend -Neighbour -Pregnancy out-of-wedlock -Be judged -Have sex -prevention	- sexual relationship -negative consequences of pregnancy -Need understandings	-Lived experiences -perception on pregnancy -Adolescents' expectation
Noot: No, after that I thought. Then, she felt afraid of [pause]. If::: that mistake happens. We decided to buy emergency pills	Mistake Emergency pills	Fear of pregnancy Contraceptive choice	Perception on pregnancy Decision making on ECPs
Fang: Girls are afraid of pregnancy. She told me that at the first to the third intercourse her boyfriend used condoms. But the fourth round, they ran out of condoms. Sansanee: after that? Fang: she went to a pharmacy for emergency pills.	Fear of pregnancy Each sex intercourse Condoms ECPs	Fear Contraceptive choices	Influencing factors Decision making on condoms Decision making on ECPs
My relative took a boy to sleep at home. Then her menstruation did not come. My auntie asked her whether she was pregnant or not because my auntie noticed from sanitary pads. My auntie took my relative to check her pregnancy as I told you before.	Sexual relationship Mother talk to the girl Pregnancy	Parents' monitoring	Parents roles

Appendix F: Drawing Diagrams




Roles regarding condoms
Males
Females
Male + Females
- seeking and pay for condoms is main responsibility of males
Noot, All
Tacy, Bond
• Bew, Ice, Tein, Fon
Noot's gf
FG, KKV
give/get effect
a workshop (outside school)
Aom, Fon, Bew, Tong, Tein
exhibition
(Tong,
PH volunteer
Friends
S
get free condoms
Sibling
hospital (FG KKV)
Condoms
buy condoms
P
cheaper (Fon, Noot, Bew,) Bon at 7-Eleven
get information (Fon, Noot)
good comunication (Fon)
use mask or helmet to conceal their identity
3 participants: Not, Tong, Bew
give/get effect
- just distribute, please do not ask students to collect condoms
- being given is different from going there for condoms.
- Tom: Amount of condoms depend on the giver.
15 June 2016
"a Pharmacist" is important
condoms
ECPs
•cheaper 3 condoms = to baht
• Not sure about quality
• no suitable size
• not many machine
• good for the shy
Bon:
C
shy
Reason: crown too young
- good quality (All at FGD in KKN)
- Expensive
Strategies to get condoms.
• ask friend go there instead (Noot)
• go night-shift (Own, Aom)
• Pick and Pay (Bon)
• avoid crowd and female sale assitant (wait a night time)
• Buy lots of thing add condoms too (Tong)
13 June 2016


Talk to each other
if
One of them
he has condoms
has no condoms
if female say no
"Bee will say no
Females insist
negotiation
by male ♥ female
-lazy to go out Aom
-no money Noot
-cannot learn travel drive
Buy
Buy Condoms
Condom
take condom off
having multiple intercourse
ran out of condoms.
females allow
no Condoms
hCPs
females did not negotiate
females first aware of using condoms
(first aware)
FGDs male KKN
Tong
No talk
-atmosphere
Drunk
Withdrawal method
FGDs female KKVC
n/a about withdrawal method
Salicylic
Herbal medicine
Pregnancy test
wait
ECP
PREGNANCY
Abortion : Tem's friend ♥ Am's relatives
Implant (hormonal)
Menstruation
4