Experiences of Repeat Pregnancy in Thai Adolescent Mothers.

being a thesis submitted in fulfilment of the
requirements for the degree of
Doctor of Philosophy

in Nursing Studies

the University of Hull

by

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August 2022

Dedication

I dedicate this thesis to my grandmother *Kam*, (อาม่าก้ำ; in Thai). She raised her *nine* children on her own. She took great pride in seeing them, and her grandchildren study, and it was she who taught us all to value education. “My dear granny, even though you are no longer with us, I know you are always with me”.

Acknowledgements

I would like to thank the fifteen young mothers who agreed to participate in this research for their bravery, honesty and openness in sharing their life stories with me. I will be a better nurse, midwife and nurse teacher, for having learned so much from them.

I thank my research supervisors, Dr. Clare Whitfield, Dr. Barbara Elliot, and Dr. Moira Graham for their support of me over the duration of my research journey. Amid the Covid-19 pandemic, and across the continents, they have been there for me. They have taught me so much and I feel privileged to have worked with them. I enjoyed our research meetings which provided insightful discussions and inspiration, leaving me feeling invigorated and excited. I will miss this time to muse about interesting things.

Thank you to all the Thai and other international students at the University of Hull for the discussions and conversations in the classroom, the café, and during other student activities. You have all kept me going.

Thank you also to the Royal Thai Government and the Office of Educational Affairs (OEA), UK, for financial support to undertake this study in the United Kingdom (UK).

Thank you to my colleagues in Boromarajonnani College of Nursing Ratchaburi (BCNR), Faculty of Nursing, Praboromarajchanok Institute, Ministry of Public Health, Thailand for understanding and allowing me extra time to be able to focus on writing up the thesis.

Finally, I would like to thank my family, my husband, and my friends for their love and support. They have spent hours on the phone with me, given me respite from work, encouraged me, sent Thai food, cards, and kept faith in me. Most importantly, I thank them for just being there.

Abstract

Aims: The study aims to increase the understanding of the experiences of repeat adolescent mothers in the context in which they live.

Objective: To explore the experiences of adolescent mothers who have at least one living child and are at least 6 months pregnant on a subsequent occasion as adolescents (a repeat pregnancy).

Sample: Purposive sampling was used to identify a sample of 15 adolescent mothers experiencing a repeat pregnancy at the time of interview.

Methods: Individual semi-structured qualitative interviews were used to gather in-depth data from participants who discussed their experiences of a repeat pregnancy. Thematic analysis (Braun and Clarke, 2006) was used to develop an analytic framework; this analysis was further organised using Bronfenbrenner's ecological theory (1979, 1986, 1994) to understand and conceptualise the relationship between individual experiences and related contexts.

Findings: The findings of this study are classified into four main themes: *Contraceptive decision-making, Relationships, Education and Employment* and *A Transformational Experience*. This analytic framework, when considered in relation to Bronfenbrenner's ecological theory (1979, 1986, 1994), raises five main issues, namely: *the experience of repeat pregnancy* at the microsystemic level, *interaction and relationships* at the mesosystemic level, *disruption from others* at the exosystemic level, *trying within constraints* at a macrosystemic level and *the life journey* at the chronosystemic level.

Conclusion: Although adolescent mothers experiencing a repeat pregnancy exercise some agency in relation to decision-making around sexual health, contraception, and family-building, they are heavily constrained by their structural context. That is, the agency available to pregnant adolescent mothers is impacted by partner behaviour, the influence of family and peers, cultural expectations and the structured function of policy and law. The organisation of education, including sexual health and relationships education itself, and the structure of employment disadvantage young mothers when they are most vulnerable. This is further evident in the lack of active enactment of protective policies and laws, including adequate, timely and confidential sexual health provision and protection from child marriage. The acknowledgment of the impact of these structures to limit the ability of young mothers to exercise agency in a Thai context is unique to this study and central to the project to reduce repeat adolescent pregnancy in Thailand.

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List of Abbreviations

ANC	Antenatal Clinic
DHSs	District Health Services
DMPA	Depot Medroxyprogesterone Acetate
IUDs	Intrauterine Devices
IUSs	Intrauterine Systems
JBI	Joanna Briggs Institute
LARCs	Long-Acting Reversible Contraceptives
MMSR	Mixed-Method Systematic Review
MoPH	Ministry of Public Health
NFE	Non-Formal Education
ONIE	Office of Non-Formal and Informal Education
OSCC	One Stop Crisis Centre
PHC	Primary Health Care
RDS	Respiratory Distress Syndrome
RP	Repeat Pregnancy
RRP	Rapid Repeat Pregnancy
SDG	Sustainable Development Goals
tToP	Therapeutic Termination of Pregnancy
UNPD	United Nations Population Division
WHO	World Health Organisation

Chapter 1 Introduction

1.0 Origins of the study

This study set out to understand the experience of repeat pregnancy among Thai adolescent mothers and draws on an analysis of the accounts of fifteen pregnant adolescent mothers who have at least one living child. The study adopted a qualitative research approach (Mason, 2002; Mason, 2017) and data were collected between October 2018 and March 2019. Thematic analysis (Braun and Clarke, 2006; Braun and Clarke, 2013) was used to develop an analytic framework; this analysis was further organised using Bronfenbrenner's ecological theory (1979, 1986, 1994) to understand and conceptualise the relationship between individual experiences and their related contexts.

My interest in the topic originates from my professional background: I am a nurse, midwife, and teacher of nursing. Within my area of my responsibility, I have often supported very young mothers during the birth of their babies. A large number of these young women were highly anxious and feared childbirth and again, many of these young women struggled to cope with pain during labour. I often heard young mothers saying "just one is enough" yet I sometimes met them a year or so later, along with other young mothers, going on to have a subsequent child while still in their adolescence. I wondered how they negotiated motherhood and what their experiences of life with their children was. In 2015 I conducted a qualitative research study exploring repeat pregnancy intention among first time Thai adolescent mothers. Data were collected using an in-depth interview method with eight young mothers on their decision-making around having a second child. One important finding which emerged from that study was that partners and family were key influences regarding their decision making around having a second child (Arayajaru et al., 2019). This, and my curiosity about their lives more generally led me to want to explore this issue in more depth, which then became the basis for my PhD study.

1.1 Repeat pregnancy among adolescents as a focus for this research

Adolescent pregnancy is an international dilemma affecting not just the adolescent women and their babies, but entire societies (Holness, 2015). The negative health consequences to young mothers are concerned with preterm labour, pregnancy anaemia, and low birth weight infants (Khashan et al., 2010; Holness, 2015; Talungchit et al., 2017).

Moreover, the main consequences of adolescent pregnancy with regards to social and economic factors are increased barriers to educational achievement and social stigma (UNICEF, 2015). The World Health Organisation (WHO) highlights several factors that contribute to adolescent pregnancy, including knowledge gaps and misconceptions about contraceptive methods (World Health Organisation, 2020). Additionally, adolescents may lack the agency or autonomy to ensure the correct and consistent use of a contraceptive method (Darroch et al., 2016).

Data from the United Nations Population Division (UNPD) shows Thailand ranked in fifth place in the Southeast Asia region by births per 1,000 women aged 15 – 19 years. While the World's adolescent birth rate is 42.0 per 1,000 adolescents in the 15–19 age group (UNPD, 2018). I considered the Thai adolescent pregnancy rate and wanted to explore this in Health region 5, where I work, as the adolescent pregnancy rate was 39.9 that higher than the rate in Thailand at 35.0 per 1,000 adolescents in the 15–19 age group (Bureau of Reproductive Health, 2018). Thailand has been providing interventions aimed at reducing adolescent pregnancy for decades, but a relatively a high rate of pregnancy among adolescents persists (Talungchit et al., 2017; Aeamsamarng et al., 2013). Repeat pregnancy among adolescents, although declining, has remained a concern among policy makers (Bureau of Reproductive Health, 2018).

A *Repeat Pregnancy (RP)* in adolescents is defined as a "woman who becomes pregnant again while still an adolescent" (which is under age 20 years) (Jacoby *et al.*, 1999). A further issue of concern is "*Rapid Repeat Pregnancy* (RRP), where there is 'pregnancy onset within 24 months of the previous pregnancy outcome" (Jacoby et al., 1999: 318). However, the definition that will be used here is based on the definition provided by the Thai Government in their recent report (Bureau of Reproductive Health, 2016) which considers repeat adolescent birth rates of women aged 15-19 years who have repeat births, regardless the number of months of interpregnancy interval (Bureau of Reproductive Health, 2016)[1].

Currently, there are no significantly effective interventions to reduce repeat pregnancy in adolescents in Thailand (Talungchit et al, 2017; Chamkajang, 2019). However, literature

[1] The literature distinguishes between adolescent pregnancy and adolescent births; a pregnancy may, or may not result in a birth. In this study the term 'repeat pregnancy in adolescence' draws on the Thai Government definition above, but includes those adolescent women with a second or subsequent pregnancy who intend to continue their pregnancies to term.

suggests that research aiming to address and reduce repeat pregnancy among adolescent women should focus on the influences of adolescent mothers' circumstances and the individual situations of these young women (Jacoby et al., 1999; Raneri and Wiemann, 2007; Charles et al., 2016; Aslam et al., 2017).

The findings from this thesis show that although adolescent mothers exercise some agency in relation to decision-making around sexual health, contraception, and family-building, they are heavily constrained by their structural context. Using Bronfenbrenner's ecological theory allows an understanding that the experiences of young adolescent mothers are shaped and impacted by broader structural forces that go beyond the agency of young women. This presents a unique approach in a Thai context. That is, the agency available to pregnant adolescent mothers is impacted by partner behaviour, the influence of family and peers, cultural expectations and the structured function of policy and law. The organisation of education, including sexual health and relationships education itself, and the structure of employment disadvantage young mothers when they are most vulnerable. This is further evident in the lack of active enactment of protective policies and laws, compounded by the lack of adequate, timely and confidential sexual health provision and protection from child marriage.

1.2 Aims of the study

This thesis aims to understand the experiences of repeat pregnancy among adolescent mothers in Thailand who have at least one living child. Moreover, to explore the contexts in which pregnant adolescent mothers are living, from their perspectives. I wanted to address the gap in the knowledge base on this issue and allow the experiences of Thai adolescent mothers who had a repeat pregnancy and were also living with their first children to be heard and better understood thorough an exploration of their circumstances and experiences.

I hope that this study will enhance an understanding of the experiences of these adolescent mothers and provide insight into the reasons for adolescent mothers becoming pregnant for a second and subsequent time. Moreover, the findings may contribute to improving the understanding by healthcare providers of this group of young women's needs and may lead to developing appropriate interventions and support policies for them within their life contexts.

1.3 Structure of the thesis

The thesis is comprised of 8 chapters: *Chapter 1* has introduced the research, explained the background to the study and set out the study aims. *Chapter 2,* a background chapter, provides an overview of adolescent pregnancy, including adolescent mothers in the global and Thailand contexts, as well as the adolescent repeat birth situation in Thailand. *Chapter 3*, a systematic review of the literature, outlines what is currently known about the related influential factors and experiences that surround the circumstances of repeat adolescent pregnancy in general, and in Thailand particularly. Using mixed research synthesis, the review aimed to integrate the results from both qualitative and quantitative studies. Critical appraisal of all eligible papers was undertaken to provide a 'strength of stage of knowledge' and identify gap in the knowledge base on the topic of repeat pregnancy among adolescents. Next, *Chapter 4* explains my understanding of qualitative research methodology underpinning this study. Bronfenbrenner's (1979, 1986, 1994) ecological theory, which underpins this study, is also explained in the chapter. *Chapter 5* details the research methods, including details about the site, the ethical processes, the sample, and the data collection and analysis methods. The chapter also addresses how rigour was addressed in the study.

Following this, *Chapter 6* presents the findings from the thematic analysis of the experiences of adolescent mothers from their perspectives. The analysis identified four themes*: Contraception Decision-making, Relationships, Education and Employment, and A Transformational Experience*. Then, *Chapter 7* discusses the findings, drawing on Bronfenbrenner's (1979) ecological model as the theoretical underpinning in this study. *Chapter 8* concludes the thesis and makes recommendations. The chapter reflects on the strengths and limitations of the research and presents the final reflections on undertaking the study.

Chapter 2 Background to Adolescent Pregnancy

2.0 Introduction

This chapter presents the background to the thesis. It starts by defining adolescence and adolescent pregnancy. It then presents the global, followed by Thailand's situation in relation to both first-time and repeat adolescent pregnancy. This includes a discussion surrounding perceptions of, and social attitudes toward adolescent pregnancy, and the related law and legislation within the cultural and social context of Thailand.

2.1 Definitions

The meaning of the word's "adolescent" and "teenager" or "adolescence" and "teen" are often used synonymously. The World Health Organisation (WHO) states that the terms "adolescent" and "teenager" have the same meaning. In this sense *"adolescent pregnancy means pregnancy in a woman aged 10–19 years"* (World Health Organisation, 2004: 5). However, adolescence is classified into three groups (early, middle, and late adolescence) based on cognitive and affective development (Steinberg, 2005). The period of adolescence is categorised into subgroups, which are characterised by the different tasks of adolescence in terms of the cognitive system, physical, behavioural, and social development (Sisk and Foster, 2004; Lerner and Steinberg, 2009; Blakemore et al., 2010). As the developing brain, behavioural, and cognitive systems mature at different rates, and are under the control of both common and independent biological processes, this period is often one of increased vulnerability and adjustment (Steinberg, 2005). During adolescence, young women will negotiate puberty and the completion of growth, take on a sexually dimorphic body shape, develop new cognitive skills (including abstract thinking capacities), develop a sense of individual and sexual identity, and develop an intensity of their emotional, and financial independence from their parents (Christie and Viner, 2005).

With respect to the three classifications of adolescence referred to above, firstly, there is "early adolescence" (age 10–14), which is generally characterised by physical development and secondary sexual appearances. This adolescent group arises around the onset of puberty and is marked by changes in hormone levels and in physical appearance, including rapid physical growth, changes in facial structure, and the appearance of secondary sexual characteristics. In this period, the first menstruation will happen in

adolescent girls who have completed reproductive organ development; however, it may not be seen until middle adolescence. These physical developments can lead to pregnancy if they are involved in sexual intercourse and fertilisation occurs (Steinberg and Lerner, 2004; Steinberg, 2005; Lerner and Steinberg, 2009). Moreover, this period is also considered important for the cognitive and social development that occurs. Concrete thinking and early moral concepts are raised. The progression of sexual identity development (sexual orientation), possible homosexual peer interest, and reassessment of body image as well as social tasks are gradually developed. Additionally, emotional separation from parents and the start of strong peer identification, early exploratory behaviours, including smoking, violence, and sexual activity, are raised (Christie and Viner, 2005).

Regarding adolescent pregnancy, 'early adolescent pregnancy' is defined as belonging to the same age group of early adolescence, which means that the pregnant adolescent is aged 10–14; it can also be identified as aged under 15 years (Alves et al., 2012; Calhoun, 2016). In the early adolescent pregnancy group, girls were more likely to experience poor adverse pregnancy outcomes than the older adolescent pregnancy group, including a greater rate of babies born prematurely and with low birth weight. Prematurity and low birth weight remained statistically significant compared to older adolescent pregnancy (Alves et al., 2012).

Middle adolescence is defined as aged 14–17 years old; this period shows heightened vulnerability to risk-taking and problems in regulation of affect and behaviour (Steinberg, 2005). For girls, this is mid-late puberty and the end of a growth spurt, the development of female body shape with fat deposition, and the beginning of menarche. Their psychological development shows abstract thinking, but self-development is still seen to be lacking. There are growing verbal abilities, the identification of the law with morality, and the start of fervent ideology (religious, political). They also have social development tasks, such as emotional separation from parents, strong peer identification, increased health risks (smoking, alcohol, etc.), heterosexual peer interest, and early vocational plans (Christie and Viner, 2005).

Lastly, "late adolescence" (age 18–21 years old), includes the last part of the adolescent years. It is classified by physical and sexual development, cognitive and affective development about risk-taking, and confidence in their own opinion and identity (UNICEF, 2011). This is also the period of mid-late puberty and the end of the growth

spurt, menarche, and development of the female body shape with fat deposition (Christie and Viner, 2005). Development of muscles, joints and bones, especially the pelvis, is almost complete (Alves et al., 2012). Furthermore, this age group is also at the period of heightened vulnerability to risk-taking and problems in regulating affect and behaviour (Steinberg, 2005). Moreover, this is the period of maturation of the frontal lobes which facilitates regulatory competence and is also when complex abstract thinking is developed (Christie and Viner, 2005). The development of social tasks in late adolescence show they have ability to develop social autonomy; intimate relationships; development of vocational capability and financial independence (Christie and Viner, 2005).

The literature has also classified the late adolescent age into different age groups. For example, UNICEF (2011) define the late adolescent as aged 15–19 years. In this age group, the subgroups can be seen as "middle adolescence" (age 14–17), and "late adolescence" (age 18–21). In this study, a late-age adolescent pregnancy may be at increased risk of prematurity and low birth weight compared to the pregnancy of a mature women (Alves et al., 2012; Ozdemirci et al., 2016).

2.2 The Sustainable Developmental Goals related to Thai adolescent mothers

The Agenda for Sustainable Development was adopted by all United Nations Member States in 2015. Underpinning this Agenda are 17 Sustainable Development Goals aimed at ending poverty, safeguarding the planet and enhancing the lives and opportunities of all peoples, worldwide. All Member State signatories committed to a 15-year plan to achieve the goals by 2030.

Encompassed within the 17 SDGs are four relevant goals related to adolescent health with the specific goal of SDG 1 being to – "*end poverty in all its forms everywhere*". SDG 3– "*ensure healthy lives and promote well-being for all at all ages*" on target 3.7 to– "*ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes*". SDG 4– "*ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*". SDG 5– "*achieve gender equality and empower all women and girls*" on the SDG target 5.3– "*eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*" (United Nations, 2016).

The aforementioned SDG's recognise that adolescent health has an impact on the economic productivity of a country, and that poor health in adolescence was connected with poorer education and employment outcomes in young people's lives and are consequently a potential economic burden to the country (Hale et al., 2015). Adolescent sexual health is recognised as being integral in the health of adolescents more generally, and so too is adolescent pregnancy, as it can negatively impact on the young person's physical and psychological health, their education, employment opportunities and it can create personal, family, community and nation state financial burdens (World Health Organization, 2018).

The Thai government is a signatory to the UN SDG's and has set in train policy across all relevant administrative agencies including governmental and non-governmental organisations, as well as business and private organisations, to achieve the SDG's by 2030. (Strategy and Planning Division, 2016). The SDG goals related to adolescent health are encompassed in this strategy.

Within the organisational structure of the Thai health system, the Ministry of Public Health (MoPH) is the national health authority with overall responsibility for the health system, particularly in relation to policy making, planning, and financing. It is the MoPH that is responsible for policy initiatives in relation to achieving the health related UN SDG's, including adolescent health and sexual health goals and the prevention of pregnancy policies. Section 2.7 of this chapter sets out in detail how Thai health services are structured and delivered, and how adolescent sexual health services are administered.

The adolescent pregnancy and birth rates in Thailand have been falling for a number of years and details on these are provided in sections 2.3.2 and 2.3.3 of this chapter. The falling rates demonstrate, in part, the effectiveness of the Thai government's commitment to positively promoting adolescent health, and in particular, sexual health. Nonetheless, there is still much to do to achieve the goals of the UN SDG's for adolescents and specifically within Thailand, the "Act for the prevention and solution for the adolescent pregnancy problem, B.E.2559 (2016)" (Government Gazette, 2016) of reducing the rate of adolescent pregnancy and positively enhancing their overall health and well-being. Pregnant adolescent women are still dropping out of school, finding employment difficult, and they and their children, suffering poverty.

Kaewhan and Sripa (2021) report that in terms of policy implementation, to achieve these goals healthcare personnel need to assess adolescent sexual health knowledge and

positively support young mothers. In their qualitative study of Thai policy implementation with regard to providing care to adolescent mothers, Jittitaworn et al., (2020) found healthcare professionals experienced many challenges attempting to do this. Their study showed that healthcare providers recognised that the political and societal contexts and the environment of care could have a positive and/or negative impact on the adolescent women, but because systems for referral or access were not well established, they were unable to use these for the benefit of the young women.

For example, in Thailand, there is no routine home visiting practice policy. Home visiting, where the health professional could follow up and gain invaluable insight into the individual young woman's health and social needs is not regarded as the role of a nurse-midwife. Sometimes it is possible to accompany social workers or community healthcare providers, whose duty it is to check on the living conditions of adolescent women who were assessed as having financial problems after they had given birth, but this is not the norm (Jittitaworn et al., 2020). Consequently, the nurse-midwife is not easily able to support post-partum adolescent mothers in their individual situations, so contraceptive issues and sexual health relationships may not be addressed, with the consequent possibility of unplanned repeat pregnancy. Achievement of the UN SDG's for adolescent women remains a goal to be realised in full.

2.3 The global and Thai contexts

This section presents the data concerning global and Thailand adolescent pregnancy rates. The adolescent birth rates are calculated per 1,000 of a specific population. The World Health Organisation (2018) defined method of measurement the adolescent birth rate as "*The adolescent birth rate is computed as a ratio. The numerator is the number of live births to women aged 15-19 years, and the denominator an estimate of exposure to childbearing by women aged 15-19 years"*. Consequently, generally, in terms of world adolescent reports, the statistics of the prevalence between countries have used rates per 1,000 adolescents aged 15–19 years. Occasionally, statistical data on pregnancies and births among early and late adolescents are also presented with the range of age 10–19 years by percentage (World Health Organisation, 2018). Data presented here focuses on adolescent birth rate aged 15-19 years old in the global, and regional and national Thailand context.

2.3.1 Global context

Over the last decades, the global trend in adolescent pregnancy has shown huge differences across regions and countries (UNPD, 2018; The World Bank, 2018). The World Health Organisation estimated *“21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million of them give birth, and at least 777,000 births occur to adolescent girls younger than 15 years in developing countries”* (World Health Organisation, 2020).

The incidence of adolescent childbearing has remained high in sub-Saharan Africa, such as in the Republic of Niger, which had the highest rate in the world, with 183.51 births per 1000 adolescents in the 15–19 age group in 2018 (The World Bank, 2018). While in high income countries the rate of adolescent births in 2018 remained lower than the world average, with a rate of 11.60 births per 1,000 adolescents in the 15–19 age group. In 2018 the United Kingdom adolescent birth rate, was 12.64 births per 1,000 adolescents in the 15–19 age group. The United States had a higher rate than the United Kingdom with 18.55 births per 1,000 (The World Bank, 2018). The European Union rate of 8.92 in the 15–19 year age group is lower than the United Kingdom and the United States but the rate varies considerably between countries with Bulgaria having the highest rate for the European Union, at 39.32 births per 1,000 adolescents in the 15–19 age group (The World Bank, 2018).

In the Southeast Asia region, according to The World Bank (2018) statistics, the adolescent birth rate has declined slightly in adolescents aged 15–19 years. In addition, when considered by single country, the Lao People's Democratic Republic had the highest rate in both the East Asia and Pacific and the Southeast Asia regions, with a rate of 64.93 births in 2018 per 1,000 in adolescent women aged 15–19 years old. This was followed by the Philippines, Cambodia, and Indonesia with a rate of 54.75, 50.72, and 46.90 in 2018, respectively. Thailand ranked fifth out of eleven countries in the Southeast Asia region, with a decreasing trend at a rate of 51.10 births in 2013 and 35.00 in 2018 at around 44.60 per 1,000 adolescents in the 15–19 age group (The World Bank, 2018).

2.3.2 Thai context

This section illustrates the situation in Thailand. Table 2.1 illustrates the Thai adolescent birth rate and trends which show a gradual decline. The statistics show that there were 70,181 adolescent women giving birth at the age of 15-19 years in 2018. The adolescent

birth rate shows a steady decline from 51.1 in 2013 to 35.0 in 2018 per 1,000 adolescent women aged 15-19 years old.

Table 2.1 Adolescent birth rate per 1000 women aged 15 – 19 years in Thailand from 2013 - 2018[2]

Data/Year	2013	2014	2015	2016	2017	2018
Births in adolescents aged 15-19	121,960	112,278	101,301	91,838	82,019	70,181
adolescents aged 15-19	2,386,492	2,342,718	2,262,832	2,162,983	2,072,138	2,003.012
Rate per 1,000	51.1	47.9	44.8	42.5	39.6	35.0

Source: Statistics on Adolescent Births, Thailand 2018 (Bureau of Reproductive Health, 2018)

There are 77 provinces in Thailand, and these are divided into 4 regions. Regarding responsibility for health care, the Ministry of Public Health has divided the 77 provinces into 13 health regions.

Health region 5 is responsible for 8 provinces in the central part of Thailand and is where I work. Region 5 is ranked as having the 2nd highest proportion of adolescent births for women aged 15–19 years compared to the other health regions with a rate of 39.9 births per 1,000 women. The statistics also show that there were 6,044 adolescent mothers aged 15-19 years who gave birth in 2018 (Bureau of Reproductive Health, 2018). The statistics by region for each of the 8 provinces are as follows: 32.7 per 1,000 births in Nakhon-Pathom, 45.4 in Samut-Songkram, 37.9 in Phetchaburi, 42.0 in Ratchaburi; 37.4 in Suphan-Buri, 40.7 in Khanchanaburi, 27.9 in Samut-Sakhorn, and 51.4 in Prajuab-Kereekhan. (Bureau of Reproductive Health, 2018). See Figure 2.1

[2] These are the statistics for the data collection period in 2018. Statistics for 2021 show a slightly decreasing trend.

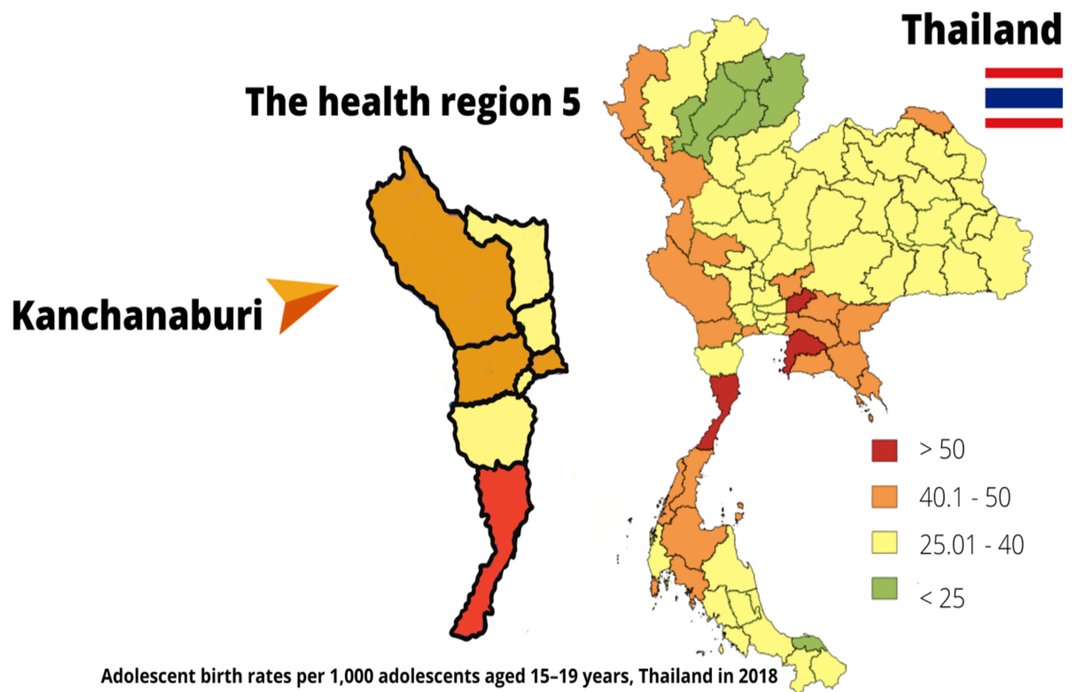


Figure 2.1 Map of Thailand with adolescent birth prevalence shown.

This study was conducted in Kanchanaburi province, Health region 5. The area was chosen, as I indicated earlier, as this is where I work in clinical teaching and home visiting postpartum mothers. Kanchanaburi province also had the second highest rate of adolescent births across Health region 5 at the time of data collection and it remains so. Kanchanaburi's adolescent birth rate is also higher than the rate in Health region 5, and the rate in Thailand. (Bureau of Reproductive Health, 2018). See Figure 2.2).

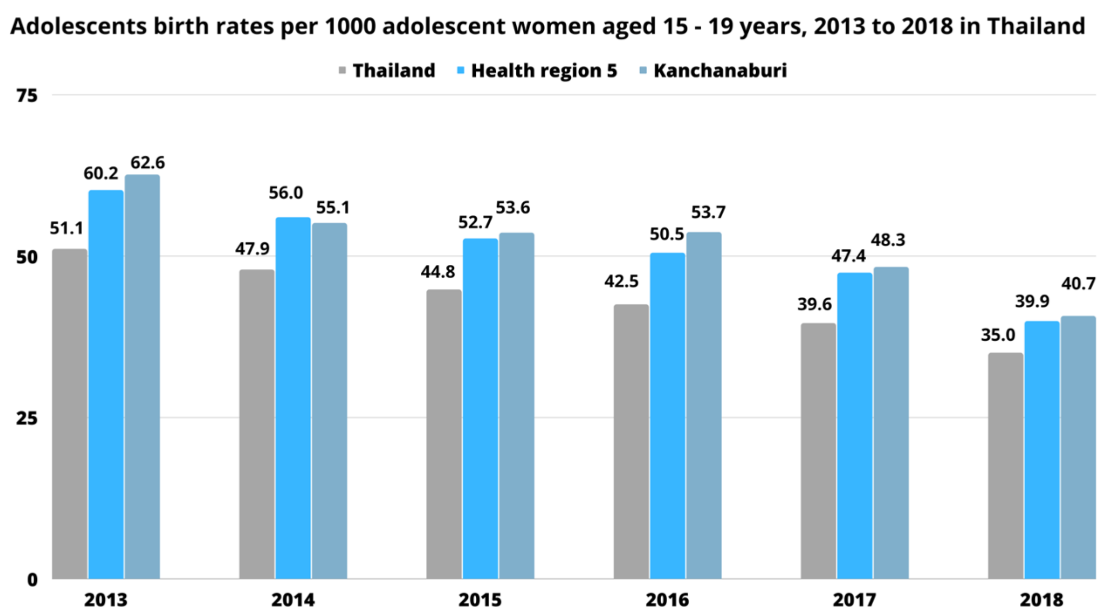


Figure 2.2 Adolescent births trends per 1,000 Thai adolescents in 2013 to 2018

2.3.3 Repeat pregnancy in Thailand

This section presents statistics on repeat births in Thailand. According to the Bureau of Reproductive Health (2018), the number of repeat births for adolescents aged 15–19 years decreased from 12.54% in 2013 to 9.32% in 2018[3]. Table 2.2 shows that 6,543 Thai adolescent women experienced a second childbirth in 2018. Adolescent birth rates have gradually decreased year on year, and so too have repeat adolescent birth rates. However, repeat births among adolescents is regarded as an important issue to address in healthcare services, and maternal health service policy (Bureau of Reproductive Health, 2018).

Table 2.2 Repeat adolescent birth rate by percentage to women aged 15 – 19 years in Thailand

Data/Year	2013	2014	2015	2016	2017	2018
Number of repeat adolescent births	15,294	14,338	12,700	11,225	9,091	6,543
Births in adolescents aged 15-19	121,960	112,278	101,301	91,838	82,019	70,181
Repeat adolescent birth rate by percentage (%)	12.54	12.77	12.53	12.22	11.08	9.32

Source: Statistics on Adolescent Births, Thailand 2018 (Bureau of Reproductive Health, 2018)

[3] The statistics at the time of data collection. This is the context at the time of data collection – however, the current context shows a steady decline to 9.1 in 2019 (last available statistics)

2.4 Overview of the effects of adolescent pregnancy and birth

2.4.1 Impact of adolescent pregnancy and birth on health outcomes

Adolescent pregnancy and birth health outcomes are raised in policy and practice as a concern for the health system and service planning. Initially, the significant negative health outcome for adolescent pregnancy and birth is the infant's health complications. Adolescent pregnancy and birth have associated risks of low birthweight infants of less than 2500 grams (UNICEF, 2015; Holness, 2015). Furthermore, the rate of preterm delivery in adolescents was higher than that in adults; in particular, the rate of preterm delivery in the 10–14 age group was higher than late adolescence aged 15-19 (Butchon et al., 2014).

Butchon et al. (2014) studied secondary data concerning "complications of pregnancy, delivery, and postpartum by age groups among Thai women aged 15–19 years". The most common complications during pregnancy among adolescent women who delivered were premature rupture of membranes (3.7%), preeclampsia (1.4%), and diabetes mellitus (0.3%). The most common complications during labour and immediate delivery were perineal laceration (4.7%), obstructed labour due to pelvic abnormality (4.9%), preterm delivery (5.9%), and foetal distress (3.6%). Complications predominantly related to the postpartum were other puerperal infections (0.3%), other disorders of the breast and lactation (0.2%), and puerperal sepsis (0.2 %).

2.4.2 The Perceptions and socioeconomic impact of adolescent pregnancy

Early motherhood is related to a range of socio-economic issues and impacts on social population development, which includes low maternal educational attainment, low family income, and high levels of unemployment (UNFPA, 2013). However, "teenage pregnancy" can be seen as a socially constructed category. This may explain why people think teenage pregnancy is a problem. As Arai (2009) states, "the social construction of teenage pregnancy is socially created as problematic", which contributes to negative consequences for young mothers and their children. These social constructions can be related to "moral panic", which can be seen as people worrying about adolescent mothers that they could be faced with the "wrong choice" in that they do not follow the "normal" life pattern by encompassing these things, finishing school, getting a job, getting married, and then having a baby. Moreover, people might express what they feel or how they think to young mothers without considering the impact on them of what they are saying.

The feeling of being socially excluded results from 'social stigmatisation' that is the result of social constructs and can be harmful to young mothers, which can lead to both physical and psychological health problems, as well as possibly also having a negative effect on the children (Whitehead, 2001). For those young pregnant women choosing not to terminate their pregnancy, they need to tackle a range of responses from people in direct contact with them, such as family and peers. Negative responses might force them to become socially excluded and isolated. On the other hand, for those young mothers who choose to terminate their pregnancy, they must confront the 'social stigma' coming from surrounding people, even including health-care providers (Whitehead, 2001). Denying the right to have a legal abortion for unwanted pregnancy can be found and debated among health-care providers who take responsibility for these situations because performing an abortion may be seen by them as immoral and sinful according to their individual cultural and religious beliefs; this may also account for their refusing the treatment (Chaturachinda and Boonthai, 2017).

The main economic and social consequences of adolescent pregnancy are increased barriers to educational achievement, which ultimately impede later life success, and social stigma in their public and private lives (UNICEF, 2015). In particular, pregnant adolescents and adolescent mothers face various barriers to continuing their education, many of which are interrelated. These barriers include being forced out of school, not receiving the support necessary to continue attending school, and not wanting to experience stigma from peers, teachers, and parents of other students. Policymakers should consider the implications this problem has for individual economic success, and on a larger scale, for economic development and human rights (UNICEF, 2015; WHO and Mathers, 2016).

2.5 The cultural and social context of Thailand

In order to better understand the experiences of Thai repeat adolescent mothers, the demographic profile of Thailand needs to be provided.

Thailand, officially the Kingdom of Thailand, previously known as Siam, is a country located in Southeast Asia. Thailand is divided into 77 provinces, and four regions: central, north, north-east, and south. The capital city is Bangkok, located in the central region; this is the largest city and is Thailand's political, commercial, and cultural centre (National Statistical Office, 2018).

The data available at the time of the data collection shows the population of Thailand at approximately 69.42 million people (The World Bank, 2018). The number of adolescent people aged 15-19 years was approximately 4.5 million people including men and women in 2018 (National Statistical Office, 2018).

Regarding living conditions in Thailand, the number of current households in Thailand is approximately 17.9 million; the average household size is approximately 3.6 persons per house. Some 98.4% of the houses are made of permanent materials. About 82.4% of households have ownership. The numbers of house owners living in non-municipal areas were higher than those of the municipal areas. By total household, most of the households had relatively safe drinking water (89.9%), hygienic types of toilets (99.0%), and accessible electric power (99.4%) (National Statistical Office, 2016; Sa-ngiamsak, 2016).

Thailand's population is, relatively speaking, of the same identity, namely more than 80% of the total population are ethnic Thais. Currently, 94.6% of Thais are Buddhists, 4.2% are Islamists, 1.1% are Christians, and the rest are Hindu and unaffiliated (National Statistical Office, 2016).

2.6 Thai family structure and fertility norms

Family structure and relationships in Thailand have changed to a decline in population growth and low fertility, which is altering the population’s age structure and has contributed to changing family structures in recent decades (Bongaarts, 2001; Limanonda, 1995). In the last two decades, household size consisted of around 4–6 family members (Limanonda, 1995). Recently, the Thai National Statistical Office (2018) reported that household size had been reduced to 3.6 family members showing a downward trend.

The recent Thai family structure is established according to three stages of family formation. Firstly, a family starts as a nuclear family type, comprising a father, a mother, young unmarried children, and sometimes one or more grandparents. Secondly, the situation arises when young newly married children remain living together in a subunit in the parental household. Consequently, the family structure becomes a small extended family. Lastly, the family structure grows when the next daughter of the family gets married or when the other couple have their first child and move out to set up their own family. Through this cyclical family growth, a once-nuclear family may become an extended family. In contrast, the family structure can change from an extended family to become a nuclear family, depending on the family life cycle (Limanonda, 1995).

The general structure of Thai families, in the Cultural Atlas (2021: e1) explained that *"the structure of Thai families is patriarchal, with the household deferring to the oldest living man. Often, several generations will live under the same roof, and grandparents, aunts, and older siblings will help raise a child. It is common for Thais to live in the home of their parents until they are married, and some newlyweds live with their families until they have children of their own. Moreover, a pregnant mother often moves back to her mother's house or invites the future grandmothers to live with them."*

Geronimus (2004: 158) asserted that *"cultural ideals are well recognized within the group. Parents and adults work actively to enable children to recognise and follow local ideals. Cultural ideals are central to the development of personal identity and, thus, to personal susceptibility to specific social control messages, and personal receptivity to specific forms of social support".* Fertility-age norms are accepted, and beliefs are inherited by other generations. Fertility-timing norms are mechanisms through which the basic cultural imperatives toward economic and reproductive success are pursued; at their best, fertility-timing norms are set to support and draw support from local family economies and caretaking systems.

In the study by Sear (2018), the availability of family does influence fertility. Data from middle- and lower-income populations asserts that having family does increase fertility, and that these relationships are reasonably driven by support among family members. In higher-income contexts, associations between family and fertility are mixed and appear particularly sensitive to how family availability and support is measured. There is some evidence that certain measures of support from family, such as emotional support or help with childcare, increases the likelihood of subsequent births.

Adolescent mothers are more likely to face poorer prospects in life than women who delay motherhood until later in life (Wellings et al., 1999). The socially approved timing of its expression and consequences underlies many of the problems relating to the maintenance of the sexual and reproductive health of young people. Early fertility may be problematic not because of inherent difficulties associated with having children early in life but because of the way in which it is socially regarded and managed in their family and social contexts (Wellings et al., 1999). Thus, family matters for fertility though these relationships may be complex and context specific. The decision-making regarding fertility is related to the involvement of family. For instance, grandparents are still important carers of grandchildren, given substantial evidence for their involvement with

grandchildren, which affects women's fertility decision-making (Wellings *et al.*, 1999). Moreover, partner roles are important with respect to the home in affecting fertility decision-making (Sear, 2018).

2.7 Relevant laws and social welfare support for adolescent pregnancy in Thailand

2.7.1 Legal definitions of a child

Thailand has a number of rather different definitions of a child as can be seen from the following legislation. For example, the Thailand Civil and Commercial Code 2545 B.E. (2002) in the Child Protection Act of 2546 B.E. (2003), article 4 defines 'Child' as a person below 18 years of age but does not include those who have attained majority through marriage (the age of consent for marriage is 17, and majority is attained through marriage). However, The National Youth Promotion and Coordination Act of 1978, which is the country's key legislation in the promotion and development of youth, defines "youth" as a person who is not over 25 years old. The definition of "youth", therefore, covers that of a "child".

a) The Act Instituting the Juvenile and Family Courts and the Juvenile and Family Procedures of 2553 B.E. (2010) defines the word "child" as a person over 10 years old but below 15. It also defines the word "youth" as a person who is over 15 years of age but below the age of 18 years.

2.7.2 The age of sexual consent and age of adolescent marriage

The age of consent for sexual activity is 15 regardless of gender or sexual orientation, as specified by article 279, 317, 318 and 319 of the Thai Criminal Code B.E.2499 (1956). Individuals aged 14 or younger in Thailand are not legally able to consent to sexual activity, and such activity may result in prosecution for 'statutory rape' or the equivalent local law.

The age of consent in Thailand is 15, while the age of consent for marriage is 17. Marriage for persons under 17 years of age requires the consent of the family court. Marriage for persons between the ages of 17–19 requires parental consent, and they attain majority through marriage (Thai Civil and Commercial Code B.E. 2545, 2002; Thailand Youth Policy Factsheets, 2014).

Thailand's statutory rape law is contravened when an individual has sexual intercourse with a person under the age of 15. There is no close-in-age exemption (Romeo and Juliet laws) in Thailand; it is possible for two individuals both under the age of 15 who willingly engage in intercourse to both be prosecuted for statutory rape (Thailand Civil and Commercial Code B.E.2529 (1986); Thailand Youth Policy Factsheets, 2014).

Moreover, there are laws that try to protect adolescent women, such as Section 277 Thai Criminal Code updated B.E.2530, (1987): Thailand's Criminal Code—Offense Relating to Sexuality, Section 277— *"Whoever has sexual intercourse with a girl not yet over fifteen years of age and not being his own wife, whether such girl shall consent or not, shall be punished with imprisonment of four to twenty years and fined eight thousand to forty thousand Baht".* This law also has a paragraph related to the offender: *"The offense as provided in the first paragraph, if the offender being the man commits against the girl over thirteen years but not yet over fifteen years of age with her consent and the Court grants such man and girl to marry together afterward, the offender shall not be punished for such offense. If the Court grants them to marry together during the offender be still inflicted with the punishment, the Court shall release such offender".*

Moreover, marriage among adolescents is both a cause and consequence of pregnancy (UNICEF, 2015). Because of family disruption, as qualitative responses from regional key informants across Thailand indicate, pregnant adolescents often get married to their partner in order to "save face" or to avoid legal complications if a male is brought to court. A few individuals have noted that the pressure to get married when pregnant is especially prevalent in more rural areas under pressure from the adolescent's parents (UNICEF, 2015).

2.7.3 Thailand Act for the prevention and solution of the adolescent pregnancy problem

Formerly in Thailand, there were three national agencies that played a crucial role in providing welfare services to pregnant adolescents and adolescent mothers, namely, the Ministry of Public Health, the Ministry of Education, and the Ministry of Social Development and Human Security (Sa-ngiamsak, 2016).

In the last two years, the government of Thailand has launched the "Act for the prevention and solution for the adolescent pregnancy problem, B.E.2559 (2016)". This is a new act and has provided many benefits for adolescent mothers and their children (Government

Gazette, 2016). This act has been endorsed by the "Prevention and Solution of the Adolescent Pregnancy Problem Committee" to co-operate and be responsible for enabling this act so as to be useful for participants. The Committee consists of (1) the Prime Minister as the Chairperson; (2) eight *ex officio* members, including the Minister of Social Development and Human Security, the Minister of Education, the Minister of Public Health, the Permanent Secretary for the Interior, the Permanent Secretary for Justice, the Permanent Secretary for Labour, the Permanent Secretary for Culture, and the Permanent Secretary for Bangkok Metropolitan Administration; (3) five qualified members appointed by the Chairperson from persons with knowledge, expertise, accomplishment, and no less than five years of experience in the fields of public health, adolescent rights and freedom protection, education, psychology, and social assistance, provided that one qualified member is appointed from each field; (4) two representatives from children and youth. The main contents comprise (1) adolescents' right to make decisions, (2) educational rights, (3) service rights, (4) employability rights, and (5) social welfare provision rights (Government Gazette, 2016). For example, the Ministry of Social Development and Human Security is the key agency responsible for providing social welfare services to women and children, especially those who are less privileged. The main responsibilities consist of income assistance, institutional care, and referrals; for example, 0.4% of the national budget is allocated to looking after those living in difficult conditions. Furthermore, in 2015, the Thai government introduced a new welfare policy aimed at all new mothers (including adolescent mothers) with a monthly income less than 3,000 Baht/month (around 45 GBP), which means providing financial support to help young mothers and their children meet basic needs (Sa-ngiamsak, 2016). Moreover, there are 77 emergency shelters providing 24-hour services for children and families who are in distress and need a temporary place to live before referral to other agencies (there is one in every province) (Sa-ngiamsak, 2016).

Moreover, social welfare provision relating to the prevention and solution of the adolescent pregnancy problem is as follows:

(1) to promote and support Children and Youth Councils at the level of Changwat and Amphoe to establish the children and youth networks in the areas as leaders in preventing, resolving, and monitoring the problem of adolescent pregnancy.

(2) to promote and support the relevant State agencies and private organisations to coordinate, monitor, and assist pregnant adolescents and their families.

(3) to provide vocational training in accordance with interests and proficiencies to pregnant adolescents, who intend to receive training, prior to and after childbirth, and to coordinate procurement of suitable employment.

(4) to provide alternative families in the case where adolescents are unable to raise the children themselves.

(5) to provide other social welfare to promote the prevention and solution of the adolescent pregnancy problem.

The undertakings under paragraph one shall be in accordance with the rules, procedures, and conditions as prescribed in the ministerial regulation (Government Gazette, 2016).

In terms of the Ministry of Public Health, it is mainly responsible for health care services based on the local hospital services by providing a Youth-Friendly Service where work with adolescents takes place in every hospital. Staff were trained for supporting youths in order to delivery and implement the related service protocols, including sexual abuse support, drugs, or domestic violence support and also contraception advice for youths who needs (Bureau of Reproductive Health, 2016).

Regarding contraception policies, there were formerly expensive long-term contraception options available, which included subdermal implantation of hormone and intrauterine devices (IUD). If women required long-acting reversible contraception (LARC), they had to pay about 800 Bath (18 GBP) for an IUD and 3,800 Bath (84 GBP) for subdermal implantation. Protection such as by Depo medroxy progesterone acetate (DMPA) injections, pills (only progesterone pills), and condoms were accessible and provided to women within the 30 Baht (0.70 GPB) health-care programme. With the rates of RP being high among adolescents, the Ministry of Public Health provided LARC free of charge in 2015, regardless of the legal conditions of their health insurance. In addition to subdermal hormone implantation, IUDs were also offered to reduce the rate of unintended RP (Chunin et al., 2016). Under this insurance, the Ministry of Public Health (MoPH) with the National Health Security Office has responsibility for *universal health coverage,* which is a comprehensive scheme that provides free health care for all Thai people for a cost of 30 Baht. However, Chunin et al., (2016) assessed this policy, and their study showed a lack of information for adolescents, resulting in missed services and that some health-care services did not provide LARC, with a lack of clinicians being stated as the reason.

2.7.4 A termination of pregnancy among adolescent Thai women

The greatest health concerns for pregnant adolescents result from the increased risk of life-threatening complications associated with “unsafe abortion” (UNICEF, 2015). As regards the limited choices regarding an unwanted pregnancy, there are laws related to two specific conditions for women whose health-care needs require a termination: risk to the woman’s health and a pregnancy resulting from rape. Several problems arise in the interpretation and implementation of these laws (Warakamin et al., 2004). However, many rural women remain fearful of the consequences of sin or “bap” if they were to undergo a termination and therefore choose to continue with an unintended pregnancy (Whitaker and Miller, 2000). Additionally, practitioners also refusing to perform legal termination for an unwanted pregnancy or for any other condition is the subject of much discussion among health-care providers, who take responsibility for these situations because performing a termination may be seen as immoral and sinful according to their individual perceptions or cultural and religious beliefs, which can lead to refusing treatment for pregnant adolescents (Chaturachinda and Boonthai, 2017).

2.8 Summary

This chapter provides an overview of adolescent pregnancy from a number of perspectives, including adolescent mothers in both global and Thai contexts, adolescent repeat birth situations in Thailand, the perceptions and attitudes of society towards teenage pregnancy, relevant laws and social welfare support for adolescent pregnancy in Thailand, and the cultural and social context of Thailand. Understanding the unique social context of Thailand is necessary to gain insight into the experiences around these varying circumstances of adolescent mothers, namely, to be clearer, the extent to which Thai’s social context can interact with or form the experiences, particularly for those who experience repeat adolescent pregnancies and undertake childrearing in the Thai context.

For the next chapter, the research aims to increase the understanding of the experiences of repeat adolescent mothers in these circumstances. Therefore, more research is required to understand how these repeat adolescent mothers alter their lives in terms of the complexities of Thai society, including society’s perceptions and attitudes towards repeated teenage pregnancies, relevant laws, and social welfare support for adolescent pregnancy in Thailand, and the cultural and social context of Thailand.

Chapter 3 Repeat Pregnancy in Adolescents: Systematic Literature Review

3.0 Introduction

This systematic review chapter aims to present a consolidation of current relevant literature regarding repeat adolescent pregnancy in the global and Thailand contexts. A systematic review approach was adopted for the selection of the literature and the analyses of the central themes of each branch of the literature.

3.1 Literature Search Methodology

This review aims to identify the gap in knowledge about the experiences of being involved in repeat adolescent pregnancy. A systematic review, which aims to include, appraise, and synthesise the content of the relevant high-quality research papers on repeat adolescent pregnancy, is used in this study as this type of review itself can provide the empirical studies. The researcher can thus systematically select research papers with a minimum bias as well as appraise their quality and summarise their results using a scientific methodology (Bettany-Saltikov and McSherry, 2016). The review begins with the clarification of the title of this research and its search question. Then, the objective review questions are developed (see Table 3.1).

Table 3.1 Search Question

Research Title	**Experiences of Repeat Pregnancy in Thai Adolescent Mothers**
Objective Review	1. To review what is the current situation of repeat pregnancy in adolescence. 2. To review what are the experiences of mothers with repeat pregnancy in adolescence.
Search Question:	1. What are the experiences of mothers with repeat pregnancy in adolescence?

Regarding the search for all relevant study papers on the experiences of repeat adolescent pregnancy, it is important to make sure that the search question is specific and comprehensive. Therefore, identifying the component parts of the search question should be considered (Bettany-Saltikov and McSherry, 2016). The next step is to separate the components into four parts. This is done by using the PEOT, which stands for population, exposure, outcome, and type of study. The PEOT itself is often used for reviewing the literature in qualitative research questions (Bettany-Saltikov and McSherry, 2016). (See Table 3.2).

After dividing the search question into PEOT, specifying the inclusion and exclusion criteria for selecting the primary studies is needed. The inclusion/exclusion criteria were used to ensure that the relevant studies were selected (see Table 3.2).

Table 3.2 PEOT and Inclusion/Exclusion Criteria

PEOT	Inclusion criteria	exclusion criteria
P - Population	Adolescent women aged 15-19 years old	- Adolescents who have not experienced repeat pregnancy - Adult women
E - Exposure	Pregnancy	- Adult pregnancy age over 20 years old - Early adolescent pregnancy aged under 15 years old
O - Outcomes	Repeat pregnancy	- First-time pregnancy
T – Type of study	Qualitative Quantitative Mixed-Methods	- Report - Commentary - Editorial

3.1.1 The rationale for mixed methods systematic review

To answer the review question that aims to include all relevant study articles with a focus on the experiences of repeat adolescent pregnancy, all primary research was included, whether qualitative and quantitative studies. There are a variety of systematic review methods that can be applied when carrying out a systematic review and data synthesis. Initially, Sandelowski et al., (2006) suggest an approach for aggregating the results from empirical research, named as a *mixed research synthesis*. The *mixed research synthesis* is defined as *"the type of systematic review aimed at the integration of results from both qualitative and quantitative studies in a shared domain of empirical research"* (Sandelowski et al., 2006: 1). The mixed research synthesis therefore allows a synthesis of the *findings* from primary qualitative and quantitative studies in a designated body of empirical research.

This approach facilitaties an integration of either data, or reported findings in order to present a summary of what is known about a relevant phenomenon and, thereby, to direct both practice and future research. Moreover, Sandelowski et al., (2006: 8) suggest that a mixed research synthesis can enable "*the mixing of differences*" to present all current findings in one analysis. This approach also allows triangulation and presents a discussion of central issues that will better extend to "*bridge the case-intensive world of qualitative research with the variable-extensive world of quantitative research*".

Other methods are underpinned by a similar principle such as Holly et al., (2016), who suggest the integration of multiple types of research. They present this approach as a "mixed-method systematic review (MMSR)"; essentially a mixing of different research designs that could be qualitative, quantitative, or mixed methods and a summarising of findings from studies with diverse designs to better understand complex interventions, programs, and phenomena in order to gain greater breadth and depth of understanding and corroboration of knowledge based on multiple types of research. The Joanna Briggs Institute (JBI) is a global organisation based in Australia, that promote and support evidence-based practice guidelines. JBI provide practical guidance for conducting a systematic review and evidence synthesis (Stern et al., 2020). JBI also use the term "*mixed-method systematic review"* and consider this to be a more comprehensive synthesis of the evidence than that currently offered by single method reviews (Lizarondo et al., 2020). Additionally, Thomas and Harden (2008) also point to the need for mixed-

methods synthesis as some research questions cannot be answered sufficiently by a single approach alone.

However, Thomas and Harden (2008), Holly et al. (2016), and JBI are based on Sandelowski and colleagues (2006) who developed three basic designs for MMSR which were adapted from the primary mixed methods literature. They include the following: (1) integrated design that involves integration of transformed data used when a combination which quantitative and qualitative data can both address the same research question, (2) segregated design which is a configuration of quantitative and qualitative evidence which address different aspects or scopes of a phenomenon of interest and therefore they can neither confirm nor refute each other but rather only complement each other, and (3) contingent design is a cyclic approach in which synthesis is conducted in order to answer questions raised from the previous synthesis (Lizarondo et al., 2020).

Therefore, I decided to conduct "*mixed-method systematic review (MMSR)*", also known as a mixed research synthesis, taking an integrated design approach as suggested by Sandelowski et al., (2006) to provide better understand the experiences of adolescent mothers' pregnant for a second or subsequent time, as clear guidelines were available about how to integrate and report findings from a range of studies using a variety of research designs. In addition, including all research available and combining findings from quantitative and qualitative research enabled me to rigorously address the review question.

3.1.2 Systematic Search

The search took place in November 2017 and was last updated in September 2021. When conducting a systematic review, it is important to retrieve all the studies, or as many as possible, that are related to the research question (Bettany-Saltikov, 2012; Bettany-Saltikov and McSherry, 2016). Thus, it is necessary to search a variety of databases to provide eligible papers that are relevant and suitable to answering the research question and also to identify current knowledge regarding the relevant concepts and context of these studies. Before conducting the systematic search, identifying any synonyms is important. The search terms and synonyms are presented in Table 3.3. These were combined with the Boolean terms "AND" and "OR"; search strategies were also created using "*"and "?" (Bettany-Saltikov, 2012; Bettany-Saltikov and McSherry, 2016). These terms were applied to the electronic database via EBSCOhost including CINAHL, MEDLINE, PsycINFO, and Academic Search Premier: social science.

Table 3.3 The PEO(T) Search Terms and Search Strategies

Column terms combined with	AND	AND	AND
OR	adolescen*	pregnanc*	"repeat pregnanc*"
OR	young*	childb* (childbearing, childbirth)	"secondary pregnanc*"
OR	teen*	gravi* (gravida, gravidity)	"multiparous pregnanc*"
OR	youth	mother* (motherhood, mother)	
OR	juvenile*		

3.1.3 Results

Initially, 445 papers were found when the search terms were applied through EBSCOhost. The results were refined to exclude irrelevant studies as shown in Table 3.4. The number of hits was reduced when excluding those which are not in academic journals and then further reduced when duplicates were removed. The 237 remaining studies were then examined on the basis of their title and abstract (see Table 3.4); a further 203 studies were then excluded which were irrelevant to the inclusion criteria. This left 34 studies remaining that were eligible for quality assessment. The updated systematic reviews were included; 391 papers were found when the search terms were applied through EBSCOhost database (from 2017–2021). 383 papers were excluded, and 7 were assessed for eligibility (see Table 3.4).

The additional papers were identified using a systematic review approach (Bettany-Saltikov and McSherry, 2016), with the aim of selecting recent empirical studies conducted with Thai adolescent mothers published in Thai journals and in the Thai language. Therefore, a search was carried out using search terms such as "repeat pregnancy". These were applied to Thailand's database of 'Thai Journal Online (ThaiJO)', which is the central electronic journal database in Thailand, and provided access to all

research articles conducted in Thailand from all different areas that were peer reviewed and were certified as meeting the academic journal standards of the Thai academic journal. The number of hits on searching was 19 papers; 15 papers were excluded because they were not relevant to the search terms, and so 4 studies remained. The updated systematic reviews were applied in ThaiJo for updating relevant articles (from 2017–2021). 39 articles were found, 4 articles were included for eligibility (see Table 3.4).

A final total of 49 were eligible for data extraction, 39 quantitative and 10 qualitative were included as shown in the PRISMA (2009) flow diagram of study selection (Moher et al., 2009) (see Figure 3.1). I also updated the search, to identify any new papers, as presented on the PRISMA (2020) flow diagram (Page et al., 2021), the updated systematic reviews, which included searches of databases, registers, and other sources. This found additional articles identified using Thai database sources as in Figure 3.2

Table 3.4 The results of systematic review through EBSCOhost and Thai database

Database	Search date	Search Terms	Number of Hits papers	Refine results	Duplicates removed	Screened excluded	Full-text assessed	Eligible paper for quality assessment
CINALH **MEDLINE** **PsycINFO** **Academic search premier: social science**	7/11/2017	(adolescen* OR young* OR teen* OR youth OR juvenile*) AND (pregnanc* OR childb* OR gravida OR mother*) AND ("repeat pregnanc*" OR "secondary pregnanc*" OR "multiparous pregnanc*")	445	313	237	201	34	34
	05/09/2021		391	391	-	384	7	7
Additional articles **ThaiJO**	9/12/2017	"repeat pregnancy"	19	19	-	15	4	4
	14/09/2021	"repeat pregnancy"	39	9	4	31	4	4
summary			894	832	241	631	49	49
Total								49

PRISMA 2009 flow diagram

Identification

Records identified through database searching (n = 445)

Additional records identified through other sources (n = 4)

-Additional Thai articles = 4

Screening

Records after duplicates removed (n = 237+4)

Records screened (n = 237 +4)

Records excluded (n = 203)

Not related to the inclusion criteria repeat adolescent pregnancy = 201

Eligibility

Full-text articles assessed for eligibility (n =34+4)

Full-text articles excluded with reasons (n = 0)

Included

Studies included in mixed research synthesis

(n = 38)

Quantitative 31, Qualitative 7

Figure 3.1 The results flow of the PRISMA diagram (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

Previous studies

Identification of new studies via databases and registers

Identification of new studies via other methods

Identification

Studies included in previous version of review (n = 38)

Reports of studies included in previous version of review
(n = 38)

Records identified from*:
Databases (n = 391)
Registers (n = 0)

Records removed *before screening*:
Duplicate records removed (n = 0)
Records marked as ineligible by automation tools (n = 0)
Records removed for other reasons (n = 0)

Records identified from:
Websites (ThaiJo) (n = 39)
Thailis (n = 0)

Screening

Records screened (n = 391)

Records excluded** (n = 0)

Reports sought for retrieval (n =391)

Reports not retrieved (n = 0)

Reports sought for retrieval (n = 35)

Duplicate records removed (n = 4)
Reports not retrieved (n = 0)

Reports assessed for eligibility (n = 7)

Reports excluded: n = 384
Reason 1: studied in first-time mothers/ not pregnancy outcomes related (n = 382)
Reason 2: not in human (n = 2)

Reports assessed for eligibility (n = 4)

Reports excluded: n=35
Reason 1: studied in first-time mothers/ not pregnancy outcomes related (n = 33)
Reason 2: not studied in human (n = 2)

Included

Total studies included in review (n = 7)
Reports of total included studies
(n = 7+4 = 11)

New studies included in review (n = 38+11)
Reports of new included studies (n = 49)
Quantitative studies = 39, Qualitativestudies= 10

*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71: http://www.prisma-statement.org/

Figure 3.2 PRISMA 2020 flow diagram for updated systematic reviews which included searches of databases, registers and other sources

3.1.4 Critical appraisal

After a comprehensive search of the literature and selection of articles based on inclusion and exclusion criteria, an appraisal of relevant empirical studies is needed to ensure that the summarization of relevant articles meet the criteria for scientific rigour. The quality of individual papers included was evaluated using critical appraisal tools, including Critical Appraisal Skills Programme (CASP) (CASP, 2017), and the Quality Assessment Tool for Observational and Cross-Sectional Studies, National Institutes of Health (NIH, 2014). (See Appendix 1 and 2). Forty-nine papers were included for quality assessment. The CASP tools were used to evaluate research using different designs, such as qualitative research, case control study, cohort study. However, a number of studies included in the review were cross-sectional studies. The Quality Assessment Tool for Observational and Cross-Sectional Studies (NIH, 2014) was used for assessing those for which no specific CASP checklist was available.

Empirical studies were critical appraised in order to evaluate methodological rigour and to identify how well the research approach used addresses the project's own research question. The aim is to provide a more enriched and analytical approach to the critical appraisal of the included articles. To ensure a comprehensive understanding of the studies, along with scrutiny of the strengths and weaknesses of those included articles, further detail is provided on Tables 3.5, 3.6, and 3.7. All 49 papers that were included and therefore eligible for data extraction are shown in the figure 3.2, namely: 39 quantitative and 10 qualitative studies.

3.1.5 Data extraction

To capture data from each paper, the purpose/aims of the studies, methodology, method, setting, sampling, main findings are extracted. Sandelowski et al., (2013: 1) developed a methodical approach for extracting data called "text-in-context" to transform findings into statements that anchor the results with key contextual information *"specifically to accommodate mixed-methods mixed research synthesis studies conducted in nursing and other health sciences"*. Sandelowski et al. (2006: 8) consider how to integrate these research design together and state that "*transformation includes qualitizing, or converting quantitative findings into qualitative form so that they can be combined with other qualitative data and subjected to qualitative analysis"*. In this study, I extracted data from qualitative and quantitative research after the quality of the studies were assessed and organised the empirical papers in alphabetical order. (See table 3.5, 3.6, and 3.7).

Table 3.5 Data extraction and critical appraisal of quantitative research

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
1. Amongin et al. (2020) **Time trends in and factors associated with repeat adolescent birth in Uganda: Analysis of six demographic and health surveys** Uganda	To investigate the prevalence and time trends in repeat adolescent birth in Uganda, and associated factors.	1084 women aged 20–24 years had a first birth <18 years.	Cross – sectional study, collecting data on maternal and child health from women's self-report of women with first birth <18 years was 1084 and there were no missing values in variables to calculate the outcome. Data was collected by trained data collectors.	Analysis was performed using STATA version 12.0. Descriptive statistics for the characteristics using proportions for categorical variables and means with standard deviations for continuous variables and the logistic regression were used.	-Women from poorer households and those of younger age at first birth were significantly more likely to report RP birth. -Women who wanted the RP later highlighted the need to support adolescents with improved family planning services.	**Strengths:** - The study provided adequate details about the method data collection using nationally representative samples. **Weaknesses:** - This cross - sectional surveys addressed self-reported information and might have been affected by response and recall bias.	-Self perception -Financial and employment

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
2. Anderson and Pierce, (2015). **Depressive Symptoms and Violence Exposure: Contributors to Repeat Pregnancies Among Adolescents** USA	To screen depressive symptoms and violence among age and ethnically/racially diverse adolescents by gravidity and parity	193 adolescent mothers approached within 72 hours of birth from one of two postpartum units of a large public hospital in Southwestern United States.	Cross-sectional Study Collecting data by trained data collectors by the adolescents were requested to complete survey questionnaires.	Percentages and frequencies described the younger (13–16 years) and older (17–19 years) adolescent demographically and the prevalence of depressive symptoms. Using the analysis of variance (ANOVA) for differentiate repeat pregnancies among groups that reported depressive symptoms.	- 58 (31.5%) responding adolescents reported more than one pregnancy, and 46 adolescents (25.4%) reported more than one living child. For 16 (8.6%) adolescents, the most recent pregnancy was reported as a third or fourth pregnancy. - Both child abuse and past traumatic life experiences were significantly found to predict adolescent parity. - Adolescents with a history of child abuse were more likely 3.5 times than one living child.	**Strengths:** - The study provided details of psychological exposure and well defined based on the rich of literature review. **Weaknesses:** - The study reported the data that might include the higher mean age of the adolescent samples (median=18), which might cope better than early adolescents.	-Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
3. Boardman et al. (2006). **Risk Factors for Unintended Versus Intended Rapid Repeat Pregnancies among Adolescents.** USA	To assess both established and hypothetical risk factors in the context of the intendedness of the repeat pregnancy.	Women who experienced at least one pregnancy as an adolescent consisting of 180 intended RRP, 354 unintended RRP, 583 pregnant adolescents.	Case control study Using data set from National Survey of Family Growth (NSFG) in 1995 and 2002 dataset	Multiple logistic regression was used to model the relationship between a dichotomous outcome variable and a set of predictor variables.	- 34% of the adolescents experiencing a rapid repeat pregnancy reported that pregnancy was intended. - Racial/ethnic, characteristics of the teen mothers (educational status and young age of the teen's mother at first birth) were not associated with either intended or unintended rapid repeat pregnancies.	**Strengths:** - The study provided clear statement of the size of the samples which was identified appropriately **Weaknesses:** - Data were collected from NSFG that some important variable might not be included i.e., early sexual experience, family factors.	-Decision making -Father of baby

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
4. Burke et al. (2018) **Correlates of Rapid Repeat Pregnancy Among Adolescents and Young Women in Uganda** Uganda	To examine characteristics associated with rapid repeat pregnancy, defined in two ways: a pregnancy occurring within 24 months or 12 months of a prior pregnancy outcome.	626 married or cohabiting women aged 15–22 with one or two previous pregnancies	Cross – sectional study Data were drawn from the 2011 Uganda DHS, a nationally representative survey.	Quantitative data analyses using Stata version 13.1. and regression analysis and bivariate analyses were tested in multivariable logistic regression models.	- Among women, 74% and 37% had experienced a rapid repeat pregnancy within 24 months and 12 months, respectively. - Rural women were more likely than urban women to have had a rapid repeat pregnancy within 24 months (odds ratio, 2.4).	**Strengths:** - The study provided adequate details about variables based on themes identified from literature review. **Weaknesses:** - The definition in this study included all reported pregnancy outcomes, not just live births. This might affect the selection bias and recall bias.	-Financial and employment

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
5. Cha et al. (2016). **Discordant pregnancy intentions in couples and rapid repeat pregnancy.** USA	To examine the association between couple pregnancy intentions and RRP among women in the United States.	3,463 multiparous women who 16-19 years cohabited with husband/partner before conception of second pregnancy were included	Cross-sectional Study using data from the 2006 through 2010 NSFG included multiparous women with history of at least 2 completed pregnancies prior to the interview.	All analyses were conducted using software (SAS, Version 9.4). Descriptive statistics, frequencies, percentages were generated to assess the distribution of characteristics by RRP and couple pregnancy intent.	This study found that the attitude of their partner was a significant factor for adolescent mothers who did not intend to have a second baby, but their partner more intended to have a baby which they were more likely to experience RRP.	**Strengths:** - The study clearly identified the outcome of RRP and the definition as experiencing a second pregnancy within 24 months included their partner's decision making. **Weaknesses:** - The study was a cross-sectional design which was unable to determine a variable of a causal relationship with their partner.	-Decision making -Father of baby

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
6. Coard et al. (2000) **Repeat pregnancy among urban adolescents: sociodemographic, family, and health factors.** USA	To examine sociodemographic, family, and health factors adolescence associated with repeat pregnancy	80 urban adolescent mothers	A longitudinal study collecting data by using 50 items questionnaires at 12 months postpartum and 24 months postpartum to determine repeat pregnancy.	Data were analysed by using descriptive statistic, correlation coefficients, and chi-squares to analyse the relationships between sociodemographic, family, and health variables.	- Using DMPA or progesterone implants in the early postpartum period accounted for 60% of those who avoided a RP within 2 years -Family characteristic was not related to RP	**Strengths:** - The study clearly explained sufficient details provided in the methods section. **Weaknesses:** - Study investigated a clinic-based sample of low-socioeconomic status which might not be generalised to other groups.	-Contraception

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
7. Cohen et al. (2016) **Twelve-month contraceptive continuation and repeat pregnancy among young mothers choosing postdelivery contraceptive implants or post placental intrauterine devices.** USA	To compare discontinuation rates and incidence of repeat pregnancy within 1 year among young mothers choosing post-placental intrauterine devices (IUDs) versus postpartum contraceptive implants.	244 participants ages 13-22 years old	A prospective cohort study Participants' information and encounter-related data were tracked in the CAMP Electronic Report on Adolescent Pregnancy (ERAP). Reviewed data at 6 and 12 months postpartum to assess LARC continuation and pregnancy rates.	Data were analysed using International Business Machines Corporation (IBM) SPSS 22. Fisher's Exact and Kaplan–Meier analyses were used to compare data.	- LARC could significantly decrease repeat pregnancy rates within 24 months postpartum, and thus high-cost effectiveness. - Most pregnancies occurred when women discontinued their initial device and did not start alternative contraception	**Strengths:** - The study provided details about contraception effectiveness and variables included LARC of any participant choosing this which might enhance the generalizability of the results. **Weaknesses:** - Evaluation was limited to a 1-year period and might not know whether the increased rate of consistent contraception beyond this study period.	-Contraception -Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
8. Crittenden et al. (2009). **The role of mental health factors, behavioural factors, and past experiences in the prediction of rapid repeat pregnancy in adolescence.** USA	To investigates the predictors of rapid repeat pregnancy (subsequent pregnancy within 24 months of previous pregnancy outcome) in a sample of urban adolescents.	Adolescents aged 12 to 19 years (N = 357) who were predominantly African American	Cross – sectional study, data were collected by research staffs at 24 months post-partum and participants were asked questions about the number and outcome of subsequent pregnancies. The dates on which their first pregnancy ended, and subsequent pregnancy began were recorded.	Bivariate analyses were performed to determine whether differences existed between adolescents who reported a RRP and those who had only one pregnancy. The independent t test was used to assess continuous variables and Pearson's chi-square test was used for categorical variables.	- Adolescents who had rapid repeat pregnancy were less confident in their ability to settle differences without the use of physical force.	**Strengths:** - The study provided details about individual interviews during pregnancy and at 24 months post-partum. **Weaknesses:** - Data collection using the self-report items might have recall bias on mental health and experiential items.	-Definition - Pregnancy outcome -Financial and employment

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
9. Damle et al. (2015). **Early Initiation of Postpartum Contraception: Does It Decrease Rapid Repeat Pregnancy in Adolescents?** USA	To determine if early initiation of contraception, and in particular long-acting reversible contraception (LARC), decreases rapid repeat pregnancy among first time adolescent mothers	340 first time adolescent mothers aged ≤ 19 with repeat pregnancy within 2 years.	Retrospective cohort study, collecting data from participants who had a live birth at 24 weeks postpartum and for which the index birth was the patient's first live, viable birth were included.	Descriptive statistics, fisher's exact test, and chi-square tests were used for the univariable analysis. Multivariable logistic regression analysis was performed for significant variables.	-Using DMPA prior to discharge from the hospital, compliance with postpartum follow up, and initiation of a contraceptive method within 8 weeks were associated with prevention of rapid repeat adolescent pregnancy.	**Strengths:** Contraceptive uses were examined by using the cohort study to examine main outcome measures of repeat pregnancy within 2 years. **Weaknesses:** - The study using a retrospective cohort could not include other aspects of contraception experiences i.e., family aspect, partner.	-Contraception

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
10. Davis (2002) **An Examination of Repeat Pregnancies Using Problem Behaviour Theory: Is it Really Problematic?.** USA	To examine repeat pregnancies of unwed adolescent mothers.	305 adolescent mothers	Cross-sectional Study, using data used from the National Longitudinal Survey of Youth (NLSY) with an unwed adolescent mother experienced a repeat pregnancy.	Logistic regression is used to analyse the effects of each of the variables in the three systems of Problem Behaviour Theory on the likelihood of having an unwed repeat pregnancy.	-Adolescents who lived in the context of adult kin were seen as a source of 'control' against engaging in sexual activity that could lead them to be an adolescent pregnancy. - Adolescent mothers who lived with their mother could increase a chance of having a repeat pregnancy by 3.197 times higher than those who did not live with their mother.	**Strengths:** -The study clearly stated variables and related to population recruitment using Problem Behaviour Theory of Donovan et al., (1988) to examine repeat pregnancies of unwed adolescent mothers. **Weaknesses:** - The limitations of the dataset could not provide a full model of Problem Behaviour Theory i.e., peer influence, which was an aspect of the perceived environment system and not available in the dataset.	-Family support

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
11. de Fátima Rato Padin et al. (2009). **Brief report: A socio-demographic profile of multiparous teenage mothers.** Brazil	To describe a socio-demographic profile of multiparous teenage mothers at a public hospital in Brazil	915 interviewed teenage girls including 170 multiparous subjects whose babies were born alive.	Cross-sectional Study, collecting data by trained staffs from participants who were between 4 and 48 hours after delivery using questionnaires.	Student's t-test was used to detect any differences in mean ages, beginning of sexual activity, and other independent variables concerning multiparous and primiparous girls. Pearson's chi-square test was used to detect possible differential behaviour between both groups	- Participants dropped out of school at 13.6 years; attended school for 6 years with only 10% still attending school when they were interviewed. - Multiparous had quitted school long before becoming pregnant which indicated that school dropout was not a result of the pregnancy and low educational level was attained prior to their pregnancies.	**Strengths:** - The study provided details of samples: multiparous and primiparous adolescent were well identified, and the research design was clearly stated. **Weaknesses:** - Data from socio-demographic profile was not compared between first and repeat pregnancy within the same group.	-Education

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
12. Drayton et al. (2002). **The Health Belief Model as a predictor of repeat pregnancies among Jamaican teenage mothers.** Jamaica	To investigate whether the dimensions of the expanded Health Belief Model can be applied to predict repeat pregnancies among Jamaican adolescent mothers.	260 Participants were females between the age of 15 and 21 who had a first live birth.	Retrospective cohort study. Birth records were obtained from the Registrar General's Birth Registration Files by using questionnaires.	Descriptive statistics, bivariate correlation with one or more repeat pregnancies were calculated for all variables using SPSS/PC version 7.5	- Participants wanted to continue their education after the birth of their first child and hoped to find an appropriate programme being suitable for their life.	**Strengths:** - The study clearly explained the Health Belief Model, study variables, and provided literature. **Weaknesses:** -The study using a retrospective cohort might include recall bias and loss to follow-up.	-Education

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
13. Gray et al. (2006) **Having the Best Intentions is Necessary but not Sufficient: What would Increase the Efficacy of Home Visiting for Preventing Second Teen Pregnancies?** USA	To identify ways to enhance the theoretically sound Nurse Family Partnership intervention during the first 2 post- partum years.	111 adolescent mothers	Cross-sectional Study, collecting data from the clinical records the nurses maintained for each teen mother who received home visits at 6,12,24 months postpartum.	Student's T-tests and Chi-square analyses were used to compare the characteristics and home visit histories of teens that had and had not conceived again at 6, 12, and 24 months postpartum.	- Obtaining competency evaluations from the nurses would be one way to determine if their failure to discuss pregnancy prevention within the context of life course development and to include boyfriends in family planning.	**Strengths:** - The study clearly determined the repeat pregnancy related to healthcare providers. **Weaknesses:** - The effective of home visit might manipulate variables focusing on outcomes.	-Healthcare service -Contraception

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
14. Han et al. (2014). **Preventing repeat pregnancy in adolescents: is immediate postpartum insertion of the contraceptive implant cost effective?** USA	To determine the cost effectiveness of a hypothetical state-funded program offering immediate postpartum implant (IPI) insertion for adolescent mothers.	171 immediate postpartum implant (IPI) insertion and 255 standard contraceptive initiation	Prospective observational cohort study, adolescents who were attending the Colorado Adolescent Maternity Program (CAMP) and who delivered at the University of Colorado Hospital over the 18 months period of June 1, 2008, to Nov. 30, 2009, were eligible for inclusion in the study cohort. All of the patients expressed the desire to prevent pregnancy for at least 1 year after delivery.	The student t- tests were used to compare means; the Chi-square test was used to compare proportions, and the Fisher exact tests were used to analyse variables.	- Offering IPIs to adolescent mothers was cost effective. -Results indicated that a publicly funded IPI program would be highly cost effective. -Study suggested that cost-efficiency in health care was a national priority, and IPI programs had the potential to have a positive impact on the limited public health care resources.	**Strengths:** -The prospective cohort had clearly identified data collection as IPI recipients and comparisons at 6, 12, 24, and 36 months postpartum using the actual outcomes. **Weaknesses:** - The prospective cohort had not included sexual experiences before pregnancies.	-Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
15. Hudgins et al. (2014) **Everyone Deserves a Second Chance: A Decade of Supports for Teenage Mothers** USA	To evaluate Georgia's Second Chance Home Network campaign that provided housing and support to parenting teenagers	415 mothers who had been discharged from any SCH Network homes.	Cross-sectional Study, collecting data from participants at 3, 12, 24 months after discharge with questionnaires	Descriptive statistics were generated for group comparisons for those contacted at each of the five data collection points.	- This study found that providing social support for young parents could increase their employment, education, and economic stability. Moreover, it could decrease the risk of repeat pregnancy before the age of 20 in these young parents.	**Strengths:** - The study clearly stated to the data collection with three follow-up points at 3, 12, and 24 months after discharge to examine RRP. **Weaknesses:** - The study reported missing follow-up data that might limit the evaluation of findings.	-Financial and employment - Family supports

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
16. Key et al. (2001) **The Second Chance Club: repeat adolescent pregnancy prevention with a school-based intervention.** USA	To examined school-based programme intervention	305 adolescents were eligible to participate in the Second Chance Club.	Retrospective cohort study, collecting data from adolescent who identified as pregnant or parenting were referred to the project coordinator, age at the birth of their baby from 14 to 19 years	The student t- tests were used to compare means, the Chi-square test to compare significant variables.	-74 (29%) had one repeat birth, 18 (7%) had two repeat births, and 3 (1%) had three repeat births. - The programmes could significantly decrease the rates of adolescent RP for those who attended at least 4 times.	**Strengths:** - The study provided details about control subjects were selected randomly. **Weaknesses:** - The study assessed the participants who participated in the programme that might more focus on program components rather generalisation of data.	-Education -Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
17. Khashan et al. (2010). **Preterm birth and reduced birthweight in first and second teenage pregnancies: a register-based cohort study.** UK	To investigate the relationship between young maternal age and adverse pregnancy outcomes among North-western region of England mothers aged 14-29 years.	55,539 mothers in the period 2004 to 2006 classified in three group; 14-17 years, 18-19 years, and 20-29 years (as a reference group).	A population-based cohort study, colling data from mothers with singleton live infants who were born between January 1, 2004, and December 31, 2006. The data were restricted to women aged between 14 and 29 years in their first or second pregnancies.	Data analysed by using a linear regression to estimate the difference in mean birthweight among teenage mother groups compared with adult women.	-Mean birthweight was reduced by 55 grams in second time mothers aged 18-19 years compared with second time adult mothers. -Adolescents had an increased risk of preterm and very preterm delivery, and this risk was greatest in their second pregnancy.	**Strengths:** - The study compared outcome measures in teenagers' first and second pregnancy with those of mothers aged 20 to 29 years and generate data from a large national data source. **Weaknesses:** - The main cohort reported lack of information on confounding effect such as maternal smoking and some missing report might affect estimate bias.	-Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
18. Lewis et al. (2010) **Implanon as a contraceptive choice for teenage mothers: a comparison of contraceptive choices, acceptability and repeat pregnancy.** Australia	To compare the incidence of repeat teenage pregnancy over a 24-month period postpartum among users of Implanon, the combined oral contraceptive pill (COCP) or depot medroxyprogesterone acetate (DMPA) and barrier methods or nothing (barrier/none).	Postpartum teenagers (12–18 years old) who self-selected Implanon (n=73), COCP/DMPA (n=40) and barrier/none (n=24).	Prospective cohort study, collecting data from who attend the antenatal adolescent clinic or having delivered within 5 days postpartum. Using self-administered questionnaires.	Univariate group comparisons were performed using Chi-square test and Fisher's Exact test to compare significant variables by using SPSS statistical software.	- Adolescents were more likely to consider the side-effects and how they might affect their desire to have another pregnancy. - Women disliked the implantation method asserted that because of the adverse side-effects such as irregular bleeding and spotting. - Adolescents who were satisfied with long-acting contraceptive methods also highlighted the positive side-effect that they did not have to remember to use it.	**Strengths:** - The study provided details of samples and methods section to and compared the incidence of repeat teenage pregnancy over a 24-month period postpartum. **Weaknesses:** - Implanon use was vigorously supported by healthcare providers dealing with adolescents, and this might have led to increased uptake in this population.	-Contraception -Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
19. Maravilla et al. (2019a) **Exploring the Risks of Repeated Pregnancy Among Adolescents and Young Women in the Philippines** Philippines	To identify correlates of repeat pregnancy in the Philippines.	4757 women aged 15–24 years old who had experienced ≥ 1 pregnancy were included.	Cross – sectional study, collecting data from five datasets (i.e. 1993, 1998, 2003, 2008, and 2013) from the Philippine Demographic and Health Survey (DHS) with participants aged 15–24 years who reported experiencing at least one pregnancy. Interviewing by trained interviewers using a questionnaire. Using the self-reported pregnancy history for repeated pregnancy outcomes.	Chi square analysis and ANOVA to test bivariate associations while using the weighted proportion in each of the measures. Univariate and multivariate logistic regression were used to identified significant variables.	- Partner characteristics such as aged of ≥ 30 years, multiple partners, and live-in status, were found to be highly correlated with repeat pregnancy in fully adjusted analysis.	**Strengths:** - The study provided rich data allowing to adjust the country-level estimates for trends of repeat pregnancy. **Weaknesses:** -Some variables from self-report might not be able to assess and may bias such as a partner characteristic before or after the repeat pregnancy occurred.	-Father of baby

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
20. Maravilla et al. (2019b) **Increased risk of maternal complications from repeat pregnancy among adolescent women** Philippines.	To evaluate the risk of adverse maternal outcomes among adolescents experiencing a repeat pregnancy in the Philippines.	2518 adolescents with an interpregnancy interval (IPI) of 24 months or less.	Cross – sectional study, collecting data from the 1998, 2003, 2008, and 2013 Philippine National Demographic Health Survey (NDHS). Including young mothers aged 15–24 years who had two singleton deliveries with a 24 months of subsequence pregnancy or less during the adolescent period (11–19 years)	All statistical tests were performed with Stata version 14, and logistic regression were used to identified significant variables.	- There were no apparent differences in the risk of poor maternal outcomes between an IPI of less than 24 months and an IPI of more than 24 months, and no association between repeat pregnancy and neonatal birthweight.	**Strengths:** - The study provided details about multi-stage stratified sampling by region and type of population. **Weaknesses:** - There were different social and obstetric characteristics among second pregnancy as compared with first-time mothers, which could lead to biased estimates.	-Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
21. Maravilla et al. (2020) **Stunting of children under two from repeated pregnancy among young mothers** Philippine	To measure the occurrence and persistence of stunting among offspring of young mothers who experienced repeated pregnancies using data from the Cebu Longitudinal Health and Nutrition Survey.	1,284 mothers aged 14–24 years and their index children who had complete data at the 12- and 24-month.	A retrospective, cohort study, the Cebu Longitudinal Health and Nutrition Survey (CLHNS) conducted in Cebu City, Philippines from 1,284 mothers aged 14–24 years and their index children who had complete data at the 12- and 24-month	Data were analysed by measuring of persistence of stunting from 12 to 24 months based on classifications developed by previous studies compared to the number of past pregnancies in reference to the index child to measure repeated pregnancies.	- Young mothers who experienced repeated pregnancy were more likely to have stunted offspring at 12 and 24 months.	**Strengths:** - The study explained a sample that reflected the population and fit with the research question. **Weaknesses:** - The study stated unclear about confounder variables such as maternal nutritional intake from diet and supplements.	-Self perception - Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
22. Maslowsky et al. (2021) **Health Behaviours and Prenatal Health Conditions in Repeat Vs First-time Teenage Mothers in the United States: 2015-2018** USA	To compare the prevalence of negative pregnancy-related behaviours and gestational health conditions in the national United States population of first-time and repeat teenage mothers.	799,756 births aged 15-19 years who gave birth between 2015 and 2018	A retrospective, population-based cohort study using annual vital statistics data from the birth data files produced by the National Centre for Health Statistics at the US Centres for Disease Control and Prevention of mothers aged 15-19 years who gave birth between 2015 and 2018,	Analyses were conducted using Stata/MP 15.1. Using logistic regression to identified significant variables.	-Repeat (vs first-time) mothers had higher prevalence of negative pregnancy-related behaviours: inadequate prenatal care, smoking, inadequate weight gain, and sexually transmitted infection during pregnancy, and they were also less likely to breastfeed.	**Strengths:** - The study described adequate details about the research design and logical steps the process of data analysis. **Weaknesses:** - The study using a retrospective cohort could not be able to examine first and second births to the same mothers because the birth records were not linked to individuals.	-Self perception -Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
23. Omar et al. (2008) **Significant Reduction of Repeat Teen Pregnancy in a Comprehensive Young Parent Program.** USA	To describe a comprehensive, multidisciplinary approach to teen mothers and their children that significantly reduces repeat pregnancies.	1386 teen mothers between the ages of 19 and younger who participated in the Young Parent Program (YPP) for at least three years.	Retrospective cohort study and collecting data by using data from patients attending the YPP at a university-based health centre with pregnancy at 19 years of age or younger.	Descriptive statistics were used to illustrate the results for age at time of first pregnancy, ethnicity, age at second pregnancy, if a second pregnancy occurred, method of contraception, and marital status.	- A comprehensive young parent programme including prenatal and postnatal care, preventive care, reproductive health services, mental health, and acute care visits, could reduce repeat pregnancy among adolescents participating in this programme.	**Strengths:** - The study provided details in variables of prenatal and postnatal care, preventive care, reproductive health services, mental health, and acute care. **Weaknesses:** - The study evaluated a clinical intervention that might contained selection bias.	-Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
24. Pfitzner et al. (2003) **Predictors of Repeat Pregnancy in a Program for Pregnant Teens.** USA	To describe repeat pregnancy among adolescents and to compare those who experienced a repeat pregnancy to those who did not.	1838 Adolescent women, 19 years of age and their child become 2 years old, whichever occurs later.	Retrospective case control study collecting data from the from the medical records Utah Teen Mother and Child Program (TMCP)	Data analysed with the initial pregnancy for comparison between those who experienced a repeat pregnancy (R) and those who did not (NR) using ANOVA and chi-square.	-Low educational achievement was a strong predictor of repeat pregnancy. -Self-report of physical and sexual abuse, depression, and substance abuse were common, but did not differ between teens repeating and not repeat.	**Strengths:** - The study clearly stated the details of method comparing aspects of teens repeating to those who did not repeat. **Weaknesses:** - The psychosocial variables experience relied on patient self-report, perception by the patient regarding these variables might change over time and affect recall bias.	-Father of baby -Educational attainment and peers

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
25. Raneri and Wiemann (2007). **Social Ecological Predictors of Repeat Adolescent Pregnancy.** USA	Aimed at to improve understanding of the individual, dyad, family, peer/community and social system-level risk factors for repeat pregnancy may lead to the development of more effective prevention strategies for adolescent mothers in a variety of settings.	581 pregnancy adolescents, white, black and Mexican American adolescent mothers at a labour and delivery unit.	Prospective cohort study using data collected from the labour and delivery unit at the University of Texas Medical Branch (UTMB) among mothers aged 12–18 within 24 hours of the index delivery and were mailed surveys to complete three, six, 12, 18, 24 and 48 months after discharge.	Using SPSS, version 14.0. The rates of repeat pregnancy and pregnancy outcomes through 24 months were assessed for the entire sample and stratified by race or ethnicity. Bivariate analyses (Student's t test and chi-square) were used to identify variables potentially associated with the outcome.	- Failure to initiate a long-acting contraceptive method within three months among RP. - The age of the first child's fathers being older than mothers for three years were more likely to experience RP than those fathers who were the same age or younger than the mother. - Adolescents who were not enrolled in school within three months postpartum were more likely to experience a RP. - Adolescent mothers who experiencing a RP were more likely to have limited economic resources.	**Strengths:** -The study provided adequate details about variables were identified by ecological theory of Bronfenbrenner's (1979). **Weaknesses:** - This study used the self-reported and measured by prospective surveys to complete at 3, 6, 12, 18, 24 and 48 months which their experiences a year later might have an impact on whether they recall bias.	-Pregnancy outcome -Contraception -Decision making -Father of baby -Education -Family support -Religious and cultural belief

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
26. Reese and Halpern (2016) **Attachment to conventional institutions and adolescent rapid repeat pregnancy: a longitudinal national study among adolescents in the United States.** USA	To examine distal factors—school, family, peers, and public/private religious ties, and their associations with RRP among adolescent mothers.	1158 female adolescent respondents who reported at least one live birth before aged 20 years including 367 respondents reporting an RRP.	Longitudinal Cohort Study and collecting data from Waves I and IV of the National Longitudinal Study of Adolescent to Adult Health (Add Health) using self-administered using computer-assisted self-interviewing (CASI).	Bivariate analyses (Pearson Chi square test for categorical variables and 2-sample t-tests for continuous variables) were used to identify variables potentially associated with RRP.	- Adolescents who reported better relationships with their parents were also less likely to have an RRP that asserted communication between adolescent mothers and their parents, especially in conversations about sexual activity and birth control. - Private religiosity might buffer the effects of life stress and provide a coping mechanism that adolescent mothers who had never prayed might lack these buffers and put them at elevated risk of RRP.	**Strengths:** -The study clearly provided details of attachments to conventional institutions of family, peers, school, and religion/church - factors that associated with RP. **Weaknesses:** - The retrospective data on fertility reports might be a subject to recall error and bias, and the influence of social connections could not be fully in-depth understood without qualitative inquiry.	-Religious and cultural belief -Family support

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
27. Richio et al. (2010). **Repeat teen birth: does delivery mode make a difference?** USA	To examine the relationship between modes of delivery in adolescent mothers having a second delivery within 2 years of a first birth.	899 adolescents delivering in Rhode Island.	Retrospective cohort study ang collecting data from medical records to subsequence births within 2 years.	Data were analysed using Fisher's exact test, Wilcoxon rank sum test. A time-to-event analysis was conducted to explore possible trends regarding based on variables.	- The pregnancy outcome data for second births showed no significant differences between two groups including gestational age, birthweight, and pregnancy complications. - Adolescent mothers with a history of a vaginal delivery became pregnant and had a second delivery earlier compared with adolescent mothers with a history of primary caesarean delivery.	**Strengths:** - The study clearly stated details of the health outcomes for the modes of delivery of first and second pregnancy. **Weaknesses:** -The study using a retrospective cohort could not be able to examine women who moved out of the state after their first birth.	-Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
28. Rosenberg et al. (2015). **Relationship between Receipt of a Social Protection Grant for a Child and Second Pregnancy Rates among South African Women: A Cohort Study.** South Africa	To explore the potential for grant loss to incentivize second pregnancy	4,845 women aged under 21 years old and women who were aged 21 year old or more at the time of the birth of their first child.	Retrospective cohort Study collecting data from medical record of women after the birth of first child was associated with timing of second pregnancy.	Using Cox-regression model to estimate ratio, Kaplan-Meier (KM) curves to present cumulative incidence of second pregnancy against time since birth of first	-Receipt of the Child Support Grant was significantly associated with lower second pregnancy rates. - Receipt of the CSG after birth of first child appeared protective against second pregnancy	**Strengths:** - The study provided the influence of potential confounders factors. **Weaknesses:** -The study using a retrospective cohort may could not be able to examine in other unmeasured ways i.e., grant of first childbirth.	- Financial and Employment Difficulty

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
29. Stevens-Simon et al. (2001) **A village would be nice but …: It takes a long-acting contraceptive to prevent repeat adolescent pregnancies** USA	To determine which components of a comprehensive, multidisciplinary, adolescent oriented maternity program help teenage mothers delay subsequent pregnancies.	373 participants with postpartum aged 13-19 years.	A cohort Study, self- administered completed by participants to collect information about their sexual and reproductive histories, the social context of their pregnancies.	Chi-square and logistic regression analyses were carried out using SPSS.	-Using a LARC during the puerperium was associated with pregnancy prevention during the first 2 postpartum years. - Encouraging to use LARC, i.e., the intrauterine device during the puerperium can help adolescent mothers remaining nonpregnant. - Adolescents who returned to school within 6 months of delivery were also significantly less likely to become pregnant again during the first postpartum year	**Strengths:** - The study provided details of personal variables and LARC contraception, and data collection process provided clear inclusion recruitment. **Weaknesses:** - Data collection using self-report about their sexual and reproductive histories might contain recall bias.	-Contraception -Healthcare provider -Education

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
30. Thurman et al. (2007) **Preventing Repeat Teen Pregnancy: Postpartum Depot Medroxyprogesterone Acetate, Oral Contraceptive Pills, or the Patch?** USA	To evaluate the repeat teen pregnancy rates, within one year of delivery among adolescents who choose the contraceptive patch (Ortho Evra) versus oral contraceptive pills (OCP) versus DMPA) for postpartum contraception.	252 Participants: postpartum teens aged 11-19 years old.	Observational, prospective cohort study collecting data of primiparous adolescents aged 11 to 19, admitted as inpatients to Medical University of South Carolina after a singleton, term, live birth was eligible to participate in the study. Using a structured telephone interview at 3, 6, 9, and 12 months postpartum.	Data were analysed using SAS 9.1 software (SAS Institute, Cary, NC). Chi square was used to analyse categorical variables.	-Postpartum teens who chose DMPA for postpartum contraception were significantly less likely to experience a repeat pregnancy. -Most pregnancies occurred after 6 months postpartum.	**Strengths:** -The study provided details of oral/injected contraception and postpartum teenage women provided in the sample section. **Weaknesses:** - Follow-up evaluation was contacted the teens every 3 months and limited to a 1-year period which was unable to examine the rate of RRP persisting beyond this study period.	-Healthcare service - Contraception

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
31. Timur et al. (2016) **Factors That Affect Perinatal Outcomes of the Second Pregnancy of Adolescents** Turkey	To examine the factors that affect perinatal outcomes of the second pregnancy in adolescents	525 adolescent mothers aged 19 years or younger who had experienced two deliveries at Zekai Tahir Burak Woman's Health Education and Research Hospital, Turkey	Longitudinal retrospective study collecting data from adolescents who delivered first and second infants.	Data were analysed using the SPSS software, Fisher exact test, and Chi square, logistic regression to indicate statistical significance.	- The second pregnancy of adolescents were associated with fewer adverse perinatal outcomes than their first pregnancy. - There was no significant difference between pregnancy outcome in the first and second delivery in this adolescent group.	**Strengths:** -The study provided details of the methods on repeat adolescent mothers and compared with their first pregnancy outcome. **Weaknesses:** - The retrospective might be unable to observe the various factors associated with adverse perinatal outcomes.	Pregnancy outcome

Authors, Date of publication, title, location	**Study aim(s)**	**Participants characteristics**	**Method of data collection**	**Data analysis**	**Main findings**	**Critical Appraisal: Strengths and Weaknesses**	**Themes identified in the synthesis**
32. Tocce et al. (2012). **Rapid repeat pregnancy in adolescents: do immediate postpartum contraceptive implants make a difference?** USA	To determine contraceptive continuation and repeat pregnancy rates in adolescents who are offered immediate postpartum levonorgestrel implant (IPI) insertion.	420 young women received prenatal care and delivered in the CAMP program.	A prospective observational study collecting data from documented in the medical record or by participant report during the phone questionnaire adolescent repeat pregnancy by 12 months after delivery.	Data were analysed using the SPSS software, Fisher exact test, and Chi square, logistic regression to indicate statistical significance.	- Adolescents mothers experienced insertion on the Labour and Delivery unit before discharge home after delivery; the remaining 13 young women intended to have immediate insertion, but no trained provider was available on Labour and Delivery, receiving it in the CAMP clinic within 4 weeks of delivery resulted in PP at 12 months for who did not receive IPI insertion.	**Strengths:** - The study used measurements reflecting the outcome of IPI insertion, and described method continuation, reasons for implant discontinuation, repeat pregnancy rates, and pregnancy outcomes clearly. **Weaknesses:** - Follow-up evaluation was limited to a 1-year period and unable to examine the rate of RRP which could not continue beyond this study period.	-Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
33. Vieira et al. (2016). **Rapid Repeat Pregnancy in Brazilian Adolescents: Interaction between Maternal Schooling and Age.** Brazil	To evaluate the effect of the interaction between maternal schooling and age on the incidence of rapid repeat pregnancy (RRP)	2,223 mothers and the exposure variable combining mother's age (10 to 19 vs. 20 to 29 years of age) and schooling (adequate vs. inadequate).	A historical cohort study collecting data from The Vital Statistics Databases of the city of Rio de Janeiro, singletons live-born infants delivered in 2002 whose mothers were up to 29 years of age and repeated pregnancy in the subsequent 24 months.	Using Chi-square tests to compare the proportions of rapid repeat pregnancy using Stata 9.	- For those with inadequate schooling were significantly higher rates of repeat pregnancy than those with adequate schooling. -Maternal age and low schooling increased the risk of RRP among adolescents with inadequate schooling.	**Strengths:** -The study identified clearly about inclusion and exclusion criteria of participants and variable combining maternal schooling and age in the log-binomial regression model. **Weaknesses:** -The study using a retrospective cohort could not be able to examine the moment when the young women dropped out of school.	- Educational attainment and peers

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
34. Wilkie et al. (2016) **Effects of Obstetric Complications on Adolescent Postpartum Contraception and Rapid Repeat Pregnancy.** USA	To determine whether complications during pregnancy or at delivery influence postpartum contraception choices and rapid repeat pregnancy rates in adolescent women.	321 adolescents under the age of 20 at time of conception.	Retrospective cohort study collecting data from medical records of deliveries to women under the age of 20 at time of conception, having documentation, postpartum contraception choice in the delivery discharge or outpatient postpartum visit	Data were analysed by using Stata/MP 13.1 using Fisher exact test, and Chi square, logistic regression to indicate statistical significance.	-Common contraception method used by young women who did not have a RRP was the (DMPA) injection (30.6%); while women who had RRP most often expressed using ‘no contraception’ (75.5%). - Poor access to LARC methods might explain the low LARC usage rates in young women which LARC were only provided in hospitals or special clinics.	**Strengths:** - The study clearly stated to the complications during pregnancy and delivery along with subsequent contraceptive using were investigated. **Weaknesses:** -The study using a retrospective limited at 12 months may could not be able to examine RP rate beyond this period.	-Contraception -Pregnancy outcome -Healthcare service

Note: See articles of qualitative research in number 35th -41st in table 3.6

Table 3.6 Data extraction and quality assessment of qualitative research

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
35. Bucknall and Bick (2019) **Repeat pregnancies in teenage mothers: An exploratory study** UK	To explore young mothers' experience of rapid repeat pregnancy.	Six young women were purposively sampled from a Family Nurse Partnership programme in the South London.	Qualitative exploratory study, using semi-structured interviews conducted in spring 2017 elicited experiences of repeat pregnancy with face - to - face and by telephone.	Data were analysed following Ritchie and Spencer's (1994) frame - work approach: familiarisation with the data, identification of a thematic framework.	- Common concerns focused on a perceived risk that LARCs could become embedded in the body and cause other potential side effects. Several women reported LARCs removal because they had experienced prolonged vaginal bleeding. - Participants reported a tension between the importance of having trust in a family nurse, whilst recognised that over dependency on access to them.	**Strengths:** The study provided sufficient details about the setting, purposive sample of participants, inclusion-exclusion criteria. - The study also provided adequate description of the data analysis following Ritchie and Spencer's (1994) framework. **Weaknesses:** - The study stated potential biases in the sample since all six participants were recruited through a family nurse. partnership and some might not receive family planning service.	-Contraception -Decision making -Healthcare service

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
36. Clarke (2010) **Repeat Teenage Pregnancy in Two Cultures–The Meanings Ascribed by Teenagers.** UK	To explore and understand their experiences and meanings to describe their repeat pregnancies among two different and diverse groups	26 respondents from the Caribbean islands of Jamaica and Barbados and the other group of 26 respondents from London, who had experienced repeat teenage pregnancies.	A qualitative comparative approach, collecting data using an in-depth qualitative semi-structured interviews to participants who were up to 20 years old and had had two or more pregnancies, regardless of the outcome of the first pregnancy.	Frears and Schneider's (1981) categorisation of loss were used to underpin the analysis, three types of losses emerged from the accounts of the respondents.	-Adolescents reported experiences of struggling between the two cultural ethnic groups. - One-third of these young mothers experienced a loss of educational opportunities with an incidence of refusal by their schools to allow them to return to school. They were asked to quit school after having to stopped attending school while, for the London respondents, they reported a lower incidence of being asked to leave school.	**Strengths:** - The study provided enough details of the participants perspective and thick description about the context and clearly themes emerged. **Weaknesses:** -The study had not provided enough explanation to the recruitment process.	-Education

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
37. Conroy et al. (2016) **The Enigma of Rapid Repeat Pregnancy: A Qualitative Study of Teen Mothers.** USA	To examined adolescent mothers' perceptions of their decision-making and behaviours that helped prevent or promote rapid repeat pregnancy.	15 American young mothers aged 16-21 years who experienced a repeat pregnancy within a year of their first child's birth.	Qualitative study using semi-structured interview. All interviews were conducted in a private space.	Qualitative data analysis using inductive coding technique.	- Young mothers expressed their sense of control over their life and decisions, other mothers expressed positive feelings toward motherhood and feeling empowered. - Many of them intended to use LARC but found there were barriers to accessing this contraception method, included insurance struggles, challenges with keeping appointments for LARC, or difficulties picking up a prescription. - LARC where available at an affiliate medical site, they were faced with multiple duties that made it hard to manage.	**Strengths:** - The study provided adequate details of the study participants. -Evaluation techniques were included and state clearly what study's analysis approach. **Weaknesses:** - The study had not provided enough explanation to the data analysis.	-Self perception -Contraception -Decision making

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
38. Dallas (2013) **Rapid Repeat Pregnancy Among Unmarried, African American Adolescent Parent Couples** USA	To describes rapid repeat pregnancy (RRP), getting pregnant or giving birth again within 24 months of giving birth, and to examine paternal involvement.	21 adolescent mothers 14 to 19 years of age and unmarried, experiencing their first full-term pregnancy having subsequent pregnancies, 24 kinship system 24-month interview, and 580 qualitative interviews in total.	Longitudinal qualitative study that examined paternal involvement of unmarried, low-income, African American parent couples using individually interviewe during late pregnancy and when the adolescents' babies were 1, 6, 12, 18, and 24 months of age.	Data were analysed using the constant com-parison method	- For those who had separated from a relationship, they might undervalue the need for family planning and might be unprepared to prevent pregnancy in a new relationship - Adolescent others indicated having experienced at least one incident of intimate partner violence during their relationship.	**Strengths:** - The study provided details about using Bronfenbrenner's ecological theory (1989) as theoretical approach. - Thick description provided contextual background information and prolong engagement. **Weaknesses:** - The study stated unclear about the collecting data from unmarried couples and their family member about their relationships.	-Father of baby -Family support

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
39. Herrman (2006) **The voices of teen mothers: the experience of repeat pregnancy.** USA	To explore the voice of the 'teen mothers who experienced repeat pregnancy; the impact of mothering on intimate relationships; and explored the insight of American adolescent mothers regarding their life aspirations.	16 participants being adolescent mothers 16-19 years old, living with the first child and being currently pregnant with a child will be born during adolescent year.	Ethnographic study design interviewing adolescent mothers who had at least one living child by using semi-structure interview.	Using Ethnograph 5.0 analyse qualitative data.	- The results from the perceptions of young mothers on the effect of having children on their intimate relationships were perceived as mixed. - Some mothers stated that having children improved their relationships with their partner. - All of them mentioned the need to be in school. They felt that education could increase the opportunity to have better chances or have positive effects on their life course including being a good role model for achieving an education, and increasing the ability to get greater work opportunities, and for living a good life.	**Strengths:** - The study presented clearly adequate evidence to support the analysis, contexts, and perspective of adolescent mothers with RP. **Weaknesses:** - The study had not given to any limitations of the methods or data.	-Definition -Self-perception -Father of baby -Family support -Education -Financial and employment

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
40. Herrman (2007) **Repeat pregnancy in adolescence: intentions and decision making.** USA	To determine the perceptions of young mothers concerning their intentions about repeat pregnancy and to determine shared meanings concerning intentionality and decision making about sexual activity and use of birth control.	Young mothers aged 16 to 19 years with a repeat pregnancy.	Ethnographic descriptive study examined 12 young mothers' to the intentions and decision making associated with repeat pregnancy and focuses only on the young mothers with a repeat pregnancy.	Using Ethnograph 5.0 analyse qualitative data in which key words, such as birth control, intentions, pregnancy, and sexual activity, were used in coding.	- The study reported that it was difficult to assess the level of decision making attended by each participant, although mothers did not intend to get pregnant, they also did not intend to prevent pregnancy. - Adolescent mothers referred to the pregnancy as happening as the unplanned consequence.	**Strengths:** - The study provided thick description about decision making of RP based on perspective of adolescent mother who had one child. **Weaknesses:** **-** The study was unclear about the context of the setting.	-Decision making

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
41. Reddy et al. (2017) **Rapid Repeat Birth: Intersections Between Meaning-Making and Situational Support Among Multiparous Adolescent Mothers.** USA	To examined interpretations of motherhood among adolescents who have experienced rapid repeat births	19 participants completed at least two research interviews	The interpretive phenomenological approach using home visiting and in- depth, in-person research interviews.	Data were analysed using an interpretative, phenomenological, and person-centred approach that highlighted participant perspectives and experiences of young mothers.	- Young mothers referred to “good mother” and “family building”; while some showed a personal stabilization, adult responsibilities, the enjoyment of motherhood. -The lack of motivation for continued schooling. - Relationships with their partner and their parents became stronger. - Adolescent mothers appeared to be working toward independent adult lives through the experience of motherhood and increased responsibility and motivation as well as feelings of comfort and improved self-concept drawn from the motherhood role.	**Strengths:** - The study explained findings and provided participants data fitting the views of the studied participants who had experienced rapid repeat births. **Weaknesses:** **-** The study was unclear about the advent of repeat birth, nor did they consistently collect participants’ perspectives on the motherhood identity.	-Self perception -Financial and employment

Note: See articles number 42nd -49th in table 3.7

3.2 Findings from the Literature: Repeat Pregnancy in Adolescent Mothers

This section provides findings from mixed research systematic review (Sandelowski et. al, 2006). 49 eligible studies (39 quantitative and 10 qualitative) met the inclusion criteria and quality assessment criteria. The findings from this mixed research systematic review were examined in a narrative approach, and an overview of categories of identified adolescent repeat pregnancy experiences were extracted and categorised (Holly et al., 2016). Braun and Clarke (2013)'s approach was used to synthesise the data and develop themes.

I integrated the data to establish what is currently known, and to identify the gaps in knowledge, around the experience of repeat pregnancy among adolescents both globally and in Thailand in order to better understand relevant factors underpinning repeat pregnancy and the context. Eleven themes emerge from this analysis, including differences in definition, and these are presented below.

3.2.1 Definitions of Repeat Pregnancy

To understand the context of repeat pregnancy in adolescence, the definition of terms needs to be clarified. The selected studies refer to both repeat pregnancy (RP) and rapid repeat pregnancy (RRP). Regarding definitions, various empirical studies that referred to RP among adolescents as an adolescent mother having a pregnancy again while still under 20 years old, i.e. being an adolescent mother with living child while being currently pregnant with a child that will be born during the adolescent age range (Herrman, 2006). Furthermore, RRP is a subsequent pregnancy occurring within 24 months of a previous pregnancy outcome or having an interpregnancy interval of within 24 months, regardless of previous pregnancy outcome (Crittenden et al., 2009). The interpregnancy interval comprises the period between the delivery of a live birth and the conception of the subsequent live birth, typically measured in months. The literature shows that those adolescents that have an RRP with shorter interpregnancy intervals might be at the greatest risk for adverse pregnancy outcomes (Crittenden et al., 2009). However, in this study, I will focus on repeat adolescent pregnancy irrespective of whether it is an RRP or an RP that was found from the systematic literature review, which would help to understand the essential knowledge in a wider perspective.

3.2.2 Pregnancy outcomes in repeat pregnancy among adolescents

Primarily in terms of the demographic profiles of repeat adolescent pregnancy, the literature found that early age at first birth increased the risk of repeat adolescent pregnancy. In de Fátima Rato Padin et al. (2009), a cross-section of a socio-demographic profile of Brazilian multiparous and primiparous adolescent mothers was studied with regard to personal characteristic profiles among Brazilian multiparous and primiparous adolescent mothers. The results found that the age at first pregnancy of the multiparous group was younger than that of the primiparous adolescent group, which means that early age at first pregnancy makes it more likely that they will experience RP within adolescence. de Fátima Rato Padin et al. (2009) also found that the multiparous mothers had their first sexual experiences around 6 months earlier than those who were primiparous mothers. This study can be considered relatively rigorous with clearly identified study aims that focused on primiparous and multiparous adolescent mothers, and the research design was clearly stated. However, there were some weaknesses in this study, for example, data from socio-demographic profile were not compared between first and repeat pregnancy within the same group.

Furthermore, Raneri and Wiemann (2007) carried out a survey for up to 48 months among American adolescent mothers which aimed to improve understandings of the individual, dyad, family, peer, community and social system-level risk factors for repeat pregnancy. They conducted the research using social ecological predictors of repeat adolescent pregnancy. Their sample comprised 581 young mothers. The results found that 254 (42%) adolescent mothers experienced an RP within 24 months. Seventy-three percent of these RPs resulted in a second birth; the rest resulted in miscarriage (14%) or abortion (13%). This study provided adequate details about how variables were identified using Bronfenbrenner's (1979) ecological theory, which illustrated the related contexts around adolescent mothers.

For the outcome of RP, there are previous empirical studies that have examined adverse pregnancy outcomes among adolescent mothers. The experiences with RP included pregnancy outcomes and the outcome for their child. Khashan et al. (2010), for example, used a cohort study to investigate the relationship between young maternal age and adverse pregnancy outcomes among mothers aged 14–29 years in a north-western region of England. Their samples consisted of 55,539 mothers during the period 2004 to 2006. The samples were classified in three groups: 14–17 years, 18–19 years, and 20–29 years

(as a reference group). The study compared outcome measures in teenagers' first and second pregnancies with those of mothers aged 20 to 29 years. Regarding the preterm birth outcome, the study found that the risks of preterm birth and very preterm birth increased significantly in both first and second - time mothers aged 14–17 years compared to the reference group aged 20–29 years. Moreover, regarding the baby outcome, it was found that women aged 14–17 years at the time of their second delivery had babies with a significantly smaller birthweight compared to second births in the reference group of adult women. Nonetheless, the second birth in this age group, when specified in terms of the babies, indicated that there was a non-significant increase in risk of small for gestational age (SGA) and very SGA. In the second births of 18–19-year-olds compared to adult mothers, the study found that mean birthweight was reduced by 55 grams in second-time mothers aged 18–19 years; the result was similar when the analysis was restricted to full-term babies. These adolescent women were at significantly increased risk of preterm birth but not at increased risk of SGA and very preterm births in this group. The strength of this study is the comparison of outcome measures across teenagers' first and second pregnancies and uses data from a large national data source. However, it lacked a consideration of confounding effects, the main cohort reported lack of information on confounding effect such as maternal smoking and this missing detail might affect estimate bias.

However, Maravilla et al. (2019b) evaluated the risk of adverse maternal outcomes among adolescents experiencing a repeat pregnancy in the Philippines. This study collected data from 2,518 young mothers aged 15–24 years who had two singleton deliveries of a subsequent pregnancy, within 24 months or less, during the adolescent period. The study found that there was no association in the risk of poor maternal outcomes between RP of less than 24 months and RP of more than 24 months and no association in neonatal birthweight. Although the study provided details about multi-stage stratified sampling by region and type of population, there were different social and obstetric characteristics among those with a second pregnancy as compared with first-time mothers, which could lead to biased estimates.

Timur et al. (2016) examined the factors that affect perinatal outcomes of Turkish adolescents' second pregnancy. They conducted a longitudinal retrospective study on adolescent mothers aged 19 or younger who had experienced two deliveries at Zekai Tahir Burak Woman's Health Education and Research Hospital, Turkey. Data were collected for the first and second pregnancies to be a reference group for the first pregnancies,

including factors such as body mass index (BMI), number of antenatal care visits, weight gain during pregnancy, anaemia rate, smoking status, gestational week at delivery, caesarean rate, and birth weight. This study provided details of the research methods on repeat adolescent mothers and compared with their first pregnancy outcome. The study found that there were 525 adolescent births, and 66 of these delivered twice during their adolescence. Interestingly, there was no significant difference between pregnancy outcomes in the first and second deliveries in this adolescent group. Conversely, the statistics show that adolescents who were experiencing their first pregnancy had a higher risk of an adverse pregnancy outcome than those who were in their second pregnancy.

Richio et al. (2010) studied the relationship between modes of delivery in adolescent mothers having a second delivery within 2 years of a first birth. This was because the caesarean delivery group may be related to a longer length of time for a subsequent pregnancy. The hypothesis of the study emerged from the question concerning whether adolescent mothers who had caesarean deliveries would have a lower rate of repeat births within 2 years after a first birth compared with adolescents who had a vaginal delivery. Using a retrospective cohort study to explore 899 adolescents delivering in Rhode Island, USA, the results showed that there was no significant correlation between modes of delivery and repeat adolescent pregnancy. The findings from this study are relatively robust as the researchers clearly stated details of the health outcomes for the modes of delivery of both first and second pregnancy.

In terms of the personal characteristics, including behavioural factors and mental health factors that were related to RP, Crittenden et al. (2009) conducted a prospective longitudinal study to examine these factors. Three hundred and forty-five African American adolescents aged 12–19 years were individually interviewed during pregnancy and at 24 months after childbirth. The results showed that self-reported efficacy and attitudes about aggression were the significant predictors of RRP in this study. Crittenden et al. (2009) also pointed out the self-reported confidence of young mothers who had experienced an RP was lower than the confidence of those who had not experienced an RP. They were especially “less confident in ability to settle differences without the use of physical force”, “less confident in their ability to settle differences with people close to them without using force”, “agreed more often that sometimes people must use physical force to show importance”, and “felt more provoked by others to hit and push if they didn’t want to”. The finding from this study can be considered as relatively robust as a

good level of detail was provided about individual interviews during pregnancy and at 24 months post-partum.

Additionally, when considering other personal characteristics and mental health factors Crittenden et al. (2009) found that an ethnic/racial identity was not significantly associated with RP among adolescents. This is supported by Anderson and Pierce's (2015) work, a cross-section of the contributors to RPs among American adolescents. Anderson and Pierce (2015) aimed to screen depressive symptoms and violence among age and ethnically/racially diverse adolescents by gravidity and parity. The results found that both child abuse and past traumatic life experiences were significantly found to predict adolescent parity. Adolescents with a history of child abuse were 3.5 times more likely to have one living child than those who did not. Moreover, the socio-demographic statistics in this study reported that from 193 adolescent respondents, 58 (31.5%) reported more than one pregnancy, with 46 adolescents (25.4%) reporting more than one living child. For 16 (8.6%) adolescents, the most recent pregnancy was reported as a third or fourth pregnancy. However, the study reported findings that included the mean age of the adolescent samples (median=18), who might cope better than early adolescents.

Although, many studies provided strengths in terms of methodological soundness, there might be some points of weakness. Quantitative studies may be unable to observe the various personal perceptions associated with adverse perinatal outcomes. Moreover, data collection using the self-report questionnaires might have recall bias on mental health and experiential items.

3.2.3 Self-Perceptions and childrearing of young mothers with repeated pregnancy

Reddy et al. (2017) explored interpretations of motherhood among American adolescents who had experienced rapid repeat births. They interviewed 19 young mothers from 57 who had experienced RP within 24 months from a total of 704 mothers, who were part of the home visiting programme, Healthy Families Massachusetts. This study used an interpretative, phenomenological, and person-centred approach that highlighted participant perspectives and experiences of young mothers. The study collected data exploring the views of participants who had experienced repeat births. The study found that the young mothers referred to "good mother" and "family building"; while eight mothers in this study showed evidence of personal stabilisation, the assumption of adult responsibilities, enthusiastic enjoyment of motherhood, and a lack of motivation for

continued schooling. Moreover, young mothers also expressed that their relationships with their partner and their parent became stronger.

Reddy et al. (2017) also reported that young mothers appeared to be working towards independent adult lives through the experience of motherhood. They mentioned increased responsibility and motivation as well as feelings of comfort and improved self-concept drawn from the motherhood role, and mothers felt proud of their personal growth and avoided negative behaviour, such as quitting smoking, for the sake of their children. Similarly, Herrman (2006) conducted an ethnographic study and interviewed adolescent mothers who had at least one living child, using semi-structure interviews. The study found that repeat young mothers revealed positive changes in their behaviours, such as improvements in decision-making, goal orientation, optimism, and sense of responsibility.

In a qualitative study, Conroy et al. (2016) examined adolescent mothers' perceptions of their decision-making and behaviours that helped prevent or promote RRP. They used a retrospective qualitative study to understand adolescent mothers' perceptions of their own intentions and behaviours. Their sample consisted of 15 American young mothers aged 16–21 years who experienced an RP within a year of their first child's birth. Conroy et al. (2016: 3) reported that young mothers expressed a range of perspectives regarding their *"sense of control over their life and decisions"* and voiced things such as *"I am big enough"* and that "responsibility" described their feelings. For example, *"I believe that if I'm big enough to lay there and do this, then I'm big enough to take care of my responsibility."* Moreover, other mothers expressed positive sentiments towards motherhood and feeling empowered or "proud" of their own actions; for example, "I felt good because I was like well she's already one (year old)… I did it" and "Some parents, they can't do it. I was still in school and I didn't drop out like, I just, I got day-care for her and everything. I felt good."

The study of Amongin et al. (2020) showed that the wantedness of subsequent pregnancy has changed over time. Amongin et al. studied time trends and factors associated with repeat adolescent births in Uganda. The quality of the findings reported in this study is increased by the strong rationale provided in relation to is study provided adequate details about the data collection methods and the use of nationally representative samples. The study analysed six demographic and health surveys from 1988 to 2016. They found an increase among adolescent women with repeat adolescent births in their preference to have the second child later, 22.5% in 1995 and 43.1% in 2016.

However, there were some young mothers who expressed having little control over their choices and feeling disappointed or failed by the situation regarding RP. In Reddy et al.'s (2017: 707) study, it was found that there were young mothers who described a range of viewpoints, including that they still continued being adolescents or the lack of developmental transformation resulting from motherhood. Some described mothering as *"Good. You have somebody to play with, and when you're down, they make you feel happy. They make you forget about your worries. Just fun."* Moreover, these young mothers were still living with their parents and depended on them. Some expressed the meaning of second-time motherhood as about the same but harder: *"about the same. It's a little harder now."* Similarly, Herrman (2006) reported that coping with the stress of having more than one child was not easy, saying *"I was so happy with one…I don't know …now I have two…it is so much harder."* Another study of Bucknall and Bick (2019) semi-structured interviews as part of a qualitative exploratory study to explore young mothers' experiences of an unplanned RP within 24 months of giving birth to their first child in the UK, to understand the reasons for their second pregnancy. Six participants were interviewed. The study found that adolescent women described their surprise and shock on learning the news of a subsequent pregnancy and described the difficulties of trying to get on in life, having missed lots of education. There are problems with this study however, for example, all six participants were recruited through a family nurse partnership, and some might not had access to the family planning service within 24 months.

The childrearing of young mothers with RP is a concern in empirical studies. The effects on children health outcomes were studied in Maravilla et al.'s (2020) study, which focused on nutritional deprivation, which may lead to poor infant growth among their children. They measured the occurrence and persistence of stunting among the offspring of young mothers who experienced RPs using data from the Cebu Longitudinal Health and Nutrition Survey, Philippines. The results found that children of young mothers with RP experience an increased occurrence of stunting before the age of two compared to first-time young mothers. However, there were no interactions by maternal age, which suggests no substantive difference between the risk of offspring stunting in women aged 14–19 and 20–24 years. In addition, the study did not clearly consider confounding variables, such as maternal nutritional intake from diet and supplements.

Maslowsky et al.(2021) conducted a retrospective research using annual US birth data to compare the prevalence of negative pregnancy-related behaviours and gestational health

conditions in the national US population of first-time and repeat teenage mothers. The study focused on pregnancy-related behaviours, including adequacy of prenatal care and weight gain, sexually transmitted infection, smoking, and breastfeeding. The results found that repeat mothers had a higher prevalence of negative pregnancy-related behaviours: inadequate prenatal care, smoking, inadequate weight gain, and sexually transmitted infection during pregnancy; they were also less likely to breastfeed. This study concluded that repeat teenage mothers experienced a lower prevalence of physical health complications during pregnancy but engaged in more negative pregnancy-related health behaviours that can lead directly to poor perinatal outcomes for infants. The study has some strengths; adequate details were provided about the research design and logical steps were sued in the process of data analysis. However, the use of a retrospective cohort approach did not allow examination of first and second births to the same mothers because the birth records were not linked to individuals.

Although, this theme illustrates integrated findings from qualitative and quantitative studies investigating adolescent mothers' perspectives, there were some gaps around the issue of understanding the perspectives of adolescent mothers' who had experiences of a subsequent pregnancy while rearing their child at a young age.

3.2.4 The Experiences of Contraceptive Failure

A number of studies found that adolescent mothers who had an RP experienced contraceptive failure. Wilkie et al. (2016) used a retrospective cohort study to investigate experiences of postpartum contraception choices, collecting data from medical records of deliveries to women under the age of 20 at time of conception. The results showed that for postpartum contraception choice in the repeat American adolescent pregnancy group they were less likely to use LARC than those with a non-RRP. The principle of contraception is divided into two groups: firstly, long-acting reversible contraception (LARC), including intrauterine devices (IUDs) and hormonal implants; and secondly, non-long-acting reversible contraception (non-LARC), including abstinence, condoms, a vaginal ring, oral contraceptive pills (progesterone only and combined oestrogen/progesterone), a contraceptive patch, Depo-Provera injection, and sexual activity without contraception (Wilkie et al., 2016).

Raneri and Wiemann (2007) had similar findings. They studied the predicting factors related to RP among American adolescents, which included individual, dyad, family, peer/community, and social-system factors. The results, particularly of the individual

factors, revealed that there was a repeat adolescent pregnancy failure to initiate a long-acting contraceptive method within three months of delivery among the repeat adolescent pregnancy group. Similarly, Stevens-Simon et al. (2001) found that using LARCs during the puerperium was associated with pregnancy prevention during the first 2 postpartum years. Coard et al. (2000) also found that adolescent mothers who used medroxyprogesterone or progesterone implants in the early postpartum period accounted for 60% of those who successfully avoided a repeat pregnancy within 2 years.

Regarding non-LARCs, the studies reported that adolescent women using a contraceptive method that was non-LARC had a high risk of RP. The study of Wilkie et al. (2016) reported that the most common contraception method used by young women who did not have a RRP was the depo medroxyprogesterone acetate (DMPA) injection (30.6%); while women who had an RRP most often expressed using ‘no contraception’ (75.5%). Having sexual activity without contraception for those women means taking a high risk of repeat conception in their initial postpartum period. However, the study used a retrospective sample, limited at 12 months, and therefore may not be able to examine RP rate beyond.

Furthermore, Raneri and Wiemann (2007) reported that young women can be poor users of oral contraceptives, forgetting to take them consistently or discontinuing them without seeking another method, thus increasing the risk of unintended pregnancy. They further explained that condoms are highly effective for avoiding pregnancy and sexually transmitted diseases (STDs) when used consistently and correctly, but among adolescents they are, in fact, commonly used inconsistently and incorrectly.

Regarding the experiences of inappropriate contraceptive methods in repeat adolescent pregnancy, these were reported as obstacles in their life and were likely to affect adolescent mothers’ selection of a future contraceptive method, either LARCs or non-LARCs. In terms of non-LARCs, the contraceptive choices of young mothers also depend on their intention to have another baby. Wilkie et al. (2016) reported that many young mothers believed that the use of LARCs, especially IUDs, leads to infertility. Fear of an inability to conceive may be driving some adolescents to avoid more effective contraception methods. Adolescents may be trying to ensure that they are fertile and therefore are choosing not to use LARCs. Additionally, adolescent mothers may be aware of the common side-effects of hormonally based LARCs. Lewis et al. (2010) studied long-acting implant contraception as a contraceptive choice for teenage mothers. The results revealed obstacles regarding contraception choice in adolescents; they were more likely

to consider the side effects and how they might affect their desire to have another pregnancy. As Lewis et al. (2010) further reported, those women disliked the implantation method because of the adverse side effects, such as irregular bleeding and spotting. However, young women who were satisfied with long-acting contraceptive methods also highlighted the positive side effect that they did not have to remember to use it. On the other hand, both studies Wilkie et al. (2016) and Lewis et al. (2010) show that there were adolescent mothers who were motivated to become pregnant again and who were more likely to either use no contraception or to have chosen barrier methods.

Accessibility to contraception is also important for repeat adolescent pregnancy. As Raneri and Wiemann (2007) reported, many adolescent mothers become sexually active within 2–3 months of delivery. The early adoption of easy-to-use, long-acting contraception is highly effective in preventing RP. According to Wilkie et al. (2016), poor access to LARC methods may explain the low LARC usage rates in young women. In general, in the postpartum period, an implantation, IUD insertion, and hormonal-based contraceptive methods like DMPA have only been provided in hospitals or special clinics.

Wilkie et al. (2016) further suggested that immediate postpartum LARC is beneficial to adolescents, and this highly motivated them to obtain contraception while they were still an inpatient following a delivery. The LARC insertion after delivery or at the postpartum visit is crucial in the case of adolescent mothers. Damle et al. (2015) considered whether early initiation of contraception, and in particular LARC, decreases rapid repeat pregnancy among first time adolescent mothers. In particular, whether the use of DMPA prior to discharge from the hospital, levels of compliance with postpartum follow up and the initiation of a contraceptive method within 24 weeks were associated with prevention of rapid repeat adolescent pregnancy. Moreover, other studies (for example Cohen et al. 2016) have also found that the high rates of DMPA use have been at the initial postpartum period, which possibly reflects their easy access, yet adolescent mothers were at high risk for 'non-attendance' and 'failure to follow up'. Therefore, the discontinuation of contraceptive use in adolescents is an issue. Cohen et al. (2016) compared discontinuation rates and incidence of repeat pregnancy within 1 year among young mothers choosing post-placental intrauterine devices (IUDs) versus postpartum contraceptive implants. They found that adolescent mothers who have an RP were more likely to discontinue contraceptive use.

However, some studies reported that in some areas DMPA is the only form of contraception available to be administered on the postpartum ward. This was thus the only immediately effective postpartum contraceptive method that women could easily access after giving birth (Damle et al., 2015). Being an adolescent mother makes it more likely to experience obstacles in contraception choice and accessibility. Conroy et al. (2016) conducted a qualitative grounded theory study to examine American adolescent mothers' perceptions of their decision-making and behaviours that helped to prevent or promote an RRP. The results from the perceptions of adolescent mothers who had an RP was that many of them intended to use an LARC but found there were barriers to accessing this contraception method. In this study, the barriers expressed included insurance struggles, challenges with keeping appointments for an LARC, or difficulties picking up a prescription. Conroy et al. (2016) further reported that, although adolescent mothers were receiving medical care for long-acting contraception where available at an affiliate medical site, they were faced with multiple duties that made it hard to manage. Moreover, a qualitative study (Bucknall and Bick, 2019) explored young mothers' experience of rapid repeat pregnancy and found that adolescent mothers have a common concern centred on a perceived risk that LARCs could become embedded in the body and cause other potential side effects, such as vaginal bleeding and some of adolescent women reported LARCs removal because they had experienced prolonged vaginal bleeding.

Despite the fact that quantitative findings showed various factors that influence RP, there were some gaps in understanding the experiences of young mothers in relation to contraceptive problems that need to be explored further.

3.2.5 Pregnancy Decision Making in Adolescents

In terms of intention and decision-making regarding repeat adolescent pregnancy, there are ambivalences regarding RP among adolescent mothers who experienced RP. The literature found that most of them neither intended to avoid RP nor intended to have second baby either. Conroy et al. (2016) used semi-structured interview to examine adolescent American mothers' perceptions of their contraceptive decision-making and behaviours that helped prevent an RRP. This study found that intention to prevent RP in non-RRP among adolescents showed a strong intention to prevent pregnancy, while those who experienced RP were reported as more likely to have ambivalent feelings regarding RP. In particular, adolescent mothers who were not actively seeking to prevent pregnancy were "susceptible to pregnancy" or "pregnancy receptive", while those who did not

strongly endorse the intention to prevent pregnancy should be considered high risk. Moreover, the results also found that those who experienced RP 'did not care' about the outcome.

Regarding the intention to prevent pregnancy, Herrman (2007) studied the intentions and decision-making regarding RP among American adolescent mothers. An ethnographic methodology was used to conduct the research, using semi-structured interviews to explore the shared meanings regarding their experiences in RP. Herrman (2007) stated that although it is difficult to assess the level of decision-making by each adolescent mother, the important finding was that even though the young mothers did not intend to get pregnant, they also did not intend to prevent pregnancy. The results revealed that all of the young mothers stated that their RPs were "unintended". Adolescent mothers referred to the pregnancy as happening as the consequence of a "mistake". Regarding their intentions to get pregnant again, young mothers expressed "not meaning to get pregnant", "not wanting to get pregnant", and "pregnancy not being in my plans". Similar to Clarke's (2010) study, this highlighted that none of the respondents in this study viewed their pregnancy as "unwanted". They often pointed to them as "mistimed" or "unintended" but not unwanted. Herrman's (2007) study also found that several common meanings of intention were related to sexual activities which were determined by young mothers to be a spontaneous act of sexual activity that lacked planning or consideration of the results. Herrman (2007) also explored decision-making before an unprotected sexual activity; the young mothers stated that either they did not consider the consequences or that the consequences were not powerful enough to change behaviours. Sexual activity was shown to be with knowledge of a potential pregnancy and as a choice made before sex. Moreover, young mothers did seem to engage in some decision-making about future sexual activity and methods of contraception, yet these were not strong intentions. Experiencing sexual activity without potential protection was found to be a common cause of unintentional pregnancy. As such, the use of male and female condoms and calculating "safe sex" periods within their menstrual cycle were reported even though they knew the results of these less effective contraception methods (Herrman, 2007).

However, success in preventing RP via contraceptive use is not only based upon the individual self-decisions of young mothers; it is also built up via the opinion of their partner. The study of Conroy et al. (2016: 4) reported that American adolescent mothers have a collaborative approach with their partner contraceptive decision-making and that it is important to do this together. As some young mothers said, *"My partner. No matter*

what it is. Even though we have our problems, I always value his opinion. Always" and *"We, we're joint in the efforts. So, we both are pretty firm on and agree what to do."* On the other hand, some young women made contraceptive decisions independently of their partner, often denying their partner a voice: *"Well to me he really doesn't have a choice 'cause this is my body. So, he be, he's fine with it. He didn't like it at first but I didn't really care because this is my body"* and *"[My partner] doesn't have no say so 'cause I'm the one that's going to be carrying the baby. So, he's just got to listen."*

Conversely, partners also influenced the women's contraceptive choices (Bucknall and Bick, 2019). Similarly, in Herrman's (2007: 93) study, it was also found that partners lack ownership of the responsibility for contraception, as in *"he don't like condoms"; "he uses 'em sometimes" or "condoms were an option sometimes."* There were not strong intentions to protect themselves from RP while still young.

In terms of their intention to have a second baby, there are some interesting factors that can lead to planning to have a second baby experience. Raneri and Wiemann (2007) found that American adolescent mothers who planned to have a second baby within five years were more likely to experience an RP within 24 months. In Conroy et al.'s (2016) study, it was found that some young mothers who have a clear intention to become pregnant again can experience more second pregnancies than those young mothers who did not intend to. The reason why this happens could be that young mothers have a positive attitude to motherhood and see it as fulfilling their life. Furthermore, Cha et al. (2016) studied the association between couples' pregnancy intentions and RRP. The results highlighted that paternal intention might have an important role in reproductive decisions. This study also found that although American adolescent mothers did not intend to have a second baby, in the case of fathers with greater intentions to have a baby, they were more likely to experience RRP than those young mothers who wanted to have a new baby, but the fathers did not want to. This is similar to Boardman et al.'s (2006) findings. They studied the risk factors for unintended versus intended RRPs among American adolescents. Interestingly, the results found that 34% of the adolescents experiencing an RRP reported such pregnancies to be intended. In addition, the risk factors for having an intended RP show that having the RP intended by the adolescents' partners meant they were more likely to experience an RRP within 24 months. However, Boardman et al. (2006) found that racial/ethnic characteristics as well as the characteristics of the teen's mother (educational status and age of the teen's mother first birth) were not associated with either intended or unintended RRPs.

In summary, the qualitative and quantitative studies provided some idea of young mothers' decision-making surrounding having a baby while in young age. However, there is a need for further exploration regarding the experiences of adolescent mothers who had already have at least one living child.

3.2.6 Father of baby

Intimate partner characteristics may be found to significantly predict factors related to RP among young mothers. Regarding partner age, Dallas (2013) found that around 75% of adolescent fathers were between14 and 19 years of age and the rest were more than 20 years old. Furthermore, Raneri and Wiemann (2007) found that if the age of the first child's father was more than three years older than the adolescent mother, they were more likely to experience RP than when fathers were the same age or younger than the mother. The attitude of their partner also found as a significant factor for adolescent mothers who did not intend to have a second baby but their partner reported more intending to have a baby, adolescent mothers were more likely to experience RP than those young mothers who desire to have a second baby but their partner did not want to (Cha et al., 2016).

The study of Maravilla et al. (2019a) explored the risks of RP among adolescents and young women in the Philippines by comparing an increased risk among 15–19 years old compared to 20–24 years old. The results revealed that partner characteristics were associated with RP among young women, suggesting male involvement, especially that of older partners, in family planning. However, there were some aspects not included in the self-report survey, such as such as partner characteristics before or after the repeat pregnancy occurred and these omissions may lead to bias in the findings.

In terms of the relationship with the father of their children, the literature found that paternal relationships were a crucial factor directly impacting young mothers who experience an RP. Herrman (2006) studied the voice of the teen mothers who experienced RP, the impact of mothering on intimate relationships, and explored the insight of American adolescent mothers regarding their life aspirations, the change in their life as a result of parenting, and their beliefs about the impact of RP on their aspirations and life course. The results from the perceptions of young mothers on the effect of having children on their intimate relationships were perceived as mixed. Some mothers stated that having children improved their relationships with their partner. On the other hand, young mothers perceived that their partners did not pay attention to them and their children as before.

A longitudinal qualitative study by Dallas (2013) found that repeat American adolescent mothers experienced intimate partner relationships in different ways. These included separate relationships, not cohabiting, and having new partners. For those who had separated from a relationship, they may undervalue the need for family planning and may be unprepared to prevent pregnancy in a new relationship. Similarly, Raneri and Wiemann (2007) studied the dyad level as an RP predictor. The results showed that adolescent American mothers who were no longer in a relationship with the father of their first child at three months after childbirth were more likely to have an RP than were those still involved with their baby's father. Additionally, some adolescent mothers with new relationships may be eager to become pregnant with the child of a new potential long-term partner to create a new and shared family (Raneri and Wiemann, 2007). On the other hand, Boardman et al. (2006) reported that American adolescents who had been married at the time of second conception were less likely to experience unintended RP than those who were not married.

The experience of intimate partner violence is often discussed in the empirical studies. Raneri and Wiemann (2007) studied the risk factors for RP. An important and significant result was that adolescent mothers who experienced intimate partner violence within three months after delivery were more likely have an RP within 24 months than those who had a healthy relationship with their intimate partner. Additionally, sexually active adolescent mothers who experienced verbal abuse were less likely to use condoms than those who did not, and those who experienced intimate partner physical abuse were more likely to become pregnant than those who did not. Furthermore, Raneri and Wiemann (2007) indicated that adolescent mothers who are in violent relationships may find it difficult to refuse sexual activity or to negotiate contraceptive use with an agitated partner. The study by Dallas (2013) found that a number of adolescent mothers indicated having experienced at least one incident of intimate partner violence during their relationship. The types of intimate partner violence found in this study included slapping, choking, or kicking the adolescent mother, destroying her clothes, screaming at her, insulting, or swearing at her, and calling her names.

To conclude, although the findings from both quantitative and qualitative studies provided insights into the factors that influence RP, there is still a need for a clearer in-depth understanding of a young mother's perspective towards the father of her baby.

3.2.7 Educational Attainment and Peers

Educational attainment can also influence young mothers who are at risk of RP. Furthermore, childrearing can have the greatest impact on their life for those young mothers who have at least one child and are facing a second pregnancy (Herrman, 2006). Regarding education, which is one of the predicting factors of RP among adolescent mothers, Raneri and Wiemann (2007) studied factors predicting RP among American adolescent mothers. The results revealed that after postpartum young mothers who were not enrolled in school within three months postpartum were more likely to experience a RP than those who had re-joined school. Furthermore, de Fátima Rato Padin et al. (2009) studied a cross-sectional socio-demographic profile of Brazilian multiparous and primiparous adolescent mothers. Regarding the educational profile of the participants, the first-time mothers had a higher educational level than the multiparous ones. Moreover, the results showed that 36.4% of primiparous mothers were still going to school, whereas only 10% of multiparous mother reported that they were still going to school. Additionally, Vieira et al. (2016) studied the interaction between maternal schooling and age among Brazilian adolescent mothers. Their results revealed that those with low schooling along with inadequate schooling had a higher risk of RRP than those who had adequate schooling interaction. Stevens-Simon et al. (2001) also found that teenagers who returned to school within 6 months of delivery were also significantly less likely to become pregnant again during the first postpartum year.

The greatest impact of education on childrearing for those young mothers who experienced at least one child and faced interacting with schooling were reported in Herrman (2006). She used ethnographic research to gain insight into African American adolescent mothers who experienced RP, and were living with the first child, in order to inform future research and develop better interventions to help this adolescent group. She adopted the ethnographic method to explore the shared meaning in the experiences with respect to their life aspirations and life course within childrearing. The results highlighted the impact of mothering on education; attending school while parenting was a challenging situation requiring juggling school and children. From 16 participants in this study, there were 10 who had dropped out of school, while 8 of them left school either during their pregnancy or upon the birth of their first child. Some made the decision by themselves to leave school and just stayed at home with their baby and family.

However, interestingly, all of them mentioned the need to be in school. Some of the young mothers felt that education can increase the opportunity to have better chances or have a positive effect on their life course; therefore, they did not intend to quit school and decided that being in school was part of their educational plans or goals. One participant noted: *"cause I am still in school with two children...I am still gonna do what I was gonna do ...whether I got kids or not"* (Herrman, 2006: 247). Drayton et al. (2002) similarly found that most of the respondents reported wanting to continue their education after the birth of their first child and hoped to find an appropriate programme that fit in with their life.

Furthermore, Herrman (2006: 247) reported that adolescent mothers were aware of the positive impact of education with respect to their children, which included being a good role model by obtaining an education and increasing their ability to get better work opportunities and live a good life, for example, *"I want to brag to my kids about a college education."* Herrman (2006: 246) further reported that those young mothers who did not intend to leave school had continued their education through alternative programmes in which they could handle both getting an education and childrearing to achieve their goals and be more amenable to further children: *"Now that I dropped out…I see that education is everything ...I'm back in because I have a fear of not being able to provide for my kids…I don't want to be in fast food for the rest of my life."*

Clarke (2010) used an in-depth qualitative study to explore and understand their experiences and meanings to describe RPs among two different and diverse groups, which included young mothers from London and from a Caribbean Island. All of the participants had had two or more pregnancies, regardless of the outcome of the first pregnancy. In terms of the experience of educational attainment, the results found that there were different experiences of struggling between the two cultural ethnic groups. For the Caribbean participants, almost all respondents did not return to school after the first pregnancy. One third of these young mothers experienced a loss of educational opportunities due to the refusal of their schools to allow them to return. They were asked to quit school, after having stopped attending, without any alternative provision being offered. While for the London respondents, they reported a lower incidence of being asked to leave school. Same in Pfitzner et al. (2003) found that low educational achievement is a strong predictor of repeat pregnancy.

In terms of the relationships with friends in connection with RP, Raneri and Wiemann (2007) studied the relationships between adolescents' peers and RP among American adolescent mothers. The results revealed that adolescent mothers who reported that half of their friends were young mothers said that half of their friends who dropped out of school had an increased risk of adolescent RP.

Regarding the impact of mothering on friend relationships, Herrman (2006) conducted a qualitative study of African American repeat adolescent mothers and their experiences. The study found that adolescent mothers have various experiences related to their relationship with friends. Firstly, the participants discussed the necessary refocusing of attention from friends to children. They mentioned that friends offered only negative impacts on their children, and so they desired to leave previous friends behind. Secondly, the loss of previous friends, the lack of emphasis on friends, and the lack of enjoyed activities were discussed as reasons for their inability to participate in previously enjoyed activities. Thirdly, for young mothers with two children, they noted that mothering two children had an even greater negative influence on their social life and friendships and posed a greater risk for social isolation, for example, *"It's hard ...even if I want to try and get out ...it's like I can't ...I can but…being pregnant and trying to lug another baby along…it's too much…I'd rather stay put"* (Herrman, 2006: 246). Lastly, there were some young mothers who expressed that they became closer to their friends after having a baby, giving as a reason that personal change had made them more responsible in their friendships and that their children could be the centre of relationships, for example, *"they love my kids…they are more excited about them than I am", and "even people that didn't like me before…they speak to me now."*

In summary, the included research, both quantitative and qualitative studies, provides some picture of education and employment struggles of young mothers who experience RP. The findings from these studies suggest a need to explore in more detail, the way in which the young mothers manage the balance between education and work while having children under difficult circumstances.

3.2.8 Family Support

As stated by Raneri and Wiemann (2007), who studied factors predicting RP among American adolescent mothers, family context can influence RP. The study found that young mothers experiencing an RP were less close to their mothers and described lower family support than young mothers who did not experience an RP. However, the

quantitative study of Davis (2002) that was conducted among American adolescent mothers about factors associated with RP found the converse, particularly for the environment variable. The study clearly stated variables and related to population recruitment using Problem Behaviour Theory to examine repeat pregnancies of unwed adolescent mothers. This study found that living with the mother of adolescent mothers can increase the chance of having an RP by 3.197 times than those who do not live with their mother. In other words, adolescent mothers who live with their mother are more likely to have an RP than an adolescent who does not live with their mother. Davis (2002) further reported that this could be because the adolescent mother does not have the individual responsibility of caring for the child. Moreover, Davis (2002) further reported that they have live-in babysitters and caregivers and they do not experience the work it takes to raise a child. However, the limitations of the dataset could not provide a full model of Problem Behaviour Theory i.e., peer influence, which was an aspect of the perceived environment system and not available in the dataset.

In a qualitative study, Dallas (2013) looked at adolescent parent couples from the perspective of their kinship system. This study found that there was less support from the young mothers' families. Dallas (2013) further showed that RPs were a cause of concern for all members of a kinship system. Paternal and maternal grandmothers worried about the impact of additional children on the family, fearing that it might impact on financial resources and the ability of the adolescent parents to cope with parenting challenges.

In a qualitative study, Herrman (2006) examined the perspective of RP experiences. The study reported that young mothers expressed that having a baby did not change the already unhealthy patterns of their families. However, in Herrman (2006), some of the participants also referred to positive support from their families. These young mothers pointed out they received more emotional support from their family members, which enhanced the relationships with their mothers and formed closer ties with their siblings.

In summary, although some of the research, such as Dallas (2013), discussed above, found that there was less support from the young mothers' families, others, like Herrman (2006), reported that young mothers expressed that having a baby did not change the already unhealthy patterns of their families. Moreover, some pointed out that they received more emotional support from their family members. However, there are gaps in understanding that need to be explored in greater depth, particularly in relation to a second pregnancy,

such as the impact of a second pregnancy on the willingness of the wider family to maintain financial support, or support in relation to ongoing childcare.

3.2.9 Financial and Employment Difficulties

In the quantitative study of Crittenden et al. (2009), the socio-demographic of American young mothers who experienced RP was explored. In this study, it was found that approximately 44% came from households whose family was living below the subsistence level for a family of that size. Moreover, nearly all participants were unemployed (92.4%).

Reddy et al. (2017) explored interpretations of motherhood among American adolescents who had experienced rapid repeat births. They interviewed 19 young mothers from the home visiting programme, Healthy Families Massachusetts. Regarding financial and employment difficulties, young mothers highlighted the consequences of lack of resources and social support; some reported that they experienced homelessness during their pregnancies. In Reddy et al.'s (2017: 709) study, one mother explained her hard experiences and lack of social support after having a second pregnancy. The mother said that *"with her second pregnancy, she was kicked out of her foster home, then her boyfriend moved away without telling her".* She found herself *"running on nothing — on her own with two children".* The need for social support was stated by other repeat adolescent mothers. In the study of Hudgins et al. (2014), they evaluated Georgia's Second Chance Home Network campaign that provides housing and support to parenting teenagers in the United States. This study found that providing social support for young parents can increase their employment, education, and economic stability. Moreover, it can lower the risk of RP before the age of 20 in these young parents.

In a qualitative study, Herrman (2006: 247) examined the impact of childrearing on the financial status of African American young mothers and their families. Some participants referred to social deprivation and money worries as a crucial concern in their lives, as in *"We always had to struggle…we were never first class."* The mothers also discussed a lack of financial resources and the need for more money to support their children.

In the literature, it was commonly found that cash provision was the key concern in the social support programmes in several countries; money was needed to help young mothers and their children meet basic needs. However, these cash transfer programmes may impact further on repeat adolescent mothers. Rosenberg et al. (2015) felt that these

programmes might increase support incrementally as the number of children increased. The study argued that this condition can create perverse incentives for women to have more children in order to receive a larger monthly payment. Using a cohort study to examine the relationship between the Child Support Grant (CSG) and second pregnancy among rural South African women, Rosenberg et al. (2015) found that receipt of the CSG after the birth of the first child appeared to be protective against a second pregnancy. Additionally, mothers who were CSG recipients had a significantly longer months' delay in RP than those who were non-recipients. Moreover, the study showed that young mothers who received the CSG lived in slightly wealthier households, were more likely to have some formal education, and were more likely to be married to their partner.

In terms of the effect of mothering on work, Herrman (2006: 247) reported that several young mothers' experience with pregnancy and having children was that it impaired their ability to work. They needed to juggle taking care of their child with work, for example, *"that's the only hard part of bein' a teen mom…when you have a job and your kids get sick…and you got to take off for that."* Furthermore, young mothers referred to the difficulties faced with employment: *"It's bad when fast food places turn your down" and "no one wants to hire you when you are young and pregnant."*

Moreover, Burke et al. (2018) studied 626 married or cohabiting women aged 15–22 with one or two previous pregnancies. They found that rural women were more likely than urban women to have had an RRP within 24 months.

To conclude, the research discussed above considers the impact of pregnancy and childrearing on financial status and the ability to work. In addition, a lack of education is identified as a barrier to well-paid employment. However, little is known about how these issues are encountered by pregnant adolescent mothers in Thai contexts.

3.2.10 Religious and Cultural Beliefs

Currently, there is limited research on attachment to religious and cultural beliefs in RP among adolescents. Therefore, Reese and Halpern (2016) studied the attachment to conventional institutions and adolescent RRP among American adolescents, using a longitudinal study to examine distal factors, including school, family, peers, public/private religious ties, and their associations with RP among adolescent mothers. Conventional institution is a social factor related to adolescent pregnancy. Social development theory was used in this study, which asserts that social bonds, consisting of

attachment to others and commitment to conventional values and behaviours, can lead to healthy development and protect against risk behaviours, including sexual risk. The attachments were focused on socio-contextual factors, including attachment to family and peers, attachment to school, and attachment to religion/the Church. This study clearly provides details of attachment to conventional institutions of family, peers, school, and religion/church -factors that associated with RP. The results of this research found that attachment to conventional institutions is related to the possibility of an RP. This was especially the case with adolescent mothers who never prayed and were never involved in church-related youth activities. Furthermore, adolescents who anticipated more peer-related social rewards from having sex were more likely to have an RP than those who did not anticipate them. Additionally, adolescent mothers who had strong relationships with their parents were less likely to report an RP. However, this study did not find a significant association between school attachment and RP, although an in-depth understanding of the influence of social connections cannot be appreciated without qualitative inquiry.

Another quantitative study by Raneri and Wiemann (2007) also looked at the social context of repeat American adolescent mothers. The study of the social ecological predictors of repeat adolescent pregnancy was conducted to examine the factors, including individual, dyad, family, peer/community, and social system, that predict RP within 24 months. They used social ecological theory to provide the research framework for understanding the effects of multiple levels of influence on individual experiences and attitudes, especially for the social context, from those that were distal factors to the individual yet important, such as individual experiences and attitudes, to those that are distal features of the social environment. The results that related to attachment to conventional institutions were found in the social system factors; adolescent mothers who experienced an RP were more likely to have limited economic resources than those who did not experience an RP.

However, although there is some research considering the impact of religious and cultural beliefs, this is limited. The importance of these issues in a Thai context needs further consideration and requires particular attention to the meanings given to these issues by Thai young mothers themselves.

3.2.11 Support from Health Care Provider

Many studies have pointed out that repeat adolescent pregnancy involves major costs to the healthcare system, which include increased costs to take care of the mother and children with adverse outcomes, whether preterm birth or low birthweight Han et al., 2014).

Regarding contraceptive intervention to prevent or reduce the rate of repeat adolescent pregnancy, various studies have provided contraception support for young mothers (Cohen et al., 2016; Han et al., 2014; Lewis, et al., 2010; Stevens-Simon et al., 2001; Tocce et al., 2012). Furthermore, various studies reported that non-LARCs were the contraceptive method that adolescents were more likely to choose (Damle et al., 2015; Thurman et al., 2007). Unfortunately, studies reported that DMPA is the only contraception available on the postpartum ward (Damle et al., 2015). Moreover, Thurman et al. (2007) found that in terms of non-LARC, DMPA significantly decreased RP rates, following oral contraceptive pills and patches respectively. Therefore, the previous studies suggest that an effective way for healthcare providers to help adolescent mothers avoid RRP is to encourage them to use LARC or DMPA in the early postpartum period (Han et al., 2014; Lewis, et al., 2010; Tocce et al., 2012).

However, although various effective contraceptive prevention programmes have been provided to adolescent mothers, RP rates still appear to be high (Lewis et al., 2010). For these results, Lewis et al. (2010) argued that there were many teenage mothers already planning an RRP as early as 6 weeks postpartum, which means that many rapid repeat adolescent pregnancies have been planned. It is obviously important for healthcare providers to directly ask about further pregnancy plans because adolescent mothers planning another pregnancy are less likely to use effective long-lasting contraception. Interestingly, Tocce et al. (2012) revealed that healthcare-provider bias is a possibility in these situations and that they might be very supportive of LARC without understanding young mothers' pregnancy planning. Additionally, Lewis et al. (2010) suggested that contraception counselling is the key to success in contraceptive planning and providing health information to benefit delaying RRP; this should thus be included in the contraceptive planning programme. Wilkie et al. (2016) asserted the poor access to LARC methods may explain the low LARC usage rates in young women. This because in the postpartum period, an implantation, IUD insertion and hormonal-based contraceptive methods like DMPA were only provided in hospitals or special clinics.

Other interventions focus on the individual components that are intended to reduce RP. For instance, Omar et al. (2008) found that a comprehensive young parent programme including prenatal and postnatal care, preventive care, reproductive health services, mental health, and acute care visits, was able to reduce RP among adolescents who participated in this programme.

Another form of effective intervention is a home visitation programme. Key et al. (2001) examined school-based programme interventions, including (a) weekly group meetings through the school year, focused on parenting, career planning, adolescent issues, and group support; (b) participation in school events, such as a school club; (c) individual case management and home visits; (d) medical care for the adolescent and infant through both a linked university-based clinic as well as the school-based clinic; and (e) service projects selected by the group that provided outreach to the community and to at-risk middle-school girls. These programmes can significantly lower rates of adolescent RP for those who attend at least 4 times during the programme.

Various studies have suggested that the most important factor for success in a prevention programme is to be fully aware of and consider individualised rationales concerning the adolescents' life course, benefits, and their choices for all those adolescent mothers in post-partum period (Pfitzner et al., 2003). Moreover, Gray et al. (2006) suggest that healthcare professionals should consider the views of the father of the baby and/or other boyfriends in relation to contraception and involve them in family planning decision-making.

Bucknall and Bick (2019) explored young mothers' experience of an RP within 24 months of giving birth to their first child in the UK. Six participants were interviewed about the influence of any advice or information received and about their experience of support from health professionals. The results revealed that adolescent mothers value the trust established through long-term relationships which have nurtured a therapeutic alliance. Building trust can make adolescents feel comfortable in discussing sexual health problems. Moreover, the study also found that the questions that were very personal made the young mother feel judged by preconceived ideas about young mothers, questioning their suitability, and looking for problems rather than offering support in managing. These make adolescent mothers more likely to absent from contact when they fall pregnant again.

In conclusion, research considered above identifies various supported services provided by healthcare professionals that need further exploration. In addition, young mothers who

experience a RP might face barriers to accessing appropriate sexual health support, including difficulties accessing contraception as well as appropriate advice and information about how to use contraceptive methods and what to do if things go wrong.

3.3 Recent Empirical Research Studies in Thailand

As I have explained in 3.1.3 to the additional papers retrieving from Thailand database that there were identified using a systematic review approach (Bettany-Saltikov and McSherry, 2016), results from this searching strategies had been already included in the PRISMA (as in figure 3.1 and 3.2). I decided to make this part separately illustrated to the Thai eligible studies included in this study. My aim is to portray this part to show the stage of knowledge and the gap of knowledge in Thailand particularly.

According to the mixed methods systematic literature review, I applied the same searching strategies and the CASP quality assessment were employed (Holly et al., 2016). Moreover, the concept of mixed research synthesis were used into this part as well as integrating qualitative and quantitative empirical research articles (Sandelowski et al., 2006). The results show there have been a limited number of empirical studies relating to Thai adolescent repeat mothers. There were only 4 recent empirical studies that have focused on RP among Thai adolescents who experienced an RP during the first systematic review in 2017, and an additional 4 articles were included after updated searching in September 2021.

To sum up, eight eligible studies were included; 1 research study on the prevalence of RP and related pregnancy outcomes, 4 research studies on factors associated with intended and unintended repeat adolescent pregnancy, and 3 qualitative studies considering the factors related to and consequences of repeat adolescent mothers and the cultural context. As show in table 3.7 below.

Table 3.7 Data extraction and quality assessment of quantitative and qualitative research were retrieved in Thailand database

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
42. Aeamsamarng et al. (2013) **Risk factors of unintended repeat pregnancy among adolescents. Journal of Public Health.** Thailand	To identify risk factors of unintended repeat pregnancies among adolescents.	234 pregnant adolescents aged 19 years and younger who had repeated pregnancies within 24 months, in the east of Thailand. 117 study group 117 control group	Case-control study, collecting data by using self-administered questionnaires.	Data were analysed using descriptive statistics, and binary logistic regression analysis	- Pregnant adolescents whose partners did not want babies were 41 times more likely to have unintended repeated pregnancies than those whose partners wanted babies -Those who inconsistently used contraception were 3 times more likely to have unintended repeat pregnancies than those consistently used	**Strengths:** - The study provided adequate details about variables and measurements using Theory of Triadic Influence: TTI of Flay and Petraitis (1994) including personal, social, and cultural variable. **Weaknesses:** - The data collection materials were mainly self-reported which might contain a recall bias.	-Father of baby -Contraception -Decision making

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
43. Arayajaru et al. (2019) **The Lived Experiences of Adolescent Mothers: Intended or Unintended Repeat Pregnancy** **Thailand**	To explore the insights of young mothers regarding their decision making toward their repeat pregnancy.	Eight participants with a repeat pregnancy	Qualitative research, using semi-structured interviews by face – to -face interviewing at participant's house.	Data were analysed using content analysis.	- The six of the young mothers indicated that their repeat pregnancies were unintended. - Contraception issue about "missed" pill was showed in common issue of young mothers with repeat pregnancy. -Lack of partners in involve in family planning.	**Strengths:** -The study provided perspective of adolescent women with RP and fits the views of the participants. **Weaknesses:** -Not enough explain why the participants were selected.	-Contraception -Father of baby

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
44. Huangthong et al. (2019) **The Factors Related to Rapid Repeat Pregnancy among Teenage Pregnant Women** Thailand	To examine the rapid repeat pregnancy rate and factors related to rapid repeat pregnancy among teenage pregnant women.	75 teenage pregnant women who has second pregnancy at recruitment and receiving services at antenatal clinic, Nopparatrajathanee Hospital, Klang Hospital, and Taksin Hospital, Bangkok	Descriptive correlational study using personal data, and perceived intensity of repeat pregnancy in teenager questionnaires.	Statistics used for data analysis included frequency, percentage, mean, standard deviation, Chi-square test, and Fisher's exact test.	- Teenage pregnant women had 62.70% of rapid repeat pregnancy rate, aged 16-19 years old -78.88% of participants planned to have second baby - Factors that related to rapid repeat pregnancy were the utilization of contraception problems, marital status, and fulfilling need to have children.	**Strengths:** The study clearly stated details about inclusion - exclusion criteria and variables using ecological perspective of McLeroy (1988) within individual factor and interpersonal factor were included to study. **Weaknesses:** - An interpersonal variable did not present to intimate partner variable and family aspect were not included because of limit dataset.	-Decision making -Contraception -Father of baby

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
45. Pancharern et al. (2020) **Factors related to the intention to repeat pregnancy among pregnant adolescents** Thailand	To determine factors related to the intention to repeat pregnancy among adolescents.	174 multiparous adolescents who attended prenatal care unit	Descriptive correlational study using questionnaires comprising the demographic data, the attitude towards repeated pregnancy, the subjective norm, the perceived behaviour efficacy in preventing repeated pregnancy, and the intention to repeat pregnancy.	Data was analysed using descriptive statistics, and the Binary Logistic Regression.	-Pregnant adolescents who had intention to repeat pregnancy mostly were the late adolescence (Mean=18.42 years), 51.72% planned to have second baby. -For those who had low family income, had contraceptive or contraceptive consistency, had a new husband, having a husband as a source of financial support. 76.70% had new partner who is the father of second baby. -Participants had a positive attitude towards pregnancy, had the subjective norm or believed that their close relatives wanted them to have repeat pregnancy had related to the intention to repeat pregnancy.	**Strengths:** -The study provided details of sample within multiparous pregnancy and included data of their partner, and perception of subjective norm. **Weaknesses:** - The subjective norm might could not provide enough details without qualitative aspects.	-Cultural belief -Subjective norm -Contraception

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
46. Pengpuang et al. (2021) **Repeated Adolescent Pregnancies on Hmomg Ethnic Groups in Thoeng District, Chiangrai, Thailand** Thailand	To describe the factors effect on repeated pregnancies among Hmong ethnic adolescents in Thoeng district, Chiang Rai	Eighteen Hmong ethnic adolescents who are recurrent pregnancy or have a history of having second pregnancy.	Naturalistic qualitative research study using in-depth interviews and non-participant observation were used for collecting data 18 participants who intended to have repeated pregnancy.	Data were analysed by using thematic analysis.	-Participants who intended to have repeated pregnant adolescents, the average age was 17 years. -The gap of repeated pregnancy from the first time is about 1-2 years. - Positive attitude towards repeated pregnancy was accepted due to early marriages are common in Hmong people, resulting in pregnancy at an early age. - Childbearing was a duty for the needs of the family and their dependence on the husband, such as economic status.	**Strengths:** -The study provided details of using Process-Person-Context-Time (PPCT) model of Bronfenbrenner's (2005) framework to describe factors on RP context. **Weaknesses:** -Only focus on ethnic minority group who intended to have RP adolescents some unintended may difference perception. This might difference in majority Thai people.	-Cultural belief

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
47. Pungbangkadee and Ratinthorn (2014) **Factors and Consequences of Repeat Pregnancy among Teenagers: A Case Study in Bangkok Metropolis.** Thailand	To explore the factors and consequences of repeat pregnancy among urban teenagers.	30 participants who were teenagers with repeat pregnancy and having previous child aged less than 24 months	Qualitative study, and data were collected through in-depth interviews and observation during home visit	Data were analysed by modified content analysis of Spradley's method.	-Lack of awareness of repeat pregnancy; not receiving effective contraceptive service were reported. -Consequences of repeat pregnancy concluded into 3 categories 1) increased financial burden; 2) could not fully perform maternal role; and 3) lack of motivation in continuing education.	**Strengths:** -The perspective of adolescent women with repeat pregnancy the representation of data fits the views of the participants studied. -Discussed about data were analysed by modified Spradley's method **Weaknesses:** - Not clearly stated particularly on the methods chosen.	-Contraception - Education

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
48. Talungchit et al. (2017) **Prevalence of Repeat Pregnancy Including Pregnancy Outcome of Teenage Women.** Thailand	To determine the prevalence and possible factors of RP pregnancy including their pregnancy outcomes compared to primi-gravida.	1,684 medical records of all adolescent pregnancies either delivered or which received termination of pregnancy, at Siriraj hospital, Bangkok	Cross – sectional study using medical data records including teenage pregnancy aged under 20 years old at the date of delivery using self-administered questionnaires.	Data were double entered into Epidata and transferred for statistical analysis using R program (version 3.0.0). Comparison of patient characteristics and pregnancy outcomes were analysed using the Wilcoxon rank-sum test for continuous and the Pearson's Chi-square test or the Fisher's exact test for categorical variables.	-Pregnancy outcomes among primi-and multi-gravida teenagers were not significantly different, long-term outcomes of both teenage. - Multigravida were significantly diagnosed as anaemia before delivery. - Primigravida were more likely to experience adverse outcomes than those who RP	**Strengths:** - The study well identified material and method to collecting data and including details of the outcome variables. **Weaknesses:** - Dataset provided only demographic and contraception did not provide related variables to RP i.e., partner variable, family related attitude.	-Pregnancy outcome

Authors, Date of publication, title, location	Study aim(s)	Participants characteristics	Method of data collection	Data analysis	Main findings	Critical Appraisal: Strengths and Weaknesses	Themes identified in the synthesis
49.Wisarutkasempong and Muangpin (2015) **Factors Related to the Intention to Repeat Pregnancy among Pregnant Adolescents.** Thailand	To determine factors related to the intention to repeat pregnancy among adolescents	70 repeat pregnancy adolescents who attended prenatal care unit at Maharat Nakhon Ratchasima hospital in the north-east of Thailand.	Prospective cohort study collecting data by using questionnaires comprising the demographic data, the attitude towards repeated pregnancy, the subjective norm, the perceived behaviour efficacy in preventing repeated pregnancy, and the intention to repeat pregnancy.	Data was analysed using descriptive statistics, and the Binary Logistic Regression with SPSS.	- Among 52 participants who intend to have repeated pregnant adolescents, the average age was 18.09 years. The 87% of pregnant adolescents had second pregnancy. - Those who have older husbands and no contraceptive or contraceptive inconsistency, had positive attitude towards pregnancy, had the subjective norm or believed that their close relatives wanted them to have repeat pregnancy.	**Strengths:** - The study provided details of participants selection criteria and provided clearly stated in context of family cultural and subjective norm. **Weaknesses:** - The study might could not provide enough details in the subjective norm without qualitative aspect.	-Father of baby -Decision making -Religious and cultural belief -Subjective norm

Note: This table included eight Thai eligible articles; 5 quantitative research, and 3 qualitative research.

3.3.1 Pregnancy Prevalence and Outcomes of Repeat Pregnancy among Thai Adolescents

Talungchit et al. (2017) studied 1,684 medical records of adolescent pregnancies which were either delivered or terminated at Siriraj hospital, Bangkok. The prevalence of repeat adolescent pregnancy was 20%. Regarding the pregnancy outcome, maternal outcomes, including abnormal pregnancy, delivery modes, gestational age, and preterm births in first or second adolescent pregnancies, were not significantly different between first and second pregnancies. In terms of maternal complications, including postpartum haemorrhaging and pregnancy-induced hypertension between first and second adolescent pregnancies, these were not significantly different. Lastly, regarding the foetal outcomes, including foetal birth weight and Apgar scores, foetal intensive illnesses were not significantly different between the first and second adolescent pregnancy groups. Although the statistics show similarities between pregnancy and baby outcomes, first-time mothers were reported to be more likely to experience adverse outcomes than those who were multiparous adolescent mothers.

3.3.2 Factors Associated with Repeat Adolescent Pregnancy

The study of Talungchit et al. (2017) also reported several important factors associated with RP among adolescents and that the partner ages of multiparous adolescent mothers were significantly higher than those who were primiparous. Similarly, Wisarutkasempong and Muangpin (2015) explored the age of the partner and found it to be significantly associated with the intention to repeat adolescent pregnancy especially if the age of the partner for those young mothers who intended to have an RP was higher than 20 years old.

In the quantitative case control study of Aeamsamarng et al. (2013), the risk factors for unintended RP among adolescents was examined. Their sample comprised 234 pregnant adolescents aged under 20 years and who had an RP within 2 years in the east of Thailand. The sample was divided into two groups: 117 of those with unintended pregnancies were the study group, and those who had an intended one were the control group. The study found that pregnant adolescents whose partners did not want babies were 4.1 times more likely to have unintended RPs than those whose partners wanted babies. Other results

revealed that those who inconsistently used contraception were 3 times more likely to have unintended RPs than those who consistently used contraception.

In a descriptive study, Wisarutkasempong and Muangpin (2015) explored the relationships between selected factors and intention regarding RP among pregnant adolescents. The sample consisted of 70 RP adolescents in the north-east of Thailand. Demographic data, including the attitude towards repeat adolescent pregnancy, the subjective norm towards repeat adolescent pregnancy, the perceived behaviour efficacy in preventing repeat adolescent pregnancy, and the intention towards RP were explored by using questionnaires to gather data. The study found that 74.3% of them intended to have an RP, while 25.7% did not. Moreover, the attitude towards repeated adolescent pregnancy and the subjective norm were significantly associated with the intention to repeat adolescent pregnancy. This is consistent with Huangthong et al. (2019), who examined factors related to RRP among teenage pregnant women. The results revealed that those with RP planned to conceive the subsequent pregnancy and their family had the traditional belief that they are mature enough to get pregnant and fulfil their need to have children with 78.88% of participants planning to have a second baby. This is like the study of Pancharern et al. (2020), who argued that the subjective norm and positive attitude towards RP were influential factors. The study highlighted those participants believed that their close relatives wanted them to have an RP.

With the respect to contraceptive use, the empirical studies found that before pregnancy both groups commonly used oral contraceptive pills. However, long-acting reversible contraception, like an IUD or subdermal implantations, were not mentioned in either group (Talungchit et al., 2017). Moreover, the consistency of contraception before pregnancy was significantly associated with the intention to repeat adolescent pregnancy (Wisarutkasempong and Muangpin, 2015).

In terms of socioeconomic factors, with respect to the educational factor, primiparous mothers had a higher student status than multiparous mothers (Talungchit et al., 2017). This is consistent with the study of Wisarutkasempong and Muangpin (2015), who asserted that the education and occupation factors were also significantly related with the intention to repeat adolescent pregnancy. Pancharern et al. (2020) also highlighted that family income and young mothers’ financial support were positive influences on the intention regarding RP among adolescent mothers.

Furthermore, the study of Aeamsamarng et al. (2013) found that adolescent mothers who reported having friends become pregnant were 2 times more likely to have unintended RPs than those who did not. However, the study found that factors concerning education, maternal age, self-esteem, attitude towards pregnancy, attitude towards pregnancy prevention, and marital status were not significantly different between mothers who intended or did not intend to have a repeat adolescent pregnancy.

The qualitative study of Pungbangkadee and Ratinthorn (2014) aimed to explore the factors and consequences of RP among urban adolescents in Thailand. Using a qualitative study, they interviewed 30 repeat adolescent mothers having a live child and living in the Bangkok urban area. Demographic data of the participants reported that 26 participants were married, while half lived in a separated-parent family. Twenty-three cohabitated with their partner and were living in the same house with a maternal or paternal parent. All of them referred to this pregnancy as unplanned. Furthermore, inconsistent contraceptive use was found to be common among these participants. The main results showed the factors involved and the consequences of RP. Regarding the factors involved, these were found to be lack of pregnancy awareness, and experience with adverse contraceptive complications, such as having abnormal bleeding from DMPA, then changing to oral conceptive pills but forgetting to take them regularly. A lack of contraceptive information and a lack of being given effective information by healthcare providers were also reported. Moreover, the findings pointed out the lack of contraceptive choices; some health services were not providing long-acting contraception, as only DMPA and pills were provided.

Regarding the consequences of repeat adolescent pregnancy, it was found that young mothers referred to the increased burden of cost of living. Adolescent mothers mentioned that it was hard to deal with rearing two children and that having more than one child is harder. As a consequence, young mothers reported a lack of motivation with respect to continuing their education (Pungbangkadee and Ratinthorn, 2014).

The father of baby is an important factor in relation to adolescent repeat pregnancy; Huangthong, et al. (2019) found that 57.33% couples stay together, while 42.67% are couples where a new partner is the father of the second baby. Their partner also influence to contraceptive use and show the lack of responsivity to contraception among partners as found in the qualitative research (Pungbangkadee and Ratinthorn, 2014). This is similar to the study of Arayajaru et al. (2019), who conducted qualitative research using semi-

structured interviews among adolescent mothers who having subsequent pregnancy in 2015. Eight participants in this study reported that their RPs were unintentional. An important finding in this study was that although the young mothers did not plan to get pregnant, they likewise did not intend to prevent having a second child. Additionally, a lack of ownership regarding responsibility for contraception was found among their partners in this study.

Pengpuang et al. (2021) looked at RP among eighteen Hmong ethnic adolescents in Thoeng district, Chiangrai, Thailand. This study explored the personal factors and cultural context of adolescent mothers. The results reported that a positive attitude towards RP was accepted due to early marriages being common in Hmong people, thus resulting in pregnancy at an early age. Moreover, the family is the external support that directly affects them. It affects the social status of Hmong women, which changes after marriage when they depend on their husband, for example, with respect to their economic status. Additionally, childbearing was a duty for the needs of the family.

In summary, although this study explored the experiences of repeat Thai adolescent pregnancy, the methodology only focused on identifying the factors and consequences of RP among urban adolescents. Only two factors were studied: firstly, the unmet need for family planning in relation to RP and secondly, the ineffective contraception used. Additionally, this study focused on urban adolescents in the Bangkok metropolis. This might be different from other areas and other social contexts, which might involve different healthcare services. Moreover, the study highlighted the cultural context, which has a potential influence on RP in people who live in the same culture. This also pointed to the fact that healthcare and policy support should be aware and more understanding in their cultural context.

3.4 Summary

The literature review in this chapter outlines what is currently known about the related influential factors and experiences that surround the circumstances of repeat adolescent mothers globally and in Thailand, in particular. Whether these negative and positive experiences are shown, the literature nonetheless has shown that adolescents' social context and the support they receive are important. Any experiences of adolescent mothers in developing countries, such as Thailand, might be different and need to be explored.

The majority of the studies in this systematic review used a quantitative methodology. These empirical quantitative studies provide the current state of knowledge about repeat adolescent pregnancy. For the qualitative studies, there are only a limited number that used a qualitative approach found within this systematic review of the repeat adolescent pregnancy perspective.

Thai research is relatively limited, and knowledge is still lacking as regards several significant aspects of the experiences of Thai repeat adolescent mothers. As this chapter shows, 8 empirical studies have been conducted in Thailand. Indeed, only five quantitative studies have focused on prevalence, influential factors, and pregnancy health outcome. Three qualitative studies focused on the factors and consequences for repeat adolescent mothers focused on identifying the factors and consequences of RP among urban adolescents and the cultural context.

Overall, the systematic review shades an ambiguity picture of repeat pregnancy among adolescent mothers. Moreover, Thai research shows relatively limited, and knowledge is still lacking understanding related aspects of the experiences of Thai repeat adolescent mothers who have at least one living child. Therefore, this research study endeavours to answer the question about what the experiences of repeat pregnancy among adolescent mothers in Thailand having at least one living child are.

Therefore, this thesis aims to explore and investigate the experiences of being a repeat pregnancy among Thai adolescent mothers with the research questions that what are the experiences of repeat pregnancy among adolescent mothers in Thailand who have at least one living child? How do Thai adolescent mothers experience having a repeat pregnancy? How do the live contexts influence repeat pregnancy among adolescent mothers?

Next, I provide the research methodology that set out to answer this question.

Chapter 4 Research Methodology

4.0 Introduction

This chapter outlines the research methodology used in studying the experiences among Thai repeat adolescent mothers, in particular, the justification for the research approaches, the philosophical assumptions, and methodological approaches. Moreover, this chapter also presents Bronfenbrenner's ecological theory framework, which underpins this study.

4.1 Justification of the Research Methodology Approaches

As presented in chapter 3, there is limited knowledge about the experience of repeat teenage pregnancy in Thailand. The initial focus of this study, therefore, is to explore the experiences and circumstances of repeat adolescent pregnancy among Thai adolescent mothers, that is, adolescent women who have a repeat pregnancy and live with their child.

I began developing an understanding of the nature of the research methodology by conceiving the "essence" of my research, following Mason's (2017) suggestion that the researcher be conscious of their "position" and what the research is about. I then considered and strove to answer the following questions:

- What is the nature of the phenomena, entities, or social reality that I wish to investigate? (My ontological perspective)
- What might represent knowledge or evidence of entities or social reality that I wish to investigate? (My epistemological perspective)

These questions will portray the philosophical assumptions in my thesis, as illustrated in the next section.

4.2 Understanding Philosophical Assumptions

This section begins with an overview of understanding the philosophical assumptions of the research. Philosophy means the use of abstract ideas and beliefs that inform our research (Creswell, 2013; Creswell and Poth, 2017). Thus, in this section I explain my philosophical assumptions, including the *ontological, epistemological, axiological, and methodological assumptions* of my thesis.

The *ontological* assumption relates to the nature of reality and its characteristics. It is about the fundamental way and intellectual effort in identifying the research topic. This involves the "nature" and "essence" of things in the social world. Thus, the ontological perspective of research can be seen as a position which should be established and understood as its own view of the research (Mason, 2017). Therefore, my ontological position in this study is to understand the experiences of repeat adolescent pregnancy mothers as seen from their perspective and their context.

The *epistemological* assumption is about knowledge and evidence of things in the social world. The epistemological position of the research concerns how social phenomena can be known and how knowledge can be demonstrated (Mason, 2017). Thus, my epistemological position in this study is that the adolescent mothers who have a second pregnancy are knowledgeable about themselves and their own lives, where and how they live in their surroundings. Their experiences are narrated from their perspective.

The *axiological* assumption is the idea of 'what is the role of values in the research?' All researchers bring values to a study, but researchers make their values known in a study (Creswell and Poth, 2017). In this study, value comes from what participants voice and the interpretation of data from their perspective. I have given primacy to these participant perspectives at every stage of the research process.

The *methodological* assumptions in this study flow from, and are grounded in, the ontological, epistemological, and axiological positions, and I was conscious that the methodological approach should not contradict these other assumptions. With this in mind I rejected a quantitative approach as it is framed in terms of using numbers rather than words as an outcome in research and this approach would not have facilitated the foregrounding of the adolescent mothers voices (Creswell and Creswell, 2018). I also rejected a mixed methods approach because it is based on a pragmatic worldview, using both qualitative and quantitative approaches to understand problems and find the solutions (Creswell and Creswell, 2018). Again, an approach that would not have prioritised the adolescent mothers' narratives. In contrast, qualitative research is an approach for exploring and understanding the meaning individuals or groups use to describe their own perspective on a social or specific phenomenon (Creswell and Creswell, 2018). Therefore, the philosophical assumptions underpinning my thesis are best matched to a qualitative research methodology as this approach does specifically spotlight the views of the young women themselves (Mason, 2017).

Hence, the logic the qualitative researcher follows is inductive, from the ground up, rather than handed down entirely from a theory or from the perspective of the inquirer. Sometimes the research questions change in the middle of the study to better reflect the types of questions needed to understand the research problem. In response, the data collection methods are often flexible and "*The more open- ended the questioning, the better, as the researcher listens carefully to what people say or do in their life setting"* (Creswell and Poth, 2017: 55). Therefore, from these philosophical beliefs, *qualitative research* theory is appropriate to use as the research methodology in this study (Creswell, 2013). To understand the world in which the adolescent mothers with repeat pregnancy live, I situate *social constructivism*, which is often described as *interpretivism*, for use as the theoretical lens in this study. Social constructivism itself is focused on the subjective meanings of individual experiences. These meanings are varied and multiple and rely on participants' views of the situation and the interaction between the individual and the context (Creswell, 2013).

In the next section, I further justify the use of a qualitative research methodology.

4.3 Justification for the Qualitative Research Methodology

In this section, I endeavour to consider and explain the justification in terms of differences in qualitative research methodology and approaches. Moreover, I have also included my rationale for adopting or not adopting some other approaches. There is a range of qualitative research strategies. Therefore, I considered a number of potential approaches for the enquiry. Firstly, I shall provide the answers to the key questions considering a variety of approaches, following Mason (2017): How do qualitative approaches conceptualise and use sources and methods? How useful is their approach for my project? What do I want to use from them?

Braun and Clarke (2013: 32) define *methodology* as being broad and referring to the framework within which the research is conducted: *"Although each qualitative methodology is unique, they share many similar features, like siblings in a big family. And like siblings, some methodologies are more similar than others, and get along better with other methodologies (they share similar core assumptions)"*.

I considered the various qualitative methodologies and found that they shared similar features. Although, there are some other qualitative approaches that I considered, they were not adopted. First, after I had conducted the systematic literature review (in chapter 3), I found that *grounded theory research* could have been a relevant research approach, but I did not plan to use it because the research objectives themselves need more understanding and exploration of what life is like rather than to generate new knowledge as grounded theory research does. From a grounded research approach, Glaser and Strauss (1967) developed grounded theory to emphasise new knowledge in the form of theory. Additionally, *"grounded theory differs from other approaches to research in that it serves to explain the phenomenon being studied' and 'the strategies used in data collection and analysis result in a generation of theory that explicates a phenomenon from the perspective and in the context of those who experience it"* (Birks and Mills, 2011). Moreover, grounded theory methodology is more than just a method of data analysis; it is an entire approach to conduct field research, such as for data collection, analysis, and theory development or to provide a framework for further research (Creswell and Poth, 2017).

Another approach is *phenomenological research*, which is a relevant methodology, but it has not been used in this study. This is because a phenomenological study focuses on *"the common meaning for several individuals of their lived experiences of a concept or phenomenon about what they experienced and how they experienced it"* (Creswell, 2013: 76) rather than explaining a phenomenon from the perspective and the process or interaction in the context of those who experience it (Birks and Mills, 2011).

I also considered *ethnography research*, but again it has not been used as the methodology in this study. The reasons for not adopting ethnography as the research methodology is that firstly, *"ethnography is the work of describing a culture"* and the main aim of ethnography is *"to understand another way of life from a native point of view"* (Spradley, 1980: 3). Secondly, ethnography research tends to be grounded in a commitment to first-hand experience and exploration of particular social or cultural settings on the basis of (though not exclusively by) participant observation (Mason, 2017). I could have considered ethnographic research as my research methodology, but I decided not to do this because my thesis objective was to explore more the insight of adolescent mothers' experiences related to having a second pregnancy at a young age from their perspective and how individual participants interact with their social context. Furthermore, the use of participant observation is an essential method in ethnographic methods as data generation

(Atkinson et al., 2001), but in this study, I was examining the experiences of an adolescent mother having a second pregnancy from her perspective. Thus, observation may not have been appropriate to my study.

On the basis of these points, ethnographic research has not been used, but I kept the idea of an ethnographic research to mind. I did, however, consider the advantages of ethnographic research in terms of studying people and their contexts. Heyl (2001: 370) points out the *"changing conceptions of ethnographic interviewing'* that *'the theory and practice of ethnography have been scrutinized in the international debate during the 1980s over qualitative methods and methodology, alongside the broader debates over epistemology and the crisis of authority and representation in most humanities and social sciences"*. The literature focusing specifically on the implications of these debates for ethnographic interviewing have focused specifically on conducting interviews with an awareness of the postmodern and feminist critiques in anthropology and sociology (Briggs, 1986; Kvale, 1996). Furthermore, they recognise that what the interviewees in each study choose to share with the researchers reflects conditions in their relationship and the interview situation. Central to this process is how interviewees reconstruct events or aspects of social experience, as well as how interviewers make their own sense of what has been said (Heyl, 2001). At the beginning of this chapter, I made clear the philosophical assumptions underpinning this study, including the values, or axiological assumptions, where I highlighted the importance this study places on valuing the voice of participants and their perspectives in interpretation of the data. This perspective aligns closely with a feminist approach or methodology, where the views and experiences of the participants, or 'the researched', particularly those who may be vulnerable, or on the 'margins' of society, are prioritised over those of the researcher (Reinhertz and Davidman, 1992).

Feminist methodologies have their origins in feminist theory which focusses on the gender role, not only on women per se, but on how gender relations structure family dynamics and interactions with other social institutions (Allen et al, 2013). Feminist theory more broadly, highlights the unequal power processes underpinning oppression and injustice in society (Alvesson and Sköldberg, 2017). I have taken cognisance of this in the interpretation and discussion of the findings in this study.

Feminist research methodologies seek to address the unequal power relations which underpin traditional research methods, where the 'researcher' and the 'researched' are in

an unequal relationship and where power rests with the researcher (Holland and Ramazanoğlu, 2002). While I have not specifically referred to the empowering approach I have used in this research as a feminist methodology, it is in essence one. I have been caring and respectful of the young women participants at every level of their engagement with the study: while designing the study, on approaching the participants, during recruitment, throughout data collection, data analysis and interpretation, and in writing up the research. I have given primacy to the young women participants' accounts, and at every step of the research, reflected on my role in shaping each step along the research process (Ramazanoğlu and Holland, 2003).

After considerable deliberation, I decided to adopt a qualitative research strategy with a "*constructionist/interpretivist approach",* which appeared appropriate and flexible enough to generate knowledge in this study. Whether it is called *interpretive research* or *qualitative research*, a core belief of this paradigm is that the reality we know is *socially constructed*. Researchers therefore have access only to a socially constructed reality (Willis, 2007). *Social constructivism* is a belief that *"multiple realities are constructed through our lived experiences and interaction with others"* (Creswell and Poth, 2017). According to Mason (2002: 56), *"interpretivist approaches, are, of course, possible and common for researchers to conduct interpretivist ethnographies. What is distinctive about interpretive approaches, however, is that they see people, and their interpretations, perceptions, meaning, and understandings, as the primary data sources*". Interpretivism does not have to rely on "total immersion in a setting" and can therefore happily support a study which uses interview methods, for example, where the aim is to explore people's individual and collective understanding, reasoning processes, social norms, and so on. In this study, I explored experiences of adolescent mothers with repeat pregnancies from their perspective and contexts.

In the next section I justify the appropriate methods used in the thesis.

4.4 Choosing Appropriate Methods

I have explained my understanding of qualitative research methodology underpinning this study in the above section. In this section, I endeavour to explain my choice of appropriate methods from my point of view. *Method* refers to a tool or technique for collecting or analysing data (Braun and Clarke, 2013: 31). Silverman (2005: 109) states that methods should reflect an *"overall research strategy"* as methodology shapes which methods are

used and how each method is used. He also states that in choosing a method, *"There are no right or wrong methods. There are only methods that are appropriate to your research topic and the model with which you are working"* (Silverman, 2005:112). Methods should be appropriate to the issue and should be open enough to allow an understanding of a process or relation (Flick, 2018). Flick (2018) suggests that a researcher should consider the rationale for the selection of appropriate methods to use in data collection, for example, if there is an explicit interest in "openness to the interviewee's subjective view", "openness to the observed person's subjective view" or "openness to the process of actions and interactions", and "openness to each text", a *semi-structured interview* should be selected rather than an ethnographic or narrative one because these methods tend to be interested in exploring a field and issues.

In this study, the data collection methods focused on adolescent women who have repeated pregnancies and also live with their child. This study aims to explore the experiences and circumstances of repeat adolescent pregnancy among Thai adolescent mothers from their perspective. The main method of data collection consisted of, *in-depth semi structured interviews, as well as notetaking (fieldnotes/ reflexive diary)* were employed because they serve as a set of documentary data which later are analysed, interpreted, and used in the writing-up process (Mason, 2017). Moreover, giving "voice" to the young women' experiences using what they said in their own words can be presented as respectful to their perspective and validating their point of view.

Regarding data collection methods, I considered this approach, but for the reasons to explore the experience and decided that the strength lay in reporting on what the young women said about their own lives in their own words. The study consisted of one to one semi-structured interviews, which for gathering data about participant's experiences and the fieldnotes were used to see their experience, emotion, perception, accounts memories, feelings and interaction between participants and their context (Holloway and Galvin, 2017). These approaches were suitable for understanding a person's point of view with attempts at describing the world in which they live in their own words (Flick, 2018). Moreover, these methods can also portray the participants' experiences, the *'thick description'* of context that involves describing a location and the people within it, giving a visual picture of the setting, as well as verbatim narratives of individual accounts of their perceptions and ideas in context (Holloway and Galvin, 2017: 7).

4.5 Theoretical Underpinning

Initially, this study focused on the experiences of repeated pregnancy among adolescent mothers and their contexts. I used a theoretical framework to understand and conceptualise the relationship of Thai adolescent mothers and their related contexts. This reminded me of the literature review chapter and that there were many related theories in terms of studying adolescent pregnancy, such as the socio-ecological model of Bronfenbrenner (1979) in the qualitative study of Raneri and Wiemann (2007), who studied the "social ecological predictors of repeat adolescent pregnancy" and using social ecological theory as a guide in terms of construction the levels of influence factors in the study. Additionally, Dallas (2013), also used Bronfenbrenner's ecological approach to explain the dynamic and mutually accommodating interactions between a human and the changing properties of the immediate settings within which the human lives throughout his or her life course. Dallas (2013) asserted that this approach is particularly suitable for studying adolescent parents, who are experiencing developmental and role transitions, while coping with challenges in the larger contexts that influence their immediate settings, for example, age, race, and socioeconomic status. The immediate setting of these adolescent parents includes the parents of the adolescent parents, the grandparents of their babies. Moreover, Arai (2009) studied what a difference a decade makes: rethinking teenage pregnancy as a problem; using a qualitative approach, she interviewed 15 mothers who gave birth before age 21 in the UK to explore various aspects of the women's lives and focused on ecological perspectives that position individuals as being influenced by factors operating at different social levels, with emphases on personal, family, neighbourhood, wider cultural influences, using Bronfenbrenner (1979). At the individual level, where reproductive behaviour may be linked to personal histories in an important and profound way, findings are organised under headings.

Hence, in order to understand experiences of repeated pregnancy among Thai adolescent mothers, I applied ecological theory to conceptualise the interaction between adolescent mothers and their contexts. Bronfenbrenner (1994: 37) defined an exposition of Bronfenbrenner's theoretical system, which is also used as a framework for illustrating representative research findings. Therefore, I used the ecological model as a way to organise associated factors from the findings and the interaction level, including the microsystem, the mesosystem (the exosystem context is discussed in the background chapter), the macrosystem, and the chronosystem to this thesis (Corcoran, 1999; Onwuegbuzie et al., 2013; Bronfenbrenner, 1979, 1986, 1994). Next, I review

Bronfenbrenner's ecological theory about the theory development and central aspect of the theory.

4.5.1 Bronfenbrenner's Ecological Theory

Urie Bronfenbrenner's theory of human development underwent considerable changes from the time it was first proposed in the 1970s until Bronfenbrenner's death in 2005. Bronfenbrenner described it as a theory of human development (Rosa and Tudge, 2013; Bronfenbrenner, 1979, 1986, 1994, 2005).

The evolution of Bronfenbrenner's theory has been developed and revised by Bronfenbrenner himself and many other scholars. His ecological model now can be seen as being in three phases of development (Rosa and Tudge, 2013). In the earliest inception of *the first phase*, Bronfenbrenner's ecological model (1979) gave prominence of place to the environment and divided an individual's environment into nested and interrelated systems: the microsystem, mesosystem, macrosystem, and exosystem. (Ashiabi and O'Neal, 2015). Bronfenbrenner named his emerging theory either an ecological approach to human development or an ecological model of human development (1979, 1986, 1994), referring to it on occasion as a science or a theoretical perspective (Bronfenbrenner, 1979; (Rosa and Tudge, 2013). Interestingly, the roots of the theory can be seen as far back as a chapter published in the 1960s, in which Bronfenbrenner showed that adolescents' responsibility and leadership varied according to the parent–adolescent relationship, gender of the child, and the family's social-class background. Bronfenbrenner's publications during this period were characterised by analysis and discussion of relevant research conducted by others in psychology and human development, most of which he used to demonstrate their methodological limitations (Rosa and Tudge, 2013). The ecological environment is conceived as a set of nested structures, each inside the other like a set of Russian dolls, moving from the innermost level to the outside (Bronfenbrenner, 1994). These structures are defined as described below.

4.5.1.1 **Microsystem**

Formally, Bronfenbrenner (1979: 22) defined a microsystem as follows: *"a microsystem is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics."* In Bronfenbrenner (1994: 39), *"a microsystem is a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to- ace*

setting with particular physical, social, and symbolic features that invite, permit, or inhibit engagement in sustained, progressively more complex interaction with, and activity in, the immediate environment." Microsystems include any immediate relationships or organisations the child interacts with, such as, the family, peer group, or school setting (Ashiabi and O'Neal, 2015). The microsystem, which represents Level 1, involves the immediate environment with which the child/adolescent closely interacts, such as the classroom, playground, recreation centre, home, friend's home, neighbourhoods, and religious institution (Onwuegbuzie et al., 2013).

Corcoran (2000) used Bronfenbrenner's (1979) ecological systems theory as the organising framework for research on teenage sexual activity and adolescent pregnancy. Corcoran also reviewed associated factors examined by Bronfenbrenner's theory at the microsystem level or individual level, which included psychological variables, particularly self-esteem and sexual activity (Corcoran, 2000; Corcoran et al., 2000).

Raneri and Wiemann (2007) studied the "social ecological predictors of repeat adolescent pregnancy" and used social ecological theory as a guide in terms of constructing the levels of influential factors for microsystem variables in a study focused on self-esteem, sexual activity, and contraceptive use.

4.5.1.2 **Mesosystem**

The mesosystem describes interrelationships between different microsystems. For example, parental involvement in children's schooling can have a positive influence on children's academic competence through children valuing academics (Ashiabi and O'Neal, 2015). The mesosystem, which represents Level 2, was defined by Bronfenbrenner (1979: 25) as *"the interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and neighbourhood peer group: For an adult, among family, work, and social life)"*. In other words, the mesosystem refers to relations among microsystems or connections among contexts such as the relationship between family experiences and school experiences, between school experiences and neighbourhood experiences, and between family experiences and peer experiences. For instance, children who are bullied at school (school experiences) might withdraw from their parents (family experiences) at home (Onwuegbuzie et al., 2013).

Raneri and Wiemann (2007) studied the "social ecological predictors of repeat adolescent pregnancy" and used social ecological theory as a guide in terms of constructing the levels of influential factors for mesosystem-level factors in a study on peers, school attendance, and dropping out of school.

Corcoran (2000) studied the mesosystem level, which is made up of the settings with which the individual interacts directly (Bronfenbrenner, 1979). The mesosystem factors in this study were focused on education, family structure, family functioning, and the influence of the peer group.

4.5.1.3 **Exosystem**

The exosystem level has an indirect effect on an individual's developmental outcome and is the "*setting in which the individual does not actively participate"*. Examples of the exosystem include the parents' workplace. Events happening at the workplace can affect children through how parents interact with their children (Ashiabi and O'Neal, 2015). The exosystem, which represents Level 3, refers to *"one or more settings that do not involve the developing person as an active participant, but in which events occur that affect or are affected by what happens in the setting containing the developing person"* (Bronfenbrenner, 1979: 25). That is, the exosystem characterises links between a social setting in which the person does not have an active role and the person's immediate context. For example, a person's experience at home might be influenced by his/her spouse's/partner's experiences at work; a newborn baby might reduce the numbers of hours slept by the mother's/father's spouse/partner, which, in turn, might affect the productivity levels of the spouse/partner at work, which, in turn, might affect the relationship between the spouse/partner and his/her supervisor and/or colleagues, which, in turn, might affect the relationship between the couple at home (Onwuegbuzie et al., 2013).

4.5.1.4 Macrosystem

Bronfenbrenner's final level is the macrosystem. It involves the society, includes cultural values, and describes the economic conditions under which families live (Bronfenbrenner, 1979), along with material resources and opportunity structures (Bronfenbrenner, 1994). The interrelations among these nested environments allow for examination of how patterns of interactions within these systems influence each other and affect individuals' developmental outcomes (Ashiabi and O'Neal, 2015; Bronfenbrenner, 1979). The macrosystem, which represents Level 4, according to Bronfenbrenner (1979: 26), refers

to *"consistencies in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying such inconsistencies."* Alternatively stated, the macrosystem, which is the highest level or outer level, involves the larger cultural context (e.g. society, community) surrounding the person, which includes "*societal belief systems, cultural norms, ideologies, policies, or laws that indirectly influence the person"*. Members of a cultural group share a common identity, heritage, and values. Macrosystems are developed temporally, meaning that they evolve over time (Onwuegbuzie et al., 2013).

Corcoran (2000) studied the macrosystem level, which is made up of the social context level. For this level, socioeconomic status (SES) has been a frequent source of study in the area of sexual activity. Moreover, subcultural and cultural beliefs are also assessed in macrosystem.

In the *second phase (1980–1993)*, Bronfenbrenner's main goal was to show the ways in which the environment was conceptualised, either theoretically or empirically, in contemporary research in human development and to deal with a gap identified in his Phase 1 writings, the lack of any explanation for the role played by personal characteristics in the course of development. These objectives were achieved in various papers (Bronfenbrenner, 1986; Bronfenbrenner and Crouter, 1983), in which he not only identified the different paradigms existing in the literature but also presented his own ecological paradigm (Rosa and Tudge, 2013). As Bronfenbrenner himself affirmed, *"from the scientist's perspective, perhaps the most important function of a review of existing knowledge in a particular area is to identify promising directions for future investigation"* (1986: 734).

However, he also identified a need to reassess, extend, and even renounce (1986) some aspects of what he had written in his 1979 volume. Specifically, in addition to paying greater attention to the role played by the individual in his or her own development, he attended more to processes of development and focused explicit attention on the passage of time. He also revised his concepts of development and of ecological environments (particularly the microsystem and macrosystem) and formulated a new research paradigm for the study of human development—*a model first termed the person-process-context model* (Bronfenbrenner, 1986, 1994; Bronfenbrenner and Crouter, 1983) and then the process-person-context model (1986). This model would be revised and broadened in the

next and final phase of the theory's development. Process-context models allow the evaluation of the influence of some external setting on a specific developmental feature, such as the impact of parents' workplace experiences on the dynamics and functioning of the family (1986). In this model, the processes that translate the contextual experiences into development are explicated, including not only the objective behaviours occurring in any given interaction but also the relevant subjective psychological states, such as beliefs and opinions of the interacting individuals (1986). During this phase, some changes were also introduced in the concepts of the microsystem and macrosystem, in particular the emphasis given to the processes that occur in each of these contexts. At the microsystem level, Bronfenbrenner stressed the psychological characteristics of all the individuals present in the immediate setting in which interpersonal interactions occur. The microsystem was thus defined as a pattern of interpersonal relations experienced face to face in a given environment *"containing other persons with distinctive characteristics of temperament, personality, and systems of belief"* (Bronfenbrenner, 1986: 227). These relations, which influence the distinctive patterns of psychological functioning, are altered as a function of the setting in which the developing person is situated (Rosa and Tudge, 2013).

During this period, Bronfenbrenner found that another problem that was generally noted in this and the other models *was the absence of any consideration of time as an important component of the research*. This meant, Bronfenbrenner (1986) argued, that researchers generally did not take into account development as a process of continuity and change. Those who did take it into account were using, he suggested, *a chronosystem model.*

4.5.1.5 **Chronosystem**

A final system parameter extends the environment into a third dimension. Bronfenbrenner (1986 : 732) states that *"Chronosystem models are those in which time is treated as being as important as the environment for human development".* Many researchers using this model "*take into account changes that occur over the individual's lifetime caused by events or experiences"*. Bronfenbrenner (1986:732) stressed that research using this model should "*accompany the developing individuals' choice before and after the events which are assumed"* to influence development that has occurred. Figure 4.1 is a visual representation of Bronfenbrenner's (1986)'s ecological system.

In this thesis I also used a chronosystem to illustrate the changes over time for adolescent mothers in their environment in which they live and their contexts.

The third phase (1993–2006), Bronfenbrenner and his colleague refined and revised his theory to what would come to be known as his *bioecological model*. This final version of his theory is named both "*the bioecological theory* and *the bioecological model of human development"*. During this time, more attention was given to differentiating between the concepts of "*environment, the person, proximal process, and the concept of time"* as they relate to human development (Bronfenbrenner, 1994; Bronfenbrenner and Evans, 2000). Specifically, Bronfenbrenner placed greater emphasis on *proximal processes* and called them *"the engines of development"* (Bronfenbrenner and Evans, 2000: 118). He outlined the centrality of proximal processes. First, Bronfenbrenner (1994) argued that:

> *...human development takes place through the processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate external environment. To be effective, the interaction must occur on a fairly regular basis over extended periods of time. Such enduring forms of interaction in the immediate environment are referred to as proximal processes. (p. 620)*

Bronfenbrenner (1994) and Bronfenbrenner and Evans (2000) argued that an adequate test of the bioecological model requires a new form of research design that draws on the two propositions relating to (a) the nature of *proximal processes* and (b) how proximal processes *interact with person and context* to influence particular developmental outcomes. Such a research design Bronfenbrenner and Evans (2000: 119) termed the *"process-person-context-time (PPCT) model"*. Moreover, although Bronfenbrenner described it as a theory of human development, from the start the developing individual was consistently viewed as influencing and being influenced by the environment. The family thus plays a key role: it does so in a microsystem context in which development occurs, in terms of the personal characteristics of all individuals in the family, and most importantly, it does so in terms of the interactions between family members as part of proximal processes (Rosa and Tudge, 2013). During this phase, Bronfenbrenner continued his development of a theory that could lead, via public policy, to improving the living conditions for children, adolescents, and their families by optimising developmental outcomes (Ashiabi and O'Neal, 2015; Bronfenbrenner, 1994, Bronfenbrenner and Evans, 2000).

Proximal Processes

Bronfenbrenner conceptualised proximal processes as the driving forces of development (Bronfenbrenner and Evans, 2000). Examples of proximal processes include playing with a child or reading activities and the relations between people and objects and symbols with which they come into contact (Bronfenbrenner, 2005). In prior research, proximal processes have been assessed using parents' disciplinary practices and educational interventions and family functioning (Tudge et al., 2009; Ashiabi and O'Neal, 2015). They conceptualised proximal processes using a proxy measure of parent–child interactions that assessed sensitivity to the child's interest and affect, development of reciprocity and regular routines, and active participation on the part of parent (Ashiabi and O'Neal, 2015).

Regarding the application of the theory to my thesis, I used the concepts and definitions of *the second and third* phases to conceptualise research findings and understand adolescent mothers' lives with respect to being a mother with a second pregnancy at a young age. I acknowledge at the beginning that this study focuses on the experiences of adolescent mothers who have repeated pregnancies and have at least one child. Bronfenbrenner's ecological model gives prominence to adolescent development at the individual level and interaction with their contexts: *the microsystem, mesosystem, macrosystem, and exosystem.* Specifically, an *ecological model* allows me to conceptualise and understand the important findings about past experiences (first pregnancy experiences) and current experiences that relate to time, *the chronosystem,* and this reflects the participants' resilience that needs to be addressed in the results of this study.

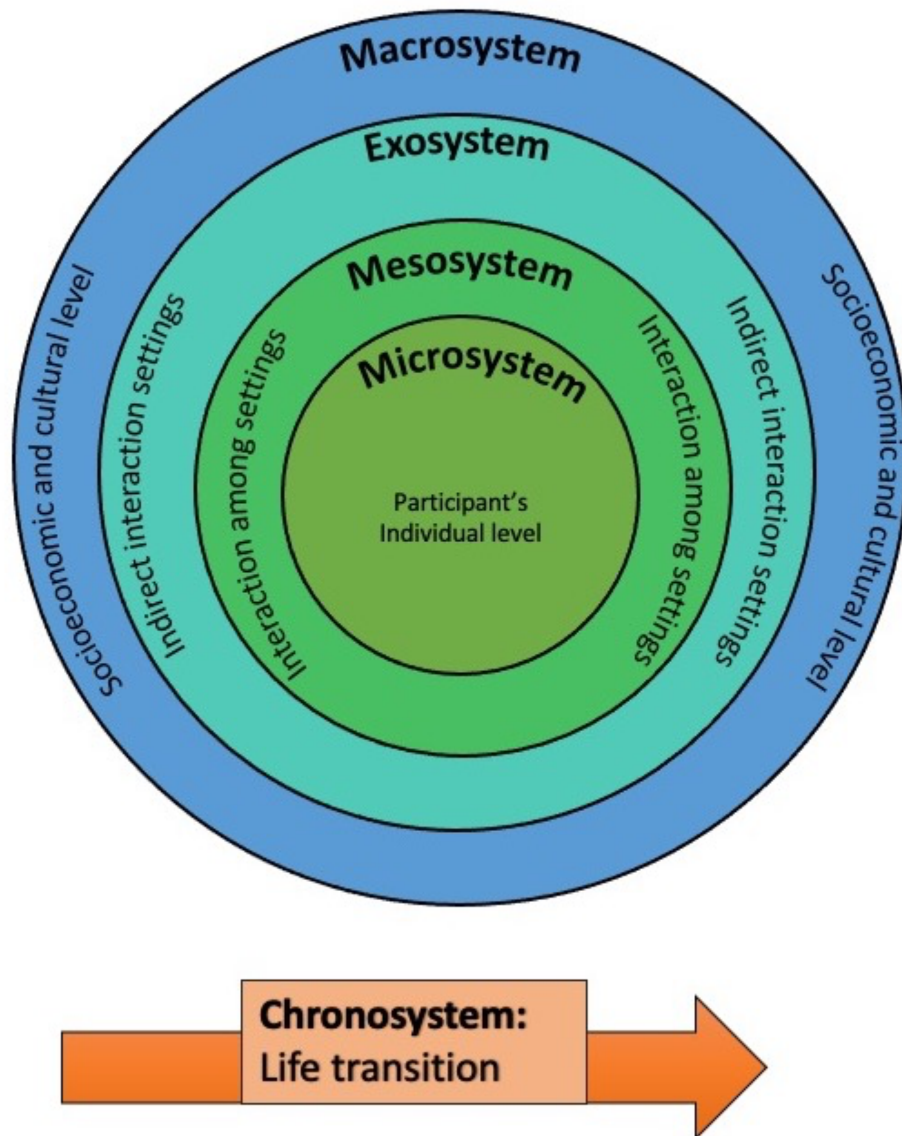


Figure 4.1 A visual representation of Bronfenbrenner (1986)

4.6 Summary

Chapter 4 provides the rationale regarding the justification of differences in qualitative research methodologies and approaches. I adopted a qualitative research method that can support a study which uses interview methods. In this study, I explored the experiences among adolescent mothers having a repeat pregnancy, examining it from their perspectives and their contexts.

This chapter also points to the theoretical underpinnings of this study. Bronfenbrenner's ecological theory was adopted to underpin and conceptualise the data analysis. With respect to the theory, I carried the concepts and definitions of the second and third phases of the theory development to conceptualise research findings and understand adolescent mothers' lives with respect to being a mother with a second pregnancy at a young age. Bronfenbrenner's ecological model can explain adolescent perspectives, individual levels, and interaction with their contexts: the microsystem, mesosystem, macrosystem, and exosystem. An ecological model has allowed me to conceptualise and understand the important findings about past experiences (first pregnancy experiences) and current experiences that relate to chronological change.

The next chapter presents the research methods and reports how data were collected.

Chapter 5 Research Methods

5.0 Introduction

Chapter 5 presents the research methods used in this study. It begins by providing information about the research site and setting and the ethical permissions gained to carry out the study. It then details the research methods used including the sample, data collection and data analysis methods. The chapter concludes by explaining how the issue of rigour was addressed in the study and how trust and confidence can be placed in the conduct of the research and in its findings.

5.1 Research site

The research site, Kanchanaburi province, was identified in chapter 1 and I have explained that this site was chosen because of my familiarity with the province through my work as a midwife and because of the high rates of adolescent pregnancy in the area.

Table 5.1 provides provincial statistics on the number of adolescent births aged 15 – 19 years in the area. The data show that the rate of births per 1000 adolescent women aged 15 -19 years in 2013 was 62.6 with a decreasing trend to 40.7 births per 1000 adolescent women aged 15 – 19 years in 2018 (Bureau of Reproductive Health, 2018). The number of adolescent births during the years preceding data collection indicated that the area was a potential suitable site to recruit participants. Data collection in this study took place in late 2018 and early 2019.

Table 5.1 Adolescent birth rate per 1000 women aged 15 – 19 years in Kanchanaburi and Thailand

Year	Adolescent births aged 15-19 years	Women aged 15 – 19 years	Rate per 1000 birth in same age group (Kanchanaburi)
2013	1,891	30,218	62.6
2014	1,637	29,697	55.1
2015	1,496	27,926	53.6
2016	1,402	26,091	53.7
2017	1,217	25,207	48.3
2018	1,007	24,734	40.7

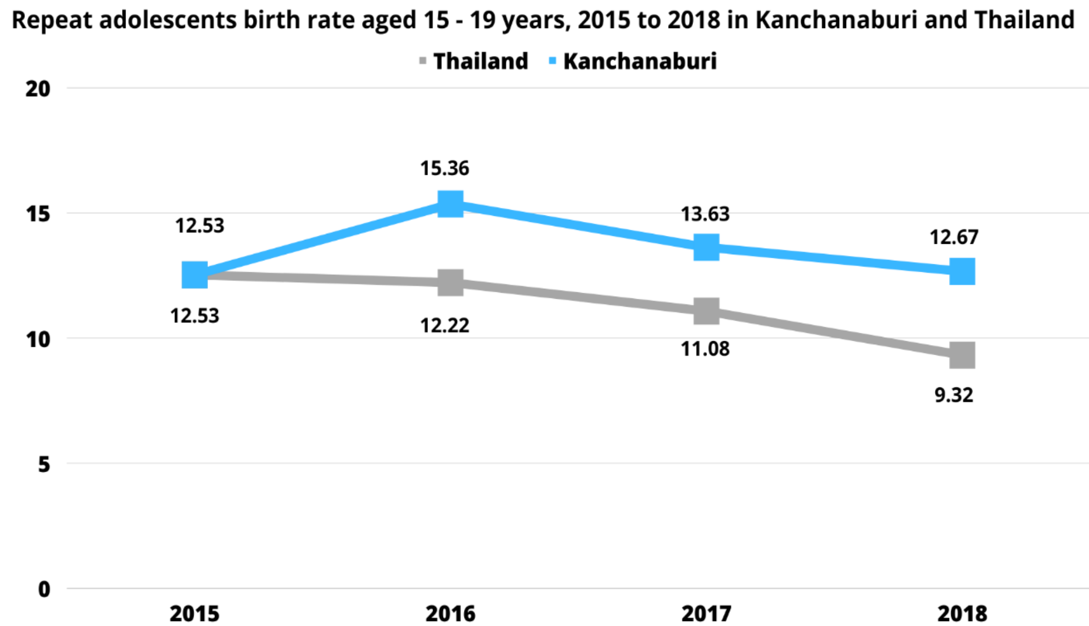


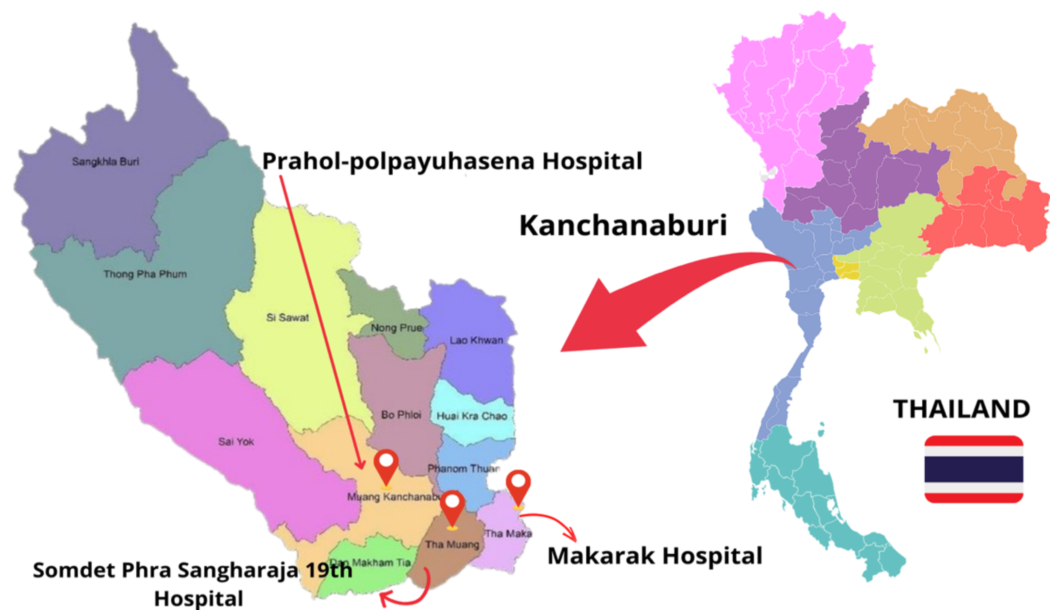
Figure 5.1 Repeat adolescent birth trends in Thailand and Kanchanaburi

Figure 5.1 shows the repeat adolescent birth trends contrasting Thailand and Kanchanaburi province. Again, these data show that this province was a suitable site for recruitment of adolescent participants with repeat pregnancy. While the data also show a decreasing trend from 12.53 to 9.32 between 2013 to 2018, in the wider Thai adolescent population, in Kanchanaburi province this increased from 12.53 to 12.67 in women aged 15-19 years.

5.2 Research Settings

5.2.1 Rationale for selecting three hospitals as research settings

Kanchanaburi province was the chosen location for this study because as highlighted in 5.1, it had a high adolescent birth rate for mothers aged 15-19 years at the time of recruitment to the study as well as having an above the national average rate of repeat adolescent births in mothers aged 15-19 years (Bureau of Reproductive Health, 2018). Moreover, there were relative similarities in culture and ethnicity in terms of the populations' circumstances and dialect and my own, which meant that I was able to communicate with potential participants more easily and because of this, gain their trust.



Three hospitals were chosen as research sites: Paholpolpayuhasena Hospital, Makarak Hospital, and Somdet Phra Sangharaja 19th Hospital. These were chosen for the following reasons: Firstly, I was familiar with all three hospital settings because of my clinical teaching experience in them all for over eight years. I had also undertaken visiting postpartum adolescent mothers in the community associated with these hospitals as part of my clinical teaching practice with nursing students. I was also used to working and collaborating with the community healthcare staff and potential gate keepers in these areas and always being conscious of and examining my own action for concerning research settings (Holloway and Galvin, 2017).

Secondly, a consideration of the health service system was also a key reason for recruiting from these sites which include both secondary and tertiary care hospitals. Pregnancy in adolescent women aged 17 and under is regarded as potentially high risk and the policy in Thailand is for adolescent women who meet the referral criteria to receive their care at these centres (Bureau of Reproductive Health, 2018). The secondary and tertiary care hospitals provide a range of specialist maternal and child health services. Paholpolpayuhasena Hospital and Makarak Hospital are tertiary care hospitals and Somdet Phra Sangharaja 19th Hospital is a secondary hospital in Kanchanaburi province. In essence, these three hospitals were all potential successful recruiting sites.

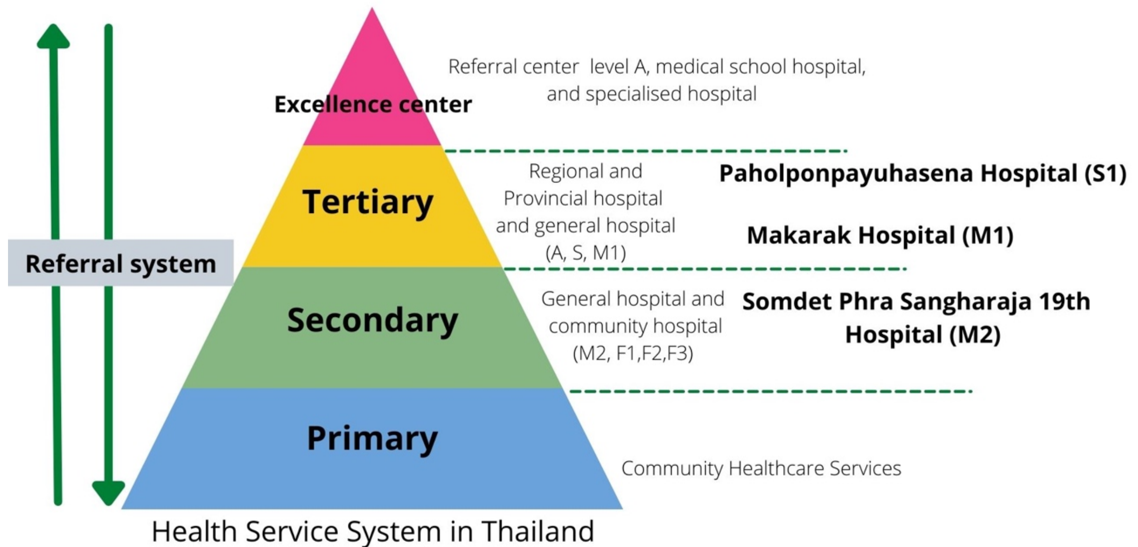


Figure 5.2 Three hospital tiers in the health system in Thailand

Lastly, these hospitals have the highest rate of maternal births for adolescent mothers aged 15-19 years. Each of the hospitals had around 200 - 350 adolescent mothers giving birth per year at the time of recruitment to the study (HPC 5, 2016). By deduction, the repeat adolescent pregnancy figures would potentially be around 2-5 persons per month in each hospital. After gaining ethical permission, I planned to visit the three settings weekly to meet the gate keepers to recruit potential participants.

5.3 Gaining ethical permission

Two sets of ethical approvals were required for this research: First from the Faculty of Health Sciences at the University of Hull and second, from the relevant local Thai Ethics Committees.

5.3.1 University Ethical Permission

Initially, this research was approved by the Faculty of Health Sciences Research Ethics Committee (EC number FHS72), see Appendix 4. This process was required to ensure that the participants and the researcher were safe over the course of the research and to minimise any risks to participants during the conduct of the study. Feedback from the University Ethics Committee further refined the project. For example, details about how data was to be managed should the participants withdraw, was required. The Committee required information on the time scales for withdrawal and a plan for how data was to be

disposed of should participants withdraw. Further, an information sheet to parents and guardians was required for any participants under the age of 18 years as parents and guardians' permission would be required in accordance with Thai law.

5.3.2 Local Research Ethical Permission in Thailand

Once the research had been agreed by the University of Hull, Faculty of Health Sciences Research Ethics Committee, then it was necessary to achieve research governance approval to access the data collection sites and recruit participants. A proposal and protocol for the study was submitted to the Kanchanaburi Research Ethics Committee for Human Research from where official authority was given to proceed and permissions were gained to access the settings and research participants. The Committee gave approval to conduct the research within the three identified hospitals. (Figure 5.3)

Following this the research approval letter from the Kanchanaburi Research Ethics Committee for Human Research, the FHS REC approval letter from the University and all research documents were submitted, as required, to the Chief Medical Officer of the Kanchanaburi Provincial Health Office for "settings" permission. This approval permission was sent to the relevant hospital directors at two of the sites. The third site required further application for approvals as they had their own protocol and ethics review board for reviewing research ethics and research conduct in the hospital. No amendments at any stage in Thailand were required. (Appendix 5)

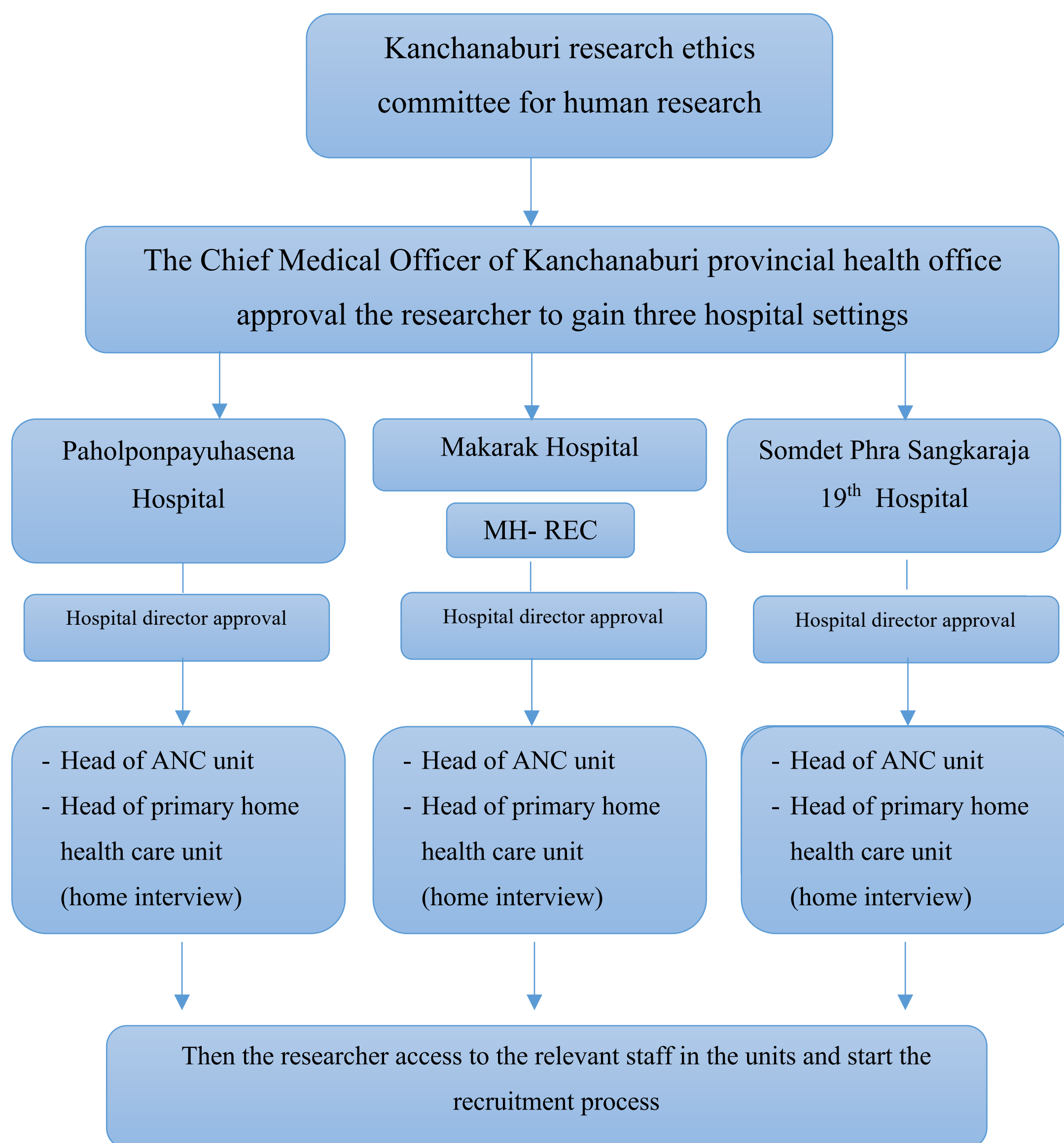


Figure 5.3 Thai ethics governance approval process

5.4 Sampling

5.4.1 Sampling and Participants' Criteria

Purposive sampling was deemed the most appropriate to gain access to the participants and the data needed for this study (Mason, 2017). This sampling method is used to recruit study participants where participants are selected on the basis of their experience of, familiarity with, and current involvement in, the field of interest of the study, or the research questions (Holloway and Galvin, 2017). Creswell and Poth (2017) asserts the importance of selecting appropriate candidates for interview to provide the most credible information to the study. A purposive sampling approach was therefore used for

identification of participants. The following inclusion and exclusion criteria were used to select the participants.

Inclusion criteria:

- **Adolescent mothers aged 16 - 19 years**. This inclusion criteria was based on the median age of adolescent mothers identified by Talungchit at al. (2017) in their study of the prevalence of repeat pregnancy including pregnancy outcome of teenage women, in Thailand. The study reports the median age of participants with second pregnancy were 18 years old (age range 16-19 years).
- **Being at least 6 months pregnant at the time of interview and having at least one child**. The focus of this study was accessing participant experiences of being an adolescent mother pregnant for a second time with at least one living child. Mercer (2004: 226) states that *"the transition to motherhood is a major developmental life event"* and *"the transition begins during pregnancy and extends into the postpartum period"*. Becoming a mother involves *"commitment, attachment, and preparation in which a women's work in becoming a mother begins, has long-rage implications"* (Mercer, 2004: 231). This inclusion criteria aimed to include potential participants who had experience of motherhood and becoming a mother again during their adolescence.
- **Defining themselves as Thai**, with a good understanding of the Thai language and able to speak to express their experiences and talk about their circumstances and contexts of being pregnant for a second time as an adolescent mother.

Exclusion criteria:

- Pregnant adolescent mothers younger than 16 and older than 19 years old.
- Adolescent women who were pregnant for a second time but with no living child. Pregnant adolescent women in this group may not have experience of being pregnant again whilst caring for another child.
- Pregnant adolescent mothers unable to speak and express their feelings and experiences. This research had no funding to support the use of a sign language interpreter or any other assistive technologies to help young women with special needs participate in the study.

5.4.2 Sample size

This section illustrates the sample size considerations in this study. As Holloway and Galvin (2017: 151) assert *"there are no rigid rules; 6-8 data units are seen as sufficient when the sample consists of a homogeneous group, while between 14-20 might be need for heterogenous sample"*. However, as Mason (2017: 72) states in qualitative research, *"the sample size may be small or large depending on the type of research question, material, and time resources"*. Mason (2017) points out that the key concern in relation to sample size is that it should generate sufficient data to enable the researcher to address the research question. This means that the researcher *"may not be able to make all of the sampling decisions in advance"* (Mason, 2017: 70).

In this study, using purposive sampling strategies, I recruited fifteen adolescent mothers who met the inclusion criteria. I decided to stop recruitment after conducting nineteen interviews with fifteen participants as I felt I had generated sufficient data to address my research question. The data was also no longer revealing anything new about adolescent repeat pregnancy and the context of the adolescent women's lives (Holloway and Galvin, 2017)

5.5 Recruitment process

Once ethical approval was achieved, I contacted the gatekeepers in the three hospital sites, including the head of the Antenatal Clinic (ANC), and the head of the primary home health care unit to explain the research and gain permission to collect data. Then I gave the ANC staff and the clinical midwives information about the study, the inclusion and exclusion criteria of potential participants, and the participant information sheet. I was given permission by the local Thai Ethics Committees to spend time in the ANC observing the work and flow in the area and this also allowed me to build rapport with the ANC staff and the clinical midwives in this study.

When the midwives met with potential participants, they explained the project to them, provided information about the research and the participant information sheet was given to them. If the young women were interested, they were asked if they wanted to meet with me. Those young women who indicated their interest were referred to me waiting in an area of the ANC. I again explained the study, checked they understood the participant information sheet and I provided a consent form to those still interested in taking part in the research. I left a folder in each of the three ANC's for those women who I might miss

at any time to place a reply card which the midwives had given them alongside the information sheets. These had a space for the young women to fill in their contact telephone numbers for me get back to them.

Participants who were aged 17 and married, did not require parental consent. At this point, I left the information sheet and the consent form and reply card with the participant and her husband for their consideration. There were no participants aged 16 years and younger recruited to the study.

Participants who were interested in this study, were contacted a week later and I gained their verbal consent to participate. Written consent was gained from all participants before the interviews commenced. Some of the women contacted me using the phone number provided in the information sheet. Regarding giving and signing consent; participants were all given a copy of the consent form. The second copy was kept in a locked cabinet at my home.

Participants were asked to choose the interview locations. The information sheets and consent forms provided detail and choices for the participant about the venues for interviewing depending on what was convenient for them and the context they found most comfortable (Mason, 2017).

The recruitment process is illustrated in Figure 5.4

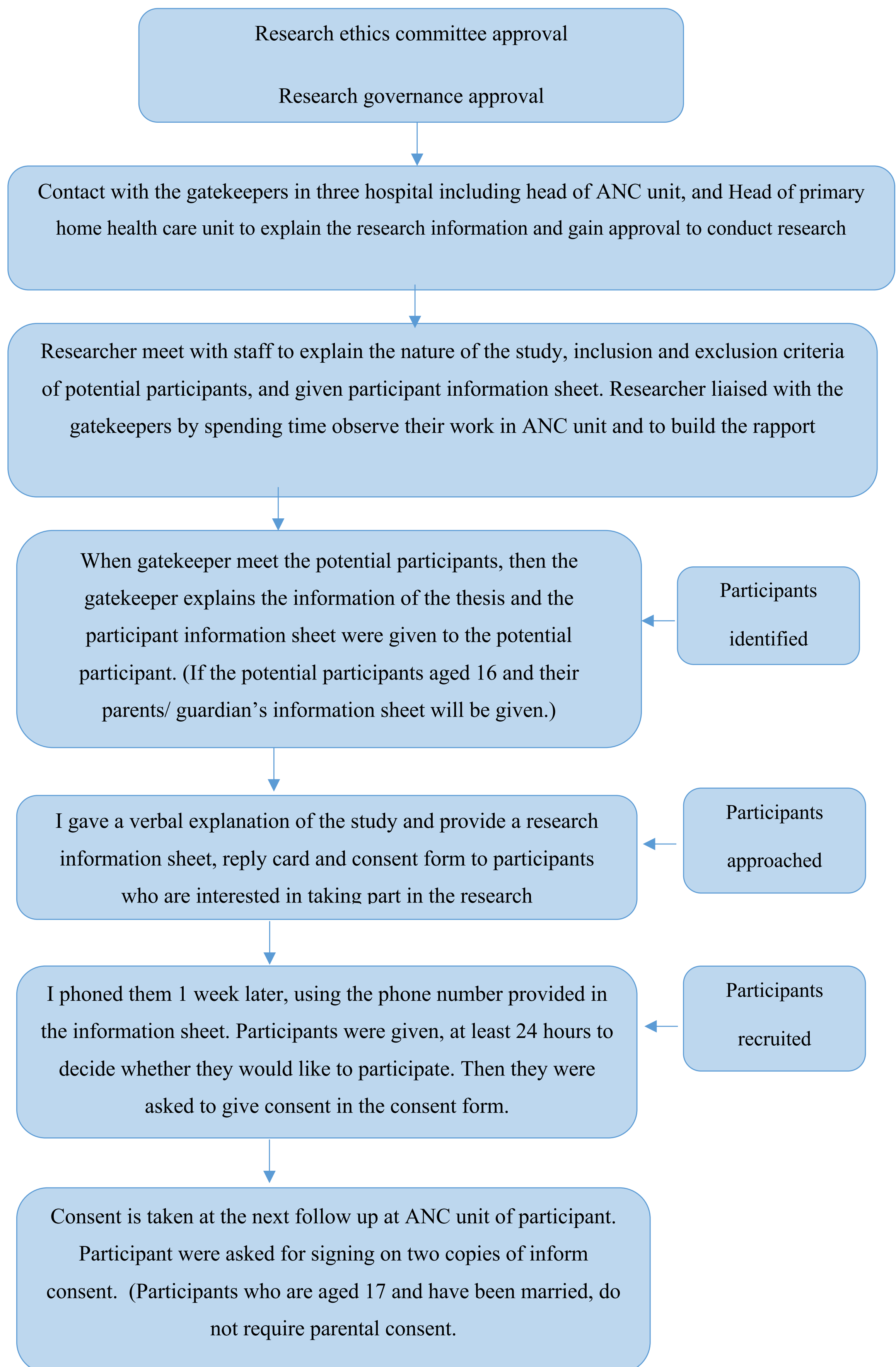


Figure 5.4 The process of participants' recruitment.

Recruitment continued for a period of six months. I recruited participants from the three hospitals, 18 potential participants were given research information and 3 potential participants were not interested in taking part. At the end of this process, 15 participants were recruited: 2 participants were recruited from Paholponpayuhasena Hospital, 4 were recruited from Somdet Phra Sangharaja Hospital, and 9 were recruited from Makarak Hospital (See figure 5.5).

I reflected on the recruitment process and the reasons the three potential participants did not take part. Two of them were initially willing to join but did not complete the consent form. After they discussed participation with their husbands, they explained that their partner was not willing for them to participate in this study. Another potential participant did not want to take part as she was too busy working. I respected their decisions, and their contact details were deleted.

Figure 5.5 Fifteen participants were recruited in three different settings

5.6 Participants demographics data

Table 5.2 provides a summary of the young mothers' demographic data and the age of their partners at the time of interview. This data was gained from the young mothers. The table also shows the young mother's ages at the time they conceived their first and second baby and the ages of the fathers of their babies. This table also shows those mothers who were still living with the fathers of their first children.

Table 5.2 The young mothers' and their partners biographical data

Name	*Age at conception of first baby*	*Age at conception of second baby*	*Age at conception of third baby*	*Age of father of first baby at conception*	*Age of father of second baby at conception*	*Age of father of third baby at conception*	*Living with original partner*	*Living with new partner*
Palmy	15	19	-	19	17	-	-	✓†
Pakar	15	19	-	18	21§	-	✓‡	-
Napar	16	19	-	18	17	-	-	✓‡
Sasi	14	19	-	20	25§	-	✓‡	-
Sukan	15	17	19	17	19	21	-	-
Kor	16	19	-	19	51	-	-	✓¥
Siri	17	19	-	19	28	-	-	✓†
Rassa	15	19	-	19	22§	-	✓†	-
Ponsi	15	17	-	18	20§	-	✓‡	-
Wilai	17	19	-	20	22§	-	✓¥	-
Sao	15	19	-	24	28	-	-	✓‡
Passon	15	19	-	16	20§	-	✓‡	-
Manee	16	19	-	25	35	-	-	✓‡
Titar	14	19	-	24	19	-	-	✓‡
Tahmas	14	18.7	-	17	21§	-	✓¥	-

§ Those who fathered both the first and second baby.
† Living with partner's family
‡ Living with young mother's family
¥ Living in their own house (rental house)

The age and the age difference between the adolescent and their partner

The young mothers ranged from 14 to 17 years of age at the time of their first pregnancies. Sasi, Titar, Tahmas had experienced their first pregnancy in early adolescence, at the age

of 14. Palmy, Pakar, Napar, Sukan, Kor, Rassa, Ponsi, Sao, Passon, and Manee were 15-16 years of age while Wilai and Siri were first pregnant at the age of 17.

Most participants were 19 at conception of their second pregnancy. Ponsi was the youngest participant, she became pregnant for the second time at age 17. Four participants, Sukan, Siri, Ponsi and Wilai, experienced a rapid repeat pregnancy and were pregnant within two years of having their first children (Boardman et al., 2006). Sukan was the only participant who was having a third child, and both her second and third pregnancies had occurred within two years of the previous one.

The young women's partners were all older than them at first pregnancy with a significant age difference between Sao, Manee, Titar and Sasi and their partners at first conception. Table 5.2 reveals a significant age difference at second pregnancy between Kor and Manee and their partners with a relatively large age difference between Siri and Sao and their partners. Seven of the participants reported that they were still together with their original partners and seven stated that they are living with a new partner - the father of their second child. Only Sukan reported being a single mother.

Partnerships and family support

Young mothers revealed how they met their partners in various situations. Some of them met via online social media such as Facebook, while some through a mutual friend. In relation to the second pregnancy, those in new relationships, some report meeting in a work setting. All the young mothers, including Sukan, whose partner had subsequently left her, were married in a religious ceremony with consent to marry given by the young mothers' parents.

Some of the young mothers were living at home with their families at the time they conceived their second pregnancy. They were all supported by their parents who provided all their essentials, housing, food, childcare support, and financial support.

Young mothers and their children

Table 5.3 highlights demographic data for the adolescent mothers' first children and current gestational age of their second pregnancy at interview. In addition, the table shows how the young mothers had fed their first babies.

Eleven of the young mothers had their babies with them and were caring for them themselves with the support of their families. Some of these arrangements lasted for about for a year when the young mothers then moved in with the family of the baby's father.

Table 5.3 The data of young mothers and their children

	Age at conception of first baby	*Age at conception of second baby*	*Age at conception of third baby*	*Gestational Age at interview (by weeks)*	*Age of their living child*	*Living circumstances*
Palmy	15	19	-	28	3	Her mother in northern of Thailand
Pakar	15	19	-	32	4 (premature birth)	Looks after her baby herself
Napar	16	19	-	30	4	Looks after her baby herself for year and then moved to father family
Sasi	14	19	-	29	5	Looks after her baby herself and relied on her mother for first few years
Sukan	15	17	19	26	4, and 2	Looked after by her mother
Kor	16	19	-	25	2.6	Looks after her baby herself
Siri	17	19	-	27	1.6	Looks after her baby herself
Rassa	15	19	-	30	3	Looks after her baby herself
Ponsi	15	17	-	35	1.6	Looks after her baby herself
Wilai	17	19	-	26	2	Looked after by her mother near the western border of Thailand
Sao	15	19	-	25	4	Looks after her baby herself
Passon	15	19	-	32	4 (premature birth)	Looks after her baby herself
Manee	16	19	-	30	4	Looks after her baby herself
Titar	14	19	-	32	5	Looks after her baby herself
Tahmas	14	18.7	-	24	4	Looks after her baby herself

Young mothers' education and employment

Table 5.4 presents the education and employment profiles of participating young mothers. The current educational level at interview shows a wide range of educational achievement at the point participants' ceased education. For example, Kor studied up until Prathom 2 (preparatory school year 4) and then left full time education without qualifications. Kor was only able to read and write her name. Siri and Titar by contrast, graduated with a secondary education level certificate, the highest secondary educational level (Mathayom 6). Rassa had a vocational certificate and was employed.

Table 5.4 Education and employment data for the young mothers

Participants	*Age at interview*	*Education level at interview*	*Employment at interview*	*Education and employment expectation*
Palmy	19	Prathom 6	Daily hire	Preparing for NFE after giving birth
Pakar	19	Mathayom 3	Self-employed / Daily hire	Preparing for NFE after giving birth
Napar	19	Mathayom 3	Employee, at 7/11 shop seller/ monthly employed	She wished she could continue study to get more paid
Sasi	19	Mathayom 2	Full-time mother/ housewife	Thinking of NFE after giving birth
Sukan	19	NFE 2	Daily hire	Continue NFE after giving birth until got NFE3 Qualification
Kor	19	Prathom 2	Daily hire	Thinking of NFE after giving birth, for be able to read and write Thai
Siri	19	Mathayom 6	Having own grocery	Satisfied with this qualification and focused on working for living expenses and for children
Rassa	19	Vocational certificate	Employee, at 7/11 shop seller/ monthly employed	Thinking of higher education level for being children's role model
Ponsi	17	NFE 1	Full-time mother/ housewife	Continue NFE after giving birth until achieved NFE3 Qualification for getting better paid job
Wilai	19	Prathom 6	Employee/ Waitress daily hire.	Focused on working for living expenses and for children
Sao	19	Mathayom 2	Self-employed/ Online seller (clothes)	Satisfied this qualification and focused on working for living expenses and for children
Passon	19	Mathayom 4	Having own rice noodles restaurant	Satisfied this qualification and focused on working for living expenses and for children
Manee	19	Mathayom 2	Having own kiosk selling foods	Satisfied this qualification and focused on working for living expenses and for children

Participants	Age at interview	Education level at interview	Employment at interview	Education and employment expectation
Titar	19	Mathayom 6	Self-employed/ Online seller (Thai amulets)	Satisfied this qualification and focused on working for living expenses and for children
Tahmas	18.7	Mathayom 1	Employee, at Srifa bekery factory/ monthly employed	Thinking of NFE after giving birth for getting more paid

Educational level system in UK and in Thailand, (The office of educational affairs, the Royal Thai Embassy, 2021)

a) Prathom 1-6, Primary education (aged 7-12)= Preparatory School (Year 3- 8) in UK

b) Mathayom 1-3, Lower secondary education (aged 13-15) = Key Stage 3, Secondary School/ Sixth Form College / College of Further Education (Year 9 – 11) in UK

c) Mathayom 4-6, Upper secondary education (aged 16-18) = Key Stage 4, Secondary School/ Sixth Form College / College of Further Education (Year 11 – 13) in UK

d) Non-Formal and Informal Education: NFE 1-3, Lower secondary education= Key Stage 3 (Year 9 – 11) in UK

e) Non-Formal and Informal Education: NFE 4-6 , Upper secondary education = Key Stage 4 (Year 11 – 13) in UK

f) Vocational certificate (aged 16-18),= Vocational school, General National Vocational Qualification (GNVQ advanced) in UK

5.7 Researching with adolescent mothers

This research focuses on a vulnerable group of adolescent pregnant women and the interview questions included sensitive topics, such as repeat pregnancy while being an adolescent mother. Reflecting on their experiences had the potential to raise sensitive issues for the young women. The four ethical principles set out by Beauchamp and Childress (2019) were used to consider the ethical issues in this study and I was careful to consider any potential risk of harm to participants and endeavoured to do everything possible to minimise this, as shown in the following sections.

5.7.1 Respect for Autonomy

The principle of respect for autonomy is to respect decisions made by those capable of making decisions (Beauchamp and Childress, 2019). Informed consent and the information sheet for adolescent mothers clearly stated that although they had decided to participate in this study, they were free to withdraw from being a participant at any time, without giving a reason, and withdrawal from the study would not affect the standard of care they received. The young women were also advised that they did not have to answer any questions they did not want to.

For example, during the interviews, I was concerned that the personal nature of the questions might cause the participants embarrassment or upset. I tried not to use direct questions when talking about sensitive topics but use softer or implied words that had the same meaning. When the participants were interviewed, should they have felt uncomfortable or distressed; I planned to stop the interview and provide emotional

support. This did indeed happen and for example, when Kor cried when talking about her lack of education, I stopped the interview to support her emotionally and only resumed because she indicated that she wanted to continue. When I first approached Kor, after she had agreed to participate in this study, I read the participant information sheet carefully to her and made sure that she understood what taking part in the research would involve.

5.7.2 Nonmaleficence

The principle of nonmaleficence is to avoid causing harm to others (Beauchamp and Childress, 2019). I ensured that the participants understood that while there were no known risks to participating that they might be asked to talk about sensitive topics and possibly traumatic incidents.

I considered that some participants may report poor practice, substance abuse, violence, rape, and criminal behaviour. To deal with these issues, the participants were clearly informed before interviewing that they could refuse to answer any questions and that they could withdraw from the study at any time. To minimise risk, to manage the issue of harm, and to fulfil my professional responsibility to report these concerns as a nurse midwife, those issues would be escalated through report to the antenatal clinic manager in hospitals; this would initiate professional support from the "One Stop Crisis Center (OSCC)" a professional support service available in every hospital in Thailand. Additionally, participants had the choice to report any crisis concerns or emergency incidents themselves and I provided an information leaflet of support groups, including the OSCC 24-hour hotline number, to participants. However, throughout the interviews, no incidents requiring referral occurred.

5.7.3 Beneficence

The principle of beneficence relates to the benefit accrued in participating in the research (Beauchamp and Childress, 2019). The participants were informed that participating in this study offered an opportunity to speak about their feelings and experiences which when the research is completed may positively improve maternal care regarding pregnancy. They were informed that the information they provide may help practitioners and policymakers better understand adolescent mothers and so lead to enhanced services for adolescent mothers in Thailand.

As a thank you token for giving their time to be interviewed, all the young mothers were given a 'baby pack' at the end of the interview. Ethical approval to do this was given by the University of Hull, Faculty of Health Sciences Research Ethics Committee. The packs contained a baby vest, mittens and socks, three disposable nappies and a bottle of baby bath wash. These were paid for from my scholarship funds.

5.7.4 Justice

The principle of justice is about ensuring fairness and equity in distribution of risk and benefits (Beauchamp and Childress, 2019). The participants were informed that as a participant, they would receive the same standard of care as usual and to withdraw from the project would not affect the care they received.

5.7.5 Confidentiality and data protection

The participants were asked permission for me to audio record the interviews and all participants agreed. Additionally, participants were informed that I would not use their own names in any document written about the research and that I would not identify any comments made as being from them. Electronic, audio and paper records were securely stored, and I used pseudonyms on all data as early as possible. Research data which included transcription files, photos, and field notes were stored in an encrypted folder on my personal password required memory hard drive in a personal locked cabinet, all in accordance with the University of Hull data storage requirements.

5.8 Data Collection

The principal data collection method used in this study is the qualitative semi-structured interview (Mason, 2017). The qualitative interview facilitates generation of data which captures the participants' experiences, emotions, perceptions, and memories from their perspective, and is in keeping with the aims of this study. I also maintained detailed field notes which I used to describe the setting and interview situations and I kept a reflexive diary to record my emerging thoughts and ideas about the research. The field notes and reflexive diary are evidence of the methods I have used to maintain rigour throughout the study.

To prepare to undertake the interviews, I attended a level 7 module, 'Collecting Qualitative Data'. Here I developed my data collection skills and enhanced my understanding of the qualitative researcher in the field.

5.8.1 Interviews

The qualitative interview facilitated an interaction between me and the participants and led to a co-production of their accounts (Kvale, 1996; Brinkmann and Kvale, 2015; Mason, 2017). Holstein and Gubrium (1995) refer to this as the "active" interview where the researcher is engaged in allowing the participants' accounts to emerge. The qualitative interview is key to exploring the ways in which participants experience and understand their world. It provides a unique access to the lived world of the young women, who describe their activities, experiences and opinions in their own words (Brinkmann and Kvale, 2018).

The term "qualitative interviewing" refers to *in-depth, semi-structured* and also loosely structured forms of interviewing (Mason, 2017). Each has its own character, but as Mason (2017) argues, all interviews have some form of structure. In this study the interview guides (see appendix 3) were developed using findings from the literature review, to help focus on adolescent mothers' experiences of repeat pregnancy. The semi-structure interview guides were designed to explore specific areas but to also remain fluid and flexible to allow me as the researcher, and the adolescent mother as the interviewee, to develop a conversation and to be responsive to unexpected emerging themes. The sequencing of questions in the interview was not the same for all participants. Some participants raised issues that needed to be followed up using additional, probing questions (Holstein and Gubrium, 1995; Mason, 2017). However, as Holloway and Galvin (2017) caution, although the sequencing of questions is not the same for every participant, the researcher must focus on the particular issue that needs to be explored and to ensure that they do not get lost.

Creswell and Poth (2017) suggests being flexible with research questions. He points out that interviewees will not necessarily answer the question being asked by the researcher and may answer a question that is planned for in another part of the interview. I prepared myself for the interviews by reading and rereading the interview guides. The interviews were conducted in Thai my first language. I asked questions that encouraged the Thai adolescent mothers to talk about their experiences and I listened carefully and actively to the young mothers, focussing on what they said. I asked ask questions in response to what was being said and I tried to encourage a relaxed conversation. In addition, to achieve depth in terms of exploration and explanation, I used probing questions in a non-

threatening way to uncover the participants story or the meaning and reasons behind the story telling (Holloway and Galvin, 2017).

All data were then transcribed into Thai and translated into English. To enhance rigour and ensure the accuracy of the data, back translation from English into Thai was undertaken by an independent English translator agency.

5.8.1.1 Interviewing in the hospital

Participants were interviewed at a place they found convenient, and the interview was conducted in a setting which allowed for privacy. Participants who are willing to take part in an interview at the hospital were asked to interview on the day of their normal ANC clinic check-up. The interviews lasted around 60-90 minutes depending on the willingness and openness of the participants to share their experiences and each participant was interviewed on one to two occasions.

Fifteen pregnant adolescent mothers were recruited, and nine young mothers chose to be interviewed at the hospital on the day of their ANC check-up. (See table 5.5). I had previously liaised with the head of the ANC units about conducting the interviews and asked for private room that was quiet, safe, and comfortable and where we would not be interrupted over the duration of an interview of 60-90 minutes. Figure 5.6 shows the private room at Makarak Hospital that is normally used for breastfeeding counselling but was free to book and use in the mornings.

Figure 5.6 Interview room in the hospital

There were some challenges in interviewing at the hospital such as noise from a new building construction close-by, and I had to adapt to this in the interviews. I also tried not to prolong the interviews as I was conscious the young mothers needed to travel back home. Interviews lasted about 60 minutes. On the few occasions that I was unable to complete the interviews fully, I followed up with a second interview. See table 5.5.

5.8.1.2 Interviewing at the participants homes

Six participants chose to be interviewed at their homes. I asked participants to give me directions and to draw a map to help me locate them. Before this I had contacted the head of the primary home health care unit first, who recorded that I would be home visiting, and they gave me the local healthcare providers contact details in case of any arising issues I needed to report from my visits or any further information I needed from the local healthcare provider.

The experience of interviewing at participants' homes was rewarding. I learned to cope with unexpected events and develop my problem-solving skills. For example, Palmy was the first participant recruited to the study and to be interviewed at home. I had phoned her the day before the interview to confirm her availability. I had expected that I would have to look for a private area to conduct the interview and I thought I would conduct the interview at a time when her child would probably be napping. When I arrived at her partner's parents' house where she was living, Palmy was waiting for me at the house which turned out to be owned by the employer of her partner's father. Her first child was away in the North of Thailand, living with her parents.

I saw a place where we could talk, a table next to the house as shown in the left of figure 5.7. Palmy's mother in-law was with her, and I introduced myself. The mother in-law was aware of why I was there as Palmy had told her. Then Palmy's mother in-law brought us something to eat; Som-Tum (she sells Som-Tum salad and noodles in her shop) and she offered these to me. I thanked her and decided to eat them first, and said I would pay for them, but she would not take any money. Later, after I had completed the interview, I bought some things in the shop as a way of paying back her generosity.

To manage any interference in the interview, I made small talk and waited for Palmy's mother-in-law to close the shop and leave the interview area. We could then talk personal issues privately.

I learned from this and applied my learning to all the interviews. When I conducted Pakar's second interview at home (see the photograph on the right of figure 5.7) I made general conversation with her and all her family members but waited until Pakar and I were alone before I started the interview properly.

Figure 5.7 Interview places at participant's homes

I met all participants initially at the time of recruitment to the study where I explained about the nature of the study. My second meeting with the participants was at the first interview and I met four of the participants for a third time at a second interview. These meetings all allowed me to build up trust and rapport (Holloway and Galvin, 2017) with the participants and facilitated the sharing of their accounts about their lives. Table 5.5 provides information about where the young women were recruited, the length of the interviews, and the number of interviews with each participant and the place where the interviews took place.

Table 5.5 Duration and place of interview

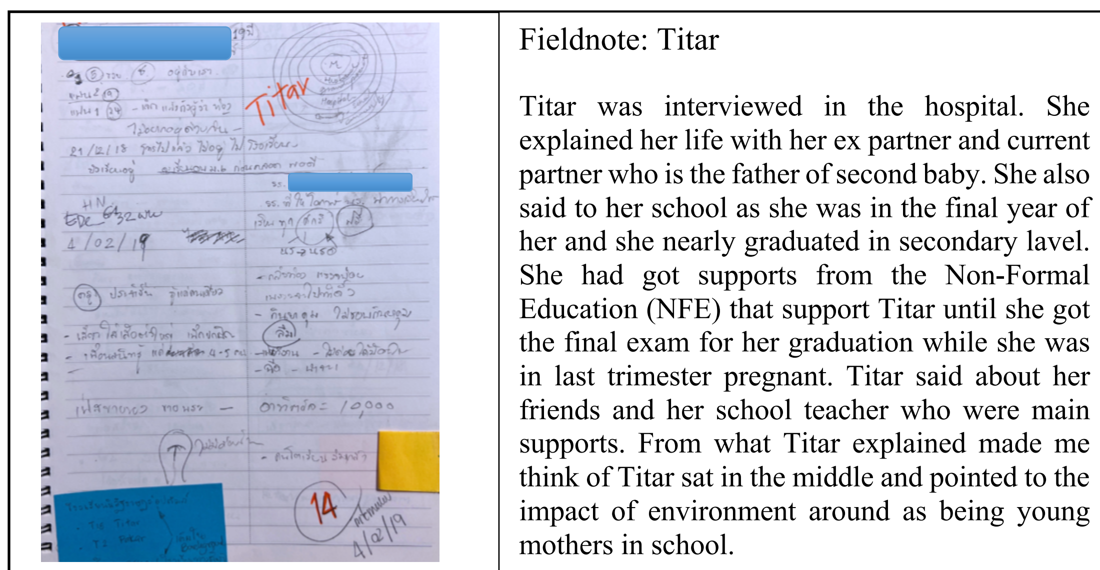
No.	Pseudonym	Recruitment site	Length of 1st interview	1st Interview place	Length of 2nd interview	2nd Interview place
T1	Palmy	MH	93 minutes	Her parents' partner house	35 minutes	Hospital
T2	Pakar	MH	87 minutes	Her parents' house	-	-
T3	Napar	MH	62 minutes	Hospital	-	-
T4	Sasi	S19H	55 minutes	Hospital	40 minutes	Her parents' house
T5	Sukan	MH	61 minutes	Hospital	-	-
T6	Kor	PPH	95 minutes	Her partner's house	35 minutes	Hospital
T7	Siri	MH	85 minutes	Her partner's house	-	-
T8	Rassa	S19H	75 minutes	Her parents' partner house	-	-
T9	Ponsi	S19H	61 minutes	Her parents' house	-	-
T10	Wilai	PPH	68 minutes	Hospital	-	-
T11	Sao	MH	65 minutes	Hospital	-	-
T12	Passon	MH	63 minutes	Hospital	-	-
T13	Manee	MH	60 minutes	Hospital	-	-
T14	Titar	MH	50 minutes	Hospital	45 minutes	Hospital
T15	Tahmas	S19H	64 minutes	Hospital	-	-

Notes: MH= Makarak Hospital, PPH= Paholponpayuhasena Hospital, S19H = Somdet Phra Sangkaraja 19th Hospital.

5.8.2 Fieldnotes and fieldwork

I wrote field notes to describe the data collection experience and to detail my interactions to maintain a faithful record of the research process. Mulhall (2003: 311) states that every ethnographer and every observer will have their own preferred strategies for recording their data and *"it is important to record field notes as closely as possible in time to when events were observed".*

I wrote my field notes up daily to record my thoughts and perceptions in the field and in such detail that I could "return to the situation" when I returned to the UK. These notes have proved invaluable in my interpretation and reflexive analysis of the data. I also used my field notes to record judgements I made over the research, and I recorded every contact in detail, from the time I first met the young women in the ANC and at every other contact. For example, I have recorded all my interactions with Titar (19 years) who chose to be interviewed at the hospital. I recorded that I had phoned her to arrange the interview. However, she was not home, and I spoke to her mother who told me she was at school, and I agreed to call back. I rang Titar again over a weekend, and this time she answered my call and was willing to talk to me at her next ANC hospital appointment. I recorded the date and appointment time and prepared myself to interview her. We met on the agreed day of her appointment. I had arrived early at the hospital to prepare the interview room near the ANC room. This was not our first meeting as we had met earlier at the time of her recruitment to the study. I have recorded that we talked about the aims and purpose of the study. I also recorded that I introduced myself, that I was in the hospital as a PhD student researcher, and that I was a midwife but not a hospital staff member. For our first interview, I waited around until Titar had finished her midwife ANC check. She noticed me waiting for her, she smiled at me, and then we walked to the booked room in the hospital. This detail in my notes about my meetings with the participants has enabled me to immerse myself in the research and it provides a clear trail of what, when and how, things unfolded in the research (Mason, 2017).



Fieldnote: Titar

Titar was interviewed in the hospital. She explained her life with her ex partner and current partner who is the father of second baby. She also said to her school as she was in the final year of her and she nearly graduated in secondary lavel. She had got supports from the Non-Formal Education (NFE) that support Titar until she got the final exam for her graduation while she was in last trimester pregnant. Titar said about her friends and her school teacher who were main supports. From what Titar explained made me think of Titar sat in the middle and pointed to the impact of environment around as being young mothers in school.

Figure 5.8 Fieldnotes example

Titar had an appointment with the dentist in the afternoon and I was mindful of this during our interview. At the end of our agreed 50-minute interview I knew that there were some questions I had not explored in the time allowed, and I asked Titar if she was willing to participate in a follow up interview. She agreed.

I added to these extensive field notes contextual details about where we sat, where the interviews took place, anything that happened during the interview, including any interruptions (see figure 5.8). I also drew some of the settings and as illustrated in figures 5.6 and 5.7, I also took photographs where possible. All of this has added to making the research process transparent (Mason, 2017).

Figure 5.9 is an illustration of two of the home settings where I conducted interviews. The drawn picture on the left of the figure helped to remind me of the challenges of this interview where the interviewee's grandfather in-law sat under a shelter about 10 metres from where I was sitting with the participant near her house. I was concerned about maintaining privacy and about the weather which threatened to disrupt the interview. I spent some time talking to the grandfather telling him who I was and what I was doing. I was careful not to talk about pregnancy in young age when explaining about the research to him but rather, that as a midwife, I was talking to women about their experiences of pregnancy in general. I asked him about how he felt about having grandchildren and he seemed happy to move on and go and sit under his shelter out of earshot. I was careful to maintain privacy during the interview.

Figure 5.9 the example of field notes illustrates the interview context in the field

The picture on the right of figure 5.9 is a scene I drew of where the participant and I sat for our interview under the eaves of the house. There was a corn field growing next to the house and it was sown and would be harvested by the participant when it was mature.

I did not take notes while conducting the interviews because I gave my full attention to the young women and their responses. I completed my handwritten field notes in Thai shortly after I finished the interviews; sometimes while sitting in my car, or in the café at the hospital. I organised my field notes using adhesive notes with a number to identify the participants. I kept these notes close to me, and I returned to read and re-read them to check my emerging perceptions and understandings of the interviews and when analysing and interpreting the data.

5.8.3 Reflexive diary

I maintained a reflexive diary alongside my field notes. Reflexivity is a process *"where the researcher engages in explicit, self-aware analysis of their own role"* (Holloway and Galvin, 2017: 9). It also includes awareness of the interaction between the researcher and participants throughout the research process, including the interviews, and how the process of the research affects the findings and eventual outcomes in the research (Holloway and Galvin, 2017). My reflexive diary documents my thinking, decision-making and feelings over the course of the research and contributes to the overall trustworthiness of the research.

5.9 Data analysis

Thematic analysis was used to analyse the research data in this study. It provides a highly flexible approach that can be modified for the needs of many studies, providing a rich and detailed, yet complex account of data (Braun and Clarke, 2013; Nowell et al., 2017). A rigorous thematic analysis can produce trustworthy and insightful findings (Nowell et al., 2017). I followed Braun and Clarke's (2013) steps:

Phase 1: Familiarising yourself with your data

The first phase of data analysis, Braun and Clarke (2013) assert, is for the researcher to spend time familiarising themselves with the data, and for accuracy, to check their transcriptions back against the original audio recordings. I transcribed the interviews myself and with re-listening to the recordings and re-reading the transcripts ensured I became familiar with the data collected from the participants. Back translation was used for three transcripts to confirm the veracity and accuracy of the data translation.

Phase 2: Generating initial codes

This second phase begins once researchers have read and familiarised themselves with the data, gaining ideas about what is in the data and what is interesting about it (Braun and Clarke, 2013). This phase involves the initial production of codes from the data, a theorising activity that requires the researcher to keep revisiting the data (Nowell et al., 2017).

Braun and Clarke (2013: 206) state that *"coding is a process of identifying aspects of the data that relate to your research question. There are two main approaches to coding in pattern-based forms of qualitative analysis which we call selective coding and complete coding"*. I decided to apply complete coding as I was looking at the entire dataset. Complete coding is aimed at *identifying anything* and *everything* of interest or relevance to answering the research questions (Braun and Clarke, 2013).

Transcriptions were manually coded. Firstly, I generated initial codes across the data to capture specific and particular meanings within the dataset, relevant to the research question (Braun and Clarke, 2006; Braun and Clarke, 2013), including simple distinctions between answers (e.g., about their partner, their contraception, their reactions to the pregnancies). Second, I read whole transcripts and identified important themes that

emerged from the data and young mothers' perspectives towards their circumstances and contexts.

I did initially consider using qualitative analysis computer software as it is useful for organising data and documenting the analysis. It also allows for easy retrieval of codes, checking these against the original interview transcripts (Braun and Clarke, 2013) and for looking through the data. It is also helpful for storing notes and memos about the analysis. I attended a university workshop on getting going with NVivo 12 and imported my initial transcripts into the software. However, while I recognised all the advantages of using the software; it made managing a large dataset much easier and the process of coding and analysing was quicker in terms of organising quotes, I found it had limitations. Firstly, the technology and quick function distracted me from the real voice of the research data, and I was conscious that with less immersion, might follow less insight. Secondly, I found myself focussing on frequency rather than the meaning of the data. It was at this stage that I decided to try manually coding some of the transcriptions and this made much more sense to me so, in consultation with my supervisors, I decided to proceed with manual coding. I felt more aware of the dataset this way, of each individual code, the coding decisions and as well as my reasons for collating them.

Phase 3: Searching for themes

The third phase begins when all the data have been initially coded and collated, and a list of the different codes identified across the data set has been developed. This phase suggests using thematic mapping and diagramming to make sense of theme connections (Nowell *et al.*, 2017) and ultimately, the phase involves sorting and collating all the potentially relevant coded data extracts into themes (Braun and Clarke, 2013).

Braun and Clarke (2013) suggest that at this stage the researcher might use tables, mind-maps, or even write the name of each code (and a brief description) on a separate piece of paper and play around with organising them into "theme-piles". I kept detailed notes about development of hierarchies of codes and themes in a Microsoft Excel table. I used concept mapping and diagrams to allow me to think critically when searching for the main themes. See figure 5.9.

I found this phase challenging and conceptualisation needed when I start thinking about the relationship between codes, between themes, and between different levels of themes. At this stage I found a set of codes that did not seem to belong anywhere, but Braun and

Clarke (2006) state that it is perfectly acceptable to create a theme called "miscellaneous" to house such codes.

Phase 4: Reviewing themes

This phase is essentially one of "quality control" and it is about telling a story that is faithful to the data (Braun and Clarke, 2006; Braun and Clarke, 2013). A visual analytic map can be a useful aid for exploring the relationships between codes and themes, sub-themes, and overarching themes (Braun and Clarke, 2013). Young mothers spoke of their lives and being a mother. Their experiences of the first and second pregnancy were both valuable and linked, so that I could not separate these. Thematic analysis allowed me to see which themes could be related to one another, which could be overlapped, or even grouped with others.

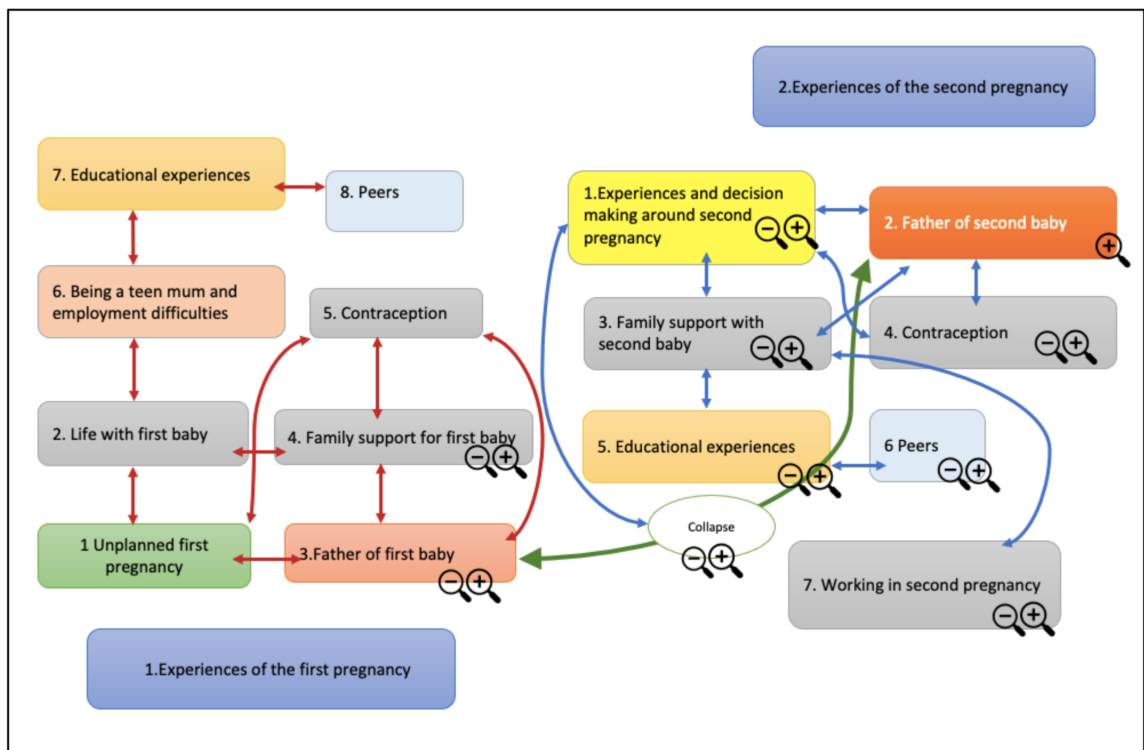


Figure 5.10 Searching for themes and the thematic mapping

I read and reread the data to ensure each theme was meaningful and had adequate supporting data and story. At this stage, I also prepared participant "stories" to support the meaning of each theme which I discussed with the study supervisors. This also contributed to establishing the credibility and quality of the analysis and ensuring the trustworthiness of the research. At this stage I considered Bronfenbrenner (1979, 1986, 1994), as an explanatory framework but I was careful not to overly limit other

interpretations of the data. Slowly the themes emerged, and I then related these to Bronfenbrenner's (1979, 1986, 1994) framework. See figure 5.10 and 5.11.

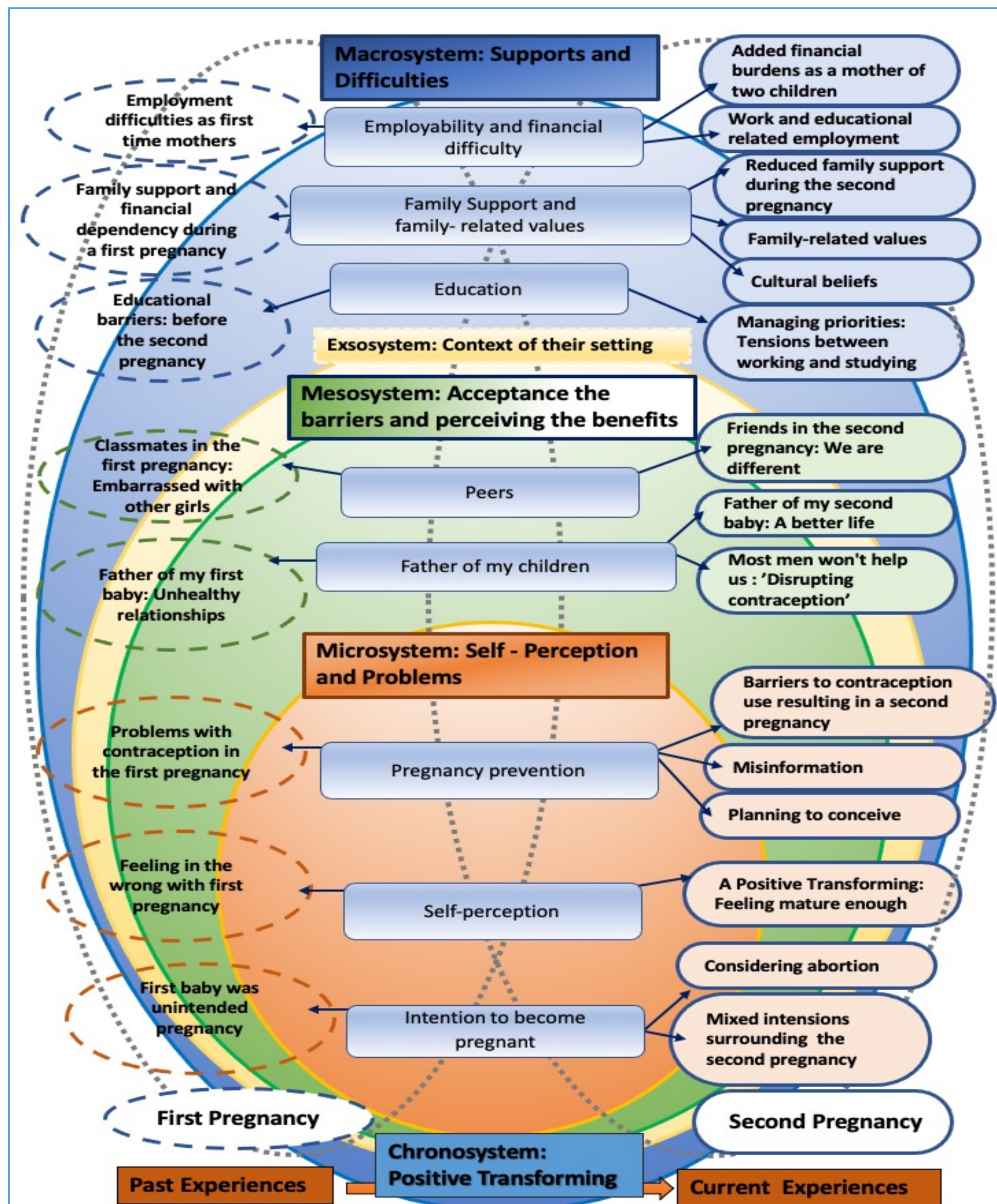


Figure 5.11 Visual analytic mapping of the main themes and sub-themes

Phase 5: Defining and naming themes

At this stage, I considered how each theme fitted into the overall young mothers' story across the entire data set in relation to the research questions (Braun and Clarke, 2013). I also defined and refined sub-themes, themes of what each theme is about and determined

what data each theme captures. I checked the name of each theme by rereading the data and organising the quotes to present a coherent and internally consistent account. See table 5.6.

Phase 6: Producing the report

This phase involves the final analysis and write-up of the report (Braun and Clarke, 2006; Braun and Clarke, 2013) and I present this stage in chapter 6. I have tried to provide a concise, coherent, logical, non-repetitive, and interesting account of the stories revealed in the data. I have also made every effort to provide sufficient evidence of the themes within the data, for example I provide adequate data extracts to demonstrate the prevalence of the theme. Moreover, at this stage, I provide an analytic narrative of the young women's accounts of repeat pregnancy.

Table 5.6 provides the outline of research's findings developed from thematic analysis. The analysis identified four themes*: Contraception Decision-making, Relationships, Education and Employment, and A Transformational Experience*. These findings will be presented in chapter 6 and discussed in chapter 7.

Table 5.6 The outline of Experiences of Repeat Pregnancy in Thai Adolescent Mothers

Experiences of Repeat Pregnancy in Thai Adolescent Mothers										
Themes	**Contraception Decision-Making**		**Relationships**			**Education and Employment**		**A Transformational experience**		
Sub-themes	***Planning and not Planning***	***Problems with Contraception***	***Partner***	***Children and Families***	***Peers***	***Education Barriers and Benefits***	***Employment and Financial Struggles***	***Feelings about Pregnancy***	***Learning from the Experience***	***Aspirations for the Future***
Past Experiences of being first pregnant mother	• First pregnancy: put it down to experience	• Contraceptive Risk-taking in previous pregnancy • Barriers to sexual health support	• Supportive relationships • Managing difficult relationships	• Bonding and mothering • Family supports	• Embarrassed to tell friends	• Accessing education and financial barriers in the first pregnancy	• Lack of access to well-paid employment	• Feeling in the wrong	• A more confident mother • Gaining maturity	• Higher qualification, more chance • Being a role model for children
Current Experiences of second pregnant mother	• Second pregnancy: planning to conceive	• Choosing contraceptive methods • Most men won't help us: disrupting contraception	• Life is moving forward	• Raising children: Preparing for another baby • Independent: my mum let me grow up • Young marriage	• We were the same • We are difference	• Children as a priority: education in the second pregnancy	• Potential dangers of working during the second pregnancy	• Feeling more like an adult		

5.10 Trustworthiness

The concept of rigour in qualitative research is known as trustworthiness. *"Trustworthiness in qualitative research means methodological soundness and adequacy. Researchers make judgements of trustworthiness possible through developing dependability, credibility, transferability, and confirmability. The most important of these is credibility"* (Holloway and Galvin, 2017: 309). Here, I consider rigour in this study and discuss how trustworthiness has been addressed throughout the research process. I conclude this section with a discussion of authenticity and this research study (Guba and Lincoln, 1989).

When conducting data analysis, the researcher becomes the instrument for analysis, making judgments about coding, theming, decontextualizing, and recontextualizing the data (Nowell et al., 2017). Each qualitative research approach has specific techniques for conducting, documenting, and evaluating data analysis processes, but it is the individual researcher's responsibility to assure rigour and trustworthiness (Nowell et al., 2017).

5.10.1 Dependability

Lincoln and Guba (1985) use the term dependability instead of reliability. *"If the findings of a study are to be dependable, they should be consistent and accurate. This means that readers will be able to evaluate the adequacy of the analysis through following the decision-making processes of the researcher"* (Holloway and Galvin, 2017: 309). In this study I have provided an account of the context of the research and described the data collection processes in detail. I have provided a detailed explanation of the analysis process in section 5.10 of this chapter where I have shown how I applied Braun and Clarke's (2013) thematic analysis process and explained my decision-making processes. I have provided descriptions of the context of the research and extensive quotations from the participants in chapter 6. I have already discussed my recordings in my field notes and keeping a reflexive diary, both of which have aided a reflexive analysis and interpretation of the data. These processes are open for the reader to judge how this study achieves the criterion of dependability.

5.10.2 Credibility

Credibility parallels the notion of internal validity (Holloway and Galvin, 2017). This means that the participants recognise the meaning that they themselves give to a situation

or condition and the *"truth"* of the findings to their own social context. Similarly, Jeanfreau and Jack (2010: 616) assert that credibility refers to the *"confidence in the truth value or believability of the study's findings"*. Moreover, the researcher's reflexivity also leads to the study's credibility as *"it helps to make the reader more aware of possible influences on the study"* (Jeanfreau and Jack Jr, 2010: 616). In this study I have maintained detailed, contemporaneous field notes and over the course of the research kept a reflexive diary where I have interrogated my ideas, thoughts, and position as a nurse midwife and researcher. I have also had regular supervision with my study supervisors, who have questioned my decision making and encouraged me to reflect on the emerging analysis and findings.

I returned transcribed interviews to three of the participants who had indicated on the consent form that they would like this, for them to read and review (Mason, 2017). I also checked my emerging analysis and interpretation of the data with a Thai nurse midwife colleague who discussed and gave me feedback on my analysis. Guba and Lincoln (1989) advocate the use of peers to challenge a researcher's constructions about a study.

Sustained engagement in the field is also a measure of credibility (Guba and Lincoln, 1989) and I spent six months collecting the data in this study with fifteen participants involving nineteen substantial interviews each of which lasted between 60-90 minutes.

5.10.3 Transferability

When considering the applicability of findings, Lincoln and Guba (1985) refer to the criterion of transferability (Holloway and Galvin, 2017; Braun and Clarke, 2013). This means that the findings in one context can be transferred to similar situations or participants. As Jeanfreau and Jack (2010: 616) explain, *"transferability or fittingness of research findings refers to the study findings" "fitting outside that particular study"* and *"the possibility that the findings would have meaning to another group or could be applied in another context"*. To do this the report of the findings needs to provide sufficient detail and information for the reader to evaluate the data analysis process and show how the findings have emerged. I believe that I have done this in chapters 5 and 6 through the thick descriptions I have provided of the data analysis process. Additionally, in this study I have developed an adapted explanatory model of repeat adolescent pregnancy using Bronfenbrenner's (1979) ecological theory which provides an opportunity to consider how these findings might be transferable to other contexts.

5.10.4 Confirmability

Confirmability is defined as the needs an audit or decision trail where readers can trace the data to their sources. When confirmability exists, readers can trace data to their original sources (Holloway and Galvin, 2017). The 'confirmability, or auditability, refers to the documentation, or paper-trail, of the researcher's thinking, decisions, and methods related to the study' (Jeanfreau and Jack Jr, 2010: 616). In this thesis, I provided in-depth details of participants' accounts in field notes, transcripts, and reflexivity diary to illustrate my decision making and establishing a confirmability to the study.

5.10.5 Authenticity

Trustworthiness, which relies on the methodological adequacy of the research, is defined as authenticity (Guba and Lincoln, 1989). A study is authentic when the strategies used are appropriate for the true reporting of the participants' perspective (Holloway and Galvin, 2017: 310). Firstly, the authenticity can be judged on whether the researcher obtained, in a fair manner, informed consent from the young mothers (Holloway and Galvin, 2017). I have given details of how the young mothers were given time to think about taking part, that they were given information about what taking part in the research involved, and they were advised that they could withdraw from the study at any time without this affecting their ongoing care. The second strategy related to authenticity is ontological authenticity and in chapter 4 I have described the underpinning rationale and justification for the selected qualitative research approach used in this study (Mason, 2017). Using a qualitative approach with semi-structured, in-depth interviews has facilitated an understanding of the young mothers' social world and their experiences. Lastly, thematic analysis was used to understand participants' experiences, reflecting a particular "analytic sensibility" (Braun and Clarke, 2013: 201); in other words, data was read, interpreted and organised through the theoretical lens of Bronfenbrenner's ecological model.

Chapter 6 The Experiences of repeat pregnancy among Thai Adolescent Mothers

6.0 Introduction

Chapter 6 presents an analysis, illustrated by data from individual semi-structured interviews. Four themes were identified*: Contraceptive Decision-making, Relationships, Education and Employment,* and *A Transformational Experience*. During the data analysis process, it became evident that the impact of the first pregnancy permeated the experience of the lived experiences of the second. In addition to experiences of the second pregnancy, women also discussed the important role of the first pregnancy and their life before becoming pregnant for a second time. Therefore, experiences of both first and second pregnancies run parallel within each theme. Table 5.6 (see above) details the overall experiences of repeat pregnancy in Thai adolescent mothers.

6.1 Contraceptive decision-making

This theme focuses on the how participants describe their experiences of becoming a young mother. They recalled their earliest memories of being young mothers following their first pregnancy and present experiences of being pregnant with their second baby. This theme considers contraceptive decision-making which is built on two sub-themes: "*Planning and not planning*" and "*Problems with contraception*".

6.1.1 Planning and not planning

Almost all participants expressed that their first pregnancy was 'unplanned'. However, the picture is more mixed in relation to the second pregnancy, some explained that their second pregnancy was 'mistimed', although they had wanted a second child at some point, while others had been 'planning to conceive'.

6.1.1.1 First pregnancy: put it down to experience

Most participants talked about their first pregnancy as unplanned, some saw it as a mistake in how they had managed contraception, that they could *put it down to experience* as is revealed in Palmy's experience.

Palmy was aged 19[4] and 28 weeks pregnant with her second baby when I met her. She left education aged 12 (year 7 - Pratom 6 in Thai) and had her first child at 15years old[5]. She separated from the father when her first baby was 2 years old and her son, now aged 3, lives with her parents in the Northern part of Thailand (around 800 km from her current home at the interview). Palmy moved in with the father of her second baby, and his family. Seven people, including his mother, father, younger sister, older brother, and his wife, lived in the house, located at the worksite of her father-in-law. This house belonged her father-in-law's employer and was in a poor condition; it was built from shipping

[4] The age of consent in Thailand "is 15, while the age of consent for marriage is 17. Marriage for persons under 17-years-old requires consent of the family court. Marriage for persons between the ages of 17-19 requires parental consent and they would be attained majority through marriage." (Thai Civil and Commercial Code, 2002; Thailand youth policy factsheets, 2014).

[5] As the age of consent in Thailand is 15 regardless of gender or sexual orientation, as specified by article 279, 317, 318 and 319 of the Thai Criminal Code. "Individuals aged 14 or younger in Thailand are not legally able to consent to sexual activity, and such activities result in prosecution for 'statutory rape'. Thailand's statutory rape law is violated when an individual has consensual sexual intercourse with a person under age 15. There is no close-in-age exemption (Romeo and Juliet laws) in Thailand; it is possible for two individuals both under the age of 15 who willingly engage in intercourse to both be prosecuted for statutory rape" (Thai Civil and Commercial Code, 2002; Thailand youth policy factsheets, 2014).

containers, painted green and separated into many rooms. Her mother-in-law used some areas to run a small local food shop selling papaya salad (Somtum), noodles, and Thai cooked to order dishes.

It was challenging to find a private area for the interview, particularly necessary as I wanted to discuss both her past and present experiences, including time spent with her ex-partner. I started by introducing myself to her partner's parents to build rapport. We talked about general topics; at the same time, I observed the dynamics between her and her partner's family. After this, I asked Palmy to talk with me alone around the table outside of the house. The interview started with the general questions about her life, before turning to more sensitive issues. Her first pregnancy was unplanned, she explained:

> ***Parichat:*** *Let's go back to your first pregnancy. How old were you when you got pregnant?*
>
> ***Palmy:*** *About 14 – 15 years old. I wasn't aiming to get pregnant. I used birth control pills. But I forgot one pill, so I became pregnant.*
>
> ***Parichat:*** *As you said you forgot to take the pills. How did you protect yourself after that?*
>
> ***Palmy:*** *I didn't. I didn't know that I had forgotten. I found out when I looked at the tablets. (T1 Palmy, 19 years old)*

As another example, Manee was 19 years of age and 30 weeks into her second pregnancy when she was recruited to the study. Her daughter was 4 years. The father of her first baby was 25 years old and she was 14 years when they met, and they lived together[6]. Manee was with him for a year. Manee often forgot to take her pills and became pregnant at age 15. Her first pregnancy was unplanned.

Pakar was aged 19 at recruitment, she was 32 weeks pregnant with her second baby at interview and she lived her parents and her partner (the father of both children). Pakar

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[6] 1) Child marriage, defined as a formal marriage or informal union in which one or both of the parties are under 18 years of age. The united nation Sustainable Development Goals (SDG) 5 : Achieve gender equality and empower all women and girls, target 5.3 aims to eradicate child marriage by 2030. In the indicator 5.3.1 eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation. (United Nation, 2022)
2) The age disparity in sexual relationships is the difference in ages of individuals in sexual relationships. But not include the violate with individuals who aged 14. "In Thailand, the individuals aged 14 or younger in Thailand are not legally able to consent to sexual activity". (Thai Civil and Commercial Code, 2002; Thailand youth policy factsheets, 2014)

was 15 and her partner 18 at her first pregnancy. Pakar talks about her first pregnancy, which was unplanned:

Parichat: *How do you feel about getting pregnant with your first baby?*

Pakar: *I didn't use it [contraception]. And my period is normally irregular anyway. When I graduated, my period was gone, so I thought it was normal. When I went to receive antenatal care, the doctor said I was seven months pregnant.*

Parichat: *How did it happen?*

Pakar: *I was fifteen years old. I met my partner at [Local market in the Temple]. We were dating and I didn't expect to be getting pregnant. Later, he came to live at my house and work. (T2 Pakar, 19 years old)*

Only one participant said that her first pregnancy was planned, and this was because her partner wanted to have children. Sao was 19 years old and 25 weeks pregnant with her second child when I met her. She had left school, prior to her first pregnancy, at age 14 (in year 9 Mattayom 2 in Thai) with no qualifications. She was 15 and the father of her first baby was 24 years old when they conceived. Sao's partner moved in to live with her and her family but his relationship with her father was poor; they often argued, and he seemingly did not respect her father who was Sao's most valued family member. The father of the first baby and her father almost physically fought on some occasions after which Sao decided to separate from him and raise her daughter, now 4 years old. Sao talked about her first pregnancy:

Sao: *"I quit my school before I was pregnant because I was bickering with my schoolmates. I was just year nine. At the age of 15, I intended to have children because my (ex) partner (father of first baby) wanted to have children." (T11 Sao, 19 years old)*

Later, at age 16 Sao met the father of her second baby (he was aged 28); Sao had used oral contraception since the first baby was born, so as she thought she might had been on hormonal contraception for a long time she worried about infertility; and so, stopped using any contraception. Sao and her second partner agreed to have a baby. Sao earned money by selling new and used vintage clothing online. She expected to exclusively breast-feed her second baby for as long as possible.

In summary, it was apparent from the interviews that most first pregnancies were unplanned, for a variety of reasons as they reported forgot pills and didn't realise, some

did not use contraception. Moreover, some used post-intercourse contraception, but this failed to prevent pregnancy. The only first pregnancy described as planned was in response to the wishes of a partner.

6.1.1.2 Second pregnancy: planning to conceive

Participants talked about how they felt about being pregnant for a second time. This second pregnancy was considered *mistimed* by some, who talked about having a plan for a second child but not just yet. Others actively wanted to have the second child and were *planning to conceive.*

Napar was aged 19 when I met her and at 30 weeks pregnant with her second baby; her son was 4 years old. Her first baby was not planned; she became pregnant after having sex for the first time. She did take oral emergency contraceptive pill or the "morning after pills", but it was not effective for her. Napar broke up with her partner when she was 7 months pregnant with her first baby. Napar began talking with her current partner (17 years old) just after the breakup, when she was around 8 months pregnant.

Napar and her current partner had used oral contraception since they had been together and had used this method for around 3 years. Napar explained that pregnancy was not in her plan and that she had not wanted a subsequent pregnancy at the time. However, Napar stopped using oral contraception almost a year before conceiving the second baby, as she was experiencing uncomfortable side effects from the contraceptive pills, such as headaches and feeling irritable. Napar was undecided about whether the pregnancy was planned or unplanned: *it's sort of mistimed*, she said. Originally, she thought to have a second baby when she was older because she did not want to have another child while she was so young, but this pregnancy came earlier than she intended.

> ***Parichat:*** *Could we talk about your life during your first and second pregnancies and about your decision to have another child.*
>
> ***Napar:*** *Actually, I wanted to have a second child. I thought I might be ready when I was twenty-five years old, but it's okay that the baby came now. I'm nineteen now. I'm working. This baby is coming before I had planned.*
>
> ***Parichat:*** *Why is it that you said you wanted to have a child when you were 25 years old?*

Napar: *It's really because I'm not ready. If someone asks if I'm ready, I'm not ready. But anyway, if the baby is coming, it's coming. Cause I don't want to use birth control. (T3 Napar, 19 years old)*

Titar also defined her second pregnant as mistimed. When she was recruited to the study, she was 19 years old and 32 weeks pregnant with her second child, her first son was 5 years old. Titar broke up with the father of first baby (aged 24) before she realised that she was pregnant. Titar was a single mother for a while before she began a new relationship, with her current partner. Titar and her new partner (aged 19), the father of her second baby, live separately.

Titar used Depot Medroxyprogesterone Acetate (DMPA) contraceptive method for two years after her first baby was born. After many cycles, she found it painful and so changed to oral contraception, However, she often forgot to take the pills, resulting in a second pregnancy. Currently, Titar works at home and has been selling amulets online via Facebook to earn money for family living expenses. Titar had planned to have cosmetic plastic surgery (rhinoplasty), however, when she found out that she was pregnant, she postponed the surgery and attended the antenatal clinic instead. Titar had a bad experience with her first birth and, although Titar and her partner had been talking about having a baby, they had decided that this was not the right time. She explained that her second pregnancy was mistimed:

Parichat: *Could we talking about your decision to have another child?*

Titar: *The first one was very difficult for me to give birth. I couldn't bear it. It hurt like I died.*

Parichat: *So why are you having this baby?*

Titar: *Actually, we [Titar and her partner] have talked about having a second baby but not this time.*

Parichat: *Um [nodded]*

Titar: *The second time I didn't mean to get pregnant. I don't know, I'm worried that I'm going to get pregnant because I'm going to have cosmetic surgery. I'm going to have a nose surgery [rhinoplasty]. I must have a pregnancy test every month because I had already made an appointment with a plastic surgery doctor. Then 3 days before the operation I took another pregnancy test, 2 lines appeared, so I stopped doing the nose surgery. So, I can't [get plastic surgery]*

Parichat: *Did you take any contraception?*

Titar: *I took the pill, but I'm a person who doesn't like medicine. I ate some, don't ate some. I controlled it for a long time, and he (partner) doesn’t live with us often. He didn't stay with us often, so I took some pills, and sometimes didn't take it. (T14 Titar, 19 years old)*

Many young mothers revealed that they have thought about having another child, but not at this stage in life. However, some participants explained that their second child was planned. and I explore this in the next section.

Some adolescent mothers stated that they had a plan to have a second child. These adolescent mothers explained about *planning to conceive* that they wanted a second child for a variety of reasons; some for exactly the same reason that older women do: “*they married, and they want a child”,* others explained that this had originated from their family’s wishes or talked about the benefits of raising the children together. Some adolescent mothers explained that they were able to use contraception effectively but felt that they had been taking it for “too long”.

For example, Sasi was aged 19 and 29 weeks pregnant with her second baby, with first child, a healthy girl, aged 5 years at recruitment. Sasi and her partner (who is 25 years old and the father of her children) live together with Sasi’s family and he runs his own business, which provides a good income. Although her first pregnancy was unplanned, she explained that they had used contraception successfully and avoided pregnancy, although sexually active, for “years”. They decided to have the second baby as their daughter was 5 years and Sasi’s mother said it was time for them to have another one. They also planned the second baby as they decided it was good to bring two children up together:

Parichat: *What made you decide to get pregnant this time?*

Sasi: *At first. After the birth of my first child, I had a contraceptive injection [about 5 years], but then my mum told me that I was young, that I would have to take the contraceptives for a long time. If I want to have another child, it's going to be hard.*

Parichat: *Did you do what your mother said?*

Sasi: *Yes, so I stopped injecting contraceptives and let menstruation [flow] normally for almost a year. And then I got pregnant with this baby. When I found out I was pregnant, my mum doesn't*

mind. She said it was happening and it's okay. It's good for me to be able to raise my babies together. (T4 Sasi, 19 years old)

A second pregnancy may be planned by the young mother alone. Manee separated from the father of her first baby. Nine months after they broke up, she met her current partner (35 years old), who is the father of this baby. Manee stated that she planned for the second baby:

Parichat: *How did the second pregnancy occur?*

Manee: *Current partner and I met and had been talking for 4 years since my first baby was 9 months old. In the 3rd year [of relationship], we moved into the same house. When we were together, I used birth control pills. But I decided to have this child. Because he (partner) is old, 35 years old, and he wants to have children.*

Parichat: *How did he react when you get pregnant his child?*

Manee: *My partner is happy to have a child. Because he's old, He was glad that I was pregnant. He said that it is good. My eldest child will have friends to play with. If my daughter is alone, has no relatives, doesn't have brothers and sisters, who will be with her or, if we get sick [in the future], who will take care of her?" (T13 Manee, 19 years old)*

Manee explained this second pregnancy was planned. She also expressed the benefits of having children close together. Manee felt ready to be a mother and desired to build a family. I also explored her intention to study because she had left school at the age of 14. Manee replied that she had not been interested in continuing her study after she left school as she wanted to look after her children and making a financial contribution to the household was her first concern.

In summary, although many of the adolescent mothers saw their first pregnancy as unplanned, when talking about their second pregnancy, some considered it as mistimed following problems managing contraception, while others planned to conceive, deciding this either on their own or together with their partners. This data suggests that those planning to conceive were thinking about the benefits of having children close in age so that they can raise them together as well as meeting expectations of others, such as families and partners. However, some also did not use contraception as a result of concerns about side effects, an issue I explore in more detail in the next section.

6.1.2 Problems with Contraception

Whether a pregnancy is unplanned, mistimed or planned is related to contraception use and knowledge and how adolescent mothers manage it. This sub-theme illustrates problems relating to contraceptive use. Experiences in relation to an unplanned first pregnancy suggests a lack of contraceptive knowledge. However, for their second pregnancy, adolescent mothers in this study show they have experience deciding about contraception methods and are more concerned with the challenge of using it. The greatest barriers to contraceptive use are method-related fears about side effects and fertility health concerns. This sub - theme shows the challenges, including "contraception issues" in their first pregnancy and ongoing problems with contraception after the first pregnancy, then resulting in the second pregnancy. This also shows a "misunderstanding and discontinuing" in using and selecting contraception. There were various barriers surrounding contraception use shown in this theme such as the discomfort of side effects associated with the selected contraception method. Furthermore, a fertility expectation or knowing that the family wants them to have another child can play a crucial role as a barrier to the use of contraception. Participants also pointed out that their partner does not share the responsibility of using contraception safely.

6.1.2.1 Contraceptive Risk-taking in previous pregnancy

This sub-theme presents the experiences of contraception that participants have expressed in relation to their first pregnancy. Participants reported sexual activity with inappropriate protection methods, and they reflected on problems with contraception as a common cause of unplanned pregnancy. Participants explained that misunderstandings about using contraception resulted in pregnancy with their first child as they had not taken the contraceptive pill consistently.

Passon told me her story about getting pregnant with her first child. She was 19 years old and 32 weeks pregnant with her second baby when she joined the study. Passon lived with her partner, the father of both her children. Her first pregnancy was unplanned. Her daughter is 4 years old and was born prematurely. She mentioned that she is quite a forgetful person. Passon was in year 12 (at aged 16) when she first became pregnant and dropped out of school since that. She had expected to continue her education, and her mother could have supported her in this, but she decided to leave to earn money to support her children. Passon had her own noodles shop with support of her partner, who worked in his rice field asides from helping in the noodles shop. She was very busy in the morning

opening her shop, so she was late to attend the ANC and often missed ANC appointments. Passon explained that she often forgot to take the contraceptive.

Parichat: *How did you get pregnant for the first time?*

Passon: *We have had sex for years. I used birth control pills. At that time, I was in grade 12 and I didn't continue studies. I finished only Mattayom 4 (year 12)*

Parichat: *Did you use any contraception to prevent the pregnancy?*

Passon: *I forgot to take birth control pills. I was a forgetful person. (T12 Passon, 19 years old)*

Another participant, Sasi, was 14 when she became pregnant after having sex for the first time, while her partner was 20. As a result, she left school without qualifications. At the time she conceived her first baby she really wanted to continue her education, but her mother took her out of school to hide her pregnancy. Sasi revealed about her risk-taking in terms of sexual health knowledge and that she was very young and lacked knowledge:

Parichat: *How did you get pregnant for the first time?*

Sasi: *I didn't use birth control pills. He didn't use anything either. Just first time that we had sex then I got pregnant*

Parichat: *Did he pressure you?*

Sasi: *I was willing at the time. He didn't hurt me, didn't force me, but I didn't think I was going to get pregnant. I didn't know about birth control pills.*

Parichat: *Did you thinking of using any birth control at that time?*

Sasi: *I was still very young. I didn't know how to use protection. When I had sex for the first time, at that time, I had no intention of getting pregnant, but it happened. (T4 Sasi, 19 years old)*

Some participants mentioned that they had sexual health education at school but could not remember or use it in their everyday lives. Like Sasi, Pakar's first pregnancy was unplanned. Pakar mentioned she had sexual health lessons at school regarding contraception but said she could not remember it and apply it to her real-life situation, and this resulted in her first pregnancy.

Some participants explained that they became pregnant with their first child unintentionally, as their partners were using condoms, but they were not sure if this was used every time. Male contraception misuse was a major cause of the participants' first pregnancy.

Siri was 19 years old and 27 weeks second pregnant at recruitment. her first son was 17 months old. Siri lived with the father of her first baby for 2 years prior to her unplanned pregnancy. They used condoms until Siri became pregnant. Siri graduated in year 13 with school leaving certificate. She began to work in an animal food factory locally to earn money for her baby, while the father of her first baby went to study an undergraduate degree. She separated with him in late pregnancy as she found out he was together with another woman. After this Siri moved to live with her parents and raised her son by herself. She decided to make money for her family first as she was satisfied with her study level.

Parichat: *How did you get pregnant for the first child?*

Siri: *We were in a relationship for about 2 years. I also prevented pregnancy because I was afraid to get pregnant, it was early. We were using condoms, but I became pregnant. Then I thought whether we used it every time. Was it used correctly?*

Parichat: *Why do condoms suit you as a contraceptive?*

Siri: *I chose the condom for sure, if I take the pill I could forget it, and because I don't know anything about birth control pills. So, I got pregnant for the first time. Then he left me. When he left me, I thought it was a life crisis. (T7 Siri, 19 years old)*

Another participant, Rassa, said that she was using condoms and emergency contraceptive pills before having her first baby. Rassa was 19 years of age and 30 weeks into her second pregnancy when she joined the study. Rassa works as a seller in a local 7-11 shop, she was on maternity leave. She lives with her partner's family; he is 22 years old and the father of both her children. Rassa became pregnant with their first child when she was in the last year of vocational school level 3 and received a leaving certificate (aged 17). In her first pregnancy experience, Rassa lived with her roommate in private student accommodation and her partner visited her when her roommate was not in the room. Her parents did not know that they were dating together. They used condoms while she herself did not use any type of contraception and used emergency pills sometimes when there were mistakes. Rassa completed her final year at a school that supports pregnant final year students and so she was able to complete her final year and leave with

a certificate. She was expected to go to university to get a bachelor's degree, but this was not possible because of her pregnancy, which changed the course of her life. She cried when asked about her study expectations. Rassa raised her daughter herself with support from her partner's parents for household expenses. The first pregnancy was the result of failed contraception:

Parichat: *How did you get pregnant for the first child?*

Rassa: *I studied in the city far from my parent's house, around 1 hour away, so I rented a room and shared with my roommate. I lived by my own.*

Parichat: *How did you meet him?*

Rassa: *I met him through Facebook, and we talked for a while, then we began a relationship. Sometimes, he came to see me at my room. We had sex and I got pregnant my first child.*

Parichat: *Did you use any birth protection?*

Rassa: *"For the first pregnancy, my partner [current partner] used condoms sometimes, but sometimes didn't. I also used emergency pills, but I did forget sometimes." (T8 Rassa, 19 years old)*

When Rassa found out she was pregnant, she felt guilty. Rassa was the youngest of 4 siblings; her sisters decided not to study so they could help her parents by working to provide enough money to support Rassa to study at the highest level she could do. As a result, Rassa felt sorry for disappointing them.

Napar was aged 19 when I met her. Napar also mentioned using emergency contraception (morning after pills) and during our discussion explained that she did not know a lot about the risks of using emergency contraception. Napar broke up with the father of her first baby when she was 7 months pregnant with the child. Napar talked about her first pregnancy and using emergency contraception:

Parichat: *How did you meet him and how did you get pregnant with the first child?*

Napar: *We met because our stores were close to each other. They were balloon dart-throwing kiosks. They move around a lot, and we kept meeting in a festival. We had been seeing each other for about a year and I took emergency pills [morning after pills], but I still got pregnant. I took two pills after having sex and then another after no more than 72 hours.*

Parichat: *How often did you use it?*

Napar: *"I only had sex once and I got pregnant while I was taking morning after pill but that it failed. Other people don't get pregnant so easily. I'm probably a different case. It only takes once to get pregnant." (T3 Napar, 19 years old)*

These statements explore some of the problems adolescent mothers experienced using contraception and reflect on how they failed to provide protection. I argue that the lack of sexual health knowledge is significantly important to the young mothers. The next category explores the sources of information and guidance and some of the associated problems discussed by young mothers.

6.1.2.2 Barriers to sexual health support

Problems with contraception are not only associated with contraceptive risk taking, but young women also face barriers to appropriate sexual health support, including difficulties accessing contraception and advice and information about how to use these methods and what to do if things go wrong.

Accessing contraception is not necessarily easy. Kor did not have access to any sexual health education at school because she had to stop studying at grade 2, before sexual health education was taught, to earn money to help her mother. Kor was 19 years of age and 25 weeks into her second pregnancy with twins when she joined the study. Her first pregnancy had been unplanned; she often forgot to take the pill and became pregnant. The father of her first baby (who was 18 years old) disappeared once he found out about the pregnancy. Kor's daughter is now 2 years and 6 months old, and she has lived with Kor since she was born. Kor was the only adolescent mother who was unable to read Thai language; she is of dual heritage; her father is Thai, and her mother is Mon ethnicity (people who live around the Thai - Burma border).

Kor did not know how to manage conception and did not appreciate the need for using contraception. She explained that her mother bought her an oral contraception, so the only access Kor had to information was the information from the pharmacist about how to use the contraception pills passed on to her by her mother. Kor suggested that as she was young at the time, and not aware about the importance of taking contraception pills appropriately. She sometimes also forgot to take the contraception pills:

Parichat: *Do you have any knowledge of contraceptives?*

Kor: *No, I didn't study in school. I see that other people of the same age as I can have children. I think that I myself could have it too….and I don't know how to protect.*

Parichat: *How did you get pregnant with the first one?*

Kor: *Once I had a boyfriend, I was just letting go, I didn't know that I had to take the pills and didn't know that I had to have an injection. My mum told me to take birth control pills. Well, my mum told me to take birth control pills. She said I was still young, and I should take the birth control pills first. But with the fact that I am still young, I took it, but sometimes forgot, so I got pregnant. At that time, I didn't think it would be difficult if I had a child when I was young." (T6 Kor, 19 years old)*

The young women indicated that their mother is their source of advice about contraception; some participants report that their mother also bought them contraceptive pills.

Palmy also talked about the guidance she received from her mother, who told her about using oral contraception and bought her oral contraceptive pills. Palmy completed the Pratom 6 (aged 12), however, she was not taught about sexual and reproductive health in school. She could only talk to her mother, who was her close friend and someone she could rely on. However, although Palmy could access contraceptive pills from her mother, she was too young to use this contraception properly.

Parichat: *Let's go back a bit to your first pregnancy. How old were you the first time when you got pregnant? How did you get pregnant with the first one?*

Palmy: *About 14 – 15 years old. I wasn't intending to get pregnant. I always used birth control pills. But I forgot one pill, so I became pregnant.*

Parichat: *You forgot to take the pills. How did you protect yourself after that?*

Palmy: *I didn't. I didn't know that I had forgotten. I found out when I looked at the tablets.*

Parichat: *At that time, who told you to take birth control pills?*

Palmy: *My mother told me to. She knew I had a boyfriend and that we had sex, so she went to buy birth control pills for me and told me to take them. After that, I bought them for myself, but I forgot plenty of times. (T1 Palmy, 19 years old)*

Another participant, Ponsi, discussed problems accessing safe contraception and accurate information easily. Ponsi was one of the participants who indicated that they had got information about contraception from unreliable sources. Ponsi got the contraception pills from friends and relatives who later also became pregnant despite using this oral contraception. Ponsi was the youngest participant in this study; she was 17 years of age and 35 weeks into her second pregnancy at recruitment. Ponsi and her partner (aged 18 and the father of the children) lived together in Ponsi's parent's house. Her daughter was 19 months old. Ponsi was aged 14 when she was first pregnant - a pregnancy which was unplanned. She used oral contraception but forgot to take it. Ponsi left school at aged 14 with no qualifications; she still studies but has moved to the Non-Formal and Informal Education: NFE. Now she is in year 9 (Mattayom 2) and Ponsi expects to study until finishing her high school level equivalence so that she can have more choices when applying for jobs. After giving birth Ponsi desired to get an implantation, but it was out of stock, so she was on a waiting list. While waiting for an implantation she used contraception injections but then was shocked to find out she was pregnant with the second baby. Ponsi got full support from her parents for household expenses as her partner only made financial contributions for baby formula for the first daughter. Ponsi explained that her first pregnancy was not planned.

Ponsi was given the contraceptive pills by the brother of her partner. He gave the emergency contraception pills to her partner, who then passed them to her. She used this method but became pregnant. This reflects Ponsi's lack of access to accurate and effective contraception and contraception advice, and the problem that people who are significant in her life, including her partner and her partner's relatives, are not necessarily reliable.

> ***Ponsi:*** *My partner used a condom before the first pregnancy, sometimes he did not use it and I had some emergency contraceptive pills. Sometimes I forgot to take it and then got pregnant. This birth control pill was bought by my boyfriend's brother. (T9 Ponsi, 17 years old)*

This excerpt above also shows that although other adults may have access to the contraceptive pills and advice, this is not necessarily true for adolescent mothers, who in this instance was the only one who did not know about how to access contraceptive information from healthcare agencies.

There are only two products agencies of postcoital pills in Thailand. It is the single progesterone only or levonorgestrel 750 micrograms. Both products contain 2 tablets in

one dose. The first tablet must be taken immediately, and the next tablet must be taken 12 hours later from first tablet. This type of contraception pill must be taken within 72 hours after intercourse. If 72 hours have passed, the emergency contraceptive pill may not be effective in preventing pregnancy. Emergency contraceptive pills has been used for emergency only and the effective rate of conception protection was relatively low compared to other oral contraceptive pills. It is not recommended to take more than 4 tablets or 2 doses per month (Sripichyakan and Tangmunkongvorakul, 2006). Yet Ponsi also mentioned another type of oral contraceptive pill that was not in the lists. The 10 tablets oral contraceptive was not registered for pharmaceutical human use in Thailand.

Ponsi: *My boyfriend's brother bought emergency pills to him then he gave me. It was containing 10 tablets per tray. My friend she did take the same kind of pills and she was pregnant as well.*

Parichat: *You mean the pill pack of 10. Is this what was used for protection? And how did you take them?*

Ponsi: *Yes, I took one pill a time, immediately after sex. and had another pill 12 hours after the first pill.*

Parichat: *Where did he get these pills; did he tell you?*

Ponsi: *No, he didn't tell. He just told me he bought it from the drugstore.*

Parichat: *This 10-tablet drug is not registered in Thailand, and it may be a fake drug that is ineffective. It should not be used as birth control pills. Because emergency contraceptive pills in Thailand only contain 2 tablets,*

Ponsi: *Umm, that's why me and my friend who took these pills got pregnant as well. (T9 Ponsi, 17 years old)*

I was concerned about this issue and told her after the interview that this make of emergency pill was not registered for pharmaceutical human use in Thailand and cannot be used to protect against pregnancy; it may be a counterfeit drug with additional risks that is ineffective against preventing pregnancy. In addition, using emergency pills alone as a contraception must be avoided.

These accounts of young mothers show that the experiences of contraception among adolescent mothers was in line with the sexual and contraceptive health literacy. Moreover, this issue is not only found among young mothers but was also conveyed

among their related significant others such as their mother, their partner and mutual friends, and some healthcare staff.

A number of barriers therefore existed for these young women in relation to accessing reliable sexual health information and contraception, which contributed to their first pregnancy. Young mothers revealed a lack of knowledge and were receiving information about contraception from unreliable sources. Next, I will explore the problems participants experienced when making decisions about contraception preceding their second pregnancy.

6.1.2.3 Choosing contraceptive methods

This category reports *choosing contraceptive methods* where misunderstandings and misinformation resulted in a second pregnancy. Participants reported a range of issues that interrupted contraceptive use.

Choosing contraceptive methods for adolescent mothers after giving birth is challenging. There are issues such as discomfort and physical problems related to hormonal contraception use. Long-Acting Reversible Contraceptives (LARC) were also discussed in participant interviews. Young mothers reported that they considered side effects and felt a lack of confidence that the implantation plastic rod will stay in place. Choosing contraceptive methods is a concern among adolescent mothers. Additionally, along with a lack of confidence that this contraceptive method will work, there were some fears of pain or fear of needles. Some participants reported that they had a fear of needles, which left them without contraceptive cover and at risk of pregnancy. Some struggled to choose an effective contraception method appropriate to them. Participants disclosed reasons about why they were not able to use hormone-based contraception, however, they did not then start using alternative protection as well.

Pakar explains about choosing the contraception method after giving birth to her first child. Pakar was aged 19 at interview. Pakar was working at her family's dairy farm to help her mother, who was injured working with cows. Pakar defined her work as heavy work, normally lifting heavy things, therefore, she fears the plastic rod implantation will not stay in her arm and felt that using implantation contraception would not fit with her job, as Pakar explained:

Parichat: *What was your contraception method after your first childbirth?*

Pakar: *After my first one, the hospital asked if I wanted a contraceptive implant. I didn't dare to get one. I was afraid the needle would come loose because I do hard work. So I got contraceptive injections for two years (T2 Pakar, 19 years old)*

Tahmas had a different experience. Tahmas was 18.7 years old and 24 weeks into her second pregnancy at recruitment. Her first daughter was 4 years. Her partner (aged 21) lived with her and her daughter in rental accommodation. After her first pregnancy at the age of 14, Tahmas used the contraceptive implant effectively over the full course of three years. When it was due to be removed, she changed to injections, and gained weight. She then changed to oral contraception, but she experienced lower abdominal pain. She stopped using any contraceptive method and became pregnant with her second child. She explains that this pregnancy was mistimed but not unwanted. Tahmas explains how challenging it was to choose an appropriate form of contraception:

Parichat: *What was your contraception method after your first childbirth?*

Tahmas: *After giving birth to the first child. Health care staff gave me an implantation[contraception]. I implanted the birth control for 3 years, until the end of the 3 year period when it was removed, and after that I gained a lot of weight and couldn't use the injection as well. After I tried taking the pills I had lower abdomen pain. So I didn't take any protection and my partner didn't help control it too…Then I got pregnant. (T15 Tahmas, 18.7 years old)*

Titar explains her experiences of trying various contraception methods and considers how it was hard to identify a contraception method that suited her. She referred to free of charge contraception methods and thought about the efficacy of contraception for the future:

Parichat: *What was your contraception method after your first childbirth?*

Titar: *At first, I used injections for a while. But after a while it hurts. So, I stopped injecting and switched to pills. Then I got pregnant with this baby (second baby). I thought about the implantable birth control, but I am afraid of pain. I don't know, maybe I will choose the implant because it would be better to prevent pregnancy. Another thing is because the implant is free for teenagers.*

Parichat: *How did you get pregnant this time?*

Titar: *I'm afraid of being pregnant, I took birth control pills, but I am a person who does not like to take medicine. then I took some but sometimes forgot… My partner went to work and wasn't with me*

often. When he wasn't with me I took some pills sometimes and sometimes didn't. (T14 Titar, 19 years old)

Participants reported *physical problems* which led to discontinued contraceptive use among adolescent mothers. Data show they were unable to endure the discomfort of using oral contraception which interrupted use and resulted in a second pregnancy. Rassa discusses this issue:

Parichat: *What did you think about contraception after your first childbirth?*

Rassa: *For the first pregnancy, we didn't have enough knowledge. The second pregnancy should be on us [young women]. The situation was not the same. When getting pregnant for the second time, it was due to an allergy to any contraception.*

Parichat: *What was your experience of contraception after your having your first child?*

Rassa: *After giving birth, I used injections for 2 years. I experienced weight loss. And then others said I'm thinner. Therefore, I switched to oral contraceptives so I might gain more weight. Once I changed to oral pills, I had 2 packs of the pills and then I had a side effect from the pills, I had dizziness, I had nausea, so I didn't take it constantly…I became pregnant then." (T8 Rassa, 19 years old)*

I interviewed Rassa at the house of her partner's parents where she lived with her first child and her partner's family. Rassa explained about her challenges of weight loss and discomfort of side effects from oral contraception.

Misunderstandings and misinformation about contraception and the pattern of discontinuing the use of contraception resulted in second pregnancies among adolescent mothers. One young mother, who used contraceptive injections, explains how this contraceptive strategy resulted in secondary amenorrhea (cessation of menstrual flow), which she considered unhealthy. This suggests a misunderstanding and lack of knowledge about contraceptive use amongst the young participant mothers.

Passon was 19 years old and 32 weeks pregnant with her second baby when she joined the study. After her first birth she explained that she decided to use DMPA, but found that she had no period afterwards. Passon listened to what her mother said about the potential damage caused when menstruation stopped and decided to return to using oral

contraception. However, she often forgot to take it and became pregnant for a second time. As the following statement shows:

Parichat: *What is the contraceptive method you have used after your first childbirth?*

Passon: *"After [the] first birth, it was a good to [get an] injection. I [don't have] period, but my mother then said that I should [go] back to taking the pills so that my period can go back to normal. My mum, she worries about is it good or not if the blood doesn't bleed at all… if the menstrual bleeding doesn't come out. My mother believes that you must bleed every month, so you don't have any residual blood remaining in your uterus." (T12 Passon, 19 years old)*

Passon understood that menstruation is healthy for women and should occur every month. Therefore, as having an DMPA injection was leading to amenorrhea or menstrual change, Passon was concerned that this was not good for her body. Potentially, this suggests a lack of understanding about the possible side effects of contraception and so a lack of knowledge necessary to weigh up the risks and benefits of using DMPA.

Moreover, data shows that participants received misinformation about the long-term use of oral contraception from unreliable resources. As Sao explained:

Parichat: *How did you decide not to use contraception before getting pregnant this time?*

Sao: *My partner wants to have children, he said he is infertile. We've been together for 2 years, I'm not pregnant and I'm on the pill. Then I would like to get pregnant. I then stopped taking birth control pills for a month. I was pregnant. My baby came as planned but it's only been a month; I really didn't think it would be this fast.*

Parichat: *What do you think about your partner saying that he is infertile?*

Sao: *I have no idea, but for me I heard some people say that if I take a lot of birth control pills, the uterus will become dry. And then I will have problems getting pregnant, so I stopped taking birth control pills.*

Parichat: *Who was that person who said about the uterus will dry up?*

Sao: *I heard some neighbours say it. (T11 Sao, 19 years old)*

Pakar and Sao mirrored the expectation of adolescent women to be able to conceive as they planned. Every hormonal contraception was taken, the most important and concerning issue from their perspective is that it should not result in infertility. As a researcher and a midwife, I explained to Sao that the uterus would not dry up as a result of the long-term use of hormonal contraception.

In addition to misunderstandings reflecting misinformation from informal sources, participants also reported receiving misinformation from formal sources, with similar consequences. For example, Pakar, after being advised by a community healthcare practitioner that using hormonal contraception could cause infertility, then stopped attending her contraceptive injections for a year, eventually becoming pregnant with her second child, as she believed that becoming infertile was a side effect of using the contraceptive injection. Pakar revealed that she and her partner had planned to have the second baby. She decided not to use the DMPA injection and or any other form of contraception for a year before getting pregnant:

> ***Parichat:*** *Why did you decide not to use contraception before getting pregnant this time?*
>
> ***Pakar:*** *I went to get them (injections) at the health centre. They (the healthcare staff) said that getting them frequently will make it difficult to have children. So I tried stopping for a year. I didn't get pregnant for a year.*
>
> ***Parichat:*** *How long did you get them?*
>
> ***Pakar:*** *I got contraceptive injections for two years. I went to get them at the primary health centre. They said that getting them frequently will make it difficult to have children, so I became worried then stopped using it. (T2 Pakar, 19 years old)*

These shows adolescent mothers' worries in terms of the lost ability to conceive. Participants explained that they were concerned that using oral contraception would lead to infertility and this led them to stop using pills or even a long-acting contraception such as injection contraception. I challenged Pakar's misinformation about taking contraceptive injections and explained that fertility will return to normal within three to six months after the last shot.

A further barrier discussed by participants, are experiences related to the hospital service. Communication from the hospital lacked clarity and this potentially puts adolescent

mothers at risk of having sex without effective protection. Participants reported that there was not enough information about contraception and the hospital (healthcare provider/staff) did not give them an appointment or any alternative healthcare service.

The example of Ponsi reflects this where she desired to get an implantation, but it was out of stock, and so she was added to the waiting list. Meanwhile, she used a birth control injection, however, she later found out she was seven months pregnant with her second baby. She was shocked as the following statement shows:

Parichat: *What was your contraception method after your first childbirth?*

Ponsi: *I could get the implantation from hospital for free, but they had run out. Healthcare staff didn't tell me when the implantation set would come in. I didn't have any appointment. Then I had to hurry to get an injection first. I continuously tried to inject again and again as in a re-injection due date. I got injected for 2 cycles – injected in every 3 months. Once I realised that I had got a bigger tummy I went to check, and I surprisingly found that I was 7 months pregnant. I didn't realize that I was pregnant, I thought I got a hormonal fat issue.*

Parichat: *Did you realise you were getting pregnant?*

Ponsi: *Not at all, because usually when I am on the contraceptive injection, I don't have a period. I didn't know that I was pregnant.*

Parichat: *If you had not got pregnant this time, what was your plan for birth spacing?*

Ponsi: *I wanted to be after 20 because I want my oldest child to be older. At an age able to attend school. (T9 Ponsi, 17 years old)*

Ponsi was interviewed at her house. For the first interview, I arrived at her house, and we talked together at the wooden table beside her house. Her daughter was 1 year and 7 months. She toddled around where we sat. She looked healthy, smiled at me, and can talk using one to two connected words. Ponsi was close to her due date and had a month left of her second pregnancy and at 17 years old, she was the youngest participant to join this study. She had injections for around 2 cycles, that would be six months. After that she found she was seven months pregnant. Perhaps it was a breakthrough pregnancy from injection contraception methods, or it might be because she conceived before the first injection. However, Ponsi also revealed that she did not get a pregnancy test at the beginning of her contraception injection series.

6.1.2.4 Most men won't help us: disrupting contraception

In this sub-theme young women talk about how contraception is managed between the two people in the couple. Accordingly, as all intercourse requires a partner, men can be a support or an opposition to young mothers' contraception decisions. Therefore, the partner's attitude about contraception can have an impact on women's decision, or their ability to enact that decision, and lead to a subsequent risk of pregnancy. Data from interviews show that partners were not taking appropriate responsibility in relation to pregnancy prevention. Participants disclosed that their partner would never share responsibility or participate in contraception use, instead, they controlled contraception by refusing to use it. Furthermore, participants revealed their perspectives of being with a partner who is disrupting contraception and not sharing responsibility about contraception.

For example, Wilai was 19 years of age and 26 weeks into her second pregnancy at recruitment; Her first son was 2 years old; Wilai lived with her mother in a small village - her mother and father divorced previously. Later, Wilai moved to a city centre to find a job with her partner (aged 22), the father of both her children. She works as a day-paid waitress in the city centre and lives in rental accommodation. Previous to her first pregnancy, Wilai and her partner did not use any contraception because she did not think about it. Before her second pregnancy, Wilai used oral contraception discontinuously because of unpleasant side effects of the contraceptive pills, meanwhile her partner did not like to use condoms when she forgot to take the pills and, as a result, she became pregnant for the second time. As Wilai explained:

Parichat: *How did the second pregnancy happen?*

Wilai: *For this baby. I forgot to take pills sometimes. This is because I determined that I wouldn't take them because I had side effects. I was dizzy. I couldn't work. I was vomiting. So I had to stop taking it [contraceptive pills]. When I stopped taking the pills, I didn't get injections either, so I got pregnant.*

Parichat: *Did your partner know you were off the pills?*

Wilai: *I told my partner that I had bad side effects to birth control pills. He didn't help me prevent [pregnancy]. He said that if I [was] going to get pregnant, then let it be, [we]don't have to control [it].*

Parichat: *What did your partner do when you asked him to help you prevent pregnancy?*

Wilai: *My partner never wears a condom. He said he didn't like it. He tried to tell me to take birth control pills. But I can't take it and he also told me to go get the injection, but I didn't go. Then I asked him why you don't wear it [condom]. Why do I have to do this alone? He said he didn't like it. (T10 Wilai, 19 years old)*

Wilai has tried to negotiate with her partner to help her prevent pregnancy, but he refused to use a method that he did not like. Consequently, Wilai got pregnant with her second baby.

Rassa experienced the same struggle with disrupting contraception from her partner and also dealt with hormonal contraception side effects. After the first baby was born Rassa has injected for 2 years. She lost weight and became thin and so she then tried oral contraception and expected to gain more weight. However, she had a reaction to pills like nausea, vomiting and yet forgetting sometimes. She then became pregnant with her second baby. Rassa explained her second pregnancy as a mixture of unplanned and mistimed. She also complained about why only women are always responsible for birth protection, but men did not care about it. Rassa questioned in the interview why people only blame women but not men for contraception failure. She expressed that the woman is usually the one who is in charge of contraception. All the responsibility to protect against pregnancy falls to women. As in the following statements:

Rassa: *Most of the time, if women [are] pregnant, people will blame only women for not [using] contraception. They keep accusing women as everything has to be a woman's duty. Why only blame women? Why they don't blame men. We (women) have tried to control it but it is missed.*

Parichat: *Who said this to you? What did they say?*

Rassa: *The people around the house said that my life and my work were going well but I am getting pregnant again. I can't say anything, I'm already pregnant. Men just do nothing.*

Parichat: *So what do you think?*

Rassa: *Blaming women as everything must be a woman's duty. Most of the time, if women are pregnant, they [other people] will blame the woman for not being able to control it. Why blame only women, we [women] took control but it failed. My partner didn't want to use a condom so I can't do anything.*

Parichat: *What did he say when you got pregnant?*

Rassa: *He had viewed these [pregnancies] as a burden since I was pregnant. I couldn't take any of these. But when my partner thinks that the child is a burden to keep things, I feel sad. I think cars and things are unnecessary. But my partner thought that the child came at the wrong time. It seems that during this period we want to build things. I feel like it was my mistake as well that I could not prevent this pregnancy. (T8 Rassa, 19 years old)*

Sukan was 19 years of age and 26 weeks pregnant with her third child when she was recruited to the study. Sukan was the only adolescent mother pregnant for the third time. She was a single mother and living with her parents. Her children all had different fathers. Her first son was 4 years old and lived with her and her parents. Her second son was 2 years old and lived with his father. Sukan was 15 years when she conceived her first child and her partner had been aged 17. Sukan has experience dealing with contraception, her ex-partner(s) opposition to her contraception and not understanding the troublesome side effects of the contraceptives used. Sukan stated that:

Sukan: *"Most men won't help us [with] protection. My [ex] partner, he refuses to use any birth protection. He never uses condoms." (T5 Sukan, 19 years old)*

I interviewed Sukan at the hospital in the private room as she was willing to talk at the hospital, because she said she is going to move to her parent's house in Nakhon Sawan which is 400 kilometres from the research setting. I respected her experiences of being mother of two and going to have another one in a few months while she was under twenty. Moreover, Sukan revealed that now she is a single mother, and she lives here trying to collect money to send to her parents for her child support. I reflected that her lived experiences are valuable to this study in terms of pointing to the problem of men disrupting contraception and how adolescent mothers experience this. Sukan tried many kinds of contraception, but it did not work. She began with oral contraception then she had an irregular bleeding with hypermenorrhoea; she changed to injections and had worse bleeding symptoms. I asked Sukan about her experiences of contraceptive use.

Parichat: *Would it be okay if I asked you to go deeper into each of your partners and the contraception you have used?*

Sukan: *I was 13-14, he was 17 at that time, I took Anna's [brand] contraceptive pills, and when I took it, my menstruation overflowed, it was too much bleeding, so I stopped taking pills and moved to injections, but it didn't help. So, the doctor said that*

I must not inject and must not use pills that are [hormonal] contraceptives at all. Then without contraception, I became pregnant. My partner did not take birth control either. (T5 Sukan, 19 years old)

Sukan and the father of her first baby drifted apart when Sukan found out she was pregnant with his baby, and he was not ready to be a father. Sukan sought out a termination of her pregnancy with her neighbour, but her father discovered this and did not agree for her to do so. Therefore, she carried her first baby while she was 15 years old.

Later, Sukan met her second partner (19 years old) when she was 16 years old, after getting a new job and moving from Nakhon Sawan to Bangkok – a distance of about 400 kilometres. They were dating until Sukan left her job, when they married and moved to live with her partner's family. Sukan found contraception a struggle:

Parichat: *Could you tell me about the guy by whom you were pregnant the second time?*

***Sukan**:* *He was the air conditioning cleaner, his chief let us know each other, we met at the coffee shop that I was a seller, and he came to clean the air conditioning. Later, when I left my job, he asked my dad to marry me, we were together 5-6 months then I got pregnant.*

Parichat: *How was your contraceptive use at the time when you were with the father of second baby?*

***Sukan**:* *When I was with him. I took emergency contraceptives because we weren't together much…and I was afraid the menstruation would come badly, so I stopped taking it. When I stopped, I became pregnant. Most men they don't help with birth control. He refuses to use birth control; he doesn't use a condom. (T5 Sukan, 19 years old)*

Once Sukan had moved to live with his family she realised he was a drug user, who frequently hit and kicked her. They separated when she found out she was pregnant because she could not live with his drug addiction and abusive behaviour. Sukan took care of her sons herself with close support from her parents; when her second son was 2 years old, he moved in with his father.

The next year, Sukan met the father of the third baby; he was 21 and in the last year as a military draftee. Sukan did not use contraception as she was worried about "menstruation

overflow". Once she told him that she was pregnant, he disappeared. His parents rang to check that she and the baby were doing well and told her that the father of baby was still missing. As Sukan explains:

> ***Parichat:*** *What about this current pregnancy, the third time? What was this guy like?*
>
> ***Sukan:*** *My brother was a soldier and invited him to visit my house, he was an army draftee, he said he liked me. At that time, there was a man in the village who liked me too. The people around here took pity on me. He would come in and ask me and my father to marry me. But I didn't choose that man. I decided to choose the man who is a father of my third baby. We got married. After that, he left for military duty to come to see me only a few times, but he escaped from the military camp.*
>
> ***Parichat:*** *Did you use contraception?*
>
> ***Sukan:*** *No, I didn't use any protection method. (T5 Sukan, 19 years old)*

Sukan did mention about her worries of using long-acting contraception which potentially affects their ability to work and is discussed amongst adolescent participants. Sukan talks about this:

> ***Parichat:*** *Did you ever consider about using long- acting contraception like an implantation?*
>
> ***Sukan:*** *I have seen the implantation contraception. I saw that in one of my neighbours, she was wearing it, and I have seen her lifting things. Then I saw the contraception rod in her arm, and I feared the little stick in her arm, so I didn't choose it. I have a fear of needles (T5 Sukan, 19 years old)*

Passon, she asked her partner to have a male vasectomy, but he ignored her. Passon lived with her original partner. Passon defined her second pregnancy as mistimed, she stated that she has talked with her partner and asked if he could have a male vasectomy. As Passon explained:

> ***Passon:*** *We [Passon and her partner] have talked about sterilisation. I asked him if he could do the male sterilisation, but he ignored me and never talked about it again (T12 Passon, 19 years old)*

These accounts suggest that the experiences of a second pregnancy are more challenging in dealing with the side-effects of contraceptive methods. In addition, choosing contraceptive methods for adolescent mothers is a concern in many participant's

statements. It could be argued that although the young mothers were using contraception, some were able to choose the contraceptive methods that suited them the most, yet some still struggled. Moreover, men took less responsibility for using contraception. Men taking responsibility for sharing contraception and supporting contraceptive decisions is essential. Participants wanted support and help from their partner in managing contraception, when they are facing the discomfort of side effects and needed to stop or change methods.

Contraceptive decision-making among young mothers in this study was impacted by different issues, in relation to first and second pregnancies, however, whether unplanned or mistimed similar issues arise: concerns about the medical impact of contraceptive use (both side effects and potential infertility), inaccurate information, whether from informal or formal sources, problems accessing contraceptive methods tailored to the individual, a lack of appropriate support by healthcare and sexual health education services and disruption from partners.

6.2 Relationships

This theme focuses on the relationships the young mothers had with their *partner*, *children and families,* and *peers* as they negotiated the complex life of being an expectant young mother and how they interacted with important people in their lives. The issue of relationships ran throughout the women's experience of both their first and second pregnancies. Some found they were able to manage daily life with supportive relationships; others were faced with unexpected issues, particularly with their partners.

6.2.1 Partner

This sub-theme presents participant experiences of the relationship with partners who fathered their children. Seven of the participants reported that they are still with their original partner (the father of their first child) and seven explained that they are living with a new partner - the father of their second child. Only one reported being a single mother.

Table 6.1 details the young mothers' ages as well as their partner's age at the time of their first and second pregnancies, and in the case of one adolescent mother her third pregnancy. All the young mothers in this study were 14-17 years of age (mean age 15.20 years, median age 15 years, mode age 15 years) when they conceived their first pregnancy. While the ages of the father of the first baby at conception were 17-25 years of age (mean age 19.53 years, median age 19 years, mode age 19 years).

Regarding the second pregnancy, 13 young mothers were over 18 years of age, two of them were 17 years of age when they conceived the second pregnancy (mean age 18.71 years, median age 19 years, mode age 19 years). Only one participant was pregnant for the third time. The age of their partner in this table shows young mothers whose current partner was 17-51years of age (mean age 24.46 years, median age 21 years, mode age 21 years). All of them were married in a religious ceremony that does not require official registration and therefore is not supported by a marriage certificate.

Table 6.1 The young mothers' biographical data and their partner(s)

Name	*Age at conception of first baby*	*Age of father of first baby at conception*	*Age at conception of second baby*	*Age of father of second baby at conception*	*Age at conception of third baby*	*Age of father of third baby at conception*	*Living with original partner*	*Living with new partner*	*Single mother*
Palmy	15	19	19	17	-	-	-	✓†	-
Pakar	15	18	19	21§	-	-	✓‡	-	-
Napar	16	18	19	17	-	-	-	✓‡	-
Sasi	14	20	19	25§	-	-	✓‡	-	-
Sukan	15	17	17	19	19	21	-	-	✓‡
Kor	16	19	19	51	-	-	-	✓¥	-
Siri	17	19	19	28	-	-	-	✓†	-
Rassa	15	19	19	22§	-	-	✓†	-	-
Ponsi	15	18	17	20§	-	-	✓‡	-	-
Wilai	17	20	19	22§	-	-	✓¥	-	-
Sao	15	24	19	28	-	-	-	✓‡	-
Passon	15	16	19	20§	-	-	✓‡	-	-
Manee	16	25	19	35	-	-	-	✓‡	-
Titar	14	24	19	19	-	-	-	✓‡	-
Tahmas	14	17	18.7	21§	-	-	✓¥	-	-

§ Those who fathered both the first and second baby.

† Living with partner's family

‡ Living with young mother's family

¥ Living in their own house (rental house)

Participants report meeting their first partner in a variety of ways: at school, in their local community or online (for example via Facebook). Young mothers explained that they also met their recent partner in various situations. Palmy, Titar, and Tahmas' accounts of how they met their current partner via Facebook. Pakar and her partner, the father of her children, met at the local market through mutual friends. Sukan and her partner, the father of her third child, met in the local community, through her cousin. Sasi and her partner, the father of her children, met at school when she was a student and while he was working

as a daily worker. Napar, Kor, Siri, Wilai, and Manee met their current partners at their workplace.

Napar, Siri, and Manee broke up with the father of their first baby shortly after conceiving their first pregnancy. They all revealed that their current partner was the father of their second child.

In general, the structure of a Thai family is mostly an extended family and patriarchal – i.e. the father is the central figure of the family. If there are not older men, older women will have the highest level of respect. A Thai extended family consists of biological grandparents, parents, children, in-laws, grandchildren, and cousins. A Thai nuclear family is patriarchal as well where the father is the pillar of a family. Most young mothers in this study often stayed in their family and their partner moved in with them into their parent's house. Pakar, Napar, Sasi, Ponsi, Sao, Passon, Manee, and Titar reported that their current partners moved in with them and their family after they were pregnant. However, Palmy, Siri and Rassa stated that they had moved into their partner's family home. Kor, Wilai and Tahmas had moved in with their partner in their own rented house. Sukan revealed she was living by herself as a single mother and working with her aunt.

Participants who are still with their original partners reflected on their supportive relationships as healthy and providing tangible support such as financial, parenting, and emotional support. Others were managing difficult relationships. Some of these participants talked about staying in an unsupportive relationship. Other participants, who are now with a new partner, discussed "leaving an unhealthy relationship". The experience of "abandonment" was also reported. However, "moving forward" was also reported; some of those living with a new partner (the father of their second baby), consider that "life is better" and one participant, although living in difficult conditions, talked about her experiences of living with a new partner, one who can help her to access social welfare, and so considers the situation as one of "improving life chances."

6.2.1.1 Supportive relationships

The seven adolescent mothers who were still with their original partners described their intimate relationships with the father of their children, and how the original partner provided both emotional and concrete support. For example, Pakar was 14 years of age, and her partner and future father of her children was 17 years of age when they first met at the local market through mutual friends. Pakar explained that they were dating for about

a year before she conceived their first child at age 15 years. After she revealed her pregnancy to her family, her partner moved in with Pakar at her parent's house. She talked about how they supported each other:

Parichat: *Can you tell me how you met him?*

Pakar: *I've been seeing him since I was in the eighth grade. I met him at the local market.*

Parichat: *What was he like when you were together?*

Pakar: *We argued, but never hurt each other. He kept quiet when we were content. When we're okay, I asked him why he was quiet and he says that we would fight if we kept talking, so he kept quiet and did whatever I asked. When he sometimes wants to go out with friends, he'll ask me for permission, and I let him.*

Pakar also talked about how her partner's behaviour changed when he became a father, explaining that he took responsibility for her and their family.

Parichat: *Does he help you for daily living and/or take care of your baby?*

Pakar: *He works only on weekdays. On weekends and holidays, he stays to help me with everything, I'm comfortable, because he doesn't let me do anything. My partner takes care of the cows. I taught him because, he'll have to do it alone after I give birth."*

Parichat: *What about taking care of your baby?*

Pakar: *My daughter was a premature baby. There might be something [premature baby lung condition] about her lungs. When she was one year old, she had pneumonia and stayed at the hospital for a week. The doctor told my partner to stop smoking or to smoke outside the house. There was still an odour, though, so my partner quit smoking." (T2 Pakar, 19 years old)*

Sasi was 19 when I met her. I interviewed Sasi at the hospital at her antenatal care (ANC) appointment. Her husband was with her, helping her by carrying her bag. We sat down in a private area and her husband left Sasi and me to talk. Sasi talked about her relationship with her partner:

Parichat: *What's your relationship with your husband like?*

Sasi: *We've been together for six or seven years. We don't fight just, fighting nonsense. We've been together a long time. When I was*

pregnant, he came to hug me, I was bored. He's worried about me getting tired of him. I just don't want to give him a hug. I felt a bit hot and sweaty. [smile and laugh]

Parichat: *That's nice! What was he like?*

Sasi: *He's a nice guy, he's never been violent with me. He always sulked to me first with nonsense, and he is a sulky man, he reconciled himself, just leave him (laughs). He never gave me trouble; he takes good care of me.*

Sasi also talked about her first pregnancy, which was unplanned. She was 14 and her partner was 20 when she became pregnant after having sex for the first time. Sasi explained that her husband provided emotional support and gave the example of how he had supported her in the early stages of her first pregnancy when she told her family about the baby.

Parichat: *What did he do when you got pregnant?*

Sasi: *My partner asked me if I felt embarrassed to quit[school]. He feels guilty. So, he apologized to my mother for not aiming to make it happen [to make her get pregnant and to quit her study].*

Parichat: *How do you feel about what he did?*

Sasi: *I didn't blame him, my mum said to move in to stay together. His father died when he was young, so he had no one.*

Sasi's partner is now aged 25 years old, and he is the father of both her children; they live together with Sasi's family, he has his own business, and it makes a good income. Sasi explained the financial support provided by her partner:

Parichat: *What does he do for a living?*

Sasi: *Installation of aluminium windows and doors with mirrors such as glass installation (pointing to the hospital glass)*

Parichat: *Self-service contractor or employee?*

Sasi: *He started with a family business as the employee of his uncle. Now his uncle let him own his business. His work is about the Installation of aluminium windows and doors with mirrors such as glass installation (pointing to the hospital glass) Self-service contractor, do anything the landlord wants. My partner made money from contracted glass windows in houses, offices, and*

ceiling fixtures and put a price on the equipment, costing money and labour costs.

Parichat: *Is there enough money spent on your own family? Do you have financial problems?*

Sasi: *Yes, enough, for the financials, I think that's enough. My husband earned money alone, we have enough. My husband took a job for about 100,000 baht [2,200 GBP] per contract. It's because he took one job like a big job, used several mirrors, all made by himself, didn't have a lot of employees, just a few. So, he don't have to pay wages for many employees, so we have a lot of savings. He lets me save all the money he has got. He takes care of me. (Smile) (T4 Sasi, 19 years old)*

The supportive relationships discussed by participants here can illustrate the interaction of young mothers with their partners. Young mothers expressed and appreciated the support from their partner.

6.2.1.2 Managing Difficult Relationships

Young women talked about situations where they had to manage difficult relationships. Three codes emerged from the analysis: *staying in an unsupportive relationship, leaving an unhealthy relationship,* and *experiences of abandonment*.

Rassa, revealed that she was dealing with an unsupportive and unhealthy relationship with her original partner but was trying to recognise the good side of her partner. However, she reported her relationship was very fragile and unstable.

Rassa was aged 19 when I met her. She lived with her partner's family. Her partner (and the father of both her children) was 22 years of age when Rassa found out she was having a second child. They met when she was 17 years and he was 20 years, and became pregnant with her first child when she was in the last year of college. I interviewed Rassa at her partner's family house, where she lives with her husband and daughter, now 2 years and 3 months old. They live in a small village in an extended family group which also includes her partner's parents, grandfather and her partner's sibling's family. Her partner was not in the house at interview, he was out at work; only his grandfather came out to talk with me and he then walked outside to see his neighbour. Rassa talked about how her first pregnancy was unplanned and the second was a mixture of unplanned and mistimed. Rassa explained that she had stayed with her original partner, even though she found the relationship unsupportive and unhealthy:

Parichat: *Could you talk about your partner? What is he like?*

Rassa: *He hasn't really looked for a job. Only I have a job. So, we often quarrel. My partner is 22 years old and addicted to games, I have been arguing about him being addicted to games. He doesn't listen. He plays an online game with friends, turn on the mic, talks very loud and so I am annoyed so much.*

Parichat: *[nodded]*

Rassa: *But, he's a good person. He had no other problems, for example, he had no problems with other women, infidelity, and he had no drug addiction. he doesn't drink, but he doesn't like to work as an employee. He likes to go to the farm. Farming and raising chickens for sale is more comfortable for him.*

Parichat: *Did he hurt you?*

Rassa: *At that time, I wasn't married to him yet, we were in a relationship, we had a fight and then I decided to go back home. He slapped my head to force me to go home with him. I wasn't hurt but I was mad at him. So, I had to stay with him at first. Then I couldn't stand it, so I returned back home.*

Parichat: *What happened next?*

Rassa: *When we were separated for a while, his parents asked me to get back together and reconcile with him. When we almost broke up I was pregnant with my first child. So I had to stay.*

Parichat: *Did he force you?*

Rassa: *No, he didn't.*

Parichat: *How about this second pregnancy? What was he like?*

Rassa: *When I have morning sickness, I want to eat something, but my partner doesn't like to take care of me. I have to buy it myself. The first pregnancy he was very happy to have a baby. But this pregnancy he acts like someone who doesn't want to have children. So, I feel sorry. I feel like I can live alone, and I will be fine without having a partner!*

Parichat: *How do you feel about him now?*

Rassa: *I will wait until he could improve himself. Now I am trying to see his good side. (T8 Rassa, 19 years old)*

This suggests a fragile relationship, with the potential for breakdown, as this young mother waits to see if her partner's behaviour improves. This also shows how a young mother may continue in an unhealthy relationship, despite feeling unsupported by their partner, ostensibly for the good of the children, a decision which she may come to regret.

Some adolescent mothers talked about *leaving unhealthy relationships* with an ex-partner. Unhealthy relationships include the experiences of unsupportive relationships and domestic violence.

For example, Napar described her experiences of breaking up with the father of her first child. He was 18 years when she conceived her first baby; he drank (alcohol) and went on nights out with friends and was not supportive; then he moved to work with his parents in the southern part of Thailand, so they had a long-distance relationship until Napar asked to separate. As Napar explains, he was not consistently supportive and did not share parenting roles:

> ***Parichat:*** *What was he like when you were together?*
>
> ***Napar:*** *At the time he went to work with his father. I came back home here (Kanchanaburi), so we were distant and far from each other. So, we broke up.*
>
> ***Parichat:*** *What was he like?*
>
> ***Napar:*** *He was drunk, and he asked if we should break up. I thought about it, so I broke up with him. Hmm, so we broke up.*
>
> ***Parichat:*** *Over the phone?*
>
> ***Napar:*** *yeah, without asking about the reasons for the break-up. We broke up when I was about seventh months pregnant.*
>
> ***Parichat:*** *How did you feel?*
>
> ***Napar:*** *I wasn't sad. I don't know why I didn't feel sad. Or maybe it was because he was working far away. We talked over the phone once in a long while, but he never came back to see me while I was pregnant with his child, even after I had given birth. We broke up over the telephone." (T3 Napar, 19 years old)*

Palmy and the father of her first baby (18 years old) lived separately then she broke up with him when their son was 2 years old because of his drug addiction and never taking responsibility for her and their baby. Palmy revealed having experiences with domestic

violence and drugs abuse. Moreover, he always asked Palmy for the money that she was earning, she had to give him every baht as he threatened her with violence.

Palmy: *It's like I didn't feel this happy when I was living with my ex, but it's much better now that I'm living here.*

Parichat: *You didn't feel this happy when you were living with your ex (repeats the answer). What was your ex like?*

Palmy: *My ex wasn't very interested in our child. He kept playing with this and that.*

Parichat: *What do you mean "playing"?*

Palmy: *Playing with bad things.*

Parichat: *Such as…?*

Palmy: *Alcohol, narcotics like methamphetamine.*

Parichat: *Did he hurt you?*

Palmy: *He hit me on days when I didn't have money for him.*

Parichat: *He hit you? What did you do?*

Palmy: *I had to give it [money] to him.*

Parichat: *You had to give him money. Didn't he work?*

Palmy: *Yes, he did, but he had debts.*

Parichat: *He worked and didn't have enough to spend? He had debts? Did you always give him money?*

Palmy. *Yes, I gave him every baht. Sometimes, I almost didn't give money to my mother.*

Parichat: *Then he spent it on drugs?*

Palmy: *Yeah. It's difficult to quit once you're addicted.*

Parichat: *Then what did you do?*

Palmy: *I decided to leave his house and look for a new job.*

Palmy left her ex-partner who was abusive, and drug addicted. She had just moved away from his house. Palmy raised the idea of "*Karma"*. Some participants discussed how Karma[7] influenced decisions, not only around termination of pregnancy, but also considered how Karma reflected on their unhealthy relationship experiences with their ex-partner as Palmy stated:

> ***Parichat**: Did you report him to the police or someone when he hurt you?*
>
> ***Palmy**: No, I didn't. I let it go. I just thought it was karma, so I left him.*
>
> ***Parichat**: You thought it was karma, so you ran away from him?*
>
> ***Palmy**: Yeah. After I ran away, he followed me for 2 – 3 days. I didn't get back to him. My mother sent me straight to work and he didn't follow. I was afraid he would follow but he didn't. (T1 Palm, 19 years old)*

After they separated, Palmy moved to find a job at Pattaya (in the Eastern part) in a Thai massage shop with her aunt. Palmy had worked there for around 10 days, then she met her current partner (aged 17 years) via Facebook. After "chatting" with him for about 2 weeks, Palmy decided to sneak away from her aunt to meet her partner at Prachubkirikhan (in the Southern part) and they have been together since then. Palmy and her partner moved to her partner's family at Kanchanaburi (in the Western part) where the interview took place.

Young mothers in this study *experienced abandonment*. Siri described experiences of a difficult time when she was abandoned by an ex-partner; she was young and scared but coped courageously with the stresses after they broke up. Siri was 19 years, and her son was 17 months old, when I met them. Siri broke up with her son's father and began to work at a local animal food factory to support herself and her child. Meanwhile, her son's father was studying towards an undergraduate degree. Siri explained that she tried very hard to maintain the relationship with him, however they broke up in her late pregnancy; she found out that he was with another woman and decided to separate from him. Siri returned to live with her parents. Siri raised her son by herself, and she decided to earn

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[7] Karma means the belief in the buddhism doctrine facilitated acceptance of and emergence from their tragic life events (Anand, 2009)

money to support her family first and if she had enough, she planned to return to education. Siri explained her experience of abandonment was a crisis for her and her family:

Siri: *When my ex-partner left me. It was like my family was in crisis. Everyone in my family is in crisis. I must go to find a job. My parents had to help me find a job. I am afraid that my baby [first baby] would not have a father. I thought I would not break up with him yet.*

Parichat: *So, what did you do?*

Siri: *But after about 2 months [since he left], I only worked. When I went to work, I didn't think of anything about him…*

Parichat: *What was he like?*

Siri: *He was always with other women, but I didn't think we would break up. But later I can't stand it… I have to work when pregnant until near the due date… So, I broke up with him.*

Parichat: *[nodded]*

Siri: *My parents were very angry and told me that they will not let my baby [first baby] live with him. My baby uses my family's surname. (T 7 Siri, 19 years old)*

Kor also experienced abandonment. Kor was 19 years old when I met her and pregnant with twins. I was able to interview Kor at her house where she lives with her current partner, her first child and her younger sister. When asked about her life and both pregnancies, Kor explained that her first pregnancy was unplanned; she often forgot to take the pills and then she found out she was pregnant. The father of her first baby, who was 18 years old at the time, went missing when Kor told him she was pregnant. Kor described her experiences of the first pregnancy as an *early life difficulty*. Kor expected to have a family like other people, but her real life was very different. Kor explained that she felt disappointed that her life is not what she expected it to be. For Kor, being abandoned while pregnant meant she would be alone, and her life would not be easy. Kor explained her life was difficult and blamed herself for being very young and doing the wrong thing:

Parichat: *How did you feel about the first pregnancy?*

Kor: *I never thought that my life would be difficult like this. When we have children and when we are together, I think it will not be*

difficult. But when I had a child (the first baby), he left me and my child so that I had to be alone. I was having a hard time.

Parichat: *[nodded]*

Kor: *I feel that I have not thought so carefully. I'm young, shouldn't have kids yet. I didn't realise at the time because I was very young (T6 Kor, 19 years old)*

Sukan revealed her disappointment in relationships; both relationships had broken down shortly after she became pregnant. Sukan and the father of her first baby broke up when she became pregnant because of his drug addiction. A year later, she met the father of her second baby, however, they broke up when she became pregnant with her second child; he said he was *not ready* to be a father. The following year, she was in a relationship with the father of her third baby. Again, she faced being "abandoned" as her current partner has just deserted from his post as military draftee. He ran away from his duty and also ran away from her and her baby.

Parichat: *What about your partner?*

Sukan: *We already broke up.*

Parichat: *Is your current husband the father of your first child?*

Sukan: *No, the first child was with another one. This is the third one. Third child and third partner.*

Parichat: *Sorry, can I ask about each partner. What were they like?*

Sukan: *The first (ex-partner) one, when I got pregnant, he said it wasn't his baby. When I was pregnant with my first baby. We went out for work together everyday, but he said this. My father got very angry with him.*

Parichat: *What was the second partner like?*

Sukan: *The second one, aged 21, was addicted to drugs, so I broke up with him to stop being physically assaulted. He wanted his baby, so I gave my son to him, but my son didn't take his family name.*

Parichat: *Who was your current partner?*

Sukan: *He hasn't contacted me since he knows that I am pregnant. He said he is not ready to be a father. I don't understand. He has*

nearly completed military service in few months, but he escaped. He would be in trouble. (T5 Sukan, 19 years old)

In this sub-theme, young mothers reflect on the support that they and their children received from their partners. Some stayed with their original partner and described the experience of being a family and feeling secure. While others, who stayed with their original partners, talked about the fragility of an unsupportive relationship, and explained that they have to stay for their children. Moreover, leaving an unhealthy relationship or managing the experience of being abandoned with a small child to support, highlights the resilience of young mothers, and drives them to find a way to put themselves and their children in a better situation.

6.2.1.3 Life is moving forward

This sub-theme presents young mothers' accounts of stepping forward from unhealthy relationships and "life is moving forward" and is considered that a new relationship brought adolescent mothers the idea that *life is better*. Some talked about living with a partner who fulfils their expectations, such as providing intimate support, parenting support, care and warmth, and while develops a paternal bond with her children. Those who had left an unhealthy relationship felt more satisfied with their new partner. Some explained they were more careful about the new relationship, to avoid repeating the same mistakes.

Manee was 19 when I met her. She was 14 when she became pregnant for the first time and she lived with the father of her first child, who was 25 years old at the time. Manee was with him for a year, and they separated when their daughter was 9 months old because of his drug addiction and domestic violence, which included physical and verbal abuse. Later, Manee met her current partner who is aged 35. They lived together in Manee's house which she was given by her grandfather. After living together for 3 years, they decided to have a second child. As Manee stated:

Manee: *"My current partner is good. He was with me when I didn't have anyone around. I broke up with my ex-boyfriend when my first child was 9 months old. So, he (current partner) has always helped me raise this child. He is happy to have a second child as well." (T13 Manee, 19 years old)*

Napar's current partner, the father of her second baby, moved in to live with her and her mother. He comforts her during the pregnancy, he takes care of her son, and they get on

well; he provides support which she did not get from the father of her first baby. As Napar stated:

> ***Parichat:*** *How do you feel about having this baby?*
>
> ***Napar:*** *With this pregnancy, I didn't worried because I'm living at home with my mother and my partner is living with me here.*
>
> ***Parichat:*** *You look happy when you talk about your life now.*
>
> ***Napar:*** *I'm no longer afraid that she'll have to live alone [her mother]. All I have to do is get ready to raise the baby. The first time, my ex-partner was not around. He didn't feel the baby or speak much because he was not around.*
>
> ***Parichat:*** *How about the father of this baby?*
>
> ***Napar:*** *With this pregnancy, the baby's father is talking and feeling the baby. I feel happy about when he is talking to the baby. (T3 Napar, 19 years old)*

Siri broke up with the father of the first baby when she was pregnant. After they separated, Siri returned to live at her parent's house. Later, she met her recent partner (28 years), the father of her second child, as they worked in the same factory. He became her close friend; he took her to the antenatal clinic to check up on her first child when its needed. As their relationship developed, Siri decided to marry him after they had been together for a year. As planned, Siri became pregnant with her second child. Siri explains how she thought carefully about the new relationship and wanted to avoid repeating the same mistakes.

> ***Parichat**:* *How did you meet him?*
>
> ***Siri:*** *I met him at work, at that time, I worked in the factory. I was pregnant with my first baby. I didn't think I would have an open mind to new relationships.*
>
> ***Parichat:*** *What did he do for you to make you open your mind?*
>
> ***Siri:*** *At that time, when I was sick while working in the factory, he came to my house and told my father that 'Dad, may I take Siri to see a doctor.' I thought to myself that this guy is weird and suspects he likes me. [Thai people call their close friend's parent as same mum and dad]*
>
> ***Parichat:*** *[nodded]*

Siri: *I was afraid that my dad would regret it again. But he [current partner] is the one who tells my dad where we will go out in free time. Every time he took me out for a date, he will ask permission from my dad first. I think I made the right choice.*

Parichat: *You think you have made the right choice. [I repeated]*

Siri: *I don't want to make myself get in trouble again. And my parents also love this son-in-law [current partner]. He's[my dad] good with my husband. I think I made the right choice. (T7 Siri, 19 years old)*

Tangible and emotional support needs during pregnancy were raised among young mothers. In *life is better,* participants revealed that they are more satisfied with their new partner than living with the father of their first baby. Although some were more cautious about their new relationship and thought carefully to avoid repeating the same painful situation.

However, some participants who were living in vulnerable situations were alert to opportunities to improve their life chances, as in the story of Kor. Kor is one young mother lives in a vulnerable situation as she has a Thai national identity issue. Kor has dual heritage, with her father being Thai and her mother is of Mon ethnicity (Mon people lived around the western border of Thai - Burma). Kor's parents had separated when she was 4 years; all of her documents, including her birth certificate, were kept by her father. In fact, Kor was entitled to Thai citizenship and the right to access all public welfare in Thailand, but as she could not access her documents to prove this, her mother took her to register for the "Pink card" (Non-Thai Identification Card) as a Myanmar (Burma) national, so at least she can legally stay and work in Thailand. As Kor explained:

Kor: *I am not ready to have this baby, I bought pills from a drug store, but I was told that the pills expired. This might be because I couldn't get it from the doctor's clinic or from the hospital, I just went to the store, I couldn't read it, I didn't know what is on the label, I didn't know the expiration date, or it might be because I forgot to take it. (T6 Kor, 19 years old)*

Parichat: *Why didn't you go to the primary health care unit?*

Kor: *After I gave birth, the healthcare staff advised me to get an injection [contraception], There were many things to do if I have get it free here, so I did not. I think it was not free and it needs my ID card. I don't have a Thai ID card I only have pink card [Non-Thai Identification Card] (T6 Kor, 19 years old)*

A Pink card with healthcare insurance (paid 1,000 Baht insurance) provides free healthcare service but is limited up to 10,000 Baht, and only at the hospital where they first registered. Kor fought for her citizenship for two years but has not been able to contact her biological father. This lack of citizenship and Thai national identity meant that Kor was unable to access health insurance and other services for free as she needed. She explained that her first relationship ended in abandonment, but her second partner (aged 51 years old and father of second child) helped her search for her biological father in order to prove her Thai nationality. After a year, Kor and her partner almost gave up, but eventually they found her father, and this gave her access to her Thai birth certificate and some evidence of support from her father. Her partner helped her contact the district office and the civil registration section. Kor explained that her partner takes part in helping and support her. As Kor explained:

Parichat: *How did you meet your father?*

Kor: *I met my current husband, and he helped me. He was the one who led me to find my father. We started by looking at the school I used to attend, then went to look in that area but he had moved away, but someone in the village can contact him. Luckily, we searched until we found my father. I now have my Thai ID card. Things were messed up before then, but it has now passed, because we were determined to solve our problems. (T6 Kor, 19 years old)*

Kor now has a Thai identification (ID) card that provides her identification number and eligibility of Thai citizenship, she received this just 2 weeks before interviewing. Kor was very happy to show me her ID card. I explored with her the barriers that came from living without access to citizenship, such as a basic healthcare service. As Kor stated:

Parichat: *How did you manage without an ID card? I mean before you got this card.*

Kor: *I can do just daily hire. I was had the rights of pink cards for foreigners.*

Parichat: *What about in the hospital?*

Kor: *I didn't dare access health care services. Because of my ID card, I went [hospital] only if I have to, because I worried about health service charge. (T6 Kor, 19 years old)*

This Thai citizenship not only supports Kor herself but also supports her first daughter and will support her twins, due in a few months. She can stop worrying about the healthcare costs for her twins, who may need expensive intensive treatment and now she can access Thai healthcare insurance free of charge. As Kor explained:

> ***Parichat:*** *Then your first children will have a problem of ID just like you, right?*
>
> ***Kor:*** *Yes, my daughter had the same issue as me. For now, I can help her to get her Thai id number, because she is my biological daughter.*
>
> ***Parichat:*** *What about this pregnancy?*
>
> ***Kor:*** *Before I got this card, I have registered for ANC check-ups, the healthcare staff suggested I was able to use my birth certificate for free, but when I gave birth, I would have to pay for my birthing and childcare if I hadn't finished my ID. So, if my twins got a complication, I would have to pay a lot of money for them, (T6 Kor, 19 years old)*

Kor would also now be able to use her Thai ID card to prove her identity and receive public services. Furthermore, she can access other private services, such as applying for a bank account.

> ***Kor:*** *So now that I have just got an ID card and I'll take it to open a bank account and I'll deposit the money that I collected. I'm saving money for our own spending. (T6 Kor, 19 years old)*

However, having a partner aged 51 years old also results in social criticism. Kor is criticised by local women living around her village, that she is taking advantage of her older partner. Kor revealed that women criticised her for getting the pregnancy and she should have been careful and used protection. They also said she had tricked him to help get the Thai citizenship and ID card. As Kor explained:

> ***Kor:*** *They asked why I rushed to have a child. They work with my mother and talk to her. They asked why my mother let me to have another child while my husband is 51 years old.*
>
> ***Parichat:*** *What do you think of what they say?*
>
> ***Kor:*** *It might be because of my husband as he had two children before. And he was abandoned by his ex-wife. Now his ex-wife has to bring up his children alone. I didn't care about what other people*

said. We [Kor and her partner] have an understanding between us, we have never quarrelled. (T6 Kor, 19 years old)

Even though her citizenship problems were resolved just in time, Kor is still being criticised by people around her. This account conveys, not only problems around inaccessible healthcare, but also in relation to inequality. Being criticised makes a young mother potentially vulnerable. In this case, Kor, and her partner were together presenting some sense of support, as she feels that he is the one offering her help in hard times. Although local women accuse her of exploiting him, the opposite may be true, in light if the age gap and the potential for male exploitation of vulnerable young women.

6.2.2 Children and families

The complex diversity of relationships between young mothers and their *children and families* is revealed in the data. The experiences reported by young mothers in this study reflects five important aspects which are considered here: "B*onding and mothering",* "*Raising children: preparing for another baby*, *Family supports*, *Independence: my mum let me grow up, and Young marriage*". This subtheme considers the support available to young mothers from families. The family provides not only emotional support but also concrete support such as safe housing, money, mothering advice and childcare.

"Bonding and mothering" explored how young mothers take responsibility for and form relationships with their children as they try to live within a challenging situation. Early breastfeeding experiences shows how young mothers endeavoured to follow the advice of their family and healthcare provider to breastfeed and are concerned about the benefit of breastfeeding for their baby. The majority of the mothers were able to breastfeed, for between about a month to 3 years, yet some are unable to breastfeed due to a lack of knowledge and opportunity and also have limited access to support. Then "family support", considers the support available to young mothers from their families. Next, "raising children" explores some of the challenges faced as, although most participants lived with, and looked after, their first child with family support, some first children were looked after by their mother for the first few years and then moved out to her parents' house where the child was cared for by her family. Next, "Independence: My mum let me grow up" explain reduced family supports, especially in relation to childcare, requiring more independence from young mothers for their second child. Lastly, provided Thai context about the parental consent and the marriage of young mothers.

6.2.2.1 Bonding and mothering

Young mothers in this study interacted with their baby with love, care, and mothered their children as well as they were able. However, with their young age, bonding with their children showed less involvement. Some of them take care of their first children themselves but were still dependent on their mother for help. Others left their children with their parent and worked to earning money.

Sasi was 19 when I met her. Sasi left school at 14 with no qualifications because of pregnancy. With her first child, Sasi's mother supported her with everything, including, housing, and childcare. Sasi revealed that she breastfed her daughter exclusively for four months and continued, as her daughter was weaned, for a year, but when breastfeeding finished, her mother became the main carer. Sasi explained that, at that time, she was very young, and her daughter calls her sister and calls her parents mum and dad Sasi describes this:

> ***Parichat:*** *Do you take care of your first child by yourself?*
>
> ***Sasi:*** *My mum helps me raise my daughter.*
>
> ***Parichat:*** *How do you think about taking care of your first child?*
>
> ***Sasi:*** *I don't know. My daughter didn't call me mum. She called me sister, called her grandparents, as a mum and dad.*
>
> ***Parichat:*** *How do feel when your daughter called you like that.?*
>
> ***Sasi:*** *Because I was a very young mother. My mother helped me raise my baby. I felt ok, I don't want to correct her now, she would know how to call me in a right word when she grow up. (T4 Sasi, 19 years old)*

Another example, Sukan, was 19 when I met her. She has been working hard in a daily paid job and yet keeps studying at the same time. I interviewed her at the hospital of her antenatal check appointment. She came to check alone. Sukan has two sons and her parents helped her take care of both. The eldest one still lives with her parents, while the second one has lived with her ex-partner since he was two years old. Sukan explained that her first son did not call her mother and instead called her sister. But her son can call her mother when he wants something like toys and kids' game:

> ***Parichat:*** *What is your eldest son like?*

Sukan: *He was spoiled by my parents. My mum and dad took him to a local market and bought whatever my son wants. When my dad came back from work he bought some toys, games and clothes to him. My son will cry and not take food when he does not get what he wants.*

Parichat: *What is your son like when he is with you?*

Sukan: *He sometimes cries when he wants some toys, but I don't give him any if he does not stop crying. I have not spoiled him much. I left my eldest son with my parents, my mother is the one taking care of my children while I went to work in Bangkok, I didn't stay at home that much. (T5 Sukan, 19 years old)*

Participants revealed that leaving their children with their parents while they worked meant they could not take on the full mothering role with their first child. which potentially affected the relationship they had with their first child and reduced their confidence in their own mothering role.

Many young mothers followed breast feeding practices effectively following advice, while some attempted to breastfeed but failed. However, young mothers showed resilience in the face of barriers to breastfeeding.

Thai health advice advocates that all women would ideally breastfeed their children exclusively for the first four to six months and continue breastfeeding with complementary nutrition up to the age of 2 years or more. Many participants were able to manage the breastfeeding policy. Most of them were aware of the baby's health benefits (although this is only true if the mother has a good diet) of breast feeding, and some of them expressed that it was a low-cost way of feeding their baby.

Sasi (19 years old) successfully breastfed her daughter for a year. She breastfed exclusively for four months as recommended by the healthcare staff who led the antenatal class. Sasi and her mother both attended the maternity class and valued the benefits for children. As Sasi explained:

Sasi: *Last time [with the first baby] my daughter only breastfed.*

Parichat: *Who taught you how to breastfeed?*

Sasi: *I fed my baby with my breast milk. And my mother told me to feed her [daughter] with breast milk. My mother was afraid that her grandchild [participant's first baby] had an allergy to cow's milk So I didn't give her cow's milk. She was breastfed until she was*

over a year of age. I take care of everything myself. Mother's milk is better than cow's milk that the hospital teaches like this. Me and my mother listened in maternal class together.

Parichat: *And when can you give other food for your child to eat?*

Sasi: *I gave my child another meal at six months of age. But my mother gave my child to eat about four months, she first fed with mashed bananas at four months (T4 Sasi, 19 years old)*

Another example, Pakar expressed the benefits of breast milk and breastfed her first baby for a year. Her daughter, now 4 years old, was born premature and, as a result, presented with bronchopulmonary dysplasia (BPD); although she was 1,080 gm at birth she has recovered and was now a normal healthy child. Pakar explained how Pakar and her partner attempted to help their baby getting better with the benefits of breast milk. Pakar explained the benefits of breast milk for her daughter:

Parichat: *What did you do to bring up your first baby?*

Pakar: *I gave birth for the first time at seven months. The baby was premature. When I arrived at the hospital, my cervix had dilated to four centimetres.*

Parichat: *[nodded]*

Pakar: *I set the wedding date for the twenty-third, but I gave birth on the twenty-first. I stayed in the hospital for one night and had to come out to get married.*

Parichat: *What about your daughter that was in the hospital?*

Pakar: *The doctor said my daughter showed symptoms of being born prematurely without healthy lungs and that I had to do breast pump for two bags of milk if I went home. If not, I had to buy canned milk (formula milk) at 500 baht per box.*

Parichat: *What did you do for the advice?*

Pakar: *Then my mother said to do whatever it took to get as much milk as possible.*

Parichat: *Um [nodded]*

Pakar: *When the wedding was over, the doctor called and said that my daughter's symptoms were 50/50 percent to survive and told me to hurry and come to see her last time. When I arrived, they said*

there wasn't anything to worry about. Her heart had seemed like it was stopping, but she had returned to normal.

Parichat: *Bless her.*

Pakar: *She stayed at the hospital for half a month. Then the doctor called me to say that the baby could leave the hospital. When she weighed 1,500 grams after being outside [off the incubator] for five days, I could breastfeed. When she weighed two kilos, she could go home. So, I breastfed exclusively and did whatever it took to let her breastfeed. We had to stay together all day and all night until my baby could leave the hospital.*

Parichat: *You are an amazing mother.*

Pakar: *Yes [smile], Now that she's grown up, she has breastfed for a year. The doctor said it was good to breastfeed because I gave birth prematurely and would have to breastfeed for the benefit of my child. I was afraid my child wouldn't be healthy, so I breastfed her since I left the hospital. I had to go back every two months because the doctor had to check and see if her weight has risen. (T2 Pakar, 19 years old)*

These young mothers' stories draw upon the response of young mothers to their child with full love, bonding, and responsibilities. Young mothers understood the benefits of breastfeeding and expected it to help their child get healthy. Moreover, these stories were in relation to early motherhood and encourages young mothers to develop a loving relationship with their child.

Some young mother participants experienced the demanding situation of mothering and working to cover living expenses. Ensuring their child has adequate nutrition is part of the mother's role whether they are working for money or staying at home and exclusively caring for their baby. These mothers were very young, living in low socio-economic status and had limited support. Participants described the situation of breastfeeding for few months then leaving their baby with their parents and formula milk feeding being used. This makes young mothers leave their baby and costs them money to buy a formula milk at about 500-1,500 Baht.

As a single mother with no support from a partner, Sukan had little choice but to work. She explained how she managed to breastfeed and work to pay for the formula milk:

Parichat: *Did your children breastfeed?*

Sukan: *He breastfed just a month, and then bottle fed with canned milk [formular milk].*

Parichat: *Is that hard for you when you have children?*

Sukan: *Having a baby means things are going to get slightly harder because there's a burden if I have to go to work. If he has canned milk [formular milk], I have to buy it. The first one had canned milk, he breastfed for about a month, and then I stopped.*

Parichat: *What do you think about buying it or staying with your child and feeding him your breast milk?*

Sukan: *It's expensive to buy canned milk, but I don't know if I'm choosing to be home or not. I have to work for mum and dad to help them buy canned milk [formular milk. (T5 Sukan, 19 years old)*

Napar was 19 when I met her. Her son was 4 years old. He was breast-fed for a few days then he was formula-fed because she thought her milk had dried up. Napar explained how she found it difficult to manage her money so she could afford formula milk as a first-time mother. She planned to breastfeed her second child, if possible, with support from her mother, who would be the main person helping her:

Parichat: *Do you have many expenses for your older child?*

Napar: *A lot!. It's a lot with my older child. When I had my first child, the baby would not breastfeed. And my milk dried up when my baby wouldn't breastfeed. The baby kept sleeping and wouldn't wake up to drink. I didn't know that I had to wake him. I didn't know what to do, so I bought formula milk. I paid almost 500 baht per box. I had to buy formula milk. The milk is almost one thousand baht per week.*

Parichat: *What about this pregnancy? What about later your second baby born?*

Napar: *I thought. I thought and planned. If my child doesn't have my breast milk, I'll have to use the money from my husband's work to buy milk. We'll buy the big box and hire my mother to raise the baby. That's what I've planned. It's like one person buys milk for the baby and one gives money to my mother. But if the baby has from me, I won't have to use formula milk and I can save the money to pay my mother to raise my baby.*

Parichat: *[nodded]*

Napar: *I can save money to buy milk for my older child and let my mother raise my baby for me. My husband is working. My mother is old. I don't want her to work under the strong sun, so I hired her to raise my baby and stay at home.*

Parichat: *Is it a heavy burden on you to have this baby?*

Napar: *It is. But it's not more than I can handle. Once I had a baby, I had to do what I'd never done before. I had never woken up to sit and care for a baby, but I had to do it then. I had never fed a baby, but I had to then. I work in shifts. I had to sleep and work again. I'm very dependent on my mother. I don't want to be dependent on her, but I have to do what I can to make it the least tiring for her. (T3 Napar, 19 years old)*

Although it is not possible to deny that low socio-economic status among young mothers means they face disadvantages in early motherhood, these stories show the resilience of young mothers. They attempt to follow breastfeeding advice and are concerned about the benefits of breastfeeding for their baby. Some were unable to, possibly due to a lack of knowledge and limited support. Young mothers explained the difficult experience of weigh up the benefits and burdens between exclusive breastfeeding or formula feeding. If they breastfeed, they lose money as they cannot work but if they work, they still lose money as they have to pay for formula.

6.2.2.2 Family supports

This sub-theme considers the support available to young mothers from families. The family provides not only emotional support but also concrete support such as safe housing, money, mothering advice and childcare. These are discussed in the "*family supports"* which reports support and dependence in relation to the family for first-time young mothers. However, during the second pregnancy, their wider family were less likely to support them financially, although for some, childcare support was still available.

All of the young mothers in this study accessed the support that their family provided for them and their child. Nine of them live with in their parental home, three of them live in their partner's family home, while three live independently in rented houses. Many of them reported their financial dependence on their parents as discussed in "financial and housing support".

For the first pregnancy, the young mothers reported being supported by their mother in relation to having access to the tangible support from their own mothers in terms

financial support in terms of financial and housing supports. Napar talks about being financially dependent on her mother in the following statement:

Parichat: *How did you take care of your first baby?*

Napar: *For my first one, I didn't know what to buy when I went to buy clothes. I had to have my mother go with me to choose clothes. My mother had to tell me everything. She told me to wash the clothes and how to raise my child.*

Parichat: *What else do you need from your family?*

Napar: *When I don't have money, she (my mother) lets me borrow some and I return it when I have money. (T3 Napar, 19 years old)*

Ponsi revealed her mother provided housing support where it is safe and secure for her children and her partner to live with. Ponsi stated her partner is the one who is working to cover living expenses. In this house, her mother shared one room of her house with the young couple and their child, electricity for the young couple to pay separately. For living expenses such as food and water, Ponsi shares them with her mother.

Parichat: *What did your mum say when you were going to have another child?*

Ponsi: *My mum wants me to complete high school, she supports me to study NFE and took care of my first baby for me when I went to school. She shared her house with us, we pay only electricity.*

Parichat: *Who pays for this?*

Ponsi: *My partner, he works for us to pay things. I am just taking care of my baby. (P9 Ponsi, 17 years old)*

The most important tangible support that a young family can have access to housing and financial supports. Housing support is the crucial support provides safety and security for a young couple and their children.

Young mothers rely on their family when taking care of their first baby. Participants discussed how they did not know what to do as a mother during early parenting and needed childcare support and advice from their own mothers. The presence of family helps a young mother feel safe and secure.

Most participants had support from their parent(s) (their child's grandparent(s)) and one was supported by their grandparent (their child's great-grandparent). For example, Palmy explained that her first child lived with her mother (in the Northern part of Thailand) and that she provided support by taking care of her first child:

***Parichat**: How did you manage with your oldest child?*

***Palmy**: I left my kid with my mother.*

***Parichat**: Who's taking care of your first child then?*

***Palmy**: My mother. I send her two thousand baht at the end of the month.*

***Parichat**: How old is your child?*

***Palmy**: About three years old. I send two thousand baht per month.*

***Parichat**: Does your mother say whether that's enough?*

***Palmy**: I know it would never be enough and she [Palmy's mum] doesn't ask for more. (P1 Palmy, 19 years old)*

Family support still takes a crucial role during the second pregnancy and in plans for childcare of the second child, especially in the breastfeeding period. In the second pregnancy, Siri revealed her mother's support was significantly important to her and plans for her second child. When she is breastfeeding, she needs her mother to help her particularly for providing traditional Thai food and Thai herbs for improving her lactation.

***Parichat:** Now you have moved into your partner's house here. Who will be your supporter when you nurture your second child?*

***Siri:** My mum will help me. She helped me last time. My son was breastfed for a year, and I was working in a factory as well, but I can collect and store* [breast milk] *for my son. My mum was taking it from the refrigerator, warming it up and pouring in a feeding bottle for my son. He was bottle fed during the day with my breast milk exclusively. When was I came back from shift, he was breastfed.*

***Parichat:** What about this pregnancy, will she come here for you?*

***Siri:** After giving birth I will move to Suphan-Buri [her hometown] My mum will help me take care of my children. My mother said that I must give mother's milk only. After giving birth if I were here, who will take care of me regarding food? Nutritious foods? Like*

banana flowers, ginger. My mum can do it for me. My mum can provide food to stimulate breast milk for me to eat. If I stay here with my two children, I can't do it myself. I can't stay. I had to move to my parent's home. (T 7 Siri, 19 years old)

These accounts highlight the importance of family relationships in providing financial support, safe housing, security, and childcare care support. Thai culture values family relationships and Thai families will offer support when young mothers need it. When particular help is needed, like providing foods to stimulate lactation, the young mother's mother is the best resource of knowledge, skills, and support. On the other hand, a young mother's family may be confronted with a financial burden, especially when they have a second child.

6.2.2.3 Raising children: preparing for another baby

Parenting at a young age requires raising children in a challenging situation. Young mothers mostly get helpful support from their family and their partner's family, but this "sharing care between families" may affect maternal and child bonding. When they are having another baby and preparing for the new member of the family, they may not be living with the father of their children. Young mothers discussed how they would manage being a mother, when "preparing for another baby".

After two years separation, Napar allowed the father of her first baby to take her son to live with his parents and *sharing childcare* together. She meets her son every weekend and sometimes he stays overnight with her. Her new partner, the father of her second baby, moved in to live with her and her mother. He comforts her Napar talked about her son growing up and now that she has a job, and some support to share the caring between her side and her son's biological father, this could allow her time to do things, but could also affect her relationship with her child:

Napar: *After I separated with him, My ex-partner asked me to allow my first baby to be raised by his parents. His father asked to raise him when he was two years old.*

Parichat: *What did you do when they asked?*

Napar: *I am okay with them, I allowed his parents to take my son on weekdays, and I pick him up on Saturdays and Sundays because he is in school. I drive to pick him up on Friday evenings to stay overnight with me and I drop him off on Sunday evenings.*

Parichat: *Are there any problems when you were not with him as it was?*

***Napar**:*	*Yes, mostly, my son is attached to his grandfather, and his grandparents raise him more than me. On weekends, he comes to stay with me for about two days. We don't live together every day. When he wants something, I take him to buy it.*
Parichat:	*How do you feel about that?*
***Napar**:*	*When I see any children's clothes, I buy them. But I have a mother's emotions. My house is only ten kilometres from my ex – partner's house, I think it is not too far apart (T3 Napar, 19 years old)*

Siri experienced abandonment by the father of her first baby, so she is not allowing her ex-partner's parents to come to see her son, nor is she allowing her son to take his father's family name and so her son carries her family name. Siri and her son's biological father do not share the care. Instead, she chose to raise her son with her current partner as she did not want the support from her son's father. Siri explained how she decided take care of the baby by herself in her current partner's family:

Parichat:	*Has the father of your son ever met him?*
Siri:	*No, but only his parents. When we broke up, my dad was very angry with him. Our family agreed to not use my son's father's family name.*
Parichat:	*You did move to this current house with your son, so are there any problems?*
Siri:	*My dad has been worried about it as well, my dad asked me about leaving my son with him, because he is worried his grandson will not be loved. But I don't care, if no one loves him but me. I have to think about our children first. If I go back [to parents], I will have my mother help me, definitely! But, I'm afraid that if next time my son asks me 'why don't you take me with you'. 'why do I have to live with my grandmother', so I think it would be better to take care of them myself, so he is with me.*
Parichat:	*How is the relationship between your son and your current partner?*
Siri:	*My son, he calls my current husband as father. They never had a problem with each other. Because he was still young, he was born and then I met this husband. He's been taken care of by my partner since he is in my womb. (T7 Siri, 19 years old)*

These young mothers reflect on the potential impacts on maternal and child bonding of not being with their older children. Young mothers also decide whether to share caring with the paternal family or to raise their children without it. They are more careful and have a sense of being a family, to keep family members close. Now the second child is coming, young mothers have plans for their baby that will be discussed next.

Young mothers were concerned about preparing for another baby and how their children would react with new partners and how their new partner would act with her first child, especially when the child has a different father. Participants suggested that a good relationship between the father of the second baby and their own first child can make life happier. Napar again brought up the case of the relationship between her first child and their non-biological father:

> ***Napar:*** *I brought my older child to live with me at the weekend. Wherever he [her son] goes, he calls my partner "Fluke" [partner's name]. He doesn't call my partner as dad but uses his name. He [her partner] gets along with my son. My son is four years old now. My boy gets along well with him too. (T3 Napar, 19 years old)*

Napar was positive about preparing for the new baby. She felt better prepared and considered the benefits of preparing. Napar did not breastfeed the first time as she lacked experience, but this time, Napar planned to collect and store her breast milk for feeding, with her mum and cousin supporting her.

> ***Parichat:*** *What do you do for a living?*
>
> ***Napar:*** *I work as an employee at Seven-Eleven. But I'm on maternal leave now. I can't do the work. I have over a month of leave left, so I think I'll breastfeed for a month or longer before I go back to work.*
>
> ***Parichat:*** *But you have got only 3 months[8] for maternal leave. What do you plan to do? Do you have some maternal classes for collecting your breast milk?*
>
> ***Napar:*** *Yes, the nurses told me. I thought that I'd store the milk and let my mother help. I've made a preparation to pump and store the milk, but I have to teach my mother first. I'll ask my cousin who lives with me to help. It's better and it saves money. There's a*

[8] Maternal leave with pay in Thailand is provided for only three months and is available only to women who are employed

cheap hand pump or I can buy an electric breast pump. There are many prices. Some of them are inexpensive and more convenient. I checked the milk bag prices online. It's inexpensive. I added them to my cart [online shopping]. (T3 Napar, 19 years old)

Sasi lives with her original partner; she was preparing for her new baby with her first child and their father. Sasi said that her daughter did not call her mum; she later explained that her daughter calls both her and her mother (the grandmother). Sasi was not worried about it and has prepared her daughter for the new baby:

Parichat: *How has your daughter reacted when she got to know you are expecting her sibling?*

Sasi: *No, she was happy to have a younger sibling to play with. Now, my daughter calls me mum. But she still called her grandparents "Dad and Mum" too.*

Parichat: *What did you do when you were together?*

Sasi: *I have taken a video while my baby is moving. She saw that my tummy was moving. She feels her younger sibling. I am happy. We sleep together every night. My husband is staying with me and my kid. When he is off from work he is not going anywhere, just staying at home. (T4 Sasi, 19 years old)*

The second child is seen as a positive event and preparing as a positive experience. However, financial limits pose a plan to overcome this rely on support from partners and/or the wider family. The relationship with their first child pointed to the experience of mothering and managing their relationship with their child that living apart and new partner. None of them abandon their first child.

6.2.2.4 Independence: My mum let me grow up

For their second pregnancy, most of young mothers in this study still live with their parents; only a few live independently, but with family still offering support. However, with the second pregnancy, their parents encourage them to grow up and although they are still there for help this is more likely reduced. Ponsi relied on her mother especially for living expenses and sometimes to take care of her first baby. However, with a second child on the way, her mother encouraged Ponsi to take care of herself and her children:

Parichat: *What did your mum say when you told her about this pregnancy?*

Ponsi: *Mum said I had to work because of my two children. My mum told me to help myself. I still don't know what to do. My mother didn't mind. But she wants me to grow up to be an adult. (P9 Ponsi, 17 years old)*

From a young mothers' perspective, they receive less support from their family during their second pregnancy; in addition, some young mothers talk about problems accessing family support if their families were already supporting other children. Passon and her partner lived with her mother. Her first child was 4 years old, and her partner worked in his rice field. Passon has her own rice noodles shop; she is very busy every morning, so she often missed the ANC appointment. She expected to open the shop until her second baby was due. Having a second baby might mean more struggle and Passon explained that her mother complained it would be more of a burden to her to have another grandchild:

Parichat: *What did your mum say when you have another child?*

Passon: *"Once my parents knew that I was having another child they complained that there are already many grandchildren. My mother said that she can't help me raising my second child as she is so tired." (T12 Passon, 19 years old)*

Wilai realised that her mother had her hands full with taking care of her grandchildren. Wilai left her first child with her mother after 6 months; her mother raised the child full-time; her son was one of 5 children from her siblings that were left with her mother. Later, Wilai moved to the city centre to find a job with her partner who is the father of both her children; they work as a day-paid wait-staff and live in rental accommodation. Wilai explained how she has planned to be less dependent on her mother after the birth of her second child, although she still needs her support:

Parichat: *What did your mum say when you told her about this pregnancy?*

Wilai: *My first child is now with my mother in [town]. My mother raised my first child for me…But for this baby (second one), my mother said that if I gave birth, she would not help me raise this child, she said she is so tired.*

Parichat: *So, what you are going to do?*

Wilai: *I think when this baby was born, I will raise it by myself because my mother is tired… I thought about going back to give birth in the hospital near my mother's house. I hope she could help me…I also think that my mother just complains anyway. I thought of*

raising the child myself but hope that there is my mother around. (P10 Wilai, 19 years old)

These accounts suggest less family support, especially in relation to childcare, requiring more independence from young mothers for their second child.

Family attitudes influence decisions young mothers make. For example, Pakar was reassured by her mother, who pointed out the benefits of having two children close in age and raising them together:

Pakar: *At first, I was going to wait until I was twenty years old, but my mother said it was okay to have children close together, so you can raise them all at once. My oldest child is already four years old. If I have children when I have a lot of work, there won't be anyone to raise them, and there will be problems because I think they would be too far apart.*

Parichat: *So, what did you do?*

Pakar: *So, I decided to stop birth control and to have this baby" (T2 Pakar, 19 years old)*

Although Siri experienced abandonment during her first pregnancy, she was married for a year before her second pregnancy. Siri explained that her family accepted she was having a second baby and her partner's family were delighted:

Parichat: *What did your parents do when you told them you got pregnant?*

Siri: *When I was pregnant with this child, my partner's parents were delighted as this child is the first grandchild of the family. Also, my partner. He is an only child. So, when they realized, they were going to have their first grandchild, they were very happy. (T7 Siri, 19 years old)*

Titar was in the same situation as Siri. Titar explained that her second child is the first grandchild of her partner's family:

Parichat: *What did your family do when you told them you were pregnant?*

Titar: *This baby is the first grandchild of my current partner, my mother in-law wanted to have a grandchild, and together with the fact I don't want to take contraception for too long, its long enough (5 years), then I don't mind being pregnant. When I am pregnant my mother in-law is very happy. (T14 Titar, 19 years old)*

These accounts suggest that family attitudes towards a second pregnancy can support a young woman's idea that they are ready to have another child. Family opinion influences a young mother's decision about having a second child and this is when they see themselves as ready and may not be based on their age.

6.2.2.5 Young marriage

The Thai context about the parental consent and the marriage of young mothers is complex and needs to be understood. All young mothers reported their parent's reactions when they told them they were pregnant. None of them were happy at first, they felt regret, sadness, worry and anger to what the young mothers did and that they were not "on the right path". The experience of young mothers towards their parents is complicated. Early pregnancy is a family crisis and parents' initial response was to ask that the partner take responsibility to marry. Young mothers' parents were concerned about their lost virginity, and if the partner did not take responsibility, parents threatened to report this issue as statutory rape because of their child's age. Some participants experienced their first pregnancy at 14 years.

For example, Sasi, was 14 years, and her partner was 20 years when she got pregnant for the first time. Sasi lived with her parents and her original partner. Sasi explained her first pregnancy and her parents' responses:

> ***Parichat:*** *How old were you when you had your first pregnancy?*
>
> ***Sasi:*** *At my first pregnancy. I was about 14 years old.*
>
> ***Parichat:*** *At that time, was your partner in trouble for breaking the law?*
>
> ***Sasi:*** *No, in my first pregnancy, when I found out I was pregnant, I consulted my mum. My mum said I was wrong. There's nothing I can do. My partner, he feels guilty. So, he apologized to my mother.*
>
> ***Parichat:*** *What did your mum or your parent do after that?*
>
> ***Sasi:*** *They never said anything bad to me, or made me feel bad. They didn't scold me. They consulted my relatives. Then my cousin said if I was pregnant then let me get married. I was about 14 years, so my mum didn't want me struggle alone if he [partner] gets into legal trouble.*

Parichat: *What did your mum say about not wanting your husband to get into legal trouble?*

Sasi: *Umm [nod], She said to my relatives that I'm young, and if he goes to jail, my baby won't have a father, so my parents managed to get us married and told him to take responsibility for my pregnancy. My parents agreed to our marriage.*

Parichat: *[nodded]*

Sasi: *My parents believed my husband already had a job. He's mature. So, my parents didn't make it an issue. (T4 Sasi, 19 years old)*

Sasi's account shows that her mother was concerned about making sure the child was legitimate, she consulted the wider family to get advice about whether to let a young couple marry or to sue Sasi's partner. They decided that it would be better to let them stay together as a family and expected them to marry and considered this the partner taking responsibility for the pregnancy.

The concern in this case is about the age of consent and parental consent. Practically by law, the age of consent in Thailand is 15 regardless of gender or sexual orientation, as specified by article 277[9] of the Thai Criminal Code. Individuals aged 14 or younger in Thailand are not legally able to consent to sexual activity, and such activities result in prosecution for "statutory rape". Thailand's statutory rape law is violated when an individual has consensual sexual intercourse with a person under age 15. There is no close-in-age exemption (Romeo and Juliet laws) in Thailand; it is possible for two individuals both under the age of 15 who willingly engage in intercourse to both be

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[9] Thailand's Criminal Code - Offense Relating to Sexuality

"Section 277.- Whoever, has sexual intercourse with a girl not yet over fifteen years of age and not being his own wife, whether such girl shall consent or not, shall be punished with imprisonment of four to twenty years and fined of eight thousand to forty thousand Baht.

If the commission of the offense according to the first paragraph is committed against a girl not yet over thirteen years of age, the offender shall be punished with imprisonment of seven to twenty years and fined of fourteen thousand to forty thousand Baht, or imprisonment for life.

If commission of the offense according to the first or second paragraph is committed by participation of persons in the nature for destroying a girl and such girl is not consent, or by carrying the gun or explosive, or by using the arms, the offender shall be punished with imprisonment for life.

The offense as provided in the first paragraph, if the offender being the man commits against the girl over thirteen years but not yet over fifteen years of age with her consent and the Court grants such man and girl to marry together afterward, the offender shall not be punished for such offense. If the Court grants them to marry together during the offender be still inflicted with the punishment, the Court shall release such offender."

prosecuted for statutory rape (Thai Civil and Commercial Code, 2002; Thailand youth policy factsheets, 2014**).** This is managed by the family requiring the couple to marry, which potentially compounds an abusive situation.

Young mothers' parents play the crucial part in young marriage issues. Young mothers' parents were worried about their lost virginity and, if the partner did not take responsibility, parents threatened to report this issue as statutory rape because of their child's age. Some family response to a young mother who was pregnant while studying in school, as crisis evident as in Sasi's story. Sasi was in Mathayom 2 (aged 14 years); her mother took her out of school when she became pregnant the first time, saying she did not want her to have a *bad record and to avoid a bad reputation*. Sasi explained that she did not want to get a bad name for herself, and she was worried that it would go on her record that she was pregnant while at school:

> ***Sasi:*** *When I found out I was pregnant, I asked my mum to submit my resignation so I wouldn't have to lose my profile if in the future I wanted to go to school again. So I don't have to lose my profile because I have a bad history of early pregnancy. It's easy to go back, and someone in my neighbourhoods told me to submit my resignation to the school.*
>
> ***Parichat:*** *Why did you want to keep your profile?*
>
> ***Sasi:*** *Because I didn't want anyone to know that I'm pregnant at school age, I felt embarrassed around other people and friends.*
>
> ***Parichat:*** *What did your mum do?*
>
> ***Sasi:*** *When I found out I was pregnant, I consulted my mum. My mum said she didn't want me to be targeted by people who thought I wasn't good. (T4 Sasi, 19 years old)*
>
> ***Parichat:*** *Did anyone say anything to you because you quit?*
>
> ***Sasi:*** *nobody knew that I am pregnant. I decided to quit school.*

I replied to her about my understanding of teenage pregnancy policy in school.

> ***Parichat:*** *Did you know school allows students to take a break? If you're pregnant and you can come back to study.*
>
> ***Sasi:*** *Yes, I know this, but my mum said she didn't want me to get a bad record (T4 Sasi, 19 years old)*

Their parents show a lot of concern that young mothers will get a bad reputation and they aimed to protect them from embarrassment in school. This also suggests that young mother's parent decide between lawsuits and expecting them to stay together as a family.

Family attitudes can impact on and influence young mothers' decisions about pregnancy. While support from family can be a positive and encourage young mothers grow up and to be more mature, findings suggest that more family support is available to young mothers in relation to their first child but that this is less evident in relation to the second pregnancy. Family attitudes about protection and worries about young marriage are complex and need further exploration.

6.2.3 Peers

This category presents the experiences of young mothers and their relationships with their peers. The interaction with peers is different during the first and second pregnancies, although some commonalities are also evident. When discussing their first pregnancy, participants talked about the impact of school peers on their experiences; "*embarrassed to tell friends*" reflect a main concern during the first pregnancy. However, friendships during the second pregnancy were related to friends who did not attend school and centre around the mutual experience of being in the same situation; considered in: "*we were the same"*. Some participants however, who are employed report a different experience, explored here in: "*we are different"*.

6.2.3.1 Embarrassed to tell friends

Young mothers' interaction with peers were expressed in terms of embarrassment for the first-time mothers, especially when they were in school. Participants described feeling embarrassed while being around school mates during their first pregnancy, and so *concealing it* from classmates and other girls in class. Their close friends, however, were a source of emotional support.

Pakar described her embarrassment during her first pregnancy, which she kept secret from other girls in school as she was the first student in her class to get pregnant (Pakar became pregnant close to graduation from Mathayom 3, aged 15. Only close friends knew and came to see her to comfort her emotionally. As Pakar explained:

Parichat: *How did you feel the first time you were pregnant?*

Pakar: *I was embarrassed about my first time, because I was still a child when I began to have a family. At the first time, they said I was still young. I was embarrassed. My classmates didn't know. My first pregnancy was in my graduation class.*

Parichat: *What did you do after that?*

Pakar: *I was embarrassed. I was the first one to get pregnant. I didn't dare to go out anywhere. I only had 2 – 3 close friends who came to see me at home. They kept asking how I was and if I was alright.*

Parichat: *How about others?*

Pakar: *The ones who weren't close to me looked like they gossiped about me when I passed them in the local market. I didn't dare to greet*

them. I was embarrassed. I just went another way to try not to walk by her. (T2 Pakar, 19 years old)

Pakar had her close friends to talk with. Similarly, Titar confided in her closest friends when revealing her secret first pregnancy at aged 14 years. She was initially unaware that she was pregnant and had recently broken up with the father. She decided to drop-out from her studies and moved to another school after giving birth. Titar was 19 and still attended high school when, she found out she was pregnant with her second child. As she was near completion of the last year of Mathayom 6, she decided to cover her pregnancy by wearing an over-sized uniform and told only 4-5 close friends that she was having a baby. Titar expects to complete secondary school (Mathayom 6), with her qualification just before her 'due date'. Titar talked about close friends and explained that she was hiding so that she would be able to complete her studies without suspension:

Parichat: *What did you do when you got pregnant this time?*

Titar: *"When I became pregnant with this baby, I hide my bump under my big uniform because I normally look overweight. No one knows that I was pregnant. Just only 4-5 close friends that I told, and they can notice that I was pregnant…*

Parichat: *Why did you cover up your pregnancy?*

Titar: *I didn't find it difficult to cover up my pregnancy, but I chose to finish my studies. (T14 Titar, 19 years old)*

Sasi was just 14 years old and in Mathayom 2 when she realised, she was pregnant and she. Sasi felt she was very young and did not have any classmates as her close friends. Sasi kept her pregnancy secret and her family decided to take her out from school without the certificate of graduation:

Parichat: *How did you get pregnant for the first time?*

Sasi: *I didn't use birth control pills. He didn't use anything either. Just the first time we had sex I got pregnant".*

Parichat: *How did feel when you got pregnant at your school age?*

Sasi: *In the first pregnancy, nobody knew that I am pregnant. I decided to quit school. I felt scared and embarrassed.*

Parichat: *You said you were scared. Can you tell me what you were afraid of?*

Sasi: *Because I was afraid my classmates would know I was pregnant.*

Parichat: *Did you have any close friends to talk with?*

Sasi: *I just started in Mathayom 2 [year 9 in UK] and didn't have any close friends, so I didn't tell anyone. I didn't want to tell them at school. (T4 Sasi, 19 years old)*

These explanations suggest that interaction with the wider peer group is shaped by embarrassment and that peer support is limited to close friends only. Their close friends can provide a young mother with essential emotional support.

6.2.3.2 We are the same

In their second pregnancy, adolescent mothers in the study reported feeling *'unembarrassed'* and being a young mother is experienced as more of a commonality. Participants explained that their friends also had children while young. For example, although Pakar was the first one to become pregnant in her class, other classmates later experienced the same. Pakar felt sympathy for these women facing this difficult situation; however, she also felt it was good as it showed that everybody makes mistakes. Pakar did not feel uncomfortable around them now pregnant for a second time:

Parichat: *How do you feel being pregnant this time?*

Pakar: *I don't feel any embarrassment now. My friends are pregnant, so I'm not embarrassed. Some of them left after studying for half a term because they were pregnant. Then they left school. I don't feel anything right now because my friends are all pregnant. (T2 Pakar, 19 years old)*

Ponsi was 17 years old and 35 weeks into her second pregnancy when I met her. She was aged 15 when she was first pregnant; this pregnancy was unintended. Ponsi left school at 15 years of age with no completion certificate. Then she moved to the Non-Formal and Informal Education (NFE) school in year 9 (Mattayom 2). Ponsi said about her young pregnant friends:

Parichat: *How do you regarding your pregnancy this time when you were at NFE school?*

Ponsi: *At the NFE, there are many students who are pregnant and study at the same time. Because it is an adult learner, teenagers can come to study or adults can come to study. I felt that it was normal, I could study and raise my children. (T9 Ponsi, 17 years old).*

Although, Ponsi left formal school, and her friends, for her first pregnancy, during her second pregnancy she was able to attend non-formal education (NFE) which provided an opportunity for adolescents and adults to study every weekend and is normal to have children and study at the same time.

In conclusion, young mothers described not feeling different from others during the second pregnancy. The experience of feeling 'the same' and not being excluded may impact on young mothers' decisions about being pregnant for a second time at their young age.

6.2.3.3 We are different

Adolescent mothers who worked at a young age described their *experiences as different from other girls* because they were *in a different situation*. Kor explained that because she was not in school and worked for money independently, she would not be the same as girls in school. School friends were focused on their studies, but she was a worker and was friends with other women who worked and had children.

Parichat: *What do you think about being pregnant this time?*

Kor: *"I felt that I was not careful enough, that I was still young and should not have children. But at the same time, I still think that I have been working to support myself. The society that my friends lived in, it's very different to me.*

Parichat: *What is the difference? Such as?*

Kor: *My friends, they have been still studying, but I [pointed herself] already have children. With the fact that I have been working, I have met people who were working together, then I saw them have a family, I thought I could have one.*

Parichat: *[nodded]*

Kor: *I don't think it's not yet time because I was working. I did not study, I don't live like them… If they (other girls) are still studying in school, then they shouldn't have children." (T6 Kor, 19 years old)*

Participant's interactions during their first pregnancy focused on school friends but during the second pregnancy, was more focused on non-school friends. Adolescent mothers who supported themselves through work felt different from friends who still attended school.

They no longer felt embarrassed. Their life had changed and their position in society was different, they were working mothers and no longer schoolgirls.

To conclude, young mothers' experiences of repeated pregnancy shared various experiences from their perspective that are interrelated with not only with the individual themselves but also with their partner, children, family, and peers. Some stay with their original partner, while others had met a new partner, the father of their second baby. Young mothers try to ensure a positive, safe environment for their children, with support where possible, from the wider family.

6.3 Education and Employment

Education and employment represent a central set of issues that crosscut the experiences young women shared about both their first and second pregnancies. This theme presents these interrelated aspects, reporting the barriers to education as well as the perceived benefits, and considers this in relation to both the financial struggles they experience and the limited access they had to well-paid employment. Young mothers with both limited education and minimal labour market skills face many obstacles, a situation compounded by their low economic status, leaving them struggling against financial barriers. The data indicates that students appreciate the support that they can access via the school; education is important to them; however, it is not always feasible to manage the balance between education, employment, and childcare.

Thailand's educational system is provided primarily by the Thai government through the Ministry of Education from primary education to upper secondary education. A free basic education of twelve years is guaranteed by the constitution, and a minimum of nine years school attendance is mandatory. Basic education and the school structure are allocated into six years of primary education (Prathom 1-6, aged 7-12) and six years of secondary education, the latter being further divided into three years of lower secondary level (Mathayom 1-3, aged 13-15) and upper secondary levels (Mathayom 4-6, aged 16-18) (Wittayasin, 2017, Ministry of Education of Thailand, 2008).

Table 6.2 presents the education and employment profiles of participating young mothers. The educational level at interview shows a wide range of achievement at the point participants ceased education, for example Kor, studied up until Prathom 2 (preparatory school year 4) and left full time education without qualifications and can only read and write her name. Palmy, Wilai studied up until Prathom 6 achieving completion certificates (Preparatory school year 8). For secondary education, Pakar, Napar studied up until lower secondary education certificate (lower secondary school year 11), while Sasi, Sao, Manee, and Tahmas studied up until year 9-10 leaving without certificates. Sukan and Ponsi, have been studying in Non-Formal and Informal Education (NFE) in lower secondary education level (year 9-10). Passon, Siri, and Titar studied up until upper secondary education level achieving a completion of education certificate (upper secondary school year 13). Rassa is the only one who graduated in vocational education with a certificate of education completion.

Table 6.2 also provides the data of young mothers' employment. Five of them have been self-employed - Siri, Passon and Manee have their own small shops earning an income from selling food, while Sao and Titar earn an income by online selling. Four of them are working as day-paid employees - Palmy, Sukan, Kor and Wilai. Three young mothers have been employed as monthly-paid employees depending on their education qualification and maternal leave is provided. Pakar is self-employed and works with her family earning money from milking cows and selling cow milk. Two were unemployed – Sasi and Ponsi are full-time mothers, with working partners who make a financial contribution to the family.

This theme contains the two aspects that are interrelated in a young mother's life experience: education and employment. The first aspect is the 'education - barriers and benefits' which illustrates issues faced by young mothers both while they were pregnant for the first time and during their second pregnancy. The second aspect explores "employment and financial struggles' from a young mothers' perspective.

Table 6.2 Education and employment data of young mothers

Participants	*Age at interview*	*Education level at interview*	*Employment at interview*
Palmy	19	Prathom 6	Daily hire
Pakar	19	Mathayom 3	Self-employed / Daily hire
Napar	19	Mathayom 3	Employee, at 7/11 shop seller/ monthly employed
Sasi	19	Mathayom 2	Full-time mother/ housewife
Sukan	19	NFE 2	Daily hire
Kor	19	Prathom 2	Daily hire
Siri	19	Mathayom 6	Having own grocery store
Rassa	19	Vocational certificate	Employee, at 7/11 shop seller/ monthly employed
Ponsi	17	NFE 1	Full-time mother/ housewife
Wilai	19	Prathom 6	Employee/ Waitress daily hire.
Sao	19	Mathayom 2	Self-employed/ Online seller (clothes)
Passon	19	Mathayom 4	Having own rice noodles restaurant
Manee	19	Mathayom 2	Having own kiosk selling foods
Titar	19	NFE 6	Self-employed/ Online seller (Thai amulets)

Participants	Age at interview	Education level at interview	Employment at interview
Tahmas	18.7	Mathayom 1	Employee, at Srifa bekery factory/ monthly employed

Educational level system in UK and in Thailand, (The office of educational affairs, the Royal Thai Embassy, 2021)

a) Prathom 1-6, Primary education (aged 7-12)= Preparatory School (Year 3- 8) in UK

b) Mathayom 1-3, Lower secondary education (aged 13-15) = Key Stage 3, Secondary School/ Sixth Form College / College of Further Education (Year 9 – 11) in UK

c) Mathayom 4-6, Upper secondary education (aged 16-18) = Key Stage 4, Secondary School/ Sixth Form College / College of Further Education (Year 11 – 13) in UK

d) Non-Formal and Informal Education: NFE 1-3, Lower secondary education= Key Stage 3 (Year 9 – 11) in UK

e) Non-Formal and Informal Education: NFE 4-6 , Upper secondary education = Key Stage 4 (Year 11 – 13) in UK

f) Vocational certificate (aged 16-18),= Vocational school, General National Vocational Qualification (GNVQ advanced) in UK

6.3.1 Education Barriers and Benefits

The experience of accessing education illustrates the limited options available in the young mothers' life. Although the Thai government provides a free basic education for everyone, young mothers in this study were still challenged with critical moments of studying alone or sharing responsibility for their family's financial status. In the second pregnancy their life experiences are more limited, balancing mothering and working for a living, prioritising their children is more important than education.

6.3.1.1 Accessing education and financial barriers in the first pregnancy

"Accessing education" considers firstly how financial pressures are a major disruption to education during the first pregnancy and secondly, the focus on children that impacts access to education during the second pregnancy. Education experiences among participants during their first pregnancy were varied. The family's financial situation proved a barrier to education for some first-time young mothers.

For example, as a result of financial hardship, Palmy agreed to leave school to contribute to the family income by working. Although Palmy finished her studies at age 12 (year 7 - Pratom 6 in Thai), she still aimed to return to higher education, to get a better job and earn money for taking care of her children and household expenses.

Parichat: *What grade did you complete?*

Palmy: *I studied up to year 7. I wanted to continue studying, but my father didn't have money to send me to school. My father had to work by cutting sugarcane and planting rice.*

Parichat: *Did it take a lot of money for you to study?*

***Palmy**:* *I wanted to study, but he (her father) didn't let me. I had to buy supplies. I wanted to study in non-formal education up to the ninth grade. Now, I'm waiting for my year seventh certificate from my old school, so I can use it in my application. (T1 Palmy, 19 years old)*

It was clear that pressures to leave education and find employment was an emotive topic. Pakar graduated lower secondary education with a completion certificate (year 11 - Mathayom 3 in Thai). She cried when she was asked about her education and the financial problems in her family. She could no longer study. Her father, the main earner in the household, told Pakar not to get pregnant if she wanted to study as he would be unable to pay for her education.

Pakar was living with her parents together with her partner and her daughter. Pakar decided to earn money for her first child to save her family the financial cost but also so that she could start higher education when she was ready. Pakar worked at home in her local dairy farm where her mother let her manage and take care of all cow cleaning and milking (by hand). Although all the money is hers, all living expenses of the family are her responsibility as well. Her partner (21 years) works as day-paid job and gives her every baht he earns. Pakar is still working, looking after the cows alone everyday while pregnant; she plans for her partner to help with the milking when she cannot do it. As Pakar revealed:

Parichat: *How do you feel about not continuing your studies?*

Pakar: *I left because I had no money. I pitied my father because he had to work (cries as she speaks).*

Parichat: *Is this why you don't want to study?*

Pakar: *Yes. I felt sorry for my father, so I decided to raise dairy cows and help my mother because they still had no money to send me to study. So, I didn't go to school.*

Pakar: *Did your leaving school help much with your family at home?*

Pakar: *It helped a lot because my mother's knees aren't good. She can't walk sometimes. It helped. We could let her rest when she couldn't walk. (T2 Pakar, 19 years old)*

Basic education in Thailand is provided for twelve years and is free of charge. I explored Pakar's financial situation. Pakar revealed even though her school provided free tuition,

uniforms and other activities in school would cost her a lot. Pakar did try to return to school. She began Mathayom 4 (upper secondary education- year 12) but unfortunately, her mother was injured in an accident so that she had to leave school again to help her family.

> ***Parichat:*** *Is this why you don't want to study?*
>
> ***Pakar:*** *there would be clothing expenses if I went to study. Nothing's free. I really wanted to study, but I thought to leave and help my parents first. I can study at any time when I have money. I mean, people can study at any age now, right? It's alright. I studied as much as I could because my parents had to find money and they'd have to take out a loan if they didn't have money. So, I said that it would be better if I didn't go to study. My father said it was okay to not study. We have cows, so we'll raise cows at home. If I wanted to study, I could. I said that I wanted to, but we had no money so it would be better if I didn't. (T2 Pakar, 19 years old)*

Rassa became pregnant with her first child when she was in the last year of vocational college (equivalent to year 13 in the UK). During her first pregnancy, Rassa lived with her partner in private student accommodation. When she has found out she was pregnant she felt guilty as she was the youngest of three siblings; her sisters decided not to study to help her parents save enough money to support Rassa to study at the highest level she is able.

> ***Rassa:*** *I care about my parents and sister, that they gave me money to study I was worried that they would be disappointed. I'm the youngest of the house. My sister had to sacrifice by not to continuing to study. so that I could study higher My family expected me to graduate, have a good job, but then I became pregnant (T8 Rassa, 19 years old)*

Rassa completed the final year at a school that supports students who became pregnant in their final year. She was therefore able to complete the final year with a certificate. She expected to go to university to get a bachelor's degree, but this was not possible once she was pregnant. There were tears in her eyes when discussing her educational situation. These experiences illustrate how financial hardship results in educational struggles.

6.3.1.2 Children as a priority: education in the second pregnancy

During their second pregnancy, participants reported mixed experiences in relation to the economic implications of participating in education while being a young mother. Some

participants saw their baby as their most important priority and decided to earn money to support their children instead of studying.

Manee revealed that she did not mind stepping away from education, she was more concerned about the responsibilities of parenting her first child. As Manee explained:

Parichat: *Do you think about continuing your studies?*

Manee: *No, I don't care about studying anymore.*

Parichat: *Could you tell me why you say that?*

Manee: *Because I have a responsibility… I have to take responsibility for my child… I probably wouldn't go back to school. I have to work to make money for my children… Right now, me and my partner have to be responsible to earn more money because now I am going to have 2 children, so I don't think about studying…Also, I work selling things on my own, so I don't need a qualification to do it." (T13 Manee, 19 years old)*

Another example is Siri who graduated in Mathayom 6 (year 13). Having a baby meant she had to work. For Siri, prioritising her children was more important. Studying can be done later, as Siri explained:

Parichat: *Are you about to continue to the undergraduate studies?*

Siri: *No, I can do it later when my children grow up.*

Parichat: *Could you tell me why?*

Siri: *I decided that I had a child. Why am I going to study? I have to focus on my baby first. I cut down that option [study]. I talked to my father and said that I still have a chance when I'm ready. Wait for the baby to grow up before continuing to study. (T7 Siri, 19 years old)*

Passon was studying in year 11 when she became pregnant, so she left school with a year 10 qualification (Mattayom 3 in Thai). She planned on studying, and her mother was able to support her studies, but she decided to leave and earn money for her children. Passon and her partner (aged 20) lived with her mother while her partner worked in his rice field. Passon has her own noodle shop. She is very busy every morning, so she was late to book at the ANC and often missed the appointment. She expects to keep the shop open until her due date to earn more money.

Parichat: *Could you tell me why you work instead of study*

Passon: *I think I have children so I am focused on working for a living (T12 Passon, 19 years old)*

Taking care of their children was the first priority of young mothers; studying could come. These accounts of young mothers show limited study opportunities with few options.

Many young mothers explained that despite the challenges in their life, they still would like to engage in education if they had *support from the school*. Non-Formal and Informal Education (NFE) is an alternative school project for expanding the education opportunities to everyone which helped young women who could access it, get through these difficult times. NFE strategies include developing a range of life skills through distance learning, establishing workplace and community learning centres and promoting the joint sharing of resources with the formal school sector (Ministry of Education, 2008).

Although Ponsi left school at 15 with no qualifications she was the youngest participant to attend an NFE programme. She continued to study while pregnant with her second child. She had been in NFE 1, but moved to the new, more flexible NFE provision; now she is in year 9 (Mattayom 2). Ponsi plans to study until she finishes high school level equivalence to give her more choice when applying for a job. Ponsi was upset at first, until she was able to access the new version NFE school which provides educational opportunities for young mothers like her, as she explained:

Parichat: *How did your pregnancy affect your studies?*

Ponsi: *I was most upset when I was pregnant. I was shocked. I couldn't finish my studies. In my first pregnancy I'm afraid that school won't help. I covered it up until I gave birth.*

Ponsi explained that a flexible learning program provides a real opportunity to continue with education while pregnant:

Parichat: *How did you do?*

Ponsi: *I decided to move to study at an opportunity expansion school (NFE). It is an education for everyone. I have to start again at the same level from my last school. This school can accept that we are pregnant. Everyone can go to study. Just come to study every Friday ...do homework, send them to teachers. There are many people at this school who are also pregnant and studying at the same time, because it is adult education, teenagers can come to*

study or adults can come to study. I feel that it is normal because I can study and raise children (T9 Ponsi, 19 years old)

Titar graduated NFE 6 (year 13) with upper secondary education certificate. Titar also explained the need for flexibility and support from the school, to give them access to education that would fit in with their lives as mothers:

Parichat: *How did your school give support?*

Titar: *"If [student] pregnant, my school allows students to stop and I was able to return to study without having to repeat the class. This school is not an adult education. It is a school in the normal education system.*

Parichat: *[nodded]*

Titar: *We [Titar and her classmates] study every Friday, for two hours of study, there is one hour of study and one hour of exam. There are some students who come to study about three times, because she is pregnant for a third time. So, she can graduate because it is a supportive school. Teachers will collect all the study documents. Once students are ready to return, they can go back to study without having to repeat the class." (T14 Titar, 19 years old)*

Titar graduated in the upper secondary education level with the support of her school and teachers. The alternative education programme can help young mothers achieve their education expectations. An alternative program is also running, providing education only on a Friday for all students who are able to access it. This project is a NFE but expanded from the normal NFE as students in this project are able to access the same teacher and same facilities available to students attending the mainstream school system. (Act for the Promotion of Non-Formal and Informal Education, 2008).

Young mothers who wanted to improve their employment prospects expressed how they decided to continue their study while having a baby. They show hope and optimism in continuing their education, underpinned by an understanding that education improves employment prospects

Palmy finished her studies at age 12 (Pratom 6 in Thai). She is still interested in studying and aims to begin to apply for higher education after giving birth to her second child, to get a better job and earn money for her children and household expenses.

***Parichat**:* *Why do you want to continue your studies?*

Palmy: *I thought I wanted to study because I'd get more money when I work. Now, it's not the same because I've grown up. I'm working to raise a child. With only a Prathom6 certificate [Year 8], I received only 7,000 baht per month. And The school where I would go to study is not far from here. (T1 Palmy, 19 years old)*

Similarly, Sukan has been working hard with a day paid job and yet keeps studying at the same time; she has access to education through the NFE. She is in NFE 1, she studies every weekend and hopes she can finish year 11 (Mattayom 3 in Thai) which will allow her to get a better job and higher pay.

Parichat: *How did you plan your study when having this baby?*

Sukan: *I was able to live and raise my children. Because I went to school only on Saturdays and Sundays, and then my mother helped to take care of my baby.*

Parichat: *So, then you decided to get Mathayom 3 qualification? Why do you want to continue your study?*

Sukan: *I want to get a job that's better than now. I used to ask for a lighter job, for example, at 7/11, but they required Mathayom 3 qualification, so I had to continue my studies until I finished my NFE 3, to have lighter work which is not as heavy as a sugar cane cutter.*

Parichat: *Now you have three children, do you think would this be a problem?*

Sukan: *No, I am doing the same, I still go to school at the weekend (T1 Sukan, 19 years old)*

These accounts pointed to the way in which the young mothers in this study managed with the balance between education and work while having children under difficult circumstances. Flexible access to education is essential to support young mothers to complete their education.

6.3.2 Employment and Financial Struggles

This sub-theme highlighted the 'employment and financial struggles' in the lives of young mothers. Young mothers' working[10] experience in this study shows that in their first pregnancy young women were financially dependent on their families Once they have their first child they experience a lack of access to well-paid employment while during their second pregnancy they face the potential dangers of working during pregnancy.

Table 6.2 provided the data of young mother's employment during their second pregnancy. Five of them have been self-employed, four of them work as day-paid employees. There are three young mothers who have been employed as monthly-paid depending on their education qualification and have maternal leave provided. One of them is self-employed who works with her family earning money from dairy work. Two of them were unemployed because they are full-time mothers with their partners responsible for living expenses.

This focuses on the lack of access to well-paid employment that is common in young mother employment. Moreover, discussing the potential dangers of working during the second pregnancy also portrays how young mothers manage their life with one child and carrying another child.

6.3.2.1 Lack of access to well-paid employment

Participants discussed problems with employment as first-time young mothers. A lack of education barred their access to well-paid employment and had to find a job that did not require educational qualifications. Light work that paid daily was common.

Pakar was 16 when her first child was one year old. At that time, she worked near to her house and her mother took care of her child. Pakar explained:

> ***Parichat***: *What did you do for living after you quit school?*
>
> ***Pakar:*** *I did other work that doesn't require educational qualifications. I packed corn nearby to send to Taiwan. It's a factory that accepts*

[10] According to Thailand Labour Protection Act B.E. 2541 (1998) asserted that the employment of young worker defined as "An Employer shall not employ a child under fifteen years of age as an Employee" (Section 44, The Labour Protection Act. (No.2) B.E. 2551, (2008 :p20).

daily workers. I do everything. I usually cut baby corn before I was pregnant. (T2 Pakar, 19 years old)

Kor was the only adolescent mother who could not read. Her father is Thai, and her mother is of Mon ethnicity (who lived around the Thai - Burma border). This had implications for Kor as she could not prove her Thai national identity which is necessary to access employment. After her first baby was born, when Kor was 16 years old, she had a Pink-card (NTC) which meant she could only get work as a foreign worker, and with limited education, Kor worked with her mother as a day-paid labourer. This often required they move from place to place to find agricultural work. Kor is now financially supported by her partner; she no longer has to work and can focus on taking care of her daughter and herself while being pregnant with her second baby. Kor explained:

Parichat*:* *What did you do for living before having the second pregnancy?*

Kor: *Before this I had cleaning jobs that were day paid nearby my house. I usually work every day, I take my baby with me to work as much as I can here, as my bump is growing bigger, no one wants to hire me, I just stay home, and my partner leaves some money for me to manage (T6 Kor, 19 years old).*

These accounts of young mothers convey the lack of access to well-paid work because of limited education. This impacted their ability to carry out their parenting role and meant that, despite working, they were still reliant on their wider family for support.

6.3.2.2 Potential dangers of working during the second pregnancy

Young mothers deal with the employment agency who understand the safety [11] requirements for pregnancy women. Palmy worked at a day-paid job sewing sacks in a factory not far from the house. She had been concerned about working during her first pregnancy; this concern remained during her second pregnancy and although her job

[11] Acts for pregnant women were added in B.E. 2551 (2008) in section 39/1 "An Employer shall be prohibited to require a female employee who is pregnant to work between 10.00 p.m. And 06.00 a.m., to work overtime or to work on holidays. Where the female employee who is pregnant works in an executive position, academic work, clerical work or work relating to finance or accounting, the Employer may require the employee to work overtime in the working days as long as there is no effect on the health of pregnant employee and with prior consent of the pregnant employee on each occasion." (section 39/1, The Labour Protection Act. (No.2) B.E. 2551, (2008:p18)
Section 43 "An Employer shall not terminate the employment of a female Employee on the grounds of her pregnancy." (The Labour Protection Act. (No.2) B.E. 2551, (2008:p19)

would allow her to take time off, and she was not allowed to do over-time under the labour protection act, financially this was not possible:

> ***Parichat***: *When you are pregnant, has anything change at work?*
>
> ***Palmy***: *I'm more careful with this pregnancy. I have other people help me with things like heavy work or lifting heavy objects.*
>
> ***Parichat***: *[nodded]*
>
> ***Palmy***: *But I have constant work this time. I can choose not to work, but I work anyway, because I need to save money for childbirth and motorcycle payments. My partner can't do this alone. The house rent is 300 baht per room per month with another hundred baht paid to the boss for water and electricity. We use underground water, so we don't pay much. (T1 Palm, 19 years old)*

Pakar was working with her partner at her parent's house. Pakar's mother trained her to take care of the cows and how to milk them. Pakar explained her job change for her second pregnancy:

> ***Parichat***: *How did your work change after you found out you were pregnant this time?*
>
> ***Pakar:*** *Now that I'm pregnant, I'm raising cows at home without cutting corn, because it's tiring. I cut corn for the cows to eat. My partner lifts it for feeding the cows when I am pregnant with this baby. (T2 Pakar, 19 years old)*

I talked to Pakar about her work in the cowshed and asked her to explore any potential risks her work had to her second pregnancy.

> ***Parichat***: *Aren't you afraid the cows will kick you when you milk them while you're pregnant?*
>
> ***Pakar:*** *They know me. If they know you, they remember not to kick. They can smell and remember who cares for them. Then I can turn on the milking machine and walk around to do anything. I haven't been hit with anything since I started.*
>
> ***Parichat***: *I have seen many houses around here for agriculture or beef cattle farms. Why does your family raise milk cows?*
>
> ***Pakar:*** *Because we'll get money every ten days if we do the cow milking, but if you raise beef, though, it takes a long time to get money.*

***Parichat**: Who trained you with these skills?*

***Pakar:** My mum, I help my mum everyday. Now my mum lets me do it for myself. And I am going to train my partner, he must do it when we have a second child (T2 Pakar, 19 years old)*

Another example is of a young mother was self-employed and reported dealing with late ANC check-ups because the appointments did not fit in with her shop's opening hours. As a result, Passon decided to postpone the antenatal check-up:

***Parichat**: Sorry I found you have missed the check-up last time; did you have any difficulties in coming here?*

***Passon:** I have my rice noodles shop to open every morning. So, I have often missed an appointment date, but today is fine, as I have planned to close it. Luckily, my ultrasound check today is OK. I know [appointment date] but I am really busy.*

***Parichat**: Do you have someone who helps?*

***Passon:** Yes, my partner, but I can't leave him alone, because he added too many [noodles] per bowl. I open the shop in the morning, and I have to shop for ingredients in the evening like this everyday*

***Parichat**: Does this shop make a good profit?*

***Passon:** Its fine. The profit is uncertain some days I can do 300-400 Baht and some days can do 1,000 Baht. (T12 Passon, 19 years old)*

These accounts show young mothers working with more care in their second pregnancy and being more aware of safety and protection against potential risks. Moreover, the data shows that young mothers who are self-employed have to weigh-up the choices between making money or losing money on the day of ANC appointments. This reflects their financial limits, which are compounded by problems accessing to employment with good conditions, where they are able to take maternal leave or to take time out of the working day to breastfeed.

In summary, educational support is linked with financial support; having qualifications and skills is essential to be successful in the labour market. Young mothers also lack access to well-paid, safe employment because of balancing mothering constraints. For the second pregnancy, employment was more challenging.

6.4 A Transformational Experience

The last theme, “a transformational experience” considers the positive transformation as adolescent mothers mature and their experiences shift from being a teenager, to being a first-time mother and finally to being an expectant mother again at young age. The theme highlights their optimism as young women reflect on how they have learned from their experiences and reveals their growing confidence and hopes for the future. The theme is constituted by three sub-themes: “feelings about pregnancy” in both the first and second pregnancy, “learning from experience” and “aspirations for the future”.

6.4.1 Feelings about pregnancy

“Feelings about pregnancy” developed across both the first and second pregnancy. This subtheme is structured by two main categories. First, *“Feeling in the wrong”*, where adolescent mothers described their feelings about becoming a mother for the first time. Second, *“Feeling more like an adult”;* where participants discussed their feelings relating to being pregnant for a second time and shows a sense of adulthood rather than perceiving themselves as too young.

6.4.1.1 Feeling in the wrong

It is difficult to be a mother and it is more difficult still when the mother is an adolescent. The feelings toward being a young mother were explained from the participants’ perspective in various ways. Most young mothers, when asked about having a baby while still very young, described how they felt that, having the first baby was ‘a serious mistake’. They expressed feelings of anxiety about the first pregnancy, as well as a range of other emotions. Some concealed the pregnancy from parents, some reported embarrassment and some expressed the feeling of not knowing what to do as a mother.

Napar was aged 19, with a 4-year-old son and 30 weeks pregnant with her second baby when I met her. Her first baby had not been planned. and she expressed various feelings about her first pregnancy. She described feelings of panic, questioning, worrying, and being afraid of her mother if the pregnancy was revealed. Napar lived with her widowed mother at the time, her father died when she was young. She decided to tell her mother and keep her [first] baby. Napar felt guilty about her mother and what she had done and worried about leaving her alone when she moved to her partner’s house. Later, Napar broke up with the father of the first baby when she was just 7 months pregnant. Napar expressed her feelings:

Parichat: _How did you feel with the first pregnancy?_

Napar: _I panicked the first time. I cried. I questioned myself about what to do and whether should I tell my mother? I was worried. I was afraid of my mother and living alone (teary-eyed). My father died when I was in the sixth grade. He was hit by a car. When I had my first partner, I had to live at his house, and she [mother] had to live alone. I cried because I felt sorry for her. (T3 Napar, 19 years old)_

Many young mothers described their feelings about becoming a mother for the first time. They _concealed the first pregnancy_ from their parents. Participants revealed that they covered up the first pregnancy for several months or until their parents noticed. For example, Passon was scared of telling her mother and waited until her mother noticed she was pregnant. Her first conception was at the age of 15 years old.

Parichat: _How did you feel for the first pregnancy?_

Passon: _When I was pregnant with my first child, I didn't tell my mum because I was scared. I left it for 3 months and then my mum looked and knew that I was pregnant. Mother directly asked whether I was pregnant._

Parichat: _What did you do?_

Passon: _At first, I didn't answer anything. Then I told my mother, and she cried a lot" (T12 Passon, 19 years old)_

It is the same story with Pakar. Pakar said her menstruation was irregular before she noticed she might be pregnant. She got confirmation from the doctor that she was seven months pregnant. At first, she did not tell her parents.

Parichat: _What did you do when you found out about the first pregnancy?_

Pakar: _My period is normally irregular anyway. When I graduated, my period was gone, so when I went to receive antenatal care, the doctor said I was seven months pregnant."_

Parichat: _What did you do after that?_

Pakar: _"When I was pregnant, I didn't tell my parents (T2 Pakar, 19 years old)_

Tahmas lived with her grandparents. She was around 14 years old when she was first pregnant. She left school when she was in Mattayom 2 (year 9th in UK) as a result, with

no qualifications. Tahmas concealed the pregnancy from her family, after she informed them, she felt guilty for the regret they felt. Tahmas was punished by her grandfather who hit her:

Parichat: *What did you do when you found out about the first pregnancy?*

Tahmas: *I lived with my grandmother and my sister. When I was pregnant, I didn't dare to tell. I knew when I was pregnant, I didn't know what to do, I couldn't cover it up for long, I was afraid my parents would hit me, I was afraid that my grandfather would hit me because I knew he would…*

Parichat: *What did your grandfather do?*

Tahmas: *I was hit by my grandfather. He hit as if he didn't want to hit hard, he really didn't want to hit me. I made him feel regret, and he said, "why did you do this?" (T15 Tahmas, 19 years old)*

Covering up their pregnancy was how young mothers tried to manage their mistake. Some families did not understand and hurt the young women, blaming them for what they saw as a "serious mistake".

In addition to feeling guilty and *not knowing what to do as a mother*, young mothers also worried about mothering their baby. They expressed how anxious they were and that they needed support from their family. For example, Napar who lived with her mother and was first pregnant at 16, stated that she neither knew what to do or what to buy for her baby:

Parichat: *What did you do when you found out about the first pregnancy?*

Napar: *For my first one, I didn't know what to buy when I went to buy baby clothes. I had to have my mother go with me to choose clothes. My mother had to tell me everything. She told me to wash the clothes and how to raise my child. (T3 Napar, 19 years old)*

The stories above show the participants' feelings about being a young mother. Data show that young mothers' saw their first pregnancy as a mistake. I argue that all of them are courageous in facing hard times. They were young and had been doing well in school but many of them failed because of the huge changes in their lives. Therefore, I asked them, what the differences were between the first and second pregnancies, especially as they were still young.

6.4.1.2 Feeling more like an adult

During the second pregnancy, participants appear to express a positive feeling toward their experiences. Participants revealed that after having the experience of being a mother the first time, their life had changed. By the second pregnancy, young mothers had gained the trust of their own mother; they had grown up and felt like an adult mother. Some gained more confidence. Data also show how adolescent mothers tended to perceive themselves as more dependable and mature enough to raise their children on their own. For example, Passon was 19 years old and 32 weeks pregnant with her second baby at recruitment. Passon lived with her partner, the father of both her children. She talked about feeling more like an adult:

> ***Passon:*** *"For me, I thought that it was all right[time]. My first child was 4 years old now so I could raise them all together. Life is about moving on, so I never worried" (T12 Passon, 19 years old)*

For some participants, motherhood brought with it a sense of maturity, elevated responsibility, and purpose. They began to regard themselves as adults and becoming a mother meant they had to behave like responsible adults:

> ***Sasi:*** *"I already thought that if being pregnant is OK, it doesn't matter. I think I can raise [my child]." (T4 Sasi, 19 years old)*

Regarding their feelings toward the second pregnancy, participants revealed a sense of maturity and more confidence.

Participants also reported feeling more confident about being a young mother. They explained that people in the village, who did not know them, made comments, but they *no longer paid attention to what other people said*, and *no need to conceal as* Palmy explains:

> ***Parichat:*** *How do you feel about yourself when other people see that you are a teenager?*
>
> ***Palmy:*** *No. I see myself as an adult, but some people see me as a teenager. Sometimes, like when I walked in a market, they'd say "You're still a kid? You're pregnant? You're young". They're people I don't know. Just people walking in the market.*
>
> ***Parichat:*** *How did you feel?*

Palmy: *I don't feel anything. It's okay. They can say whatever they want. (T1 Palmy, 19 years old)*

Tahmas explained that she felt very different about her first and the second pregnancies. She did not feel the need to conceal the second. She said she felt more like an adult, and she put her children first, rather than herself:

Parichat: *How did you feel about this pregnancy?*

Tahmas: *"I felt like an adult since I had a child. I think I need to earn money to prepare, to raise children…I didn't feel like concealing (pregnancy) anything because I was like an adult. Since I can raise my children, there are many different ideas that have changed.*

Parichat: *What are the differences?*

Tahmas: *I have to make money first, If I don't have money, the children won't get good food. I feel more concerned about my children than myself." (T15 Tahmas, 19 years old)*

The young mothers felt more confident and ready to manage problems, even if the pregnancy was a mistake.

Another sense of feeling more like an adult is that the young women were thinking carefully and showing courage in carrying on with their second pregnancy. They also show a sense of how to *learn from mistakes*. Some participants revealed that they considered a therapeutic termination of their second pregnancy (tToP). The data show that adolescent mothers who did not feel ready to have the second child searched the internet for information about how to access a tToP. Participants also disclosed that they searched for information about an illegal termination, but they did not go through with it as they were too scared or because of religious reasons. Then they realised, look at their past experiences, that although they had been younger, they had got through that hard time, so they could do it this time too.

For example, Rassa, when she realised, she was pregnant for a second time, talked to a friend about having an abortion, she had already collected some amount of money for it. However, she changed her mind because of the fear of it being a sin. She thought about the last time and how she had managed even though she was younger and realised that she could make it again. Therefore, she decided to keep the baby. Rassa described her second pregnancy mistimed:

Parichat: *What did you do when faced with having another child?*

Rassa: *I had the idea of an abortion. My partner doesn't know. I secretly consulted my friend. I have collected the money. It was the information on the internet I didn't know if it's true or not, but friends said that abortion is extreme torture, so I did not dare do it.*

Parichat: *How did you feel about not doing it?*

Rassa: *I had an idea about an abortion but I'm afraid of sin. I went back to thinking why does this pregnancy need to have an abortion? just thinking of [abortion] sin already occurred… So, I didn't have an abortion. I'm still scared of sin. Because I think I have already contacted… At that time, I was afraid of sin. Because my family is also afraid of sin. I thought that at that time (first pregnancy) I was able get through this problem. Why can't my second pregnancy be got through as well? So I didn't reply to the chat about the abortion." (T8 Rassa, 19 years old)*

The financial burden was reported by some as the underlying issue with the second pregnancy that led to them consider a termination. For Wilai, her second pregnancy was unplanned. Wilai thought about an abortion but realised that she made it through her first pregnancy so why not this one; she changed her mind and kept the baby.

Parichat: *What did you do when having another child in this period?*

Wilai: *At first, I didn't want to have children now, but it happened. I used to think about abortion. I thought and asked the pharmacist in a drugstore what drugs to get for an abortion. The Pharmacist advised me to visit a doctor...*

Parichat: *[Nodded]*

Wilai: *I thought I couldn't raise this child. I have no money, no house, I've not got so many things. This is not the same as my first pregnancy, I thought that I would be able to raise my child, but when it comes to a second pregnancy, I never thought I would have thought about an abortion…*

Parichat: *Did you ever think that you would not be thinking about an abortion for the first child but the second one?*

Wilai: *Yes, I thought to abort [this baby] because I really can't, I definitely can't handle it…Sometimes, I almost didn't send the money to my mother… If I didn't have my mother to help raise my first child, it would be terrible.*

Parichat: *What did you do after that?*

Wilai: *My partner and I decided to carry on with this baby. Now, I still feel sin and guilt. I think I wanted to make amends… In the past, I had a bad idea thinking of abortion… Because abortion is a serious sin… but many problems make me think. (T10 Wilai, 19 years old)*

Cultural beliefs also impacted the decisions made by the young women in this study; one participant explained that she considered *abortion to be a sin*. Young Thai mothers revealed that according to their Buddhist beliefs, thinking about having an abortion is a sinful thought, even if they do not act on it. Data shows that the fear of sin makes adolescent mothers reconsider their first pregnancy experiences and to believe that their ability to get through it as first-time mothers at a young age meant they would be able to get through it a second time. However, despite these religious beliefs, participants still carried guilt and wanted to do something of merit to release sin.

During their first pregnancy, these young women were facing challenging situations, feeling like they had made mistakes and so concealing their pregnancy. In addition, they were not confident in their new role and did not know what to do as a mother.

However, in their experiences of being pregnant for a second time, participants reported that they felt more like an adult, and they could cope with the life problems they faced. They were less concerned about people judging them and did not feel the need to conceal their pregnancy. They felt they had experience and the courage to get through the hard times. The experiences of being a first-time mothers gave them a sense of maturity, elevated responsibility, and purpose. They began to regard themselves as adults and becoming a mother meant they had to behave like responsible adults.

6.4.2 Learning from experience

This sub-theme presents how young mothers in this study learnt from their previous experiences which transformed these uncertain young mothers to confident and mature motherhood.

6.4.2.1 A more confident mother

Participants discussed how they saw themselves as more able to *adjust to the maternal role* for the second pregnancy and have more confidence. For example, Napar revealed how she gained more confidence from the previous experience, and she expressed that

this time she can take care of her baby without her mother telling her what to do. For example, Napar indicated that she appreciated the benefit of exclusively breast feeding her second baby:

Parichat: *Is there a difference between this pregnancy and your first one?*

Napar: *Now, I can raise my child on my own without my mother telling me. I went to buy clothes for myself. When I don't have money, (my mother) lets me borrow and I return it when I have money.*

Parichat: *Are there any changes between your first pregnancy and this pregnancy?*

Napar: *For my first one, I didn't know that I had to wake him. I didn't know what to do, so I bought formula milk. I paid almost 500 baht per week. For this baby, I'm going to have exclusive breastfeeding. I will fight to get this baby to breastfeed because doing so will save some expense for me. I think I'll let this one breastfeeds for months before I go back to work. (T3 Napar, 19 years old)*

Considering the prospect of working as a mother of two children, Napar talked about the added financial. Interestingly, young mothers expressed what they had learnt from taking care of the first baby and planned to save money by not feeding the baby formula. Moreover, Napar also planned to use a breast pump to collect her breast milk in case she has to go back to work.

Some of participants reported that they also felt more confident and needed less tangible support from their mother and saw themselves more capable of taking care of their baby. Sao explained how she wanted to breast feed:

Parichat: *Is there a difference between this pregnancy and your first one?*

Sao: *I feel like I'm more mature than my first pregnancy. I may have helped a little bit in the first pregnancy, but for this pregnancy I wanted to learn how to breast feed. I wanted to see how long I could breast feed, because at first, I didn't know how to get full breast milk, and I had to rush to work for money as I wasn't able to breast feed properly. But with this baby, I'm going to try to breast feed my baby myself. I think I am more confident. (T11 Sao, 19 years old)*

Young mothers show greater confidence during their second pregnancy; some explained that they can mother their own child without instruction from their mother.

6.4.2.2 Gaining maturity

Gaining maturity from previous experiences among young mothers in this study illustrates the young mother's development and how they transform as they mature. Pakar revealed how she had to take responsibility for caring for her family and the household expenses, and she reported feeling more independent and less reliant on her mother. For example, Pakar stated that she behaves like an adult this time:

Parichat: *Is there a difference between this pregnancy and your first one?*

Pakar: *I was embarrassed about my first time because I was still a child when I began to have a family. The first time, they said I was still young. I was embarrassed.*

Parichat: *Is there a difference between this pregnancy and your first one?*

Pakar: *I'm an adult this time around. I know how to save from my earnings to buy my clothes. I've saved money to buy milk for my kids. This money is for buying disposable diapers and I don't need to dress up. (T2 Pakar, 19 years old)*

Even though Pakar is still living in her parent's house, she has more responsibility:

Pakar: *My mum let me save money for myself and I share with my mother. I take care of household expenses. I take care of my mother. My mother lets me accept responsibility inside the house to see whether I can handle it and manage the money. (T2 Pakar, 19 years old)*

Rassa sees herself as having more responsibility and pointed out how she has gained maturity from mothering her first child. Rassa did what she did not do before because of having a child for who she is responsible for:

Parichat: *Is there a difference in yourself when you are with your kid?*

Rassa: *I feel I have more responsibility. Earlier, waking up in the morning and living a normal life, I did not have to do anything. Now I have to wake up early to prepare my children for school. When you have children, you have to wake up early. Less time to sleep and your own free time will be less. (T8 Rassa, 19 years old)*

Siri explained she does not want to think about her past mistakes.

Parichat: *How do you feel about your life now?*

Siri: *At that time, a lot of people were gossiping. The people around, said that I just broke up with my [ex] partner. So am I having a new partner again?*

Parichat: *How did you feel with those words?*

Siri: *I realized that they were gossiping and I felt that I was driven to think that I would never make the same mistake again. Everyone has to experience a once-in-a-lifetime mistake. It definitely has to be My father said that people's words would be the driving force to not make mistakes again. I had to fight with those words. (T7 Siri, 19 years old*

Young mothers in this study showed that they had gained maturity by learning from the previous experiences throughout their life.

6.4.3 Aspirations for the future

This sub-theme focuses of how young mothers plan for the future. Some young mothers could not plan the future clearly, but they could imagine their life with words full of hope and for a bright future, such as: 'It might be better if…' and 'If I have the opportunity, I'll study until…'.

6.4.3.1 Higher qualifications, more chances

Some participants, however, saw the benefit of completing their education, as being educated could give them more choices and continuing their studies would give them an opportunity to find a better job in the future. Some, namely those with access to the necessary finances, had the opportunity to continue their studies. Napar has been employed at the 7/11 supermarket. She hopes that she can obtain a higher education certificate to increase her salary. Napar stated that if she could turn back time she would focus on education:

***Parichat**:* *What level do you hope to achieve?*

Napar: *It might be better. If I have the opportunity, I'll study until I finish the twelfth grade because it's a bit better than the ninth grade. The work is better more paid. If I could go back, I would want to study. (T3 Napar, 19 years old)*

Tahmas explained that nowadays everyone can study. She has plans to study and if she finishes she hopes to get a good job:

***Parichat**: What do you think about now and future?*

***Tahmas:** I think I'll go to study at an adult school. Nowadays, everyone can study at any time. If you are wanting to study, you can go back to study. The school gives everyone the opportunity to study…It will allow me to apply for work to earn more money. (T15 Tahmas, 19 years old)*

Tahmas expressed how success in obtaining a stable job can provide maternity benefits and financial security. If she could study, she would get higher pay:

***Tahmas:** "Now I've got salaried work and I've got health insurance included. I can take maternity leave. I have maternity leave for 3 months. If I get higher qualifications, I may got more pay (T15 Tahmas, 19 years old)*

Palmy is planning to study after giving birth. I explored her aspiration to study and what will happen if she changes her mind to not study or something disrupts her in the future:

***Parichat**: What grade do you hope to achieve?*

***Palmy**: Just a mattayom3 [year 9] certificate will be enough. It's probably too late for the twelfth grade.*

***Parichat**: Once you've given birth, do you think you'll change your mind to study?*

***Palmy**: No, I won't. I wanted to study when I had my first child. I was earning money to raise my kid. I stopped studying because I had to help my mother work to earn a living. Because my certificate was in Lampang. I will go back to take them to here to apply to NFE school. (T1 Palmy, 19 years old)*

Young mothers learnt and transformed themselves and bright the future as the setting determination of their life. However, under the mothering constraints situation young mother faced difficulty to achieve their goals.

6.4.3.2 Being a role model for children

Another positive transformation is being the children's role model. Moreover, one participant explained that educational attainment is important in providing a positive role model for their children; with the hope of encouraging their children to achieve a higher educational level than they had. Rassa indicated her reasons for wanting to achieve her educational goals:

Parichat: *Once you've given birth, do you think you'll change your mind to study?*

Rassa: *"The reason I want to study is because of my children… like I can teach my children that their mother has finished school as much as this and the child should study higher than their mother. I want to show myself as an example" (T8 Rassa, 19 years old)*

Kor expressed what she would do when her children grow up. Kor stated that she had more concerns about raising a baby:

Parichat: *Did you have any changes when you have this baby?*

Kor: *I think it's more of a concern, and we looked at it more and more, I look at a lot of things that are more like explaining, we're about raising a baby.*

Parichat: *Once you've given birth what do you want to do?*

Kor: *When my children grow up. I have thought about learning how to read and to write to be able to teach my kids that I can do it and they will not be like me. It's not too late to study. (T8 Rassa, 19 years old)*

This journey to motherhood is a transformational experience; young mothers learned from previous experiences and reflected on their feelings about their pregnancies. Their accounts show that, not only have they gained in maturity and a sense of responsibility for themselves but they are also thinking carefully about their children. They have played the important part by being a child's role model and teach their children by growing up and living better and the importance of having a good education.

6.5 Summary

Chapter 6 has presented an analysis of the experiences of adolescent mothers, including the experiences of being pregnant for the second time. Four themes, which emerge through analysis, express the way in which young mothers' experiences are constituted and shaped. This analysis provides a better understanding of the adolescent mothers' experiences of repeat pregnancy while adolescents.

Young mothers reported contraceptive decisions. These accounts by young mother's report experiences of contraception that reflect limited access to accurate, confidential sexual health and contraceptive health advice and provision. This deficiency is not only

found among young mothers but also in relation to sexual health and contraceptive knowledge among their significant others such as their mother, their partner and mutual friends and some healthcare staff.

The relationships between their partner, their children, their family, and peers shaped their experiences and responses from the important people around them mediate their choices.

Education and employment are a key, interrelated factors that illustrate critical moments in young mothers lived, where they were faced with limited options or faced a lottery as to whether they had access to the support from the education system and opportunities to improve their situation through education. The lack of access to well-paid employment is important because their mothering is limited while the young mother is working, and this keeps them dependent on their family.

These young mothers' stories show how difficult their lives are and the barriers they must overcome to be successful young mothers. They face a challenging situation where they are made to feel that the pregnancy is a mistake, leading to a need to conceal their pregnancy despite this, their lack of confidence and not knowing what to do as a mother, they carry on and have their babies. They learn from experience. They not only gain more maturity and a sense of responsibility for themselves, they are also thinking carefully about their children.

The next chapter provides a discussion of the findings which aims to relate this analysis to the context of the broader literature, integrate this framework with theory and consider how theory can elucidate these findings.

Chapter 7 Discussion

7.0 Introduction

This chapter presents a further reorganisation of the analysis using Bronfenbrenner's (1979) ecological model as the theoretical lens. The central argument in this chapter is that adolescent mothers' experiences of both first and second pregnancies profoundly shape their thoughts about pregnancy and motherhood and are related to the contexts within which they live.

Key findings identified during the initial analysis (see Chapter 6) are considered in relation to five systems; the micro, meso, exo, macro, and chrono (Corcoran, 1999; Onwuegbuzie et al., 2013; Bronfenbrenner, 1979, 1986, 1994). This informs a model to express this relationship between young other's experiences and structural constraints which shape these experiences. The chapter ends with a reflection on the theory used to underpin this thesis.

7.1 The Impact of Context

Bronfenbrenner's ecological theoretical framework (1979, 1986, 1994) is used here to understand and conceptualise the relationship between Thai adolescent mothers and contexts within which they live (Bronfenbrenner, 1994; Onwuegbuzie et al., 2013). Figure 7.1 below expresses the interrelationships between the four main themes discussed in chapter 6.

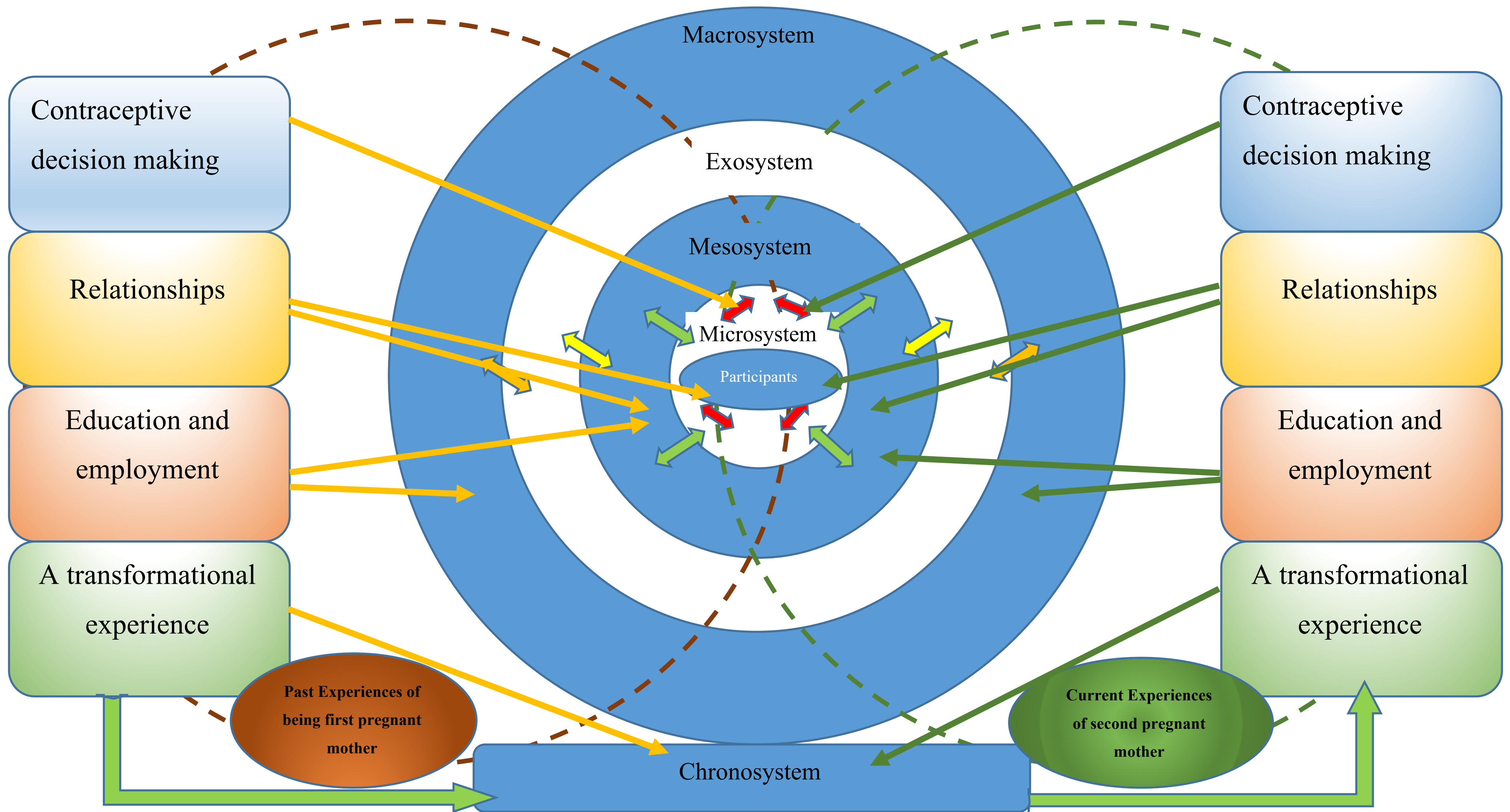

Figure 7.1 Thesis findings developing from analysed data using Bronfenbrenner (1979, 1986, 1994) to illustrate the interaction between adolescent mothers and their contexts

This model can be further developed through the lens of Bronfenbrenner's (1979, 1986, 1994) ecological model. The microsystem relates to the individual level of agency, *the experience of a repeated pregnancy,* where young mothers consider their own reasons for planning or not planning subsequent pregnancies. The mesosystem acknowledges a crosscutting of contexts across this set of individual notions and sees the impact of these contextual forces, the interaction with their *relationships,* on decision making which is influenced by their partner, family, child, and peers, with particular emphasis on the relationship between young mothers and their wider family. In the exosystem, *disruption from others* is considered, as local structures that young women interact with, but have little influence over, impact on their options and contain their agency. The macrosystem, *trying within constraints* represents broader social and cultural forces that shape and constrain the contexts within which young mothers live. The chronosystem expresses *the life journey* towards motherhood and maturity, the process of learning from the experiences of their first pregnancy as they develop strategies to move into the future and face changes over their life course and move towards increased maturity in second pregnancy.

7.1.1 Microsystem: The experience of repeat pregnancy

Bronfenbrenner (1979, 1986, 1994) defined the microsystem as the most proximal setting in which a person is situated. The individual experience of repeat pregnancy exists within the microsystem, comprising the experience of contraceptive use, decision-making and their feelings toward their pregnancies.

Findings from this study point to a lack of access to sexual health information, guidance, and efficacious contraception available to young mothers that effected their contraception use. Firstly, the analysis revealed that contraceptive risk taking before the first pregnancy was shaped by a lack of sexual health knowledge which in turn impacts on contraceptive use. Participants explained that misunderstandings about using contraception resulted in their first pregnancy. However, although risky contraceptive behaviour is apparent, this is not solely the responsibility of young mothers. Others have a role in shaping these decisions and the contexts within which they are made and enacted, such as actions of their significant others, including their partners, family, school, and more broadly, healthcare professionals.

Before their second conception, young women experienced the challenges of unpleasant side effects of contraception; participants report that they stopped using hormonal

contraception when the side effects became unmanageable, however other forms of protection were not readily available, resulting in a second unplanned pregnancy for some.

Findings in this study revealed interrupted contraceptive use, shaped by misunderstandings and misinformation about using contraception. Young mothers discussed contraceptive injections, explaining how this contraceptive strategy resulted in secondary amenorrhea (cessation of menstrual flow), which participants considered unhealthy. Some suggested that women should “take a break” from using hormonal contraception, both oral contraception or DMPA, as they believed it could harm a woman’s body and lead to infertility. These issues highlight the inadequate information about contraception methods provided to these young mothers. This must be addressed when developing sexual health education (Raneri and Wiemann, 2007) and potentially included in the further development of hormonal contraception (discussed in the *macrosystem*)

A lack of adequate information about contraception options and sexual health advice is particularly evident before the second pregnancy (as evidenced in 6.1.2.2 *choosing contraception)*. This includes receiving inaccurate advice from formal sources such as health care providers and pharmacists and a lack of contraceptive choices provided by health services, key factors resulting in subsequent pregnancy among Thai young mothers in the puerperium stage (Pungbangkadee and Ratinthorn, 2014). Literature suggests that the use of long-acting reversible contraception (LARCs), such as contraceptive implants and intrauterine devices, can lower rates of repeat pregnancy more effectively than shorter-acting methods among those who decline postpartum contraception (Tocce et al., 2012; Damle et al., 2015). The puerperium stage at six weeks after childbirth is essential for providing effective contraceptive advice and suggests a need to intensify and lengthen services to young mothers at this point (Cohen et al., 2016).

Findings also show that partners can be disruptive; they can be unsupportive of contraceptive decisions, refuse to use contraception, or do not share their knowledge about sexual health and contraception. This is particularly key, as many were adult men (over 20 years old), having sex with women under 15 years old and were less likely to take appropriate responsibility in pregnancy prevention. Young mothers in this study felt that it was entirely the woman’s duty to protect themselves – this perspective does not acknowledge that men are also responsible. Participants disclosed that their partners not only rarely shared responsibility or participated in contraception, but also controlled it by

refusing to use it. Young mothers should not be held responsible for contraception alone, their partners also need to participate in the process (Pungbangkadee and Ratinthorn, 2014).

The second issue in the microsystem relates to pregnancy *decision making*. Young mothers in this study explained that their first pregnancies were unplanned and some revealed that they were not ready to be a mother. While second pregnancies were referred to as "mistimed" and participants had been "planning to conceive" the second child at some point.

Luker (1975) asserted that women use rationale to describe their decision-making process. (Luker, 1975; Bartz et al., 2007). However, it is not only young mothers who are held responsible for this issue alone, when their partner also engages in this situation. Decision-making is complex and contextual, and it is difficult to separate out a single influence. (Barrett and Wellings, 2000; Barrett and Wellings, 2002; Barrett et al., 2004; Santelli et al., 2003). To make it clearer, Luker (1975, p. 78) explained that the classical decision-making theory model is that "individuals perceive options, assign values to these various options, choose one option as preferable to another, and then act to implement that choice in behavioural terms". The main conceptualising idea here is having a pregnancy comprising of three main factors, which are "stance"- the desire and expression intentions, "context"- the personal circumstance/timing and partner influences, and "behaviour"- the contraceptive use and pre-conceptual preparations (Barrett et al., 2004; Barrett and Wellings, 2002). Some young mothers planned to have a second child and get pregnant for exactly the same reason that older women do: "*they get married, and they want a child".* This study shows that a partners' desire to have a baby is a reason given for a subsequent pregnancy. This supports findings by Cha et al. (2016), who found that a partner's desire for children is a significant factor influencing reproductive decision-making among women. Participants from this study revealed that those whose partners are a lot older than them planned a second pregnancy.

The decisions made by young mothers were not only influenced by partners, but their families are still important and had some sway. A young family often live within the extended family and the fertility-timing norms in their family also influence their decision-making process. In the story of Pakar, she spoke about her second pregnancy and that her mother pointed out the benefits of having a second baby not long after the first and raising them together. This advice meant Pakar decided to stop using

contraception and resulted in the subsequent pregnancy. (This issue of family norms will be discussed more in the *meso level)*. Stories like this reflect that young mothers are making decisions and attempting agency within very tight contextual constraints where they are held responsible for situations that are not in their power to control – but actually are in the power of others who are not then held responsible, such as their partner and their family.

The *individual feelings* of young mothers show that they regard their pregnancies as valuable and remarkable. Adolescent mothers in this study described their feelings when becoming a mother for the first time with feelings of anxiety as well as a range of other emotions such as worry, loneliness, and fear of living alone if moving to a partner's family. Young mothers spoke of "not knowing what to do as a mother". They report feeling embarrassed for being a first-time mother at a young age and the need to conceal the first pregnancy from their parents until they noticed.

However, in their second pregnancy, participants expressed their experiences in a positive way and spoke to their feelings as being mature enough for a second pregnancy. Participants also discussed how they saw themselves as being more able to adjust to the maternal role and having more confidence as their experience of being a mother had changed their life in a positive way. Young mothers explained that they perceived themselves as adults since becoming mothers, and show responsibility and courage with their desire to carry on with the second pregnancy. They did not terminate the second pregnancy and they did not abandon their children. As shown in Wilai's story, she mentioned about the positive turning point of carrying on with their pregnancy because she spoke about being more mature than in the past experience of her first pregnancy, and so she then decided to carry on her second. Participants also do not feel the need to conceal their second pregnancy, unlike the first, and have a greater sense of control over their life. Young mothers are positive family builders rather than undermining their family or society. As Reddy et al., (2017) suggests, young mothers appeared to be working towards independent adult lives throughout the experience of motherhood. Repeated pregnant mothers had increased responsibility and motivation as well as feelings of comfort and improved self-confidence drawn from the motherhood role.

The next section looks at the mesosystem where the interactions with the mother's relationship experience are analysed.

7.1.2 Mesosystem: Relationships

The next wider context is the *mesosystem*, Bronfenbrenner (1994: 40) defined this as *"the process taking place between two or more settings containing the developing person" … "in other words the mesosystem is a system of the microsystem".* This section includes the relationships with their partner, children, family, and peers and also conceptualised the interaction of young mothers' education and employment because some young mothers in this study were studying and some were employed. These factors are contexts that influence a young mothers' experience at a *mesosystem*.

In respect of young mothers' relationships, as all intercourse requires a partner, the closest relationship to pregnant young mothers is with their *partner* (Boardman et al., 2006; Luker, 1975). Raneri and Wiemann (2007: 41) used Bronfenbrenner's (1979) ecological theory and identified the "dyad" factors as being at the individual level. Chapter 6 shows adolescent mothers shared various experiences from their perspective that are interrelated with their partner. In this section the relationship with their partner is placed in the mesosystem.

Firstly, about half of the young women in this study stay in a relationship with the father of their first child. This is a similar pattern to findings reported by (Huangthong et al., 2019) who found that 57.33% stay in a relationship with their original partner.

Participants in this study, who were still with their original partner (the father of their first child) explained that their partner provided both emotional and tangible support and that the baby's father "improved" when becoming a father. This is similar to Herrman (2006) who report that young mothers found having children improved their relationship. Although the participants identified their own mothers as the primary source of social support, support from the father of the new-born was key to the young mothers' self-perception of parenting (Herrman, 2006). The participants in this thesis also discussed both positive and negative parenting behaviours of their partners from their perspective. These men were trying to help young mothers by contributing to "building families" (Reddy et al., 2017).

Unhealthy relationships with the father of the first baby, who now was their ex-partner, are also considered in this mesosystem. Those that indicated they had unhealthy relationships with their ex-partner explained that they had not been consistently supportive or did not share parenting roles. These findings show that many relationships

ended in marital dissolution when there was little support from their partner. Spousal dissolution or divorce is one of the most dramatic events that can occur in a family (Braver and Lamb, 2013; Peterson and Bush, 2013). Braver and Lamb (2013) explained in the social exchange theory of marital dissolution that couples are constantly, and perhaps subconsciously, evaluating their marriages and other relationships in terms of reward-cost ratios to either make a "profit" or at least to reduce their perceived losses. If their perceived costs become too high and continual losses are experienced, then separation becomes more likely. Young mothers in this study spoke of evaluating their relationship before separation, such as Palmy, who considered her ex-partner abusive and decided to separate from him.

After participants' relationships ended, young mothers spoke about moving forward. Young mothers tried again to build a family; consolidating support for their own family, protecting the safety of the first child and preparing to be a shared family. In traditional Thai culture men are often referred to as the leader of the household or "hua nah kropkrou" (Coyle and Kwong, 2000). Young mothers indicated that a good relationship between the father of the second baby and her own first baby can make life better, happier and more satisfying when their partner shared the responsibility for their family. Young mothers again show that they evaluate men in relation to their ability to support them both emotionally and in relation to family tasks and not just financially.

For those who had separated from a relationship report the experience of increased financial burden and responsibility for their children. Darroch et al. (1999) suggests one potential explanation, that young women may have a much older partner because they were pressured into the relationship, or to escape an unhappy or deprived home environment. An older partner is more likely to be employed and in a better position to care for a family (Sriprasert et al., 2015). This is reflected in this study as some young mothers with an older partner explained that this allowed for a better life. Similarly, Raneri and Wiemann (2007) studied dyad-level as a repeat pregnancy predictor and found that some adolescent mothers with new relationships may be more likely to become pregnant with the child of a new potential long-term partner in order to create a new and shared family (Raneri and Wiemann, 2007).

In addition, young mothers in this study who experienced abandonment revealed that their ex-partner said they were "not ready" to be a father. All of the ex-partners who abandoned young mothers in this study were younger than 20 years old. It could be hypothesized that

the young men's feelings and experiences of becoming a father is a difficult transition to make at that age. It cannot be claimed that the young father did not see the meaning and importance of fatherhood, but they may have lacked preparation for fatherhood and lacked readiness, which had a negative influence on the adolescent's initial reaction to the news about the pregnancy (Carvalho et al., 2010; Graham, 2013). This abandonment may need more investigation through further research about why men abandon a family, in order to help them understand the risk and provide the appropriate support for these young fathers.

As mentioned above in *microsystem*, although young mothers in this study revealed that they were having a second pregnancy to comply with their partner's desire, the risk of non-use of contraception still needed to be anticipated, especially within the wide age gap between them and their partner. The issue of men disrupting contraception relates to the idea of a power imbalance between young women and not just older partners. However, the age gaps in their second pregnancies were larger than the first, with most of the young mothers' partners being older than she is; the largest age gap in this study was 32 years (Kor is 19 years old and her current partner is 51 years old). In relation to these age gaps for the second pregnancy, the literature review found that the couples that have both a large age gap and an older father are much more likely to become pregnant (Darroch et al., 1999; Rubin and East, 1999; Boardman et al., 2006). Raneri and Wiemann (2007) found that if the age of the first child's father was more than three years older than the adolescent mothers, it meant that they were more likely to experience a repeat pregnancy than those fathers who were the same age or younger than the mother. The sexual relationship that occurred among older partners and young women may result in the non-use of contraception (Darroch et al., 1999). These findings suggest that one of the relevant factors in repeat pregnancy is the age gap and associated partner influence in sexual and contraceptive risk-taking behaviours.

Secondly, relationship with their *children* is a significant factor when it comes to second pregnancy in young mothers. A child can prompt a strengthening of familial ties (Reddy et al, 2017; Herrman, 2006). Children are sources of influential stimulus on their parent's behaviour and wider patterns of family interaction (Bush and Peterson, 2013). Findings in this study revealed that young mothers were trying again to make a family, with '*family building*' aimed at consolidating support for and protecting the safety of the first child (Reddy et al., 2017). The reason why this happens could be that young mothers have a positive attitude to motherhood and see it as the fulfilment of their life. Findings in this

study show young mothers accepted their second pregnancy baby, as they were planning to have another child at some point. Some young women actually plan their second pregnancy and view early motherhood as a chance to create a new identity which will change the course of their life for the better. These also show that the young mothers understand and value the importance of building their family and that the second child is a positive event (Graham, 2013; Cha et al., 2016; Bull and Hogue, 1998; Kurz, 2000; Stapleton, 2010).

Young mothers responded to their children and the preparations for a new member of the family presented an idea of family practice that is clearer in the second experience of being a mother. In addition to preparation for the new baby, young mothers were concerned about how their child reacted to a new partner and how their new partner acts with the first child.

A third important relationship that provides strong influence and support for the young mother is that between her and her wider *family.* The majority of Thai young mothers in this study live with their parents. Only a few adolescent couples were living in their own home, but still had their kinship homes around them. Their experience of first getting pregnant revealed that they were mainly financially dependent on their family. In addition, the adolescent's parents offered the tangible support of taking care of the first baby and this is a key part of supporting adolescent mothers to get through transition into being a mother. Repeat pregnancies were a source of concern for all family members (Dallas, 2013). Their families worried about the impact of additional children on their families' financial resources and on the childrearing challenges faced by adolescent parents.

Findings in this study reveal that participants' experiences in their first pregnancy clearly portray the support they received from their family, be it either financial support or grandchildren rearing support from their parents. This helped a young mother feel safe and secure and built confidence in their own mothering ability.

Young women in this study were well-supported, and their parenting status was accepted by their families (even though not all parents initially welcomed the pregnancy). Many young women were able to work or study with the help of their families. This meant that they coped well with the transition to parenthood and were keen to point out the benefits of early motherhood (Reddy et al., 2017). One example of this is Sukan. She was the only one who reported being a single mother, and she spoke of positive support from family that helped her get through this hard time.

However, that positive experience of support should not imply that the young mothers did not struggle. After having their second child, the participants still need family support but potentially, not as extensive as during their first-time experience nor with the prospect of financial dependence; however, childcare while they went to work and family emotional support when needed was an essential part of their plans.

The importance of family support in Thai society is mirrored in the study by Sriyasak et al. (2013) where they conducted research among Thai teenage mothers and explored the experiences of being a teenage mother and taking care of infants. The study reported various levels of support from their families, including their partners' families. They provided physical, emotional, and financial support which helped to reduce the mothers' stress and tiredness. Moreover, it boosted their confidence in being able to care of their infant. Some of the teenage mothers noted that receiving love from their partner's mother also supported them in their maternal role. Instruction and assistance with infant care could build their self-confidence in this role and in the childrearing (Sriyasak et al., 2013).

Lastly, their interaction with their *peers* found that a young mother's relationships with friends changed in terms of their past experiences and again during their second pregnancy. During their first pregnancy, young mothers in this study revealed that they were not comfortable talking to peers such as their schoolmates, about their pregnancy. This was not the case during their second pregnancy.

In the first pregnancy, young mothers experienced embarrassment, especially when they were in school. As a result, some concealed it from other girls in their class. However, others revealed that their close friends were a source of emotional support. This is similar to Ngum Chi Watts et al. (2015) study, which found that young mothers considered friends as a source of support for first-time adolescent mothers.

After becoming pregnant and being a mother, they had nothing in common with their previous adolescent peers. This meant that in their second pregnancy, adolescent mothers in the study reported feeling "unembarrassed" and saw being a young mother is a common situation and that they *do not need to conceal it,* unlike in their first pregnancy. Besides, participants asserted later that their friends have also had children while young. It was rare for young mother participants who have a second pregnancy to report being friends with other teen mothers, unless they had got to know others at work. Moreover, adolescent mothers who experience work at a young age describe their experiences as different from

other girls because they lived in a different situation. However, later when their life has changed, they seem “unembarrassed” and felt no different from others.

Jones et al. (2019) studied young mothers and found that their desire to maintain a positive self-image leads them to engage in negative evaluations of “other girls” in the same situation. Findings in my study found the same phenomenon of defining themselves as different from other girls. For example, Kor, who experienced work at a young age, described the experience as different from other girls because they were in a different situation and they could have children. I argue that adolescent mothers who experienced work and supported themselves feel different from those at school because they were in a different situation and protected themselves from social blaming.

The experience of *education and employment* for young mothers pregnant for a second time, is also included in the meso level and draws the links between education and employment in a young mothers’ life. Young mothers in this study described both positive and negative experiences in relation to education and employment.

Young mothers face a challenging situation, juggling parenting, education, and employment. The family’s financial situation was a barrier to education attainment for first-time young mothers, while in the second pregnancy they recognised the benefit of education to their lives and for their children as well as their own employability as a mother. However, financial barriers limited opportunities for getting into education. Some participants decided to leave school as a result of their family financial problems. Some participants had access to alternative education such as Non-formal and Informal education (NFE); these alternative schools provided flexibility which enabled young mothers to work or take care of their child and also study as appropriate with their life and their choices.

However, their second pregnancy experiences were more limited, with mothering and working for a living being the focus, and most young mothers unsurprisingly prioritised their children as more important than education. Participants highlighted the economic implications of participating in education during their second pregnancy, while being a young mother and decided to earn money for their baby instead of studying. While some individuals saw their baby as their most important priority and decided to earn money to support their children instead of studying, others were aware of the importance of education in improving life chances and of the potential for education to expand opportunities for themselves and their children. Participants explained they *perceived the*

benefit of completing their education and that this can allow for more employment choices and so expected to continue their education in the future.

Some struggled to access education, a more flexible learning program while pregnant would give them the choice to continue their education. Flexible support from school is essential to overcome this barrier and enable them to fit education around their role as a young mother. The education in Thailand was formerly strict and excluded girls from school while pregnant, yet today the various educational systems provide Non-Formal and Informal Education (NFE) for adolescents that fits their time and fits with their choices (Neamsakul, 2008). Providing an appropriate programme that fits with their daily life can support young mothers and their children (Drayton et al., 2000).

While *employment* takes priority over education - pregnancy takes away the choice about education and employment. For example, Pakar and Kor had to leave education and find employment to support their children and contribute financially to the family. During the first pregnancy participants reported that they are working for their family, or some found a job that did not require educational qualifications and so was daily paid and light work. The lack of access to qualifications maintained the young mothers' status as vulnerable and dependent on their partner or family for financial support.

There is greater burden with a second child. The young mothers also discussed a lack of financial resources and the need for more money to support their children. Findings reported that several young mothers' experiences with pregnancy and having children resulted in impaired ability to work. They needed to juggle taking care of their children with work. In the experiences of working when they were pregnant and had one child, participants revealed dealing with more financial burden and dealing with child rearing expenses.

Young mothers who were self-employed had to weigh-up between making money or losing money on the day of an ANC appointment, as in Passon's story. Having to work and manage a business and also attend the necessary check-ups during pregnancy was not possible. The range of these consequences above are broad and impactful as they result in a late booking at ANC and therefore a delay in seeking necessary medical support. However, this leaves the unborn child and the young mother at physical risk as well as proving a barrier to any support that they may need during the journey through pregnancy to motherhood. These first experiences potentially impact on the experiences of motherhood and 'becoming' a mother, and this may have implications for their first, as

well as subsequent children. This highlighted that ANC appointment attendance is not supported by the release from work to attend essential appointments. It is evident that the healthcare services need to provide some flexible evening times for ANC which would promote access for working and specifically for self-employed women.

In their second pregnancy, young mother accounts of working focused on being more careful, safe and protective against potential risk. Young mothers spoke about being aware of potential dangers from work, such as heavy lifting and not walking on a slippery floor. They take care of themselves and try to protect their baby from potential dangers that may affect the pregnancy. I argue that they have been trying very hard to improve their life and their family and think positively about getting away from social blaming and also to transforming their lives by engaging in education and employment. These accounts pointed at the way in which the young mothers in this study managed a difficult life balance between education and working, at the same time as being a mother and providing care for their children under strain in stressful contexts.

7.1.3 Exosystem: Disruption from others

The exosystem *"comprises the linkages of the third community influences on family functioning"* or *"the settings which events occur that indirectly influence process"* (Bronfenbrenner, 1986: 782; Bronfenbrenner, 1994: 40). The exosytem employed here considers the effect of disruption from others but also how it influences young mothers' experience of repeat pregnancy. Young mothers can also be indirectly contacted by some people who are not face-to-face contacts but still influence their life in the repeat pregnancy. This disruption by a third person can impact and shape a young mother's circumstances and influences her repeat pregnancy experience.

Some participants reported being given ineffective contraception pills from third parties, such as their partner's friend. For example, Ponsi got emergency contraception pills from friends and relatives then later became pregnant despite using this oral contraception. This reflects the lack of access to accurate and effective contraception and contraceptive and sexual health advice from people that influence the young mother. Importantly, it highlights the accessibility to appropriate formal contraceptive services for adolescent mothers (Sa-ngiamsak, 2016).

Another issue that lies within their exosystem is that young participants revealed that people in the village who do not know her made comments to her about her second

pregnancy. As Sa-ngiamsak (2016: 122) suggests, *"in traditional Thai culture, premarital sex is considered unacceptable for "a respectable woman" and highly damaging to her reputation and that of her family"*. Young mothers in this study were sometimes criticised by people around the village, for example, Kor described how people around her house spoke about her when she was not there, and Kor's story reflects how these young mothers are victims of social blaming (Sa-ngiamsak, 2016).

7.1.4 Macrosystem: Trying within constraints

Young mothers live under Thai structures and cultural norms. These are influencing factors on a young mother's experience in their second pregnancy. The *macrosystem* includes factors such as social norms, healthcare policy, educational and employment policy, and the ineffective law enforcement to protect young mothers. I highlighted this data to shine a light on the barriers that young mothers experience during their second pregnancy. The religious beliefs and cultural practices play a crucial role in young mothers' repeat pregnancy experiences, as follows.

Firstly, social norms have long been considered an important way in which social contexts are related to individual behaviours (Mollborn et al., 2014). Early fertility and the families' and communities' norms against teenage childbearing affected teenage mothers' life courses in negative ways (Mollborn and Jacobs, 2012). Young mothers are perceived as setting negative examples to other teenagers and give a bad reputation to the community and their families (Ngum Chi Watts et al., 2015).

Findings in this study show that a first pregnancy conceived at a young age is not acceptable to the young woman's family. Young mothers were impacted by these taboos after revealing their first unplanned pregnancy to their family. They experienced blaming by their family which left adolescent women feeling pressurised (Sa-ngiamsak, 2016).

Thai social contexts surrounding parental consent toward young marriage can be complex (Sa-ngiamsak, 2016). The family notion of wanting to protect young women from a bad reputation may lead young mothers to live in an uncertain situation as shown in relationships with partners where half of them were abandoned or experienced abusive relationships, after being together (Sa-ngiamsak, 2016; Sriyasak et al., 2013). All young mothers reported their parent's reactions when they told them of their first pregnancy. None of them were happy at first, they felt regret, sadness, worry and anger towards the young mothers and their pregnancy, concerned that they were not on the right path.

However, they encouraged the young mothers and their partners to get married in a religious ceremony in order to support and legitimise the relationship.

On the other hand, in their *second pregnancy*, young mothers in this study spoke of the fertility-timing norms of their family. Young mothers who report planning to conceive a second pregnancy explain that their family accepted or even suggested this. Cultural ideals are well recognized within the group and are central to the development of personal receptivity (Geronimus, 2004). Geronimus (2004: 159) asserted the *"fertility-timing norms are critical mechanisms through which the basic cultural imperatives toward economic and reproductive success are pursued; at their best, fertility-timing norms are well calibrated to support and draw support from local family economies and caretaking systems"*. In this study the young mothers and their family praised the second child as a positive event. For example, Siri was married for a year before getting pregnant. She revealed that her family accepted the second pregnancy and that her partner's family were delighted. Another example, Titar, explained that the second child is the first grandchild of her partner's family, and so was welcomed.

Thai family values were expressed by young mothers in this study, as family plays a crucial role on their decision to have a second pregnancy. In the Thai rural areas, the family unit is most typically an extended family with many generations in one house, or many houses within the same compound. Typically, the oldest male enjoys the highest-ranking position in the Thai family. Younger persons show respect to their elders by listening, being obedient, following suggestions, and avoiding arguments (Neamsakul, 2008). Thai culture would also expect family support when it comes to having a child, even if the mother was at a young age. Srinon et al. (2016), asserted that Thai young mothers' parents believed that having a grandchild is a positive situation. I argue that positive perceptions on having a child play a crucial role in Thai culture and these may imply a better understanding of the repeat pregnancy and of the positive support that a family provides to young mothers.

Meeting family expectations of fertility and reproduction is important to Thai culture. Customarily, Thai family culture focuses on family relationships and kinships. The Thai family is the smallest unit in society and plays a crucial role in childhood development (Neamsakul, 2008; Sriyasak et al., 2016). Family is the place where Thai children learn codes of behaviour or enact their socially expected roles that will guide them throughout the rest of their life (Neamsakul, 2008). The Thai family emphasises the importance of

living together, places a high value on marriage and children after marriage. In rural areas like Kanchanaburi it is seen as unacceptable for unmarried couples to live together in the community, whereas unmarried couples might be more acceptable in Bangkok or in another big city (Neamsakul, 2008).

When looking at a mother's decision to have a child, participants with some financial ability as a result of having a job, had not considered a termination of their pregnancy. A termination of pregnancy is illegal and profoundly immoral in Thailand (Sa-ngiamsak, 2016). About 95% of Thais are Buddhists who believe that life originates when fertilization occurs (Neamsakul, 2008). All of the young participants in this study believe in Buddhism and understand therapeutic termination of pregnancy, even the thought of this, as forbidden and sinful. Data also shows that the fear of sin makes adolescent mothers re-evaluate their first-time pregnancy experiences and conclude that their ability to get through the difficulties they faced as first-time mothers at a young age, would get them through this second pregnancy. This illustrates how religion impacts on a young mother's fertility decisions. However, due to their religious beliefs, participants still carried on feeling guilt and wanted to 'make a merit' to release the sin.

In terms of Thai law, it only approves requests for legal abortion in cases of rape, serious complications for the mother, or expected physical deformity or mental disability in the baby (Bureau of Reproductive Health, 2016). Many rural women remain fearful of the consequences of sin or "bap" if they were to undergo a termination of pregnancy, and therefore choose to continue with an unintended pregnancy (Whitaker and Miller, 2000). However, Thai abortion law has gradually changed over time, the government amended the Thai Penal Code to relax restrictive regulations by decriminalizing the procedure during the first twelve weeks. Nowadays, a termination of pregnancy in the first trimester is legalised; however, this amendment was published after the interviewing for this study (Government Gazette, 2021) [12]. I argue that these Thai traditional notions, the law towards a termination of pregnancy, all represent structural forces that limit choices available to young mothers.

[12] The amendment was published in the Government Gazette on February 6, 2021 and took effect on the following day. (Act Amending the Criminal Code (No. 28), B.E. 2554, sec. 2.).

A further barrier evident is the influence of *healthcare services and healthcare policy.* Young mothers spoke of experiences that indicate a lack of clarity in the contraceptive advice provided by hospital-based healthcare professionals; this potentially puts adolescent mothers at risk of having sex without effective protection. Participants reported that there is not enough information about contraception and hospitals did not give them an appointment or any alternative healthcare service. Findings from this study suggests that healthcare professionals must provide greater information about negative side effects such as irregular bleeding to address the high numbers of women withdrawing form hormonal contraception. These findings also suggest that contraception and sexual health education in the puerperium stage is important and needs further research to identify the gap in provision of effective services (Damle *et al.*, 2012; Tocce et al., 2012).

Other issues lie with the inaccurate advice given by trusted *informal sources* such as their mothers. Young mothers indicated that their mother provided advice about contraception or bought them contraceptive pills. Some participants indicated that they received unreliable information about contraception from sources such as friends and relatives, who have some contraceptive experience. It is important that these findings highlight situations of young participants living with their significant others who lack knowledge of, or misunderstanding about, contraceptive use. The reliance on these informal sources reflects gaps in sexual health and contraception support and advice available from healthcare professionals and pharmacists. Healthcare providers need to be aware of potential barriers and facilitators to young mothers and also investigate their suitability and preferences of methods (Charles et al., 2016; Aslam et al., 2017; Pungbangkadee and Ratinthorn, 2014). Contraceptive practices by healthcare professionals such as contraceptive counselling, insertion and injection were suggested by this study in terms of training needs, especially in the adolescent group (Chunin et al., 2016).

Findings in this study also demonstrated a lack of contraception procurement from the health service. For example, in Ponsi's story. This issue reflects a lack of both contraception procurement and reflect the inadequate practice of the healthcare provider (Pungbangkadee and Ratinthorn, 2014).

Chunin et al. (2016) explored the contraceptive service provision of hospitals in Thailand. Contraceptive services are offered at both governmental and private hospitals across the country. The results found that, although the contraceptive services provided by the hospitals either before pregnancy, or after childbirth, are free of charge for all teenagers

who are under 20, there were problems with the availability of contraception in some hospitals. In Thailand, the Ministry of Public Health is mainly responsible for healthcare services based on the local hospital services by providing contraception accessibility (Bureau of Reproductive Health, 2016). Regarding contraception policies, there were formerly expensive long-term contraception options available which included subdermal implantation of hormone and intrauterine devices (IUD). Women who require LARC have to pay about 800 Baht (18 GBP) for an IUD and 3,800 Baht (85 GBP) for subdermal implantation. Protection, such as by Depo Medroxy Progesterone Acetate (DMPA) injections, pills (only progesterone pills), and condoms were accessible and provided for women within the 30 Baht (0.70 GPB) health care programme. With the rates of repeat pregnancy high in adolescents, the Ministry of Public Health provided free of charge LARCs services in 2015, regardless of the legal conditions of their health insurance. In addition to this, subdermal implantation hormone and intrauterine devices (IUDs) were also offered for free in an attempt to reduce the rate of unintended repeat pregnancy (Chunin et al., 2016). However, as this study found, there is still a lack of confidential information available to adolescent women, resulting in the discontinuation of contraception services and that some healthcare providers should be aware of the importance of giving accurate advice to young mothers.

Also evident in the macrosystem is the impact of *education and employment policy*. This study pointed to the importance of providing flexible schooling and a safe working environment for pregnant adolescent mothers. Although the Thai government provides a free basic education for everyone, young mothers in this study revealed the educational support they receive does not always fit with their life as a young mother. Non-Formal and Informal Education (NFE) was identified as an alternative to school that would expand education opportunities to everyone; many young mothers spoke of the importance of accessible education.

The NFE strategies include developing a range of life skills through distance learning, establishing workplace and community learning centres and promoting the joint sharing of resources with the formal school sector (Ministry of Education, 2008). The Thai educational system provides many options for people to select a schedule and curriculum that fits their needs (Neamsakul, 2008). Under the principles of the “Act for The Promotion of Non-Formal and Informal Education, B.E.2551” (2008) to promote and support equity in the access and receipt of extensive, thorough, fair, and of the suitable quality for people’s living conditions. This can be beneficial to pregnant adolescent

mothers. Further research would identify useful changes of the education support policy and how to support young mothers effectively.

Limited qualifications limit access to well-paid employment with safe working conditions. This compounds the socioeconomic strains placed on the pregnant young mother. A safe working environment would protect both young expectant mothers and their unborn child.

Young mothers in this study were 14-17 years of age when they had their first baby and 17-19 years of age when they conceived their second pregnancies. All the young mothers had entered 'marriage' unions with the fathers of their expected children, most because of pressure from their families, and all because adolescent pregnancy is frowned upon in Thai society and seen as bringing shame on the family (Liang et al., 2021). Marriage, formal and informal, gives legitimacy to the young woman and her baby and absolves the family's dishonour.

Child marriage is defined as a formal marriage, or informal union, in which one or both of the parties are under 18 years of age (UNICEF, 2016). It is a human rights violation and a harmful practice that disproportionately affects women and girls globally (United Nations, 2022). Child marriage is associated with high fertility and poor pregnancy spacing, including repeat childbirth within less than 24 months, multiple unwanted pregnancies, and pregnancy termination (Liang et al., 2021). Further, it blights the young persons' educational attainment and economic opportunities (Shameenda, 2018), and it also has socioeconomic costs and major implications for economic development at both the national and global levels (Hodgkinson et al., 2016; Liang et al., 2021).

The UN SDG's, specifically goal 5, target 5.3, aim to eliminate harmful child practices including child, early and forced marriage by 2030 (UNICEF, 2022; United Nations, 2022). Child marriage in Thailand has been decreasing in young women under age 18 but it is still higher than in other, similar, middle-income countries in South East Asia such as Indonesia, and the Philippines (Liang et al., 2021). UNICEF (2019) data reveals that 1 in 5 young women in Thailand were married in childhood. Thailand has several strategic plans at national and subnational level aimed at ending child marriage and these run alongside the UN SDG targets for ending child marriage by 2030 (Choomgrant et al., 2017; Liang et al., 2021; Forte et al., 2019).

Child marriage in Thailand is however a complex issue, and as Hodgkinson et al., (2016) point out, child marriage is at the intersection of social norms, economic issues, societal

structures and family motivations. In this study some of the young mothers' parents used the law which facilitates marriage in women under the age of 15, to get the men to be accountable for having fathered a child. This supports findings by Neamsakul (2008), who also found that young women and their families used the law to negotiate with the men and their families to take responsibility for their babies. Young mothers' parents in this study stated that it would be better to let the young woman and her partner stay together as a new family, to avoid family disgrace. These decisions from the young mothers' family raise the issue of coercion, where young mothers might enter an uncertain fragile relationship, where, as this study found, some young women experienced neglect, and even domestic abuse, and where the men were able to take advantage of young women, without punishment by law[13].

The issue of adolescent pregnancy and child marriage fits within the *macrosystem,* as child marriage is, as Hodgkinson et al., (2016) discuss, so embedded with the social norms, beliefs, and religious and cultural practices of a society. However, the complexity of this issue notwithstanding, as the UN SGD's (United Nations, 2016) highlight, unless tackled, child marriage and its health, educational and economic consequences will afflict the lives of young women personally, their children and families, but also nation states more generally.

7.1.5 Chronosystem: The life journey

A transformational experience reflects the chronosystem, as at this level charts changes over time of personal characteristics and the environment in which a person lives (Bronfenbrenner, 1994). The journey of young mothers from their experience of becoming a mother for the first time to the second pregnancy is remarkable. Young mothers in this study, pregnant for a second time, show a positive transformation, with

[13] *Section 277 Thai Criminal law updated B.E.2530, 1987 : ..."The offense as provided in the first paragraph, if the offender being the man commits against the girl over thirteen years but not yet over fifteen years of age with her consent and the Court grants such man and girl to marry together afterward, the offender shall not be punished for such offense. If the Court grants them to marry together during the offender be still inflicted with the punishment, the Court shall release such offender."*

bright aspirations and ambitions for the future, even under these constrained contexts. They show maturity and the strength to overcome barriers to motherhood and are willing to embrace the responsibility of their growing family.

Firstly, young mothers in this study viewed their child as a motivation to complete school, and some considered enrolment in college, believing they would continue their education in the future. As in finding in this study that young mothers have plan to conceive. This reflects the positive transformation towards building their own family. Participants perceive themselves as more able to adjust to the maternal role and parenting as they engage in *family building* (Reddy et al., 2017; Herrman, 2006).

Young mothers appear to become more mature and think positively over their life. However, when talking about *aspirations* for the future the findings in this study show that some young mothers have been thinking about their future but could not plan it clearly. They reflect on their lives with the words in hopeful terms, such as:- "It might be better if…" and "If I have the opportunity, I'll study until…". Adolescent mothers are acknowledging the need to set goals for the future and yet showing a lack of concrete plans. Many of the adolescent mothers were aware of the benefits of completing their education or finding employment, but they did not describe any definite plans for the future, and the future still seemed far away from the demands of the parenting roles they were currently dealing with in their life, and they had to focus on the present.

Having educational goals may positively contribute to an adolescent mother's self-perceptions of parenting (Herrman, 2006). As highlighted previously, research by Brown (2015) has shown that becoming pregnant represents an opportunity to change and transform their lives by engaging in education and employment. Although this was evident in this study, the constraints of mothering, and the confining structures within which young pregnancy mothers live, make these goals difficult to realise for young pregnant mothers.

In addition, along with their attitude towards their own educational aspirations, participants in this thesis revealed a sense of maturity in relation to being a *children's role model* and desired that their children get an education higher than them. Young mothers' accounts not only show they gained more maturity or responsibility for themselves but that they are also thinking carefully about their children. They have played the important part as their children's role model and to teach their children to grow up and appreciate the importance of gaining a good education.

All young mothers in this study were concerned about the care of their first child, they do not abandon them. With the ongoing hardships associated with the of mothering their first baby they decided to continue with their second pregnancy, and this is indeed remarkable. Young mothers revealed a sense growing maturity, thinking carefully about continuing their second pregnancy, as was the case in Rassa and Wilai's stories. Although, some young mothers did not plan to have a second child, they disclosed searching for information about illegal termination of pregnancy but were too scared to carry it through due to religious reasons. However, they realised that as they had managed through the challenges of a first pregnancy when they were young, they had the strength and experience to face this second pregnancy now they were older. This shows the resilience of young mothers. Data from this thesis also shows that adolescent mothers tend to perceive themselves as *more dependable* and be able to raise their children by themselves (Conroy et al., 2016). Moreover, young mothers felt proud of their personal growth and of avoiding negative behaviour for their children.

Understanding and non-judgemental advice from agencies that work with young mothers, such as healthcare professionals, schools, and their communities, would provide more effective support, –with understanding from partners and families, young women would be better able to embrace the responsibility. They show they are able to make good decisions in difficult circumstances and have great potential to maximise their positive contribution to society, economically as part of the workforce, but also in terms of ensuring future generations are physically, mentally and emotionally healthy. There are also families where the father of the first child stays and is a supportive partner and this needs to be acknowledged.

Finally, evident in the literature is the issue of how early pregnancy is socially constructed as problematic and associated with various negative outcomes, such as poor health outcomes, low maternal educational attainment, and socioeconomic problems (Khashan et al., 2010; Akinbami et al., 2000; Wilson et al., 2011; Graham and McDermott, 2006; Pallas, 2003). However, research also indicates that early motherhood can be experienced positively, when mothers have a sense of control over their life (Arai, 2009; Conroy et al., 2016; Brown, 2015).

Findings from this study presented *both negative and positive experiences* of repeat pregnancy at a young age as individual actions of women are constrained within complex structural forces. Although young mothers revealed that they were thinking carefully and

courageously to enact agency, they did this within very tight contextual and as a result, faced many barriers. Working and studying whilst mothering is remarkable yet managing relationships with everyone important in their life such as their partner, children, family, and peers could be considered astonishing. These findings convey that as a society, a change in our perspective is needed, to acknowledge and address the constraints within which these young mothers are producing our next generation. They need to be listened to, they need to be understood and they need to be supported.

7.2 Towards a model: Thai adolescent mothers in context

In this section I refine the model that conceptualises the relationship between young mothers and the contexts within which they experience repeat pregnancy. Using Bronfenbrenner's theory to further organise the analysis, a model is presented that illustrates the interaction between the agency of the young mother and the structural, contextual layers of young mother's life. Figure 7.2 (below) presents visual representation of the analysis organised using Bronfenbrenner's (1979,1986,1994) approach, to illustrate the interaction of adolescent mothers and contexts. This focused on the experience of repeat pregnancy among expectant Thai adolescent mothers who have at least one living child, considering both the first and subsequent pregnancies side by side.

Figure 7.2 (below), further refines this and focuses on understanding the second pregnancy in more detail. This final model considers individual experience in context, allowing a clearer view of the process of individual development is related to broader structural contexts. This shows how experiences of adolescent mothers are interrelated with their children, partner, parents, and peers who are important in shaping the experience of being pregnant. In addition, the findings show how self-development impacts on young mothers' perceptions as they move from feeling in the wrong in their first pregnancy and feeling more capable as mothers during their second pregnancy.

Figure 7.2 expresses the link between the microsystem, that refers to the young mother's agency in contraceptive decision making and the planning (or lack of it) of a second pregnancy and the interaction with the "relationship" that including their partner, children, family, and peers in the mesosystem. This is supported by the issue that younger children are heavily dependent on their parents, therefore, contextual and family factors are more likely to have a greater influence on their developmental outcomes. (Ashiabi and O'Neal, 2015; Tudge et al., 2016; Bronfenbrenner, 1994). The new findings in this study asserted that a second pregnancy can be understood using this model, as in a second pregnancy, the "partner" as well as the "individual" play a crucial role whereas in their first pregnancy were more dependent on their parent and the misuse of contraception. This shows the complexity of their life and illustrates young mothers' intertwining of their complex relationships under constrained contexts yet try to broaden their own family and to bring a positive situation to their children, as shown in mesosystem.

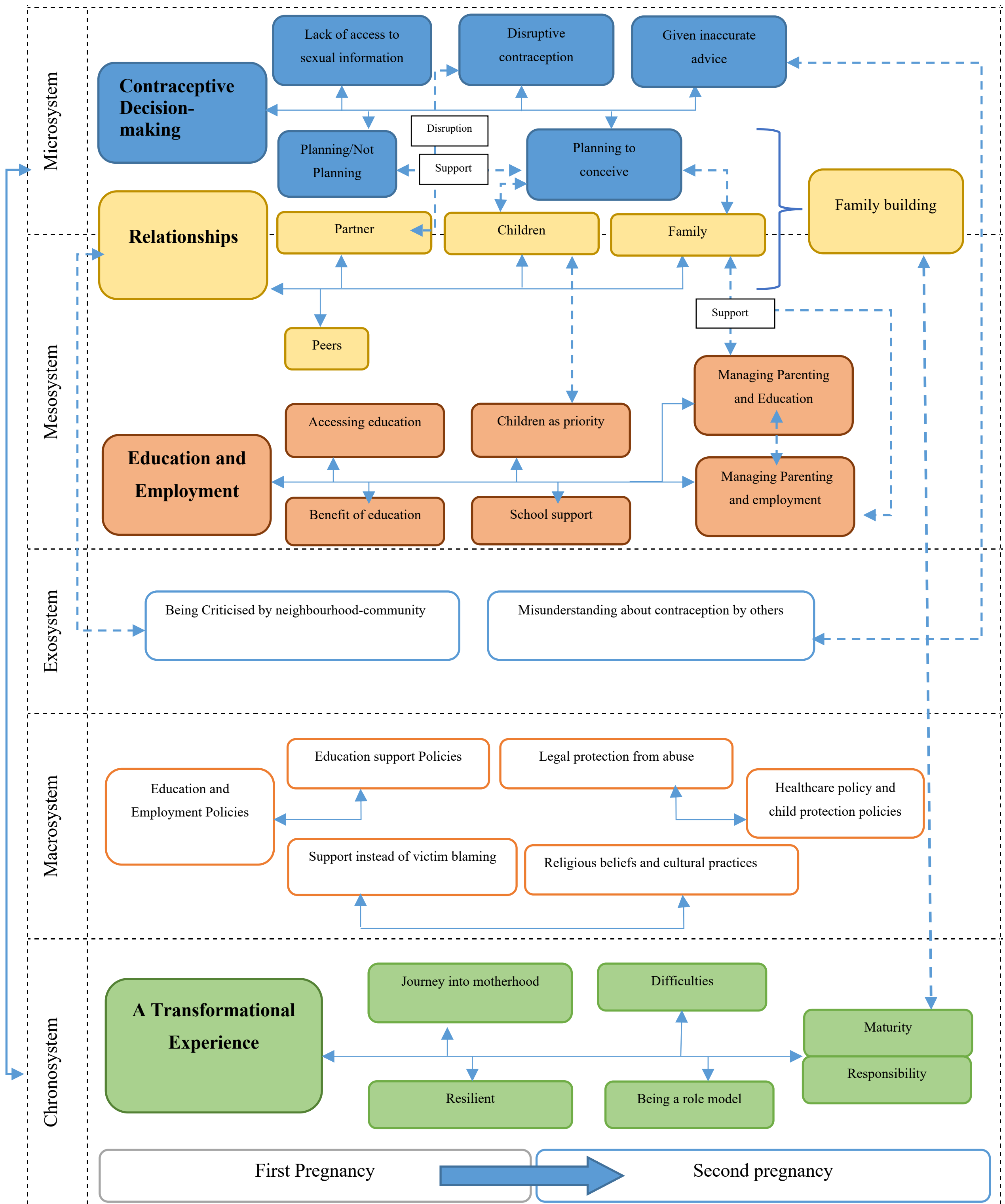

Figure 7.2 The visual diagram presentation of research findings and Bronfenbrenner's theory

The exosystem presents interaction with broader factors, such as the community which influences young mothers (Bronfenbrenner, 1994). However, in this study it was found that mothers were "being criticised by the neighbourhood-community" and "others who misunderstand about contraception". Pregnant adolescents face moral sanction, shaming and victim-blaming by those who do have some power to shape the context; as a result, these vulnerable young women, barely out of childhood themselves, and their children, have to face the consequences (Sa-ngiamsak, 2016).

The macrosystem includes education and employment policies, and is constituted by: education policies, that provide support, instead of victim blaming, legal protection from abuse, healthcare policy and child protection policies, and religious beliefs and cultural practices. These structural features impacted and shaped young mothers' experiences across the macrosystem. Religious beliefs and cultural practices are included in the microsystem, as they represent forces that, in part, shape family norms and practices that influenced decisions surrounding whether repeat adolescent mothers faced forced child marriage or were provided with support (Ashiabi and O'Neal, 2015; Tudge et al., 2016; Anand, 2009).

In the chronosystem, participants show their valuable experiences from "lessons learned" during their first-time mothering journey and they now are being a mother of two while still young. Their life journeys were full of difficulties. They had learned from the past and adapted to many changes that they had learned before. They were young and innocent but ended up traveling the path to motherhood. The participants described both rewarding and difficult experiences that happened during the journey. Both support and difficulty progressively helped the participants develop and transform into more mature and responsible adults. Participants in this thesis show a "positive transforming" that could show adolescent mothers transforming together with a "resilience concept" to the interaction between individual and their context (Malindi, 2018; Singh and Naicker, 2019). Using Bronfenbrenner's (1994: 40) theory for conceptualising findings could show me perfectly in terms of understanding insight into the lived experiences of being repeat adolescent mothers. I argue that the chronological level or "chronosystem" could be used to explain *a transformational experience* from shifting over of being teenager to being a mother of the first child which is now their past experience in contrast to the current experience of being a mother of two.

7.3 Reflection on theory

This study focuses on the experiences of repeated pregnancy among adolescent mothers and their contexts. An in-depth interview approach was used to collect data from adolescent mothers and thematic analysis was used to interpret this data. Four main themes emerged and these need to be understood more comprehensively. Therefore, a theoretical framework, Bronfenbrenner's social ecological model (1979,1986,1994), was used to understand and conceptualise the relationship of Thai adolescent mothers and their wider related contexts. The literature review conveys various factors that shape a young mothers' experience. This approach is particularly suitable for studying adolescents, who are experiencing developmental and role transitions, while coping with challenges posed by broader contexts that influence their immediate settings, for example, age, race, and socioeconomic status. An ecological perspective positions individuals as being influenced by factors operating at different social levels which emphasises the personal, family, neighbourhood as well as wider societal and cultural influences (Bronfenbrenner, 1979, 1986; Ashiabi and O'Neal, 2015; Dallas, 2013).

However, I conducted the research among adolescent mothers, pregnant for the second time and this approach resonates conceptually with the findings perfectly. Using Bronfenbrenner's theory to illustrate how the *microsystem* at the individual level inter-linked with *mesosystem* and presents the interaction of young mothers with partners, their children and their families. The interaction at this level is reflected an interweaving of their relationships with significant others in their life. This also shows the impact of the *proximal process* which is seen as the driving force in development (Bronfenbrenner, 2005; Ashiabi and O'Neal, 2015; Bronfenbrenner, 1994).

Wider contexts such as the *exosystem*, and *macrosystem* also influence their lives as members of the community and society. This level reflects how structural forces constrained them and made life harder. Lastly, Bronfenbrenner (1994: 40) identified the final *chronosystem* which "*encompasses change or consistency over time not only in characteristics of the person but also of the environment in which that person lives*". Findings in this thesis mirror the life changing over a life course such as the life structure of young mothers having a second pregnancy, having a new partner, moving forward to the next journey with the father of the second baby and being the mother of two children. This resonates with how they have learned and developed as a result of past experiences into current experiences on their motherhood journey.

7.4 Summary

This chapter further organises the analysis presented in Chapter 6, to consider crosscutting contexts using Bronfenbrenner's (1979, 1986, 1994) ecological model as the theoretical underpinning. In this chapter, the ecological model is used to conceptualise the interaction between adolescent mothers and their contexts. Findings here show that adolescent mothers' experiences are interrelated with their partner, children, family, and peers; and are important in terms of being a young mother as well.

Pregnancy in adolescence is a complex issue, with many factors to consider. The adolescents themselves need to be engaged in the issue, they need to know that they are being listened to and their choices are being reinforced. Especially, in puerperium stage as it was a golden opportunity for young mothers to obtain contraceptive choices and appropriate contraceptive information which should be provide quickly after childbirth.

With the respect of support, understanding from partners, family, and non-judgemental advice from healthcare providers, school, policy support and their communities, young women will be able to adopt the responsibility as a mother. They can be positive contributors to society, including economically as part of the workforce, but also in terms of ensuring future generations are healthy physically, mentally, and emotionally.

Chapter 8 Conclusion and recommendations

8.0 Introduction

This chapter draws together the analysis presented in this thesis and addresses the research question which focusses on the experiences of Thai adolescent mothers who are pregnant for a second time. In addition to the research contributions and recommendations, this chapter considers the strengths and limitations of the thesis. Finally, I reflect on myself as a researcher throughout my research journey.

8.1 Addressing the research question

This study aimed to understand the experiences of repeat pregnancy in Thai adolescent mothers; more specifically, to address the research question: *"what are the experiences of repeat pregnancy among adolescent mothers in Thailand who have at least one living child?"* The study draws from the qualitative experiences of fifteen Thai adolescent mothers. Data, collected using an in-depth, semi-structured interview approach, were then thematically analysed. Bronfenbrenner's (1994) theoretical framework was also used to understand and conceptualise the relationship between Thai adolescent mothers and the contexts within which they live.

The main finding identified in this study is that the experiences of young mothers are contextual and complex. Experiences of young adolescent women in relation to pregnancy are shaped in part by the contexts within which they live, and it is important to acknowledge the impact of these contexts on their ability to exercise agency in relation to sexual activity, contraceptive decision-making and pregnancy.

Bronfenbrenner's ecological model provides an opportunity to consider the impacts of the context on young pregnant mothers at multiple levels. Using this approach, four main issues emerge. The first issue relates to young mothers' contraceptive decision-making. Whether they consider their second pregnancy to be planned or mistimed, the thematic analysis revealed that decision-making about their fertility timing is shaped by contextual forces, such as the wishes and agency of their partner, their family and consideration of the needs of their expected child. For example, barriers to contraception, as well as accurate, confidential, and timely contraception and sexual health advice, impact on the ability of young mothers to exercise agency in relation to informed decision-making. This

is shaped and impacted by a lack of effective support from healthcare professionals and the healthcare service. In addition, sexual health education does not provide young women with information in a way that supports sexual health and contraception decision-making. This removes or at least reduces, the ability of young women to make informed choices and enact those choices. Although this has been documented elsewhere in relation to broader international contexts, for example in the United Kingdom (Khashan et al, 2010; Clarke, 2010; Bucknall and Bick, 2019) and Europe (Timur et al., 2016) and the United States (Raneri and Wiemann, 2007; Gray et al., 2006; Reddy et al., 2017), this has not been noted in relation to a Thai context and therefore provides a unique and important insight. Without understanding the reality of this context within which adolescent mothers are pregnant for a second time, the necessary support and policy will not address this issue.

The analysis also highlights that decision-making about these issues are shaped and constrained by relationships with significant people in the lives of adolescent mothers. Forces, beyond the agency of young mothers impact here, such as the actions of their partner, family, and peers, in addition to their concern for family building and the needs of their existing children. Decisions about staying with the father of their first child or moving on, to find a partner who can support their developing family unit, shows some of this use of agency. For example, the agential action young mothers use as they try to shape a positive environment for both their baby and existing children, to provide a safe environment, if possible, with the support of their family.

The value of family is essential in Thai culture (Neamsakul, 2008; Sriyasak et al., 2013), and the analysis identifies this as a structural force that shapes family-building amongst young mothers. For example, the fertility-timing norm has an influence on young mothers' decision-making. Thai structures and cultural norms are influencing factors on young mothers, shaping their experience and decision-making in relation to their second pregnancy. A second child is seen as a positive event by young mothers and their family. These "fertility-timing norms" are critical mechanisms through which the basic cultural imperatives toward economic and reproductive success are pursued (Geronimus, 2004). A positive aspect of this is that fertility-timing norms are well calibrated to support and draw support from local family economies and caretaking systems (Geronimus, 2004). The analysis presented in this thesis suggests that, although families are not initially accepting of the first pregnancy, many young mothers gain their trust and are able to

access family support and family culture may influence young mothers to not delay a subsequent pregnancy.

Young mothers have been criticised for not adequately accessing antenatal care, for example not attending clinic appointments. However, this analysis shows that some young mothers struggle financially and must weigh-up choices between earning money or losing money on the day of an ANC appointment. In other words, these decisions are not agency-driven alone, but are a response to broader structural constraints, such as the lack of flexibility of healthcare services to the needs of these young mothers and the constraints within which they live.

In addition, this need for young mothers to financially support themselves and their children is not acknowledged in the enactment of labour and employment policies. The analysis suggests that young mothers who are working during their second pregnancy try to take greater care and are aware of the need to maximise safety behaviours and protect against potential risks. However, the need for employers to ensure their safety and the implementation of safe practices at work is not always forthcoming. This can threaten the health and safety of the mother, the unborn child, or present young mothers with an impossible dilemma, to work and economically provide for their existing child or to withdraw from the labour market and protect the health of their unborn child. This has a broader impact on Thai society both in terms of the health of the next generation, but also as the skills and work of these young mothers are needed in the labour market.

Moreover, as shown by using Bronfenbrenner's theory (1979, 1986, 1994) to explore the analysis of the thesis, transitional changes across time are illuminated. Young mothers have shown their transition through changing experiences; moving from being a teenager to being a mother of their first child, and now to being a mother again while still young, yet they have positively transformed themselves to become more mature. This study found that young mothers learned from previous experiences and reflected on their feelings about their current pregnancy. Their accounts not only show that they are gaining more maturity and sense of responsibility for themselves, but they are also thinking carefully about their children. Participants also discussed how they see themselves as more able to adjust to their maternal role during the second pregnancy and grown in confidence as motherhood brought with it a sense of maturity. However, they still lacked the opportunities to achieve the actual goals they wanted.

8.2 Strengths and Limitations

8.2.1 Strengths

There are two principal strengths to this research study: Firstly, it is one of the few qualitative studies to date conducted in Thailand to take a holistic approach to explore the experience of repeat pregnancy in adolescent mothers. Therefore, this research contributes to a developing body of literature that has been successful in illuminating the wider contexts in which adolescent women with repeat pregnancy live and nurture their children and in highlighting the impact of partners, family and peers, education, including sexual health and relationships education, policy and the law, and cultural expectations on this experience.

Secondly, the research is the first in Thailand to conceptualise the experience of repeat pregnancy using Bronfenbrenner's (1979, 1986, 1994) theory and it offers an alternative more nuanced understanding of the contexts and constraints in which adolescent mothers live and make decisions about their children and their families' lives.

8.2.2 Limitations

Inevitably, as with all research, this study has its limitations and on reflection, the main critique of this study is the absence of the voice of boys and men in the experience of repeat pregnancy in Thailand. The findings in this study highlight the role boys and men have in sexual health relationships with adolescent women more generally, and importantly, in repeat pregnancy. The part men play cannot be separated from those of adolescent women, and this points to the need for future research to include boys and men in all research concerned with adolescent sexual health and relationships.

8.3 Contribution to knowledge

What this analysis shows is that although adolescent mothers exercise some agency in relation to decision-making around sexual health, contraception and family-building, they are heavily constrained by their structural context. That is, the agency available to pregnant adolescent mothers is impacted by partner behaviour, the influence of family and peers, cultural expectations and the structured function of policy and law. The organisation of education, including sexual health and relationships education itself, and the structure of employment disadvantage young mothers when they are most vulnerable. This is further evident in the lack of active enactment of protective policies and laws,

compounded by the lack of adequate, timely and confidential sexual health provision and protection from child marriage.

Using Bronfenbrenner's ecological theory allows an understanding that the experiences of young adolescent mothers are shaped and impacted by broader structural forces that go beyond the agency of young women. This presents a unique approach in a Thai context.

8.4 Recommendations

This section makes recommendations in four areas: Firstly, for policy development, secondly, for practitioners working with young mothers, including midwives, thirdly, recommendations for sexual health education, and lastly for further research.

Recommendation for policy development

1) Laws and policies and multi-sectoral policies/programmes that protect children and young people from child, early and forced marriage in Thailand should be given a greater urgency and momentum to realise the goal of ending child marriage.
2) Laws and policies that uphold health and safety in the workplace should be enacted and enforced.
3) Interventions that aim to reduce repeat pregnancy should target partners as well as young mothers and focus on respectful relationships and consent and require that men and boys respect and support the contraceptive decisions made by girls and women.
4) Education polices should be developed to provide flexible supportive and non-judgmental access to education for pregnant adolescents including those pregnant for the first and on subsequent occasions. Non-Formal and Informal Education (NFE) provision should be extended and made available to all pregnant adolescents.
5) Pregnant adolescents should be provided free support to maximise their employability and to succeed in their employment goals, so they are enabled to make their positive contribution to society.

Recommendations for practitioners

1) Accurate, non-judgemental, and tailored support and advice should be aimed at both boys/men and girls/women at all contacts.

2) Accurate, flexible, respectful, confidential, and timely sexual health advice and contraceptive services and support should be made available to all at no cost to the individual.
3) Those who provide sexual health advice and contraceptive services should be adequately trained and monitored to ensure the advice they provide is accurate and the contraception they prescribe and/or sell are effective.
4) Health care educators, practitioners and those concerned with providing sexual health education and services require full updated sexual health and sexual health advice- giving education, including equality and anti-discriminatory training, so they are able to provide accurate, non-judgemental and tailored support and advice to all those who need their services.
5) Sexual health advice should be made available online so that those who need information and support are able to access accurate information when they need it.
6) Efforts should be targeted at improved availability and access to sexual health counselling services to provide respectful, confidential advice and support that is timely and tailored to individual need.
7) Practitioners should develop individual counselling skills and practice to provide better care for young mothers and their family.
8) Contraception services and family planning education in the early post-partum period following the birth of the first child is important and should be provided to both mothers and fathers.

Recommendation for sexual health education

1) Sexual health education, contraceptive responsibility and respectful relationships should focus on boys and men as well as girls and women.
2) Sexual health education provided by schools should explicitly be aimed at both adolescent men as well as adolescent women and include the shared responsibilities between both those involved in sexual activity, with the issue of consent and respectful relationships and the skills to negotiate contraceptive decision-making at the core of sexual health education.
3) Sexual health education should be age-appropriate and provided across the curriculum to both boys and girls.
4) A range of teaching methods and approaches should be used, which acknowledge that sexual health education goes beyond information-giving and includes the

development of skills to negotiate respectful relationships, consent and contraceptive use.

Recommendation for further research

1) Research that focuses on the role men and adolescent boys play in repeat pregnancy is urgently needed.
2) Research that explores fathers' role in repeat pregnancy.
3) Research that explores sexual health information giving and information seeking, including attitudes and behaviours, amongst all adolescents to inform effective policy development.
4) Research that explores the most effective way to provide education to the wider family in relation to shared responsibilities between sexually active partners, laws around consent and accurate sources of sexual health advice and support.
5) Further research to find ways of providing effective contraceptive services in a Thai context.

8.5 Final reflections

The idea for this research stems from my practice as a midwife, nurse, and teacher of nursing in Thailand and from my master's degree, where I investigated the issue of adolescent pregnancy and childbirth. I have often encountered adolescent mothers struggling to cope with the pain of childbirth and frequently wondered why, with all the struggles associated with being an adolescent mother, these women while still in their adolescent years, went on to have a subsequent child, despite all their previous difficulties.

I was successful in gaining a Royal Thai Government Scholarship to study for a PhD overseas and as I was interested in qualitative methodologies, my Thai academic supervisor suggested I study in the UK because of its strengths in this methodological area. I submitted my research proposal to the University of Hull, and I was then interviewed by people who became my supportive supervisors. This is how my research journey began.

As an international student from Thailand, I had to open my mind to new ways of doing things. To do this I started by taking an advanced English language course for non-first language English speakers. I developed my English language skills and began to learn about British culture through my English teacher. I also learnt classroom skills such as how to interact in class via a virtual learning environment: CANVAS. I met local people

through being a student activity volunteer for the Student Union. These activities allowed me to adjust to my new environment, new people, and to practice the English language. This was a period of significant growth for me personally and academically.

Alongside these activities I stepped up into being a PhD student working with supervisors who are experts in my area of interest. I am grateful to have had a first supervisor who has worked with me over the duration of my PhD and who encouraged and understood me when I felt unable to move forward. My first co-supervisor taught me much about research and after her early retirement, I gained my current co-supervisor and we have worked well together because she is very keen and knowledgeable of young mothers.

Along my journey I realised that independent learning is important in PhD study in the UK. To this end, alongside my PhD, I have gained a Post Graduate Diploma in Research Methods by undertaking research modules that addressed my learning needs, helping me to complete my PhD research but also be a more knowledgeable researcher in the future. I chose modules that supported me to understand how to undertake research, such as "the introduction to qualitative research", "the research and literature review", "collecting and analysing qualitative data", "research ethics" and "the systematic review". I also worked at gaining research skills in other areas and completed "managing Microsoft Word documents", "Endnote referencing", and "analysing qualitative data with NVivo" all with the support from the library Skills Team who have been an important part of my PhD learning journey.

I have learned from being in a different academic culture and it has changed me and my thinking. Firstly, the practice of *reflection and reflexivity* was new to me, and I have observed how it runs through all the postgraduate learning I have undertaken. I now realise that this is an important skill underpinning being a good researcher which I have applied to my research study and which I will take forward into my future career as a researcher. Secondly, I have learned about the effectiveness of supervision. Without guidance from the experience of my supervisors I would not have got through this research journey, and I have appreciated every supervision meeting that I have engaged in. Thirdly, I have learned about the value of peers, and I am grateful to the other PhD students who have shared their experiences with me, encouraged me, and for the emotional support that they have extended to me. These are three key things that I learned from being in a different culture that have allowed me to develop as a future researcher.

My learning also extends into the field work which I have undertaken in Thailand. I have learned about working with healthcare professionals and gate keepers, to recruit potential participants and then about engaging with and interviewing adolescent participants. With respect to the research participants, they were young mothers, so I needed to be open and honest and genuine to gain their trust. I presented myself to them and their families as a PhD *student* researching second time and subsequent pregnancy in young mothers. I acknowledge how brave they were to take part in this study. I have learned so much from them about their lives and the difficult contexts in which they found themselves. Transcribing, translating, and analysing their interviews was emotionally hard work and I am very grateful to these young mothers for engaging with my research while they had so much else of importance going on in their often-difficult lives. I will be forever thankful to them for their generosity. Their stories have changed me and my understandings of adolescent pregnancy forever.

The qualitative methodology which underpins this research has been successful in generating new and important insights into repeat pregnancy in adolescent women. My supervisors encouraged me at first to consider using Giddens' (1986) "structuration theory" to underpin my thinking about repeat pregnancy, but I found Bronfenbrenner's (1979, 1986, 1994) ecological framework most appropriate to understand the complexity of the individual within society. Bronfenbrenner's (1979, 1986, 1994) theory has been critiqued for not having been tested empirically, in particular, the interacting role of the individual at the microsystem with the exo and macrosystems (Christensen, 2016), but it has been successful in illuminating the complex issue of repeat pregnancy in adolescent women in this study, and for health professionals, those I will be preparing for practice, offers a useful way to understand the issue.

My intentions for the future are to make a difference for young mothers, their children, and their families, and I aim to do this through my future research, my teaching, and in my practice as a midwife.

8.6 Conclusion

In order to untangle the complex issue of repeat adolescent pregnancy it is necessary to consider the impact of structural forces evident across the different levels, usefully expressed using Bronfenbrenner. This approach shows that to address issues that underpin the "problem" of repeat pregnancy in adolescent mothers, an acknowledgment of the

actions and impact of structural forces, more powerful than the agency afforded to young adolescent mothers, is necessary. Reform, therefore, must address these issues as well as supporting the agency of young women, if we are to develop policies that genuinely tackle the problems. At the very least, we must start the conversation if there is to be any hope that we can unpack this complex, contextual issue.

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Appendix 1 Example of Critical Appraisal Skills Programme (CASP, 2017)

10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Qualitative Research) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed.*

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Screening Questions

1. Was there a clear statement of the aims of the research? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

---

2. Is a qualitative methodology appropriate? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

©Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist 13.03.17

4. Was the recruitment strategy appropriate to the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

---

5. Was the data collected in a way that addressed the research issue? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

---

6. Has the relationship between researcher and participants been adequately considered? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? ❐Yes ❐Can't tell ❐No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? ❐Yes ❐Can't tell ❐No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

☐Yes ☐Can't tell ☐No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

---

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix 2 The Quality Assessment Tool for Observational and Cross-Sectional Studies

Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies

Criteria	Yes	No	Other (CD, NR, NA)*
1. Was the research question or objective in this paper clearly stated?			
2. Was the study population clearly specified and defined?			
3. Was the participation rate of eligible persons at least 50 %?			
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants?			
5. Was a sample size justification, power description, or variance and effect estimates provided?			
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?			
7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?			
8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?			
9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
10. Was the exposure(s) assessed more than once over time?			
11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?			
12. Were the outcome assessors blinded to the exposure status of participants?			
13. Was loss to follow-up after baseline 20% or less?			
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?			
Quality Rating (Good, Fair, or Poor)			
Rater #1 initials:			
Rater #2 initials:			
Additional Comments (If POOR, please state why):			

*CD, cannot determine; NA, not applicable; NR, not reported

Source: National Institutes of Health (2014). Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies. Available online at: https://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/cardiovascular-risk-reduction/tools/cohort (Accessed 15 Jan 2017)

Appendix 3 Semi-structured interview guide

Semi-Structured Interview Guide

No	1. Asking broad opening questions	Note
1	Could you tell me where do you live?	(With your family, partner or by yourself?)
2	How do you support yourself and your baby?	
	Asking about experiences (All pregnancy history**)**	
3	How has your life changed since you became pregnant with the second baby?	
4	How do you feel about yourself as a mother/ as a young mum with the second pregnancy?	
5	Could you tell me the story of how you found out you were pregnant?	
6	Tell me about how your family has responded to your second pregnancy?	
7	Could you tell me about how the child's father responded to your second pregnancy?	
8	Could you tell me how your close friends responded to your second pregnancy?	
9	When you found out you were pregnant for a second time, what happened at school, if you were still attending school?	
10	How did other people (particularly your neighbour and community) react to you when you became pregnant for a second time at a young age?	
11	Could you tell me about your experiences since you have had a second pregnant? if you were at work?	
	Probes questions: Could you tell me more about that? Can you give me an example of that? What does that mean to you? How did that make you feel?	

Appendix 4 FHS Ethics Approval Letter

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PRIVATE AND CONFIDENTIAL
Parichat Arayajaru
Faculty of Health Sciences
University of Hull
Via email

3rd September 2018

Dear Parichat

REF FHS72 - Lived experiences in repeat pregnancy among adolescent mothers in Thailand.

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

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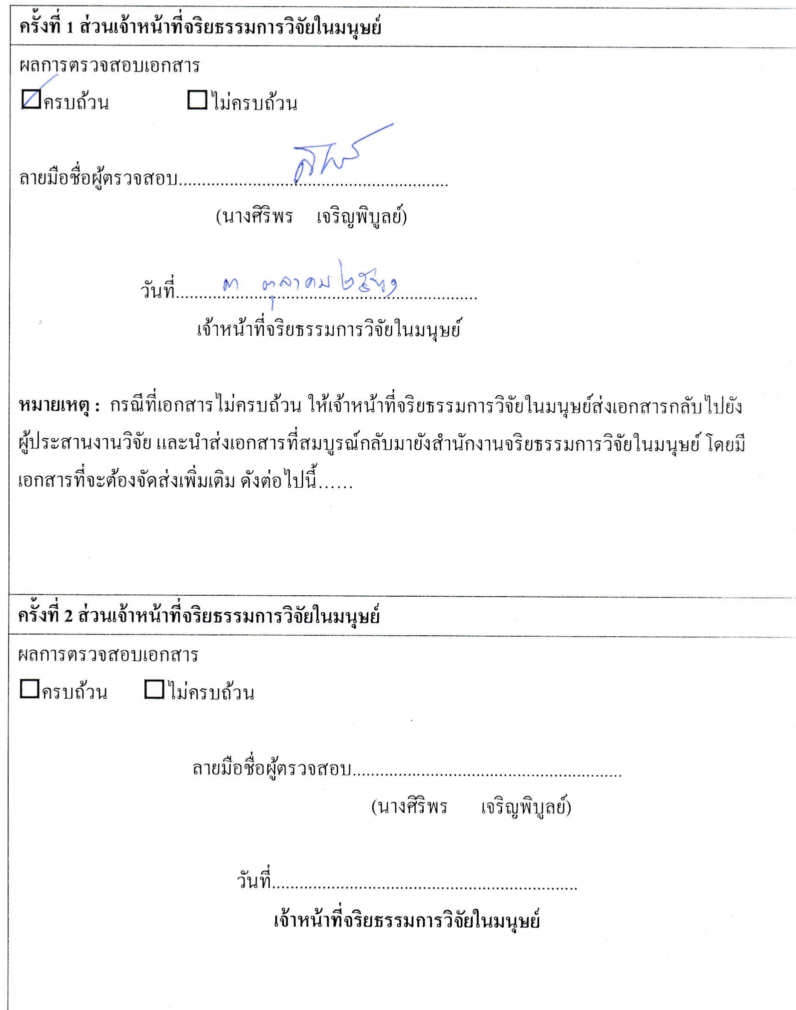
Appendix 5 Thai Ethics Approval Letter



ผลของการวิจัยเรื่อง "ประสบการณ์ชีวิตการตั้งครรภ์ซ้ำ ในมารดาวัยรุ่นไทย"

ผู้วิจัย นางสาวปาริฉัตร อารยะจารุ

ครั้งที่ 1 ส่วนเจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์

ผลการตรวจสอบเอกสาร

☑ครบถ้วน ☐ไม่ครบถ้วน

ลายมือชื่อผู้ตรวจสอบ...

(นางศิริพร เจริญพิบูลย์)

วันที่ ๓ ตุลาคม [illegible]

เจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์

หมายเหตุ : กรณีที่เอกสารไม่ครบถ้วน ให้เจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์ส่งเอกสารกลับไปยังผู้ประสานงานวิจัย และนำส่งเอกสารที่สมบูรณ์กลับมายังสำนักงานจริยธรรมการวิจัยในมนุษย์ โดยมีเอกสารที่จะต้องจัดส่งเพิ่มเติม ดังต่อไปนี้......

ครั้งที่ 2 ส่วนเจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์

ผลการตรวจสอบเอกสาร

☐ครบถ้วน ☐ไม่ครบถ้วน

ลายมือชื่อผู้ตรวจสอบ...

(นางศิริพร เจริญพิบูลย์)

วันที่...

เจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์

การอนุมัติให้ทำการวิจัย

ส่วนเจ้าหน้าที่จริยธรรมการวิจัยในมนุษย์	
ผลการตรวจสอบเอกสารเห็นควรเสนอผู้อนุมัติ ☑ เห็นควร ☐ ไม่เห็นควร ลายมือชื่อผู้ตรวจสอบ... (นางศิริพร เจริญพิบูลย์) วันที่.....๓ ตุลาคม ๒๕๖๑..... กรรมการและเลขานุการคณะกรรมการจริยธรรมการวิจัยในมนุษย์	อนุมัติให้ทำการวิจัย ☑ อนุมัติ ☐ ไม่อนุมัติ ลายมือชื่อผู้อนุมัติ... (นายแพทย์รักษ์พงศ์ เวียงเจริญ) วันที่.....๑๑ ตุลาคม ๒๕๖๑..... **ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์**