CHAPTER II

LITERATURE REVIEW

2.1 Introduction

To understand the issues and concepts related to the dissertation, this chapter investigates sexual activities and reproductive health, risk behavior, and its consequences among young women. This chapter is composed of 4 parts: **the first part** reviews literature on young people's sexual activities, factors influencing youth on having sex, sexual debut, and unsafe sex. **The second part** consists of literature related to consequences of unsafe sex, the thoughts and feelings of the individuals concerned, factors influencing their decisions, outcome of their decisions, their attempts to seek services to terminate or continue their pregnancies, and the consequences of unsafe abortion. Furthermore this part presents their intentions and need to use the reproductive health services. **The third part** presents study in Thailand and other countries on characteristics and types of youth friendly services that are identified by young people, and existing reproductive health availability in Thailand. Finally, *the* **fourth part** examines the theoretical related health seeking behavior and other theories that examine women's reactions to the problems that they face. By the synthesis of the theory, and researches help us understand that once women are faced with the problem, how do they interact and think about themselves. To understand this situation, social theories include symbolic interaction theory, health seeking behavior theories, and gender issues are reviewed in this part. This information is crystallized in order to help guide formulating a theoretical model of decision-making process and help-or health-seeking patterns of young women with unplanned pregnancy.

2.2 Sexual Activities Among Young People

2.2.1 Number of Young People in Bangkok, The Capital City of Thailand

At present, there are a large number of migrants as young people move to Bangkok in order to find a new job or study. According to the latest data from the Local Administration Department, Ministration of Interior (2001) pointed out that Bangkok has become crowded with an estimated total number of residents 5,726,203 of which 620,127 or 11.7 percent are females, and 627,184 or 11.8 percent are males with aged between 10-24 years. However, the figures quoted in this report are lower than actual figures because these numbers are drawn from the population registration with the local administration, while many young people who temporary reside in Bangkok might not register with the Department of Local Administration, Ministry of Interior (Ministry of Interior, 2001). There is a social dimension emerging following the process of urbanization, industrialization, and globalization. Among young people, it seems that they have developed their own culture referred to as the "pop culture" which increasing influences their sexual lifestyle. Many studies reveal that there are increasing levels of pre and extra –marital, non-commercial, sexual interaction (UNESCO/Thailand, 2001; Boonmongkon et al., 2000; Ford and Kittisuksathit, 1996; Soonthorndthada, 1996; Havanon et al., 1992). These changes have been linked to the increasing rates of unplanned pregnancies, and illegal and/or unsafe abortions. While young people have revealed as a major problem (Boonmongkon et. al., 2000; Porapakkham et al.,1985; & Deemar, 1980 as cited in Soonthornthada, 1996).

2.2.2 Factors Influence Youth to Have Sex

Physical and Emotional Development.

Adolescence is a transitional phase from childhood to adulthood. It is a critical period that lays the foundation for reproductive health of the individual's lifetime. It is also a period when *"sexuality"* emerges in the form of physical body changes. Feeling, psychological changes including emotions and consciousness about sexuality, and the opposite sex also occur at this time. It is also a phase of life where one searches for self-identity, which is vulnerability to behavioral and social problems (AIDC, 1999).

As adolescent become adults, they consider sexual relations, marriage and parenthood as signs of maturity. They seek information and clues about sexual life from a variety of sources – parents, peers, religious leaders, health providers, teachers, magazines, books and mass media. While youth receive a wealth of information from diverse sources, a good deal of that information is incorrect, incomplete or misleading. Adolescents obtain information and make decisions within the context of the culture in which they live. Decisions and actions may be affects by violence, drug and alcohol use, school attendance, work, economic opportunities, self-image and autonomy in decision-making (Barnett & Schueller, 2000).

General Characteristics

General characteristics include age, education, and work status details are as follows:

Age. Age may affect sexual attitude and behavior (Bell, 1971 as cited in Sartsara, 2002). Age differences among adolescent have a clear relationship to differences in premarital sex attitudes. At puberty, the life of children is still controlled by their parents, however, as they grow up, family influences are replaced by peer influences. Younger adolescent are more susceptible to peer pressure. With the onset of puberty, sexual interest begins, thus they may initiate sexual activities.

Education. Isarabhakdi, P. (2000) revealed that educational status is an important factor in shaping adolescent behavior. While adolescents are in school they are under teacher supervision as well as bounded by school regulations. Moreover, they are more likely to socialize with friends, who are in school, while out of school groups may have more freedom in choosing friends. The out of school youths may have more independence from parents than those in school. Thus, young people who are not in school and have less educational ability are more likely to have sex earlier than those who are in school.

Work status. Out of school youth are more likely to be employed and earning money. Youth who currently work may have more independence and chance to make

friends of the opposite sex. They may have more ability to protect themselves against the consequences of sexual intercourse than those who are unemployed (Sartsara, 2002).

Family context. Family context includes parental influences, household membership, living arrangements, sex education at home, and counseling when faced with problems.

Parental influences. Parental influences on sexual behavior are strong. Young people who perceived their communication with their parents as poor are more likely to initiate sex early (Book & Furstenberg, 1990 as cited in Sartsara, 2002). Not only do family relations directly affect sexual behavior, but educational status of parents also affects their children's sexual behavior. Highly educated parents may have liberal ideas, which increases the acceptance of permissive behavior by their children. In contrast, some argue that parents who have had high education desire their children to reach higher educational levels; therefore they may be against any sexuality by their children (Suwannathat, et al., 1986 as cited in Sartsara, 2002).

Other cases include young people whose parents are divorced, widowed or separated. These parents can provide little support when their children have problems and it is possible this leads these young people to face loneliness, isolation, vulnerability and alienation (Berglund, 1997 ; Muss, 1990 as cited in Sartsara, 2002).

Furthermore, the number of sexually active sisters or an adolescent childbearing sister these young people have. These are linked to young people engaged in positive intentions for future sex, and being more likely to be a non-virgin (East et al., 1987 as cited in Lerner & Galambos, 1998).

Household membership. Household membership is a factor that may affect adolescent sexual behavior. In the past, the number of household member was large so that they could help in the farms. At present, the number of household member has changed to be 2-3. This decrease in average household size may have positive or

negative influences on the interaction of its members and the social interaction with others outside of the household. A study in US found that large family sizes affected parental attitudes negatively. Parents felt unable to control their children's actions, made more complaints and were dissatisfied with their leisure time (Sartsara, 2002).

Living arrangements. Young people still depend on their family for food and accommodation, which gives them a feeling of belonging and care, of emotion and social support. The study by Prasartkul, P. et al. (1987) found that female adolescents who live alone were four times more likely to have had sexual experience than female adolescent who live with parents or close relatives.

Sex education at home. Parents tend to be reluctant to discuss sexuality with their children. They feel it is extremely difficult or impossible. They feel embarrassed by the topic and often expect that the school will be responsible to provide such knowledge and preventive messages. Some parents hold the opinion that it is not necessary for parents or teachers to provide knowledge about sexuality for young people. They believe that the young people will eventually learn about sexuality by themselves (Havanon, & Markmee, 1996). Thus, young people seek information about sexual life by themselves from various sources. While youth receive a wealth of information from diverse sources, a good deal of that information is incorrect, incomplete or misleading.

Counseling when faced with problems. Communication is important for the family members. If family members do not communicate with each other, when problems arise, they cannot help each other.

Social factors. Social factors include relationship situation, peers pressure, and gender situation.

Relationship situation. There are a strong relationship between dating experiences and young people's sexual behavior. Those who have regular partners are more likely to have premarital sex than casual daters. Males' teenagers tend to be more

willing than females to engage in uncommitted sex. Young girls are likely to report that sexual activity occurs with regular or steady partners (Havanon, & Markmee, 1996).

Peers. Many Thai studies regarding sexuality among young people found that peers have the most influence when youth decide to have sex or not. Young people are likely to obtain information about sexuality from friends (UNESCO/Thailand, 2001; PATH, 2001b; Isarapakdee, 2001; Ford & Kittisuksathit, 1996; Soonthorndthada, 1996; Havanon et al, 1992). They feel comfortable discussing these issues with their friends, and believe that their questions will be treated sympathetically, with understanding and discretion. Furthermore, evidence suggests that peers have very strong influence in forming teenagers' beliefs and regulating their sexual behavior. They tend to take an active role in each other's sex education. Deciding to initiate first sex is more related to the perceived peer approval of premarital sexual intercourse than that of parents or teachers (Havanon, & Markmee, 1996).

Furthermore, there was a study showing that the number of sexually active girlfriends that an adolescent female has, is linked to her having permissive sexual attitudes, having positive intentions for future sex, and being more likely to be a non-virgin (East et al., 1987 as cited in Lerner and Galambos, 1998).

Gender. In Thai society, males have higher power and social status through sexual behavior. Premarital sex for males is common, while it is stigmatized in females (Gray & Punpuing, 1999). There are many studies which reveal that males are more likely than females to accept premarital sex UNESCO/Thailand, 2001; Boonmongkon et al, 2000; Ford & Kittisuksathit, 1996; Soonthorndthada, 1996; Havanon, & Markmee, 1996).

Psychosocial Factors

One study conducted by Morgan, C., George N., & Fisher, M. (1995) at the Long Island, New York in 1989, investigated whether psychosocial factors differentiate sexually active teenagers who become pregnant from those who do not. Data was collected from 64 unmarried adolescents who attended a suburban health clinic for a

pregnancy test or for contraceptive care. Thirty-nine percent of the sample had been or were later pregnant, and 61 percent had never been pregnant. Two significant differences were found: adolescents with a history of pregnancy had first intercourse at the mean age of 15 rather than 16 and scored higher than never-pregnant teenagers on the "Powerful Other" Health Locus of Control subscale, a measure of strong belief in external control by others. No significant differences were detected between the groups for self-worth or life events perceived as stressful during the past year. This data indicates that in a middle-class suburban population of sexually active teenagers, first intercourse at an early age and the influence of powerful others are important variables associated with pregnancy.

Bases on the literature review, there are many factors that affect the sexual behavior among young people. The key factors include (a) general characteristics including physical and emotional change, age, sex, education, work status; (b) family/environmental context factors including parental influences, parental marital status, parental education, living arrangement, household membership, inadequate or lack of sex education, family relation and communication; (c) Social Factors including peers, and gender. All these are factors or independent variables that will lead to young people sexual activities. These factors are influenced youth to have sex at a difference level from place to place.

Sexual Debut

To understand the sexual and reproductive health situation of young people in Thailand and give us perspective on where we stand, it is worth our time to compare the Thai situation towards age at sexual debut with other countries. Table 1 shows the percentage of youth reporting sexual intercourse and age at sexual debut, as focused on unmarried youth, as well as among special populations including youth who are about to be married and seeking health care service in Thailand and other near-by countries. The results revealed that the age at sexual debut was 18, which was similar compared between Thailand, and the Philippines. Where as, Viet Nam and China were more slightly higher from 20-23 years. Percentage of sexually active males is higher than females and is highest in China (WHO, 2001).

Table 2.1: Premarital sexual activity among youth in Thailand and other nearby countries, 1990s.

Site/country	Sample Population	Age Range	Percent Sexually Experienced		Age at Sexual Debut (mean or median)		Source
			Female	Male	Female	Male	
Thailand North and North-east	Rural household survey	15-24	2	51	18[1]	16[1]	Isarabhakdi, P., 1995
Thailand Bangkok	Females, school-going and factory workers	15-19	3	Ns	18[1]	Ns	Soonthorndhada A,. 1994
Thailand Chiang Mai	Factory workers, married and unmarried	13-25	6	75	18[1]	16[1]	Rugpao, S., 1997
Viet Nam Hanoi, Ho Chi Minh City	College students	17-27	2	15	20[1]	20[1]	Vu Quy Nhan, 1996
Philippines Dumaguete City	College students	18-24	10	50	18[1]	17[1]	Cadelina, 1998
China Shanghai	About-to-be married Females Visiting clinics for physical examination	18-29	69	Ns	21-23[1]	Ns	Gao, 1998

Source: Adapted from WHO, 2001

Remark: [1] Mean value

Compared with other countries which revealed varying ages: however, it is in Latin America the age at sexual debut appears notably earlier than in the other two regions. The case studies report that between 20 percent and 25 percent of females attending night schools in Lima, Peru and San Martin de Porres, Peru, and secondary school in Buenos Aires, Argentina reported sexual debut by age 15, as did 30 percent of males in high schools in Lima, and 57 percent of males in secondary schools in Buenos Aires. The case studies in Africa and Asia, typically median ages at debut are 18-20 years among females (WHO, 2001).

In Europe, there was one study conducted among school students in Greece in which 7.2 percent of boys and 6.7 percent of girls aged 12-14 years, 25 percent of boys and 23 percent of girls aged 14-16 years, and 36 percent of boys and 32 percent of girls aged 16-18 years replied anonymously in a questionnaire completed at schools that they have had sexual intercourse. These numbers at least indicate the magnitude of the problem in Greece, which indicated that sexual intercourse increases with age (Creatsas et al., 1995 as cited in Malamitsi-Pucher, 1999). The study by Burack R. (1999) conducted in the UK revealed that 20 percent of 13 year olds reported that they had already had either full or oral sexual intercourse with a partner. Teenage boys are becoming fully sexually active at a younger age than the girls and are taking risks in doing so. They are being influenced by peer pressure, condoning promiscuity and are declaring the intent to practice unsafe sexual intercourse. Their level of maturity would appear to be inadequate for them to comprehend the implications and consequences of their actions.

When comparing the age of young people engaging in sexual activities, it was found that age is lower in Europe than in Latin America. The age of youth in Asia of first engaging in sexual activities was found to be highest among the three regions. This showed that there remain many different factors involved in teenagers' decision-making processes about their developing attitudes towards sex and their resultant behavior due to many factors including social, cultural, and biological factors that bring the adolescent to become in fully sexually active as young as 12 or 13 years old. For females, it was found that premarital sexual activity varies widely across regions. Within each region, however, rates reported in various case studies are remarkably similar. For example: rates of sexual activity are concentrated in the 2 – 11 percent range in various settings in Asia: 12 – 25 percent in various settings in Latin America; and 45 – 52 percent in setting in Sub-Sahara Africa. Of interest is the exceptionally high rate reported among a sample group of about-to-be-married. Chinese women in Shanghai who received their "obligatory" health examination prior to marriage (Gao,1998). When marriage is imminent, premarital sex seems to occur among the majority of women, even in conservative settings. When compared to males, however, it was found that premarital sex is more prevalent among males than females, although

some of this difference may be attributed to over-reporting among males, and under-reporting among females (WHO, 2001).

Sexual Debut Most Frequently Occurs at Home

The case studies from WHO (2001), suggest that sexual activity occurs, especially at initiation, within the home of one of the partners. The home was the location of sexual debut among students in Dumaguete city, Philippines, as well as for the overwhelming majority (92 percent) of young, about-to-be-married women in Shanghai, China. So, too in the case study in Lambayeque, Peru. Almost half (48 percent) of sexually active youth reported that sexual initiation had occurred in the home of one of the partners. Other studies point out, however, that this practice is far more common among sexually active females than males. For example, among secondary school students in Buenos Aires, Argentina, females are far more likely to report sexual relations in the home (76 percent) than are males (42 percent). Among college students in Hanoi and Ho Chi Minh City, Viet Nam, too, sexual activity typically occurs in the home of a partner among two-thirds of females (63 percent) and about two-fifths of males (38 percent).

Premarital Sex Attitude

The study of premarital sex and gender issues among youth in Thailand revealed that among factory workers in Chiengmai, Thailand, almost all the males (98 percent) and nearly half of the female (44 percent) felt that premarital sex was acceptable for men. However, only 50 percent of the males and 15 percent of the females believed that this was acceptable behavior for women (Rugpao, 1997 as cited in WHO, 2001. Furthermore, the study of young men and women in rural Thailand (Isarapakdee, 2000) found that respondents who had not been married had more liberal attitudes towards males premarital sexual activities than towards that of women. Approximately, 63 percent of males' respondents and 95 percent of females agreed that unmarried women should not have sex before marriage, but only 27 percent of males and 63 percent of females felt the same about men. A relatively large percentage of both males (26 percent) and females (21 percent) agreed that unmarried men should be able to have sex with any women they want, whereas only 7 percent of males and 1

percent of females felt that this applied to unmarried women. Even after marriage, it is generally accepted that men would engage in extramarital sexual relationships (Isarapakdee, 2000).

2.2.4 Causes of Unsafe Sex

Alcohol consumption. There are many studies showing the association between alcohol consumption and risky or unprotected sexual intercourse (Ford & Kittisuksathit, 1996; Rugpao, 1997; Isarabhakdi, 2000). In Thailand, among rural males in the North and North-eastern (Isarabhakdi, 2000), the results revealed that 59 percent of respondents reported that alcohol consumption typically preceded sexual relations with sex workers. Where as 73 percent of young male factory workers reported the same (Ford & Kittisuksathit, 1996).

Forced sex. About 20 percent of girls reported that unplanned sexual experiences have occurred within the past year. Approximately one third of these encounters involved forced sexual intercourse. The other two thirds of the events involved unplanned touching. Most of the experiences were initiated by boyfriends, dates friends, or acquaintances (Whitbeck et al., 1994 as cited in Lerner & Galambos, 1998).

Condom use. As condoms have been promoted through the country as a method for the prevention of sexually transmitted diseases especially HIV/AIDS, the majority of young men always use (83 percent) when they have sex with sex workers. However, condom usage is much lower with girlfriends than sex workers. Only 21 percent of men and 4 percent of women reported consistent used of condom with their steady partner (Ford & Kittisuksathit, 1996).

The reviewing of WHO (2001) indicated that inconsistent condom used despite there was relatively high levels of condom awareness. Young people rely heavily on natural methods. Withdrawal and rhythm are frequently reported. For example in the case study in Dumaguete, Philippines, about half practiced these methods; and in Seoul, Kyongbuk, & Kyongnam, Republic of Korea, over half. Also, According to

Boonmongkon P. et al., (2000) it was pointed out that in Thailand, ECP is quite popular among young people. The product can be easily purchased from drugstores without a doctor prescription. These findings were consistent with a study by PATH, Thailand, (2000a) which found that young people prefer to use Emergency Contraceptive Pills (ECPs) with their girlfriends and condoms with sex workers.

A study by McPhail C. & Campbell C. (2001) among young people in South African Township which comprised 44 young women and men in the 13-25 year age group. Data analysis highlighted six factors hindering condom use: lack of perceived risk; peer norms; condom availability; adult attitudes towards condoms and sex; gender power relations; and the economic context of adolescent sexuality.

Knowledge, awareness, and practicing of contraception. In Thailand, the perception towards contraceptive methods is that they primarily for those are married. According to Havanon, N & Markmee, K, (1997) it was found that young people perceived that using contraceptives might imply that they are sexually active or that they wanted to have sexual relations with men. According to Issarabhakdi, P. (2000) among sexually active young women, only 2 out of 11 used contraceptive methods when first having first sexual intercourse. One female reported that her sexual partner used a condom, and another used withdrawal while 9 females did not used any method. This is understandable as most did not plan to have sexual intercourse. These findings are consistent with the study conducted by Ford, N. & Kittisuksathit, S. (1996).

In a more conservative culture like China, study on KAP survey which suggested that while about one fifth of youth are sexually experienced, few (about 20 percent) of them practice contraception properly (use contraceptives every time they have sexual intercourse), and there is widespread lack of awareness of sexual and reproductive health issues (Gao, 2002).

At initiation of sex, males are expected by females to take responsibility for contraception. However, when sexual relationships become more steadily, women are expected by men to be responsible for contraception (Havanon, & Markmee, 1997).

Also, the used of contraceptive involves a communication and negotiation process which is difficult for Thai women. By expressing the need to take precautions she may convey an image of being sexually knowledgeable, experienced, and active in the use of contraception.

Contraceptive methods and the health service systems. Unsafe sex can result from contraceptive methods and the health service systems, which include (1) unavailability of contraceptives when sexual intercourse occurred; (2) lack of access to family planning services; (3) contraceptive methods being unacceptable to some women who want to hide their use of contraceptives from friend, relatives, and parents. This can limit the types of methods chosen. Some women may fear side effects of contraceptive methods or infrequent sexual activity, thus women may not want to use contraception regularly; (4) ineffectiveness of the contraceptive method itself, or failure to use contraception, leading to unplanned pregnancy; (5) unaffordable contraceptive methods.

Family and peers. According to Isarabhakdi, P. (2000), it is interesting that the influence of peers somewhat important for the young men in first having intercourse. Approximately 40 percent of young men said they wanted to be the same as their friends, while only one female reported that as the reason. The majority of young males first had intercourse because of curiosity. Another study by Ford, N. & Kittisuksathit, S. (1996) revealed that the first introduction to sexual intercourse was often made by older friends or relatives. It's also found that first sexual intercourse with sex workers generally, or 63 percent, took place with friends of the same age.

Family and peer contexts also influence the likelihood that adolescent girls will experience an incident of unplanned sexual activity (Small & Kerns, 1993 as cited in Lerner & Galambos, 1998). A girl's history of sexual abuse, a tendency to conform to peers, and having parents whose rearing style was either authoritarian or reflective of low monitoring was predictive of her being a target of an unplanned sexual advances. Similarly, in divorced families, a mother's dating behavior and sexually permissive attitudes influences both daughters' and sons' sexual activity (Whitbeck et al, 1994).

Gender roles and double standard. The study of young men and women in rural Thailand found that respondents who had not been married had more liberal attitudes towards male premarital sexual activity than towards that of women. Approximately 63 percent of male respondents and 95 percent of females agreed that unmarried women should not have sex before marriage, but only 27 percent of males and 63 percent of females felt the same about men. Relatively large percentages of both males (26 percent) and females (21 percent) agreed that unmarried men should be able to have sex with any woman they want, whereas only 7 percent of males and 1 percent of females felt that this applied to unmarried women. Even after marriage, according to the author of the study, it is generally accepted that men would engage in extramarital sexual relationships mostly with commercial sex workers" (Isarabhakdi, 2000; Ford & Kittisuksathit, 1996; Soonthorndhada, 1996)

Among the factory workers surveyed in Chiang Mai, Thailand, almost all the males (98 percent) and nearly half of the females (44 percent) felt that premarital sex was acceptable for men. However, only 50 percent of the males and 15 percent of the females believed that this was acceptable behavior for women. These attitudes were borne out in the behavior reported by respondents (Rugpao, 1997).

Young women tend to link sexual intercourse with love and romance. They tend to satisfy the wish of their lovers rather than their own sexual needs or desires. Young women often feel that the main reason for being sexually active is being in love. Young men on the other hand, feel comfortable to mention the satisfaction of their sexual desires as the main reason for being sexually active. Thus, different values on sexuality result in unsafe sexual intercourse. Young women tend to be reluctant to initiate sexual and contraceptive discussions, the lack of assertiveness leaving them vulnerable when their partners insist on having sex.

From reviewing many studies of young people on sexual and reproductive health can conclude that factors that cause young people to engage into unsafe sex include individual knowledge, awareness, and practice of contraception; environmental factors such as community context, contraceptive methods available, and health service

system; and gender roles and double standard. Consequences of unsafe sex are unplanned pregnancy, abortion, STI/HIV. However, psychosocial consequences from unsafe sex are not measurable.

Community context. The community context also influences adolescent sexuality. In poor communities, youth have higher rates of abortion and lower rates of marriage (Sullivan, 1993 as cited in Lerner & Galambos, 1998). In turn, among both African American and European American female adolescents, living in a socially disorganized, low-income community, one wherein family planning services are not readily available, is associated with the initiation of sexual intercourse and with the young women's subsequent sexual activity. One study of a racially diverse sample of first-time adolescent mothers living in an urban area found that 35 percent had a repeat pregnancy within 18 months of the first birth (East & Felice, 1996 as cited in Lerner & Galambos, 1998).

2.3 Consequences of Unplanned Pregnancy and Abortion

2.3.1 Prevalence of Unplanned Pregnancy and Abortion

The prevalence of unplanned pregnancy and abortion are high, due to a complex set of factors such as the early initiation of sexual relations among adolescents, religious opposition to family planning, lack of sexual education, lack of female empowerment in negotiating to either avoid having sex or use of contraceptive methods and, high levels of side effects from contraceptive use the failure of contraceptive methods.

Unplanned pregnancy is the major problem facing young people who have unsafe sex (Boonmongkon et. al., 2000; Porapakkham et al., 1985; and Deemar, 1980 as cited in Soonthornthada, 1996). However, there was no written record of the experiences of women with unplanned pregnancy available. There was a study estimating that one out of three pregnancies are unplanned (Chayowan & Nodel, 1992). Furthermore, the latest study by the Population Council (2002) surveying the history of pregnancy and reproductive health status among women aged 15-59 years in

communities in a province at the northeastern part of Thailand, found that 45 percent of all pregnancies were unplanned.

In the United States (US), a study among adolescents by Van Winter & Simmons (1990) reported that of the one million pregnancies among adolescents in the U.S. each year, approximately half result in live births, 400,000 end in elective abortions, and the remaining 100,000 end in spontaneous abortion. Fully 85 percent of these pregnancies are unplanned. Teenage pregnancy rates in the US are at the highest level among Western nations. An estimated 96 per 1,000 women between the ages of 15 and 19 become pregnant each year (Repke, 1990 was cited in Trad, 1999).

In Thailand, abortion is illegal except under certain circumstances such as risk to the mother's health and rape (Warakamin, 2000b) or when the fetus has anomalies that are incompatible with life. Therefore, it is not possible to get the actual figures. The most popular source that has been cited often, a study by Koetsawang (1993) revealed that 200,000-300,000 women terminated their pregnancies every year. However, there is the most recent national survey on abortion among 787 hospitals in Thailand showing that rate of abortion was 19.5 per 1000 live births (Warakamin & Boonthai, 2001).

The overwhelming majority of induced abortions are performed illegally unsafe due to the fact that abortion is legal only when pregnancy puts the woman's life in danger or is the result of proven rape, or when the fetus has anomalies that are incompatible with life. Even under these limited conditions, it is difficult for a woman to access services to terminate her pregnancy legally.

2.3.2 Experiences of Women with Unplanned Pregnancies

Women bear the physical, emotional and usually the financial burdens and heartache of an unplanned pregnancy. Hardly anything is more debilitating or depressing than becoming pregnant at an inopportune time, whether pregnancy came about because of failed contraception, non-use of contraception, rape, or incest.

Deciding whether to carry the pregnancy to full term or to have an abortion presents a painful dilemma. A woman may not be mentally or physically prepared to bear a child. Often she must weigh serious risks to her own health and the health of her existing children against another pregnancy. When abortion is her chosen option, she faces continuing conflict. The issues include the abortion illegally, unavailable, and expensive; whether to go to an untrained practitioner because of these circumstances; risks of using clandestine services; humiliation or disrespectful treatment by a male doctor are possible additional hurdles.

Frequently a woman has no one to turn to for moral support and sympathy before, during or after an abortion even when medically safe services are available. Empathetic counseling is not commonly thought to be an important and integral part of abortion services in many countries. Women thus often endure an abortion without prior, full information on the procedure, including possible risks or side effects. Worst of all, many women seeking abortion are not given contraceptive information, services or referral (Kabir, 1989).

It is increasingly recognized that poorly performed abortions are a leading cause of maternal death throughout the developing world. Clandestine abortion, however, leads not only to death, but also to appalling morbidity. Women suffer terribly from infection, physical damage such as a perforated uterus, and sterility. Women can linger on the verge of death for several days from a septic abortion. In many places, such as Bangladesh, the chances of being treated at a hospital are small. When these women become incapable of looking after their families they may be abandoned by their husbands or the husband may take another wife. The sick woman is then left at the mercy of a co-wife or wives.

2.3.3 Physical and Psychosocial Characteristics of Women who Terminated Pregnancy

According to Warakamin & Boonthai (2001), women age 24 and lower were have the highest rate of terminated pregnancies. More than half of cases with complications were among women aged 24 and younger. Of all illegal abortion cases among unmarried women, 48.6 percent were performed on women aged 20-24, and 30

percent on those age 20 and lower. Nearly one fourth (24.7 percent) were students. Most of the women (91.2 percent) made the decision for abortion by themselves. Women were most likely to terminate pregnancy due to economic problems, social problems, inappropriate planning, studying, family problems and failure to use contraceptive methods, as shown in 56.8, 36.2, 34.4, 26.8, 20.8 and 15.6 percent respectively.

This data is consistent with the report from SahaThai Foundation that is a non-governmental organization. Their mission is to improve quality of family life by supporting pregnant and single mothers. After delivery, the foundation will screen and select foster homes for the newborn baby. 25 years of records of women, who seek the service of the foundation because of the unplanned pregnancy, showed the majority ranged from 19-23 years of age. Most of them were migrant workers, housewife - housekeepers and laborers from a low socioeconomic status from the north - eastern part of Thailand (Sahathai Foundation, 2001).

Psychosocial Factors

One study investigated whether psychosocial factors differentiate sexually active teenagers who become pregnant from those who do not. The results revealed that 39 percent of the sample had been or were now pregnant, and 61 percent had never been pregnant. The girls who had positive pregnancy tests, and sexually active girls who had never been pregnant were compared, and no significant differences emerged on socioeconomic status, race, religion, age or psychological variables. Also, this data indicates that in a middle-class suburban population of sexually active teenagers, earlier age at first intercourse and the influence of "powerful others" are important variables associated with pregnancy (Morgan, Chapar, & Fisher, 1995).

A study by Machungo at al. (1997) in the Maputo Central Hospital 103 women undergoing induced legal abortion (LA), 103 women with confirmed, recent illegal abortions (IA), and 100 randomly recruited antenatal clinic (AC) attendants were compared in order to find characteristic features regarding obstetric history, reproductive performance and contraceptive knowledge, attitude, and practice. The

study showed that women with IA were younger, had almost never undergone LA, more often had their first sexual intercourse and their first pregnancy below 20 years of age, had less knowledge of contraceptives and more often had never used contraceptives, had fewer previous spontaneous abortions and fewer previous stillbirths than LA women. There were three maternal deaths, all in the IA group. The most frequent illegal abortionist was a health worker (38 percent). It is concluded that, in this first comparative African study on IA and LA regarding reproductive profiles and post-abortion health consequences, the former are at a disadvantage regarding early unprotected sexual intercourse with first pregnancy at a young age and with almost no experience of safe, or legal abortion.

2.3.4 Consequences of Unplanned Pregnancy

2.3.4.1 Consequences of Unplanned Pregnancy: The Perspective of Young People

From perspectives of youth, consequences of unplanned pregnancy are listed as follows (Adolescent Workshop/UNPFA, 2000):

Drop out from school. Most of the schools in Thailand do not allow girls to be pregnant. In case of pregnancy, the girls required to drop out of school. Some schools allow the girls to continue her education after a few months, but some girls do not come back in order to avoid embarrassment.

Elopes with boyfriend. Once woman's sexuality is disclosed to her family and if the parents from either the boys or girls' s family do not accept it, some women elope with their boyfriend.

Forces boyfriend to marry. Pregnancy with out the present of a boyfriend or father of the baby is a social stigma. Thus, women will force their boyfriend to marry. Some boyfriends will marry, but some refuse to take responsibility in order to avoid embarrassment, by staying away from girlfriend.

Moves to another residence. Girls might move away to find a new residence so that she can avoid gossip or embarrassment of their neighborhood.

Goes into depression. Girls who have no one to consult when unplanned pregnancy occurs, might experience depression, and if the depression is more severe, might attempt to commit suicide.

Undergoes abortion. If boyfriends are not ready to assume parental roles, feel embarrassed, cannot support their new family, or do not love them, girls might decide to terminate their pregnancy. They might start to seek for information and services from friends or someone she trusts. Some girls might manage to terminate the pregnancy by themselves using various kinds of abortifacient products. Some might engage in vigorous physical activities such as jumping or lifting heavy objects. If that is not successful, then she may seek the assistance of untrained personnel, which will lead to unsafe abortion. If they can afford the cost of induced abortion, they might turn to the specialists.

Carries the baby to full term. If a girls' boyfriend does not love them or is not ready to assume the parental role, the girl might decide to keep the baby to full terms and later on either care for it or give it up for adoption.

2.3.4.2 Consequences of Abortion

Adolescents are more likely than adults to hide a pregnancy, seek late- term abortions, and have the procedure performed by untrained providers under unsafe conditions, often leading to permanent disability or death (Sertthapongkul et al., 1993; Koetsawang, 1993). The latest study by Warakamin & Boonthai (2001) revealed that 41.8 percent of women who had illegal abortions terminated their pregnancy after 12 weeks of gestation, which has a higher chance of developing complications.

Complications results from unsafe abortions are a major cause of death for these young women. Young women's frequently limited knowledge, confidence, or access to the health care system contributes significantly to complications. Apart from physical

consequences, psychological trauma also affects to many women, which is unseen and immeasurable. The common complications found among Thai women include septic abortion, pelvic inflammation, bleeding, and uterus perforating, as revealed in 12.4, 12.0, 11.8 and 7.4 percent respectively Warakamin & Boonthai (2001).

2.3.4.3 Consequences of Perinatal Outcomes

Chabra S. (1991) conducted the study on "Perinatal Outcome in Teenage Mother" in India and found that the incidence of teenage mothers coming for delivery is around 11 percent. The study deals with 400 cases of teenage mothers admitted for delivery with 400 control cases between the age group of 20 to 29 years of age. Number of women who had received some antenatal care in both groups was almost the same. Incidence of anemia was not very different. Toxemia of pregnancy was present in significantly more women of younger age. In general caesarian section rate was similar but 73.7 percent patients of breech presentation needed caesarian section among teenagers. Duration of labor was more in these women (mean duration 17 hrs and respectively). Incidence of low birth weight babies (2 kg.) was 11 percent and perinatal loss 77.5/1000 births. Teenage mothers seem to be at higher risk of child bearing with high perinatal risk.

2.3.5 Definition of Unplanned Pregnancy and Abortion

In the study by the Population Council (2001) it was found that women used the words "not being ready" in their accounts of unplanned pregnancies. Each woman's state of not being ready differed and was closely related to their life contexts at the time of pregnancy. Thus, the definition of "being ready' and "not being ready" are different from person to person.

In the definition of "abortion" depending on how women view their delayed menses, women may or may not perceive the actions that they take to cause resumption of menstruation as abortion. Some women in Thailand often seek "Ya Satree" from drugstores, a medical compound which contains many kinds of traditional herbals to "bring down a late period" with out testing for pregnancy. In this way, the woman does

not admit to herself or to others that she is trying to induce an abortion, an act that carries considerably more social and religious stigma.

In other countries where Menstrual Regulation (MR) is a common practice women may have similar perspectives. In most instances, practitioners perform MR without diagnosing pregnancy, and many women do not perceive it to be abortion (McLaurin et al., 1991).

There was a study by Nations, MK., Evans, D. & Polinard, JL. (1997) in Brazil on women's hidden transcripts about abortion. The results revealed that women defined their abortion as two folk medical conditions "delayed" and "suspended" menstruation. To resolve these conditions they were prescribed methods to "regulate" these conditions and provoke menstrual bleeding. The prescription includes ingestion of herbal medicines, patent drugs, and modern pharmaceutical drugs. The ingestion of such self-administered remedies is facilitated by the cognitive ambiguity of euphemisms, folklore, etc., which surround conception and gestation. The authors argue that the ethnomedical conditions of "delayed" and "suspended" menstruation and subsequent menstrual regulation are part of the "hidden reproductive transcript" of poor and power less Brazilian women. Through popular culture, they voice their collective dissent to the official, public opinion about the illegality and immorality of induced abortion and the chronic lack of family planning services in Northeast Brazil. While many health professionals consider women's explanations of menstrual regulation as a "cover-up" for self-induced abortions, such popular justification may represent either an unconscious or artful manipulation of hegemonic, anti-abortion ideology expressed in prudent, unobtrusive and veiled ways. The development of safe abortion alternatives should consider women's hidden reproductive transcripts.

Since women who have abortions try to keep it confidential very little information about consequences and subsequent abortion has been released to the public. Furthermore, most women seek information from their peers or their female relatives. Some women might perceive that abortion may have made them permanently infertile. Some of them may postpone contraceptive use until the return of their period

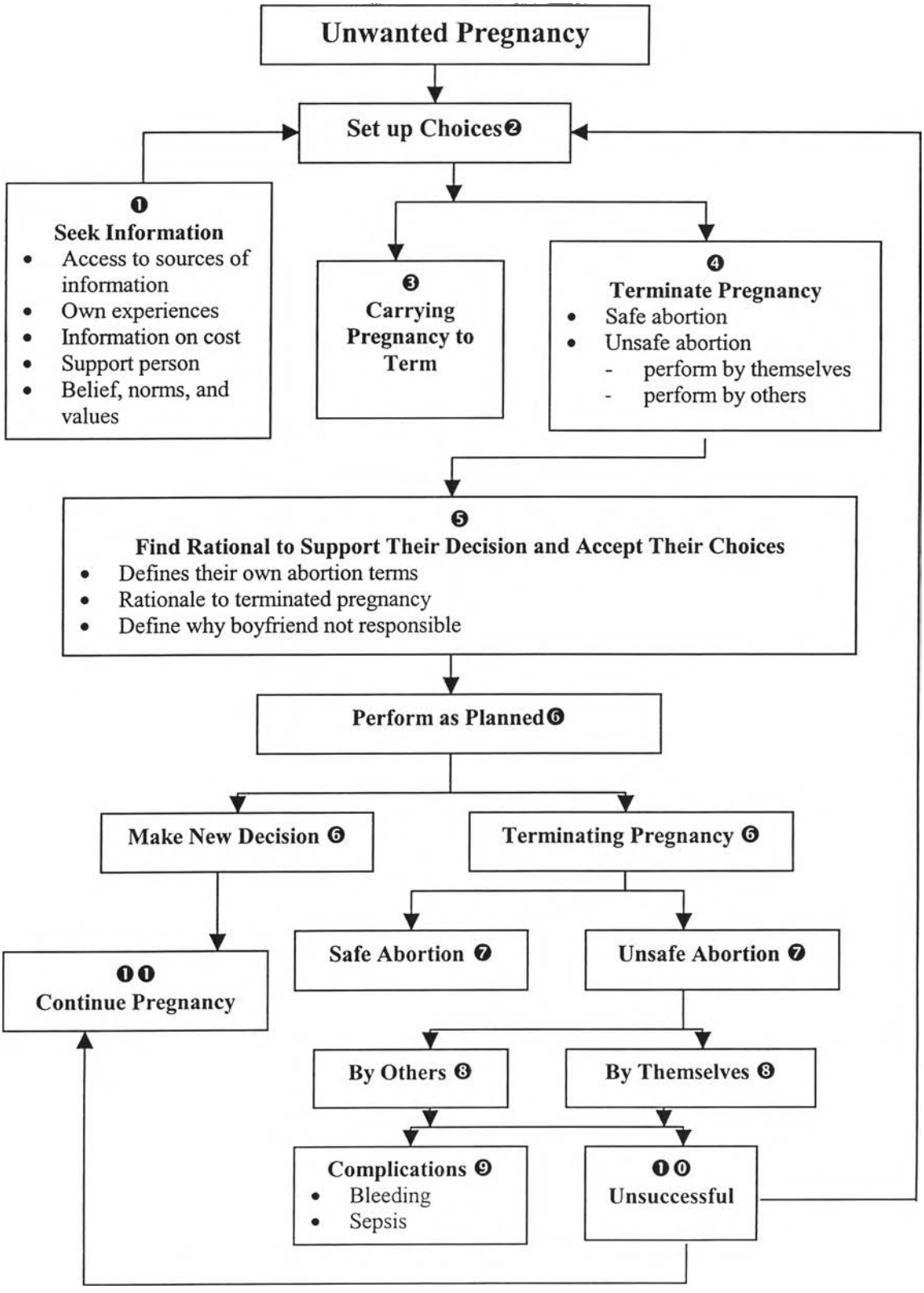
(or pregnancy) provides confirmation of fertility. Others simply do not recognize their post-abortion return to fertility until their menses resume. Whatever the variations in beliefs, understanding how women perceive their return to fertility is essential to designing services that will meet their needs—including provision of information about the risk of pregnancy and ways to avoid it (Nations, Evans, & Polinard, 1997).

2.3.6 Feeling and Decision-making Towards Abortion

To understand how young people make decisions, in order to guide them, we need to know what information they possess, what information they choose to use, and their cognitive ability (Gordon, 1996). In Thailand, to study these issues is challenging, and the results are difficult to disclose due to the political, cultural and religious norms and values. Thus, there have been few studies on this topic. However, there were two papers published recently, the first one studied by Ratchukoon, S. (1998) on Unplanned pregnancy and the decision to terminate pregnancy. The other was from the Population Council, (2000) a study on the experiences of women who have unplanned pregnancy. Both of the studies used qualitative methods as their main study.

The study by Ratchukoon, S. (1998) conducted among the women at reproductive age who terminated and continuing pregnancy in Bangkok. The decision making process could conclude that to solve the problem of unplanned pregnancy, there are processes as follows: 1) access information from various sources, including their own experiences, and especially information on cost, support, beliefs, norms and values; 2) set up choices; 3) decide to carrying pregnancy to term; 4) in the case of terminating pregnancy, there are two choices - safe and unsafe abortion; 5) find rationale to support their decision and accept their choices; 6) attempt to terminate pregnancy or continue pregnancy; 7) incase of terminating pregnancy, seek assistance from trained personnel resulting in safe abortion or seek assistance from untrained personnel resulting in unsafe abortion; 8) incase of terminating pregnancy, seek assistance from untrained personnel or attempt abortion on their own resulting in unsafe abortion; 9) unsafe abortion possibly resulting in complications; 10) unsuccessful termination of pregnancy; 11) if unsuccessful, continue pregnancy (as shown in Figure

2.1). The finding also indicated that majority of the women make decision by themselves.



Source: Ratchukoon 1998, page 173

Figure 2.1: Model on Decision Making Process for Terminating Pregnancy

Webb D. (2000) pointed out that the decision-making process regarding the abortion itself is related to the perceived advantages and disadvantages of various service providers. Around 40 percent of the respondents stated that in the event of an abortion being carried out, it would be performed either by the girl herself or with the assistance of other non-medical personnel. Less popular but still significant are traditional healers and private doctors. Formal health services tend to be rejected due to their poor perception by young people, centered on the lack of privacy and confidentiality, and the de facto illegal nature of abortion itself.

Harden, A. & Ogden, J., (1999) conducted a study to examine young women's experiences of arranging and having an abortion. The findings revealed that women aged between 16 and 24 years who were interviewed between one and three hours after their abortion revealed that having an unplanned pregnancy was experienced as a rare event that was accompanied by feelings of lack of control and loss of status. The process of arranging and having an abortion was found to lead to a reinstatement of status, control, and, normality. It was noted that this process was sometimes hindered; however by information, judgmental health professionals, and the wider social context of abortion, in which it is viewed as a generally negative experience. It was observed that most such negative experiences were associated with accessing the abortion service and the professionals who act as gatekeepers rather than with those who work within the service itself. Thus most young women had positive experiences, and supportive staff compensated at times even negative expectations.

Rylko-Bauer, B. (1996) pointed out in the special section on abortion from a cross-cultural perspective which examined from six countries including Greece, Turkey, China, Nigeria, Jamaica, that each country varied in their policies, laws, and historical context concerning abortion, in the extent to which the state supports or restrains access to abortion and contraceptives; and in persisting cultural ideologies about these and other related issues of sexuality, fertility, family, and gender roles. However, in all of these countries, women share the same concerns about unplanned pregnancies and how these influence their social and family roles, economic resources and work, the welfare of their children, and their social relationships and social status.

Women act on these concerns by regulating their fertility through various means including abortion.

Once the women face with unplanned pregnancy, most of them felt loss, and lack of control. It can conclude that terminating pregnancy is a popular solution that the women which unplanned pregnancy choose as a solution to solve the trouble. More important laws, religious, culture, and historical context towards abortion are influence women on their decision-making and access to services once facing unplanned pregnancy.

2.4 Reproductive Health Services for Young People

2.4.1 Existing Adolescent Health Services/Systems

Adolescent health is one out of ten components in the reproductive health scheme under the Family Planning and Population Division (FPPD), Department of Health, Ministry of Public Health (MOPH). FPPD is responsible as a focal point of adolescent health in Thailand that is considered to be the top priority among others (Warakamin, 2000a). The adolescent health work plan has been integrated into the 9th National Health Development Program. The relevant adolescent health activities are currently being carried out as part of regular program under the responsibility of various departments in the MOPH. These departments include the Health Department, Mental Health Department and Communicable Disease Department. Collaboration among these various departments is essential in leading to the health of young people. Since 1997, a number of preventive and curative care services for young people both in and out of school have been implemented by these organizations in collaboration with local hospitals, health promotion centers and other concerned agencies.

2.4.2 Seeking for Services - Abortion and Post- Abortion Care

In Thailand seeking induced abortion is typically a difficult process because it's attached to the culture, religious, and law. This process is more difficult for women who have low status. There are many factors that contribute to this increased difficulty. Women's generally low socioeconomic status and poor educational background, as

well as social constraints on women's sexual activities, can impede their attempts to cope with unplanned pregnancy and to prevent recurrences. Limitations included: limited (or no) time or money to locate safe abortion care services from private or commercial providers; requirements among young women who are less than 18 years for parental consent for medical treatment in the case of complications from unsafe abortion; cultural restraints on asking providers questions about the issues of sexuality and contraceptive methods.

2.4.3 Utilization of the Existing Reproductive Health Services

Ideally, healthcare facilities can play an important role for adolescents in preventing health problems, in promoting sexual and reproductive health and in shaping positive behavior. But in the Thailand situation, it was found that young people, especially unmarried women who are seeking for sexual and reproductive health services, tend to go to the private sector, especially drugstores rather than other sources (PATH, 2001d). Young people perceived that consulting and buying drugs from drugstore was low cost and convenient, but they often found that drugstore personnel did not give the correct medication (Boonmongkon, et al., 2000)

PATH (2000a) conducted a situation analysis of Emergency Contraceptive Pills (ECPs) in Bangkok in Thailand. According on FGDs, the respondents and drugstore personnel revealed that majority of purchasers are men buying ECPs for women, and it is generally men who select the method for their girlfriends. Women, especially adolescents, said that they feel ashamed to purchase ECPs themselves. Women often lack information about the pill, and during the discussions, women raised many questions about short-term and long-term effects. These findings are consistent with Boonmongkon, et al. (2000) that female partners usually bought post coital contraceptive pills or ECP that is very popular among Thai adolescents. ECP can be purchased with out doctor prescription, and is available at drugstores through out the country.

Boongmongkon, et al. (2000) pointed out in the study of government hospital, that adolescents viewed them as filled with competent health staff and good medical

equipment as well as providing low cost health services. However, adolescent cited several negative aspects of government hospitals including lack of privacy, inconvenience, long waiting time and staff paying little or no attention to the patients. Furthermore, the study also found that the perceived important benefits of private clinics and hospitals were privacy and good quality of care in terms of allowing time for the patients to ask questions regarding their health problems and for the health staff to pay attention to their patients. The perceived disadvantage of both the private clinics and hospitals was the issue of high cost.

In the last decade, the existing government health services were established with the assumption that the adolescent group did not require reproductive and sexual health services. Thus, at present, it appears that adolescents are unable to utilize available health services and the research rarely found health care services that were accessible to adolescents. The reasons behind this are that the use of health care services is complicated and stigmatizes adolescents who do come to use the service for their sexual health problems (Limsumphan, 1997; Pracharat, 1990 as cited in Boonmongkon, et al., 2000).

Factors that cause young people, especially unmarried women to not seek sexual and reproductive health services in government facilities or even private sectors include; (a) stigma, because they do not want to be seen by others; (b) perception that existing sexual and reproductive health services is for mothers and children, thus unmarried group feel that they are excluded from the services.

Young people tend to go to drugstore because it provides anonymity; low cost or bargain prices; and easy access. Thus, drugstore personnel come in more frequent contact with sexually active young people than other health care providers in public sectors.

2.4.4 Situation of Sexual and Reproductive Health Services in Thailand

Since 2000, Family Planning and Population Division (FPPD), Ministry of Public Health (MOPH) has launched a national youth services concept or "Friend

Corner" aimed at developing the best practice model for serving young people on sexual and reproductive health problems. The project starts in a few provinces in order to gain experiences and will then expand nationwide. Within this concept, the project coordinator of each province will explore innovative ways to reach young people by collaborating with the entertainment industry, shopping malls, adolescent centers and etc. to establish a " Friend Corner". With the new concept of "Friend Corner", providers include both peer educators and professional health care providers. Services include information dissemination, counseling, basic health services, and refer to specialists. Evaluation of the outcomes of the new concept is scheduled to carry out in 2002.

Thailand has numerous Non-Governmental Organizations (NGOs) concerns with health or health services. Family planning and adolescent health services are provided by many agencies. These include the Planned Parenthood Association of Thailand (PPAT), the Population Development Association (PDA), and the Association for Voluntary Sterilization in Private Clinics. These groups carry out general education, provide direct services and train auxiliary health workers. Through these services, they can provide comprehensive solutions for young people. Also, there are the Christian and Catholic missionary communities who provide direct services to pregnant women and children. These include temporary accommodation during pregnant and post partum period. These agencies include "Pakeeneesrichumpaban Committee", and"Ban Prakoon". Also, Emergency House found by Khun Ying Mae Chee Kanichtha Vichiencharoen, which is a Thai NGO, provides shelter for women who face family life crisis and have nowhere to go. Apart from these groups, there are many NGO concerned with providing adolescents with health information, education and counseling, both face to face, and hotline services.

From reviewing many adolescent health projects and initiatives to serve this group from both governmental and non-governmental organizations, it seems that Thailand does not have any one stop comprehensive services for young people who face unplanned pregnancies, or are in need of post abortion care. Most of the services are for prevention, education and information dissemination prevention of HIV/AIDS

and other sexually transmitted diseases, but not for prevention of unplanned pregnancies or management of its consequences.

2.4.5 Characteristic of Youth Friendly Services

Currently, there are some studies and pilot projects, which have been implemented through both government and non-governmental organizations in order to identify an appropriate channel to reach young people. Based on the review of projects both in Thailand and other countries, key factors include the type of services, characteristics of health facilities, personnel, administrative processes, privacy and confidentiality, and adequate time for consultation. There are some differences in the details of these factors that depend on who are the target group, because youth in different settings will have their own style.

Type of Services

The services that young people prefer to have in the center include counseling for reproductive health which start from menstruation, family planning, sexual health problems and sexuality as well as school and family problem (PATH, 2001b; Boonmongkon et al., 2000). Young people also desired to have services that covered unplanned pregnancy and abortion, treatment and care for sexually transmitted diseases and gynaecological health problems, counseling and treatment services for problem of drug addition, pregnancy test; and counseling for body fitness (Boonmongkon et al., 2000). Further more, the pilot project implemented by PATH (2001b) found that young people like to have a resource corner where they can study about reproductive health, sexuality, and other adolescent issues. It can be printed materials including magazines, books, booklets, and computer program that they are not available in university libraries.

Characteristics of Services

Convenient hours. The services should open after working/school hours and it is also recommended that hotline telephone call services should be available 24 hours (PATH, 2001b; Boonmongkon et al., 2000). An adolescent health center pilot project implemented by PATH and a Student Affaire Division at a university in the southern

part of Thailand showed that most of the telephone calls came after working/school hours, which starting from 05.00 pm to 10.00 pm. The services should be open every day, including Saturday and Sunday.

Convenient location. The location is dependant on who is the target population and where they are located. According to Boonmongkon, P. et al. (2000) study indicated that they would like the center to be at the community center. From the adolescent side, they would like the center separate from the government health facilities but it should be located in a place they can reach easily. The PATH (2001b) studies found that youth in university would like the center close to their residence and should not operate in an official building.

Appearance. PATH (2001b) found that university students would like a comfortable setting where they can have a corner for coffee, tea, and snack and where they can hang around when they have no where to go. They suggested the center should have a separate corner that would provide coffee, and tea, which could be paid from a voluntary basis.

Personnel

Personnel. From the two studies (PATH, 2001b; Boonmongkon et al., 2000), it was found the preference for the staff offering services at the adolescent center should be both male and female so that users can choose, based on their preference. The staff should have good interpersonal skills, warm personality, kind and friendly manners, treat clients problems and communication with confidentiality, have no judgmental attitude, and not be too old. Furthermore, the project implemented by PATH (2001b) would involve peers and provide a series of training workshops on sexual and reproductive health, as well as non-judgmental, and interpersonal communication skills. Thus, the consultative meetings would be more on peer to peer, and if they need a specialist assistance they would be referred to one. From the outcome of the evaluation, it was found that clients were satisfied with peer-to-peer services but there were some concerns over how to assure that their problems were kept confidential. Another concern was the competency of their peers on these issues.

Administrative Procedure and Cost of Services

Anonymous record. Confidentiality is the main concern for youth who seek sexual and reproductive health services. The anonymous record system has been used in many organizations that providing sexual and reproductive health services including HIV/AIDS. This system will help clients feel free to communicate about their problems.

Privacy and confidentiality. Privacy and confidentiality are the main concerns in providing sexual and reproductive health services for young people. A privacy setting will help young people feel relaxed and confident in communicating their problems without fear of disclosure.

Cost of service. There are no official special services offered to youth on sexual and reproductive health care established in Thailand. Most of the services that youth receive are charged at the same rate as adults depending on where they go. Some special services for youth run by family planning NGOs have set a special rate for youth as well, or are open to negotiating rates. The cost of service is one of the barriers for youth to utilize the services. If the costs are too high, young people cannot afford the services. However, if the services are free, they might assume that they will be of poor quality (McCauley & Salter, 1995; Koontz and Conly, 1994 as cited in Nelson, 2000).

Adequate time. Young people tend to need more time than adults to open up and reveal very personal concerns (Senderowitz, 1997 as cited in Nelson, 2000). Providers need to practice counseling skills or interpersonal communication skills, so that they can encourage facilitate clients to communicate more openly, asking and probing with appropriate questions and manners.

From reviewing of literatures in Thailand found that there are some researchers who have been documented about how women feel when they seek services for terminating pregnancies. Moreover, there are many quantitative and qualitative studies on abortion including characteristic of women who decided to terminate pregnancies,

prevalence of abortion, methods used for both safe and unsafe abortion. There are no any studies on decision-making to utilize health services among young women with unplanned pregnancies. There are not any quantitative studies on factors that influence these young women with unplanned pregnancies to opt for abortion, for birth and adoption, or for birth and keep the baby. The researchers on abortion failed to take into account the role of unplanned pregnancy, which is an important determinant of abortion.

2.5 Theoretical Review

In the previous sections, literature on young people's sexual and reproductive health with emphasis on unplanned pregnancy, unsafe abortion and its consequences are reviewed. Thus, It is important to examine the theoretical related health seeking behavior and other theories on women react to the problem of unplanned pregnancy, and how do they interact and think about themselves. To understand the situation, social theories including symbolic interaction theory, and gender issues are reviewed in this section.

Most of the theoretical models on health seeking behaviors and health care utilization, symbolic interaction, and gender theories have been developed from the disciplines of sociology and medical anthropology. Although these theories have primarily been generalized for health problem and population, it is possible that they can be used to explain how and why women choose or utilize health services. Hence, this section finds the linkages of the mentioned theories in order to synthesize and finally develop a pathway on health seeking behavior of women with unplanned pregnancy based on these findings.

2.5.1 Health Seeking Behaviors, and Other Related Social Theories

Sociologically-based Health Care Seeking Theories

Nelson K. (2000) pointed out that in the 1970s, a number of medical sociologists created various theoretical models to explain factors, which influence people to utilize formal health care services when they become ill. Generally, these

models fell into two major categories: (1) Decision Point (of stage) Models and (2) Sets of Variables Models. The Decision Point of Stage Model was designed to look at health problems, or illness episodes, in terms of their natural history. The stages of this natural history were generally in the form of symptom history. The stages of this natural history were generally in the form of symptom recognition, health consultation, seeking treatment and adherence. Meanwhile, the Set of Variable Models organized health behaviors and beliefs into specific categories which all work simultaneously to influence the health seeking process.

Chrisman (1977) introduced the "*Health Seeking Process Model*" by defining 5 stages of decision making that individuals go through when they are become ill. According to this model, *the first stage*, know as symptom definition, is when an individual perceives some deviation from what she/he recognizes as normal health. When deviations have been noticed, evaluated, and possibly explained, the ill person may assess the degree of threat posted by the health problem. The perceived threat has an impact on what the individual chooses to do about the illness. *The second stage,* role behavior shift, begins when the individual assumes a "sick role." A person's everyday identities and behaviors influence the appropriate behavior for this type of role. *The third stage,* lay consultation and referral, acknowledges that individuals go to many other people for advice before ultimately consulting a health care provider. Chrisman explains that this stage can be greatly influenced by an individual's health beliefs and practices as well as his/her social networks. *At the forth stage*, treatment action, Chrisman identifies four general treatment categories and five sources of treatment advice. The four treatment categories include: 1) activity alterations such as exercise, bed rest, or sweat baths; 2) the application or ingestion (or injection) of substances: 3) verbal or ritual behaviors, such as psychiatric therapy or prayer; and 4) physical interventions on the body, such as surgery or cupping. Sources of treatment advice are generally similar to the above, which include: 1) formal health professional, such as doctors and nurses; 2) licensed health practitioners, such as pharmacists, midwives, or chiropractors; 3) alternative or native health practitioners, such as herbalists, astrologers, or spirit mediums; 4) lay consultants; and 5) self. The final conceptual

stage in the health seeking process is adherence, which is the degree to which the sick person acts upon treatment advice.

For the second category of the health care utilization model, the Sets of Variables Models, two popular models are discussed. Firstly, Anderson (1968), proposes the "*Health Behavior Model*" which has three types of variables that go into the decision making process for utilizing services. The first set is the predisposition to use the services. By this set of variables, Anderson suggests that some individuals have a greater propensity to utilize services than others. *The first set of variables are predisposing characteristics* include the variables that describe the *"propensity"* of individuals to use health services. These propensities exist prior to the onset of illness episodes and are classifiable into three groups; 1) demographic variables such as age and sex; 2) social structural variables, such as education, occupation, and ethnicity; and 3) health beliefs, such as the belief that medical care can be helpful in treating illness. *The second set of variables are the enabling conditions*, which depend on family and community resources (transportation, availability of hospitals, beds and etc.) *The third set is the need characteristics,* which are based on an individual's perceived need (the individual assessment) and the evaluated need (the clinical diagnosis). According to this model, an individual is influenced by three main sets of variables in determining whether or not he/she will seek services.

Later, Aday & Andersen (1975) have expanded the theory "*Health Behavior Model*" of the individual determinants set into a more complete health systems model called the "*Framework for the Study of Access to Medical Care.*" It states that the success of access to health care does not depend either upon structural characteristics or individual characteristics alone. Rather, it rests upon the interactions between the health delivery system and the target population. In this model, Anday and Andersen first conceptualized health services utilization into *"realized access"*, an object indicator. They then tried to integrate individual characteristics with the access characteristics of the health delivery system. (such as the availability and distribution of health care providers and facilities, for example) called the *"potential access."* Furthermore,

consumer satisfaction, a subjective indicator is considered as the outcome of utilization, a component of *"realized access"*.

Lastly, Rosenstock (1974) designed the "*Health Belief Model*" which explained preventive care and the individual's readiness to adopt preventive behavior. According to this model, there are four key variables that influence the individual to take action: 1) the individual must perceive to be susceptible to the disease; 2) the individual must perceive the disease to be serious; 3) the individual must perceive benefits of health improving behavior; 4) the individual must perceive barriers to health improving behavior. The preventive behavior must be triggered by some external factors, such as advice from friends or from media campaigns. In summary, if the individual perceives susceptibility, seriousness, more benefits in taking action than barriers, and there is some appropriate cue to action, then preventive action will likely to be taken.

Although some of these models, like the Health Belief Model, have been applied in a number of research studies, medical anthropologists have criticized their applicability in the real world. For example, one of their main criticisms is that the model concentrate too much on formal health services, rather than trying to explore the other types of services people utilize (such as self treatment and traditional healers). Secondly, the model does not consider the kind of disease or illness and how differences in these can provoke different responses. For example, an individual with a reproductive health problem may take different actions than if she/he thought she/he had malaria. Furthermore, the models are generally not constructed to investigate situations involving people who do not use health services, nor do they pay adequate attention to those who have had prior experience with a particular health problem or the consequences of engaging in preventive actions.

Anthropologically-based Health Care Seeking Theories

Using a slightly different conceptual framework, anthropologists have also developed and tested theoretical principles and models on the health care seeking process. The main difference between these models and the sociological models is that sociological models examine why people use health services, while the

anthropologically based models examine why people choose which health services. However, this is not to say that the two fields are mutually exclusive from each other.

Kleinman (1975) wanted to know how health beliefs affect the decisions regarding the health seeking process. By gathering information from a number of families in Taiwan on sickness episodes, Kleinman was able to reveal even more features about the health seeking and the treatment process. Of interest was the fact that the vast majority of illnesses reported were treated within the family without consulting any practitioner. The most important factor involved in determining the health seeking strategy was the perceived severity of illness. Practitioners, either by Western physicians or traditional healers, treated all severe illness. Popular health beliefs about the acute or chronic nature of the illness, and about the efficacy of different therapeutic options were also important. In case of acute illness, for example, treatment was often sough from Western medicine, considered highly efficacious but not able to eliminate the underlying causes of chronic conditions. Indigenous practitioners were consulted for chronic illness. Treatment was sought readily from various kinds of practitioners depending on the satisfaction with treatments applied; if it was found that indigenous remedies were not helpful, Western services might be tried as well.

In 1980, after reviewing most of the health seeking behavior models, as well as his own studies on health care seeking. Kleinman began to see a natural conceptual framework emerge that incorporated most of the theoretical concepts used in the previous models. He called his framework the "*Health Care System.*" According to Kleinman, the health care system is the type of cultural system, which integrates all the health related components of a society. These components can include the patterns of belief about what causes health problems; the norms that govern choice and the evaluation of treatment and care; power relationship; interaction setting; and institutions. Providers and clients are basic components of this system and, therefore, cannot be understood apart from this context. In the same way, health seeking behaviors, health problems, and treatment are also part of the system of health care.

To understand the health care system as a type of conceptual model, one needs to first know what the actors in a particular social setting think about health care. This includes understanding their beliefs about health problems, their decisions about how to respond to specific episodes of health problems, their decisions about preventing such types of health problems, and their expectations and evaluations of particular kinds of care.

The other part of understanding this system as a model comes from studying the way people act in it and use its components. Therefore, according to Kleinman, *"The Health Care System"* is both the results of and the condition for the way people react to health problems in local, social, and cultural settings, for how they perceive, label, explain, prevent, and treat health problems. To put it in basic terms, the health care system includes people's beliefs and patterns of behavior. These beliefs and behavior are influenced by particular social institutions (eg., clinics, hospitals, health bureaucracies), interpersonal relationships (eg., provider-client relationship, client-family relationships, social network relationships), interaction settings (eg., home, school, clinic), economic and political constraints, and any other factors, including available treatment and type of health problem.

Kleinman (1980) states that all health care systems are forms of social reality. Social reality, as defined by him, is "the world of human interactions existing outside the individual and between individuals." During the process of socialization, an individual internalizes social reality as a system of symbolic meaning and norms that control her/his behavior, her/his perception of the world, her/his communication with others, and her/his understanding of both the external environment and her/his internal space. Socialization takes place in the family, but also in other social groupings through education, occupation, religious ceremonies, practices, customs, play, and other basic processes that help individuals determine normative behavior. Quite obviously, social realities differ between societies, as well as between social groups, professionals, and even families and individuals. It may also vary according to difference in socioeconomic class, education, occupation, religious affiliation, ethnicity, and so on.

All of these affects the way individuals thinks about and react to health problems and choose among the health care practices available to them.

Within this framework, Kleinman asserts that clinical practice (traditional and modern) occurs in and creates particular social worlds. Aspects about these socials worlds include the beliefs about health problems, and the behaviors expressed by those who think they are sick, including their treatment expectations, and the ways in which family and providers respond to sick persons. They, like the health care system itself, are cultural constructions, which are shaped according to the particular society. These health related aspects of social reality-especially the attitudes and norms concerning health problems, clinical relationships, and treatment activities-is what is referred to by Kleinman as "clinical reality." Social factors, such as class, education, religious affiliation, ethnicity, occupation, and social networks all influence the perception and use of health care resources in the same sense that they do for social realities, and thereby influence the construction of distinctive clinical realities within the same health care system (Kleinman et al., 1980 as cited in Nelson, 2000).

To understand the structural components of a local health care system, Kleinman divides his model into three overlapping parts: the popular, the professional, and the folk sectors (see Figure 2.2)

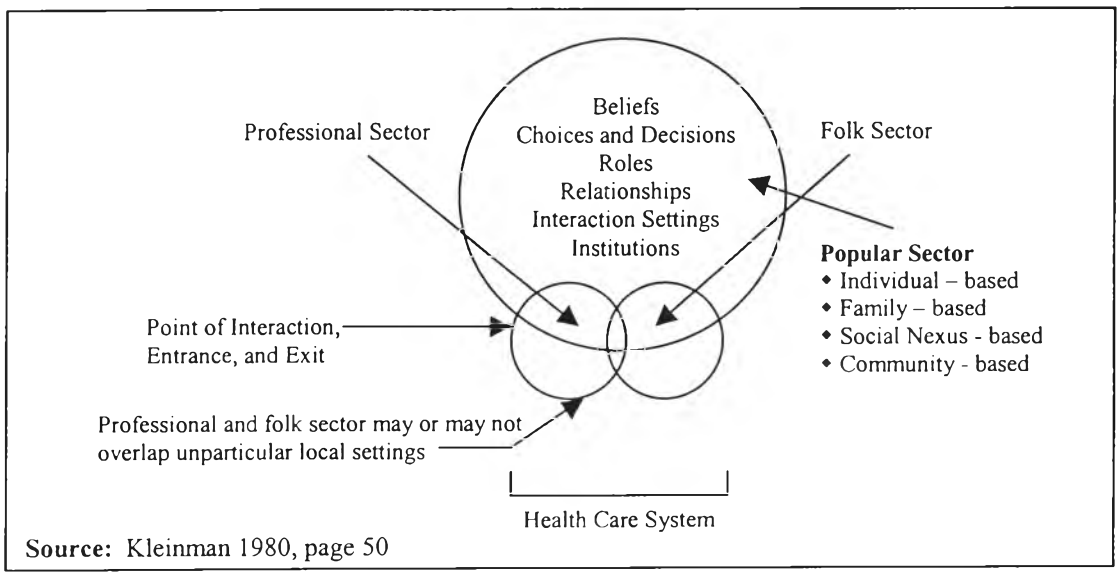


Figure 2.2: Local Health Care System: Internal Structure

The popular sector. Although the popular sector is the largest part of health care system, it is the least studied and most poorly understood. It is made up of several levels, including the individual, family, social network, and community beliefs and activities. The best way to understand this sector is to think of it as being the lay, non-professional, non-specialist popular arena in which health problems are first defined and health care activities initiated. Typically, this is where lay people activate their health care by deciding when and whom to consult, whether or not to comply, when to switch between treatment alternatives, whether care is effective, and whether they are satisfied with its quality. In this sense, the popular sector functions as the chief source and most immediate determinant of care. According to Kleinman, the sick person and her/his family utilize the beliefs and values about illness that are part of the cognitive structure of the popular culture. For example, the family can disregard signs of health problems by considering them to be ordinary or "natural." They can administer local treatments, or they can consult with friend, neighbors, relatives, and lay experts about what to do. Once people decide to enter either the professional of folk sector, they encounter different sets of beliefs and values in the cognitive structures of professional or folk practitioners. The clinical realities of the different sectors and their components differ considerably, and each work to give meaning and response to the particular health problem.

Professional sector. The second sector of local health care systems, and noticeably much smaller, is the professional sector, which consists mainly of organized medical professionals. In most societies, this is simply modern medicine. In fact, the modern medicine professional has become so dominant that studies of health care often equate modern medicine with the entire system of health care. Research by physicians and public health professionals, in most instances, are limited to issues and problems defined by modern medicine, with the explanations and solutions being derived from the same viewpoint. According to this ideology, any health – related activities undertaken by individuals themselves or by members of other sectors of the system are dangerous and should not be tolerated. The biological aspects of medical problems are the "real" ones, while the psychosocial and cultural aspects are second order and are, thus, less "real" and important. However, Kleinman states that such researchers are

unaware of this bias, since they are trained to see all of health care through cognitive framework of their profession.

The folk sector. The folk sector (non-professional, non-bureaucratic) sector makes up the last component of health care system, and actually consists of a combination of many different components; some are closely related to the professional sector, but most are related to the popular sector. Folk medicine is frequently classified into sacred and secular parts, but this division is often blurred in practice, and the two usually overlap. Shamanism and ritual curing have continued to hold the attention of anthropologists up to the present. Far less attention has been given to the most basic and mundane secular forms of healing, such as herbalism, traditional surgical and manipulative treatments, special systems of exercise, and symbolic non-sacred healing (Kleinman et al., 1980 as cited in Nelson, 2000).

It can be concluded from the theoretical literature review of the sociologically-based and anthropologically-based health seeking behavior is that there are multiple levels of influence that impact an individual's decision to utilize health care services. There are many theoretical models on health seeking behavior that attempts to explain utilization of health services. Furthermore, there are many determinants that affect unsafe sex which in turn affect unplanned pregnancy. Thus, there has been no definitive conclusion about which factors or variables can predict health care seeking decision-making process and patterns of young women with unplanned pregnancies. This is because health behavior involved a number of social and behavioral factors including attitude, perception, beliefs and interpersonal relationships with peers, partners, and family member, as well as the influences of cultural, norms, law, and health delivery system and policies.

However, as reviewed the above health seeking behavior theories has mentioned general kind of diseases or illness and did not illustrate how difference of the illness which can provoke different responses. For this study, which attaches to cultural, and moral issues will have different actions. Thus, the study is derived from a combination of factors recognized to be important determinants to explain the decision-making

process of women with unplanned pregnancy to utilize the health services. In addition, it is important to review further theories, which are mainly sociologically based that affected on women decision to seek the services. The sociologically based issues that influence women decision to seek services include:

2.5.2 Symbolic Interaction Theory

This theory deals primarily with the interaction between individual at the symbolic level (Charon, 1992; Rosenbergand Turner, 1990; Stryker, 1990). Symbols are the words, gestures, and objects that communicate meaning between people. In any given society, people share a common understanding of these symbols. Words are the most important symbols from a symbolic integrationist viewpoint.

Spoken and written words, as well as facial and bodily gesture, are important for symbolic interactionists. Human beings have an exceptional, and perhaps unique, ability to use words, and people make connections with other peoples through these words, or symbols.

The process of learning symbols about themselves and developing a Self-Concept is an individual's thoughts or feeling about herself or himself (Gecas & Burke, 1995; Rosenber, 1979). Symbolic interactions are, therefore, a theory that has something to say about how individuals think about themselves and thus how they act as individual human beings.

In summary, symbolic interactions pay special attention to the symbols individuals use to interpret and define themselves, the actions of other people, and all other things and events. By understanding the meanings that people give to these things through the use of words and symbols, it is possible to understand much of human behavior (Kammeyer KC, Ritzer G & Yetman N., 1997). This theory will help us understand how young women interact with themselves when facing the problem of unplanned pregnancy.

2.5.3 Sexual Behavior from a Sociological Perspective

Sexual behavior undoubtedly has a biological basis in human beings, just as it has in every other animal species, but biology alone does not explain sexual behavior. This is obvious if we consider the cultural differences in sexual behavior among people in different societies (Kammeyer et al., 1997).

Through the culture of a society, people learn what is acceptable sexual behavior and what is not (Irvine, 1994). They learn when sex is appropriate or inappropriate and with whom it is acceptable or not acceptable. The vary meaning of sex changes from one society to another. In some societies, sex is a pleasurable, nearly recreational, activity, while in others it is "dirty," and shameful, and rarely spoken of at all. There are some societies in which sex is a hostile battleground between the sexes, and other societies where sex is only for the purpose of reproduction. To get a sense of how much sexual behavior is influenced by societal and cultural differences, we will first consider some cross-cultural and historical examples of sexual behavior. As we examine these variations in sexual behavior from our own culture, in our own time (Kammeyer et al., 1997).

The Sexual Norms of Societies

All societies have rules and norms about sexual behavior. These norms sometimes require people to act in certain ways (have sexual intercourse if they marry, for instance); but more often, norms relating to sex prohibit certain behavior (Kammeyer et al., 1997).

The Double Standard

Kammeyer et al. (1997) stated that the Double Standard is one of the most pervasive sexual norms, found in many societies. It is defined as a set of norms that give males more sexual freedom than females. The traditional double standard includes the following specifics:

- Men may have sexual intercourse before marriage; women should not.
- Men may have sexual intercourse with women even when there is no emotional feeling or commitment; women may have sexual intercourse when they are in love, or when there is a mutual commitment.

- Men may have multiple sexual partners; women should not have multiple partners.
- Men may have sexual intercourse with women who are much lower in social status, or are "immoral" women; if a women were to have sexual intercourse with a man of lower status, it would be viewed even more negatively than with a man of her own status.
- Men may have sexual intercourse for recreation or to gain sexual experience and expertise; women are not allowed to have these motives or objectives.

Sexual norms, such as the double standard, are learned through the process of socialization. In the following, we will examine how sexual socialization occurs and how it shapes sexual attitudes and behaviors, especially of young people. The double standard is a complex of norms that gives males' greater freedom in their sexual behavior than females (Kammeyer et al., 1997).

Deviant Sexual Behavior

Sexuality is a basic human characteristic, sexual behavior is universal, and sex is a biological act; but many societal and cultural differences exist in sexual behavior and sexuality. All these variations and differences, including historical changes from one period to another, indicate that sexual behavior is influenced as much by social factors as it is by biological factors (Kammeyer et al., 1997).

Sexuality is normatively controlled in every society. The most nearly universal norms are the prohibition of sex between closely related individuals-the norm prohibiting incest. However, the norm varies from one society to another, and there are historical exceptions to even the most widely held prohibitions-parent-child and sibling sexual relations (Kammeyer et al., 1997).

To understand which sexual behavior are deviant and which are not deviant in any particular society, we need some measures or indicators. Several ways have been

suggested for evaluating whether a sexual behavior is deviant in a society (Bryant, 1982).

One measure of deviance is whether a particular sexual act is against the legal statutes of a nation or state. Acts that are illegal are presumably deviant to some degree. The problem with using the law as a measure of deviance is that laws often remain on the books for many years, even when they are no longer enforced (Kammeyer et al., 1997).

In summary, Sexual deviance, like other forms of deviance, is socially defined. The laws of a society can define sexual deviance, but its may fall into disuse. The frequency of a sexual behavior also indicates whether it is deviance; previously deviant acts often become more commonplace and thus less deviant. Deviance is also indicated by the degree to which a sexual behavior victimizes another person. In the final analysis, deviant sexual behavior, as well as acceptable sexual behavior, is determined by norms, values, and roles of a society (Kammeyer et al., 1997).

2.6 Chapter Summary

Unplanned pregnancy is a critical problem among young women. There are many internal and external factors range from their general characteristics, social, economic, cultural, political situation, relationship with others, and attitude and believes which affect on women living condition, their partner and family. All these factors affect on women decision to continue or terminated their pregnancy. When facing with the problem, young women tend to hide their pregnancy or seek late term abortion, which take them at risk of complication and/or death from the procedure preformed by unskilled providers and/or unsafe conditions. To understand the problem in a holistic manner, additional data from existing service facilities are also assessed which include reproductive health services availability for young people, and clients – providers' experienced of unplanned pregnancy at each level of facilities. Thus, this study provides a more comprehensive understanding of the health seeking behavior of women when they seek for solutions.

From review of literature in Thailand on unplanned pregnancy, it is found that there are a few studies on this regard among young people. The latest study was conducted by the Population Council (2002) on pregnancy history among women at reproductive age was emphasis more on women in a community. Moreover, there are not any studies on help or health seeking patterns of the young women with unplanned pregnancy available in Thailand.

The aim of this study is to formulate a theoretical model of help or health seeking patterns of the young women with unplanned pregnancy. Moreover, the analytical studies of predicting factors on choices of the women with unplanned pregnancy allows predicting the women's decisions and their utilization of services.

The findings are put together suggestions for policy and decision makers designing interventions and services to help young women make the transition from adolescent to adulthood without or less physical and psychosocial trauma from unintended pregnancy. Moreover, the help or health seeking patterns model help providers understand why and how women utilizing the services, which in turn can provide more appropriate services that serve the needs for young women.