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BECOMING A THAI TEENAGE PARENT

Atcharawadee Sriyasak

2016



School of Health, Care and Social Welfare

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Atcharawadee Sriyasak

Akademisk avhandling

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School of Health, Care and Social Welfare

Abstract

The aim of this dissertation is to contribute to the understanding of Thai teenage parents' experiences of becoming a parent as well as to examine healthcare providers' reflections on their experiences of caring for teenage parents.

The findings are based on three studies using mixed methods and resulting in four papers. The empirical data were collected in western Thailand between 2013 and 2015, in a province with a high incidence of teenage pregnancy. Paper I: Empirical data were based on three self-reported validated questionnaires. The sample consisted of 70 teenage and 70 adult fathers. Descriptive statistics, Mann-Whitney U-test, and Chi-square test were used for the analysis. Papers II and III: A heterogeneous group of 25 teenage couples (n=50) were interviewed before and after the birth of their first child, using grounded theory methodology. Paper IV: Four focus-group discussions were conducted with 21 healthcare providers; latent content analysis was used for analysis.

Teenage fathers scored lower than adult fathers on scales measuring the father's sense of competence, the father's childrearing behavior, and the father-child relationship (paper I). The teenage mothers reported how they struggled with physical and social changes, for example bodily changes, breastfeeding and having to leave school, while the teenage fathers gave examples of coping with their future responsibility by working hard to save money for future family needs (paper III). The teenagers' own parents were an important source of support all the way from pregnancy to childrearing, and their provision of childcare, advice, and instructions helped the teenage parents to cope with their duties. Most of the teenage parents reproduced traditional gender roles by being a caring mother or a breadwinning father (papers II-III). The healthcare providers were concerned about the young parents, viewed themselves as providing comprehensive care, and suggested access to reproductive health care and improved sex education as ways to improve quality (paper IV).

The young couples' stories describe how they struggled and coped with life changes when becoming unintentionally pregnant, accepting their parenthood, and finally becoming parents. A supportive family played a vital role in the transition to parenthood.

Health promotion efforts for this particular group should be undertaken continuously to improve the quality of care for teenage parents and to promote the infants' well-being and future development.

Keywords: childrearing, fatherhood, focus-group discussions, grounded theory, healthcare providers, teenage fathers, teenage parents, Thai teenagers

*Success is no accident. It is hard work perseverance,
learning, studying, sacrifice and most of all love of what you are doing.*

Pele

*To my family for the unconditional love and support,
without you nothing seems possible.*

ABSTRACT

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LIST OF PAPERS

This dissertation is based on the following four papers, which are referred to in the text by their Roman numerals:

- I Sriyasak, A., Almqvist, A-L., Sridawruang, C., & Häggström-Nordin, E. (2015). Father role: A comparison between teenage and adult first-time fathers in Thailand. *Nursing & Health Science*, 17(3), 377–386. doi: 10.1111/nhs.12200
- II Sriyasak, A., Almqvist, A-L., Sridawruang, C., Neamsakul, W., & Häggström-Nordin, E. (2016). The new generation of Thai fathers – breadwinners involved in parenting. *American Journal of Men's Health* (Epub ahead of print). First published online May 23, 2016 as doi: 10.1177/1557988316651062
- III Sriyasak, A., Almqvist, A-L., Sridawruang, C., Neamsakul, W., & Häggström-Nordin, E. (2016). Struggling with motherhood and coping with fatherhood – A Grounded Theory study among Thai teenagers. *Midwifery*, 42, 1-9. doi: 10.1016/j.midw.2016.09.005
- IV Sriyasak, A., Almqvist, A-L., Sridawruang, C., & Häggström-Nordin, E. Healthcare providers' experiences of caring for teenage parents in Thailand. *Submitted to BMC Pregnancy and Childbirth*

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndromes
ANC	Antenatal care
CSE	Comprehensive Sexuality Education
CSMBS	Civil Servant Medical Benefits Scheme
DOH	Department of Health
FIGO	International Federation of Gynecology and Obstetrics
FCB	Father's Childrearing Behavior
FGD	Focus group discussions
FSC	Father's Sense of Competence
GA	Gestational Age
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoPH	Ministry of Public Health
NICU	Neonatal Intensive Care Unit
NRCT	National Research Council of Thailand
NSO	National Statistical Office
PCUs	Primary Care Units

PHCs	Primary Health Care Centers
RFC	Relationship between Father and Child
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SSS	Social Security Scheme
UC	Universal Health Coverage
UNFPA	United Nations Population Fund
WHO	World Health Organization
Wks	Weeks

PREFACE

I graduated as a nurse from McCormick faculty of nursing, Payap University in 1990, and worked at the Maternal and Child Hospital in Phon district, Khonkaen province, Thailand. In 1996, I received a Master's degree from the Faculty of Public Health (Family Health) at Mahidol University in Bangkok, Thailand. My thesis had a quantitative design and the topic was "Factors associated with adolescent mothers' adaptation to roles during the postpartum period". Financial support for the thesis was provided by the office of the National Research Council of Thailand (NRCT). Since 2006, I have taught Nursing Science at Prachomklao College of Nursing, Petchaburi province, Thailand. In 2007, I got a certificate for a short training course for neonatal nurse practitioners (4 months), at Ramathibodi Hospital, Mahidol University. My specialty is newborn and adolescents. I have also worked with the Women's Health and Reproductive Rights Foundation of Thailand as a volunteer on the abortion issue since 1999. In 2012, I received a Master's degree in Caring Science (specializing in Nursing) from Mälardalen University, Sweden. My qualitative master thesis "Childrearing among Thai first-time teenage mothers", was published in the Journal of Perinatal Education in 2013. In 2012, I applied to become a doctoral student with the project "Becoming a Thai teenage parent" at Mälardalen University, Sweden.

INTRODUCTION

This dissertation has been written within the area of Caring Science and the research field Health and Welfare. This topic is in line with both international and Thai national goals for Sexual and Reproductive Health and Rights (SRHR), including reducing teenage pregnancy. The researcher uses a combination of quantitative and qualitative methods to gain a broader and deeper understanding of the needs of teenage parents in the Thai context. Nurses and midwives are the main healthcare professionals who interact with the pregnant woman, both before and after birth, and with their newborns and families. Historically, fathers have been invisible during the prenatal, intrapartum, and postnatal periods, as well as during child care, but today fathers are beginning to be more involved. This dissertation focuses on both teenage mothers and fathers, and their experiences of pregnancy and parenting.

BACKGROUND

Teenage period

The teenage period, or adolescence, is the transitional period from childhood to adulthood (Steinberg, 2011). The World Health Organization (WHO) defines adolescence as lasting from 10 to 19 years of age (WHO, 2002). A teenager or teen is a young person within the age range 13–19 (“Teenager”, 2015). The terms “adolescents”, “teenagers”, “teens”, “youth”, and “young people” are all used interchangeably, especially when translated into Thai. In this study, the term “teenager” is used for girls/boys in the age range 13–19. Steinberg (2011) divided the teenage years or adolescence into three periods: early adolescence (age 10–13), middle adolescence (age 14–17), and late adolescence or youth (age 18–21). According to Steinberg (2011), the major developmental tasks of this period are developing an identity, gaining autonomy and independence, developing intimacy in a relationship, developing comfort with one’s own sexuality, and developing a sense of achievement. Steinberg (2011) referring to Piaget (1954), states that formal operational thought is usually acquired in the middle teenage period.

Teenage pregnancy rates globally and in Thailand

Teenage pregnancy and early parenthood remain a concern in many countries. In 2011 WHO published guidelines with the UN Population Fund (UNFPA)

on preventing teenage pregnancies and reducing poor reproductive outcomes (WHO, 2016a). The World Health Statistics for 2014 indicate that the average global birth rate among 15 to 19 year-old girls is 49 per 1000 (WHO, 2016a). Different country rates range from 1 to 204 births per 1000 woman aged 15–19 (World Bank, 2016). The highest rates are found in low-income countries in sub-Saharan Africa, such as the Republic of Niger, with a rate of 204 births per 1000 women in the 15–19 year age group (World Bank, 2016). Among high-income countries, the US has the highest rate, with 24 per 1000 woman aged 15–19 (World Bank, 2016). Many Asian countries have high adolescent birth rates, but Laos has the highest, with 65 births per 1000 teenage women (World Bank, 2016). Thailand is facing an increasing birth rate among teenagers, growing from 40.7 in 1992 to 44.3 in 2015 (Figure 1), according to Thai Public Health reports (Bureau of Reproductive, 2015).

Factors contributing to the high teenage pregnancy rate in Thailand include a non-comprehensive sex education curriculum, a lack of parental guidance, social stigma regarding contraception, gender inequality, and sharing of misleading information via digital media (Termpittayaprasith & Peek, 2013). Teenage pregnancy is a major contributor to maternal and child mortality, and to the cycle of ill-health and poverty (WHO, 2016a).

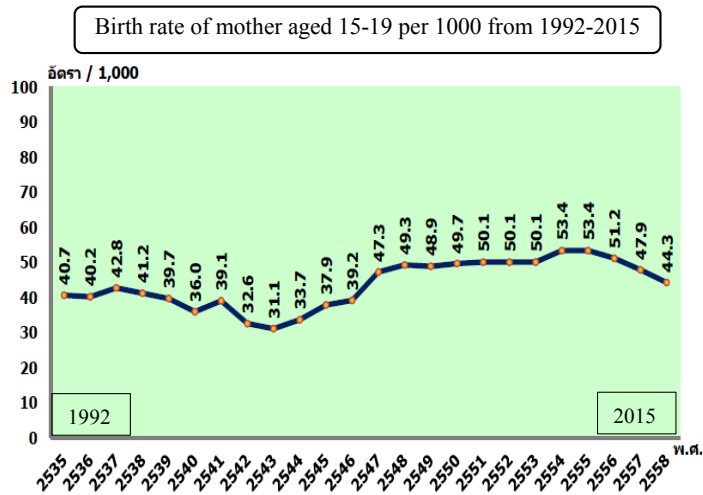


Figure1. Birth rate of mothers aged 15-19 per 1,000 from 1992 to 2015 in Thailand, Retrieved from http://rh.anamai.moph.go.th/download/all_file/index/%E0%B8%AA%E0%B8%96%E0%B8%B2%E0%B8%99%E0%B8%81%E0%B8%B2%E0%B8%A3%E0%B8%93%E0%B9%8C_RH2558_WEBSITE.pdf

The impact of pregnancy and parenthood on teenagers' health and welfare

Being a pregnant teenager means being at greater physical, mental, social and economic risk than adult women (Isaranurug, Mo-Suwan & Choprapawon, 2007; WHO, 2007). Pregnant teenagers also have an increased incidence of obstetric complications such as anemia and fetal distress, as well as poor neonatal outcomes for their babies, for example low infant birth weight and preterm delivery due to immature biological age (Liabsuetrakul, 2012; Olausson, Black, & Starr, 1999; Qazi, 2011). Parenthood is a transitional phase in the family life cycle, and performing the parenting role is expected not only of mothers but also of fathers (Petch & Halford, 2008). Becoming a parent is likely to affect women more than men, partly because pregnancy, birth and breastfeeding place major physical demands on women's bodies (Cowan & Cowan, 2000). Furthermore, women are more likely than men to be the primary caregiver of their child (Martins, Pinto de Abreu, & Barbieri de Figueiredo, 2014; Pancer, Pratt, Hunsberger, & Gallant, 2000). The transition to parenthood is more difficult for teenage parents, who face difficulties with adapting to child care as well as with balancing parenting and work (Logsdon, Birkimer, Ratterman, Cahill, & Cahill, 2002). Fostering this trust while struggling to establish one's own sense of identity is often emotionally and physically stressful for a teenage parent (Young, 1988). Teenage parenthood has an impact on both the teenager and on family and society as a whole.

Teenage motherhood not only has an effect on maternal and infant health, it also encompasses socioeconomic disadvantages including insufficient education and limited career and economic opportunities (Chirawatkul et al., 2011; Ekéus & Christensson, 2003). In Thailand, pregnant teenagers are not forced to marry, but they often have to rely on their families. Many drop out or leave school, are unemployed, or become housewives (Chirawatkul et al., 2011). In cases of teenage parenthood, young mothers are probably still students lacking sufficient income to cover their living expenses, which will cause financial problems in the family as the young couple become a burden for their parents (Somsri & Kengkasikij, 2011). Those who are employed often have unskilled jobs or jobs with low wages, such as being farmers, factory workers, or general laborers. Teenage mothers and teenage fathers have to either rely on their families or live on an insufficient income (Chirawatkul et al., 2011).

The father role

The birth of a child brings about major changes in a family. It can trigger a family crisis or even a life crisis for a first-time parent who is adapting to the new role (Bobak & Jensen, 1993). The transition to fatherhood is a significant change, affecting the physical and psychological health of a first-time father (Bartlett, 2004). Fathers must make major psychosocial changes in order to adapt to their new role (Finnbogadóttir, Svalenius, & Persson, 2003). Thai men becoming first-time fathers described feelings like being stunned, being unprepared for fatherhood, and being worried about finances (Sansiriphun, Kantaruksa, Klunklin, Baosuang, & Jordan, 2010). Ferketich and Mercer (1995) found that first-time fathers suffered from more anxiety and depression four and eight months after their baby's birth than did experienced fathers. Japanese research indicates that parental involvement for first-time mothers and fathers increased gradually between three and six months postpartum, after which it was stable until 12 months (Ohashi & Asano, 2012). Being a father is described as a process of maturing (Premberg, Hellström, & Berg, 2008). Psychological maturity is described as involving independence, self-acceptance, productivity, and a stable sense of identity (Seglow & Canham, 2002).

The father role is defined as providing for, taking care of, and protecting a child. The provider role refers to a willingness to provide an income for the family; the caregiving role is defined as expressing feelings, as well as behaving in a way that promotes the infant's development; the protecting role refers to the father protecting the infant from harm. Little is known about young men's experiences of fatherhood in Thailand (Sansiriphun et al., 2010). Few studies have examined the differences between how teenage and adult first-time fathers construct their roles in Thailand. One of the specific aims of this study is to try to fill this gap.

The Thai context

Thailand is situated in Southeast Asia, and with a population of 67 million is ranked the 20th most populated country in the world. Since 1980 it has transformed from an agricultural into an industrialized society with an upper-middle income economy (World Bank, 2016). Buddhism is practiced by 95% of Thais. Thai is the official language for speaking and writing, but English is widely taught. Thailand has a tropical climate and is divided into six geographical regions: the Central Region (including the capital city of Bangkok), the North, the North-East, the West (including Phetchaburi province), the East, and the Southern regions (Figure 2).



Figure 2. Map of Thailand, Retrieved from <http://thumbs.dreamstime.com/z/thai-regions-map-thailand-color-white-background-41732529.jpg>

Thailand achieved the Health Millennium Development Goals (MDGs) before the target year 2015 (Waage et al., 2010). The total fertility rate dropped from 2.0 in 1992 to 1.5 in 2013 as a result of a high contraceptive prevalence rate (79%) (World Bank 2016) (Table1). While the overall birth rate in Thailand is declining, the teenage birthrate is rising, which poses a challenge for Thai society. A national campaign aims to reduce the teenage birth rate to less than 50 per 1,000 women aged 15–16 (Ministry of Thailand Public Health, 2012). However, the proportion of both male and female students who reported always using a condom during intercourse was below 30% (n= 26,430) in 2011 (Bureau of Epidemiology, 2013). To address the teenage pregnancy problem, Thailand developed the Act for Prevention and Solution of the Adolescent Pregnancy Problem, B.E. 2559 (2016). Five main ministries, the Ministry of Public Health, Ministry of Social Development and Human Security, Ministry of Education, Ministry of Labor, and Ministry of the Interior are responsible for this law, which focuses on adolescents' rights, and

are implementing an integrated approach to preventing adolescent pregnancies (Ministry of Thailand Public Health, 2016b).

Country profile

Table 1. Selected socioeconomic and reproductive health indicators, Thailand

Indicators	
Total population	67.73 million
GDP (current US\$); Upper middle income	\$373.8 billion
Population growth (annual %)	0.4
Urban population (%)	50.4%
Median age of total population	36.7
Proportion of population aged 15–24 (%)	14.78
Life expectancy at birth, female (years)/ male (years)	78/71
Fertility rate, total (births per woman)	1.5
Mortality rate, under 5 (per 1,000 live births)	12
Mortality rate, infant (per 1,000 live births)	11
Birth rate, crude (per 1,000 people)	10
Maternal mortality ratio (modeled estimate, per 100,000 live births)	26
Pregnant women receiving prenatal care (%)	98
Births attended by skilled health staff (% of total)	100
Contraceptive prevalence (% of women aged 15–49)	79
Unmet need for contraception (% of married women aged 15–49)	7
Adolescent fertility rate (births per 1,000 women aged 15–19)	45
Prevalence of HIV, total (% of population aged 15–49)	1.1

Source: World Bank, 2016; World Factbook, 2015

Phetchaburi province

Phetchaburi province, located in western Thailand, is a rural area of about 3,000 km². It is situated approximately 160 km south of Bangkok (Figure 3). The province is divided into eight districts (*amphur*), which are further subdivided into 93 townships (*tambon*) and 681 villages (*muban*). The health care sector, under the Ministry of Public Health, comprises one provincial hospital, seven district hospitals, and 116 Primary Health Care centers in this province. The nurse to population/patient ratio is 1:2,840. In 2014, Phetchaburi had a total population of 451,308 (219,074 males and 232,234 females) of which 32,278 were aged 15–19 years (Phetchaburi Provincial Public Health Office, 2015). Phetchaburi is one of 19 provinces whose teenage birth rate has doubled between 2000 and 2012. The birth rate among teenagers in Phetchaburi increased from 48.0 to 59.3 per 1,000 teenage women during 2003–2013 (Termpittayapaisith & Peek, 2013).



Figure 3. Map of study area in Phetchaburi province, Retrieved from <http://www.mapsofworld.com/thailand/maps/phetchaburi-map.jpg>

Health and Welfare in Thailand

In 2001 Thailand launched a Universal Health Coverage (UC) plan after various attempts had been made since 1971. By 2002, Thailand had achieved universal coverage for the entire population through a general tax-funded Health Insurance Scheme (Tangcharoensathien, Prakongsai, Limwattananon, Patcharanarumol, & Jongudomsuk, 2007). This was in response to section 52 of the 1997 constitution which states that “*All Thai people have an equal right to access quality health services*”. The aim was to provide Thai people with health services that are both accessible and equitable (Yiengprugsawan, Kelly, Seubsmann, & Sleight, 2010, p.2). At the beginning, an individual was required to pay no more than 30 baht (around 1 USD) per visit for either outpatient or inpatient care, including medicines (Damrongplasit & Melnick, 2009). Today, there is no longer a fee for using the UC. Universal health care is provided through three main programs: the Civil Servant Medical Benefits Scheme (CSMBS) for civil servants and their families, Social Security Scheme (SSS) for private employees, and the UC scheme theoretically available to all other Thai nationals. The UC scheme covers 74.4% of the population, SSS covers 15.4%, and CSMBS 8.6% (National Statistical Office (NSO), 2013).

SSS covers teenagers who are eighteen or more years of age and work in the private sector, but teenagers under eighteen years use the UC scheme.

Health care services in Thailand

Health care services in Thailand include three levels which are mostly managed and run by the Ministry of Public Health (MoPH). Primary Care Units (PCUs), or Health Centers, are defined as the first level of health services, and are mainly set up to serve people in rural areas. In 2010, there were 10,052 PCUs at the sub-district and district level, providing preventive care and primary medical care for outpatients, and also able to refer patients to specialists (Wibulpolprasert, 2011). There are 3–5 health professionals at each PCU (but no physicians). District or community hospitals are the secondary level of health services. Community hospitals are located at the district level and are classified by size; large community hospitals have a capacity of 90 to 150 beds, medium-sized community hospitals have a capacity of 60 beds, and small community hospitals have a capacity of 10 to 30 beds (Jurjus, 2013). Community hospitals in the districts can admit 10 to 150 patients, provide basic medical care, and refer more advanced cases to the general or regional hospitals. General and regional hospitals are defined as the tertiary level of care. General hospitals are located in provinces or major districts, and have a capacity of 200 to 500 beds. Regional hospitals are located in provincial centers, have a capacity of at least 500 beds and have a comprehensive set of specialists in their staff. In 2010, there were 988 public hospitals, including hospitals associated with the military, universities, local

governments and the Red Cross (Wibulpolprasert, 2011). According to Tangmunkongvorakul et al. (2012), 43.8% (n= 1745) of studied teenagers used public hospital services in 2013. Of these, 49.5% sought help because of sexually transmitted diseases, 19.0% for contraceptives, 7.5% for a pregnancy test, and 8.0% to terminate a pregnancy. The main place where teenagers got condoms was grocery stores (52.2%) (Bureau of Epidemiology, 2013).

Context of maternal and child care

Antenatal care

Antenatal care (ANC), also known as prenatal care, refers to care given during pregnancy. In Thailand, most ANC is provided at hospitals and PCUs by healthcare workers such as physicians, nurses and midwives. Nurses and midwives are the primary providers of antenatal care for low-risk mothers, while physicians are available as consultants in high-risk pregnancies. Services provided at ANC clinics include routine screening with a classification form, physical examinations, voluntary counseling and testing for HIV and thalassemia, vaccination against tetanus toxoid, health education, and the provision of folic acid and iron supplements. All pregnant women are given a copy of the Maternal and Child Health (MCH) handbook, or *pink book*, on their first ANC visit. Since 2008, governmental campaigns in Thailand have introduced parenting classes to prepare all parents-to-be for their new roles and to encourage men to participate in childrearing (Ministry of Public Health, 2012).

The Ministry of Public Health has set the following guidelines for ANC visits: (1) before 12 wks. into pregnancy, (2) 18 ± 2 wks., (3) 26 ± 2 wks., (4) 32 ± 2 wks., and (5) 36 ± 2 wks. The Ministry of Public Health recommends that 60% of pregnant women should receive ANC less than 12 weeks after becoming pregnant and make at least five visits total. The number and frequency of ANC visits depend on each hospital and PHCs, but the most common schedule is to visit the clinic every four weeks during gestational age (GA) less than 28 weeks, every two weeks for GA 28–36 weeks, and every week during GA more than 37 weeks.

The percentages of women receiving first-time ANC at less than 12 weeks and who made at least five visits for ANC were 50% and 49.6% respectively (WHO, 2015a). Phetchaburi Public Health Office (2014) reported that among pregnant teenagers the corresponding figures were 34.6% and 32.3% respectively. The Thai Department of Health (2014) recommends that the figures for both these performance indicators should be 60%.

Intrapartum care

Intrapartum care refers to care given during labor and birth. In Thailand, nurses and midwives are the primary caregivers for parents-to-be during labor and birth; obstetricians participate together with the allotted midwife if complications arise or in private cases. Governmental campaigns in Thailand have introduced parenting classes to prepare young parents for their new roles and to encourage men to be involved in childrearing. But, it is not the obligatory for all hospitals to offer such classes.

Postnatal care

In Thailand, the mean length of postnatal care at hospital for normal births is approximately two days. In cases of complications during or after labor, the mothers are cared for in the postpartum department, while the babies are taken care of in the neonatal intensive care unit (NICU) in accordance with each patient's needs.

About four to six weeks postpartum, mothers and babies receive a checkup, even if the mothers are feeling fine. The mothers are given a physical and pelvic examination and recommendations about contraceptives are made by healthcare professionals. The babies are checked up and given vaccinations.

Socio-cultural context

The rural family

By tradition, Thai families value maintaining family connections very highly. Although autonomy is encouraged to some degree, parents expect children to be obedient and to comply with their parents' wishes and demands (Cameron, Tapanya, & Gillen, 2006). Traditionally, the rural family is an extended family with many generations living in one house, or several houses in the same compound. Thai children learn codes of behavior that will guide them throughout much of their later life in the family (Limanonda, 1995). Thai society and culture are hierarchical; children are taught early to show respect to their parents, the elderly and people of higher status. Younger persons show respect to their elders by listening, being obedient, following suggestions, and refraining from arguing (Limanonda, 1995). In Thai culture, because of the intimate relationships between family members, all family members will feel responsible for solving problems for everyone in the family (Lundberg & Rattanasuwan, 2007).

Most people in rural areas are farmers who depend on nature. Geographical features and natural resources play vital roles in their lives. There is a strong sense of connection within the village community in which lifestyles and values are shared and passed from generation to generation. The conservative values and close-knit communities characterizing people in rural areas differ from the values and social structures of people living in big cities such as Bangkok or other urban areas (Limanonda, 1995). Teenagers living in an extended family usually found a partner or got married later than those living in nuclear families, because they had relatives to consult or exchange ideas with, and were taught discipline or other facts of life (Jahan, 2008). Also, teenagers who grow up in a loving family and have a good relationship with their parents have been found to be less likely to get pregnant (Termpittayapaisith & Peek, 2013).

Lifestyles and social values

Western culture has exerted influence on the modern Thai society with globalization as a result. Thai adolescents imitate Western lifestyles including sexual behaviors (Nitirat, 2007). Data show that teenagers in Thailand today view sex as something normal, and both boys and girls have sexual intercourse for the first time at 15 years of age (Bureau of Epidemiology, 2013). In a nationwide survey of students, 25.6% (n = 9,971) of male teenagers aged 12 to 19 years, and 17.2% (n = 16,459) of female teenagers aged 12 to 18 years, reported having had sex (Bureau of Epidemiology, 2013). However, traditional Thai sexual norms persist, including a gender double standard that continues to stigmatize sexual activity by young people, and especially young women. People in Thai society typically hold the conservative view that “respectable” or “good” women and girls do not engage in sex before marriage, as this brings dishonor to them and their families. Premarital sexual relations are viewed as unethical (Chirawatkul et al., 2011; Ounjit, 2011; Sridawruang, Crozier, & Pfeil, 2010a). Men have the privilege of sexual freedom, whereas Thai woman have been taught to be cautious, to control their sexual behavior, and to preserve their virginity (Ounjit, 2011). Teenagers mentioned the phenomenon of comparing “sex scores” between friends, which was more common among males than females (Vuttanon, 2010). Evidence shows that these factors put sexually active adolescents in a particularly vulnerable position, unable to seek help from their parents, health care providers or other adults (Tangmunkongvorakul et al., 2012). Even though many changes have occurred, traditional sexual values and norms still influence Thai people’s sexual life.

Structure of traditions

In Thai society, all women are expected to follow the traditional life trajectory of marriage before pregnancy. If they cannot follow the tradition, they will be condemned and their families will be dishonored. Thai people have a conservative approach to women's sexual behavior and virginity, which involves not violating cultural traditions and preserving one's virginity until the wedding day (Ounjit, 2011). Thai law allow 17-year-olds to wed, but there are no statistics about how many teenagers that are aged 15–19 and give birth are married (Termpittayapaisith & Peek, 2013). The unmarried pregnant teenagers perceived that they were devalued by others, or that their sense of intrinsic value was reduced (Muangpin, Tiansaward, Kantaruksa, Yimyam, & Vondeheid, 2010). Furthermore, pregnant teenagers felt worthless and that their life as a teenager ended when they became pregnant outside marriage (Punsuwan, Sungwan, Monsang, & Chaiban, 2013). The participants' families in the northern part of Thailand tried to follow tradition by organizing a *Wak sen* (wedding) ceremony in order to “save face” (*Gu naa*) after the mistake, and repair the damage caused when their teenagers unintentionally became pregnant, (Neamsakul, 2008). Having a wedding ceremony not only symbolizes social acceptance of the girl and her parents, but also is a way for women to gain a sense of intrinsic value and win the respect of the boy's family (Muangpin et al., 2010). The Buddhist wedding ceremony is not a legal marriage. The legal marriage registration is effected in person at any Thai civil registry office (*amphur*). Following this tradition helps people in the community to accept the pregnancy and forgive the pregnant teenagers for the “mistake” they have made.

Gender within family

Generally, by the age of seven or eight years, children will begin to imitate their parents or help them with household work (Soonthorndhara et al., 2005). Girls and boys traditionally have different roles and are differently treated in Thai culture, via direct and indirect messages conveyed by parents and relatives. Teenagers have reported that women perform most of the household work. Outdoor chores, however, and typical labor tasks such as farming, carrying water, and felling trees are reserved for men (Soonthorndhara et al., 2005). Another study in Thailand found that men still follow the traditional way by doing more household chores within the area of masculine chores and fewer within the area of feminine chores (Rattakitvijun Na Nakorn, 2004).

Thai society makes men the head of the family, and gender biases are rooted in family life (Tangmunkongvorakul & Bhuttarowas, 2005). In Thailand, men

or husbands are always referred to as “*hua nah kropkrou*” (leader of the household) (Coyle & Kwong, 2000). Furthermore, an old expression for a man is “*chang tao na*” (the front leg of the elephant, leader), and a woman is “*chang tao lung*” (the rear leg of the elephant, follower) (Pimpa, 2012). A family is traditionally headed by a man or husband, who is expected to provide for its members (Chirawatkul et al., 2011). Most teenage mothers stay at home, and therefore unavoidably become the primary caretakers and do the housework. Thus, teenage men and women, in their roles as parents, become unequal. As a result, teenage fathers have played quite a small role in childrearing.

Thai law

The Thai Penal Code sections 277–282 states that whoever has sexual intercourse with a girl not yet over fifteen years of age, and not his own wife, regardless of whether said girl consents, shall be punished with imprisonment. Some participants and their families used knowledge about these sections of the criminal code in negotiating with the boyfriends and their families about the boy taking responsibility as the father.

Induced abortion is a crime under sections 301–305 of the Thai Penal Code (1956), which states that abortion is illegal except in cases where a pregnancy endangers the physical health of the mother or when the pregnancy is due to sexual offences such as rape or incest (Center for Reproductive Rights, 2016). The abortion procedure must be performed by a physician (Thai Medical Council’s Regulation, 2005). According to regulations on abortion from 2005, a woman may seek an abortion for either physical or mental health reasons; however in the latter case two physicians must agree that the procedure is necessary (Praditpan & Chaturachinda, 2016). The destruction of a life by an induced abortion is considered a serious Buddhist sin called “*bap*”. Many rural women remain fearful of the consequences of sin or “*bap*” and therefore choose to continue with an unintended pregnancy (Whitaker & Miller, 2000). However, 86.7% (n= 3,324) of Thai physicians thought that the law was outdated and did not suit the current social situation, and 73.3% of the physicians reported that an amendment of the law would solve the problem (Boonthai, Warakamin, Tangcharoensathien, & Pongkittilah, 2005). Since the end of 2014, legal medical abortion is available under the strict control of the Ministry of Public Health, but teenagers under the age of 18 need parental consent (Department of Health, 2016). Two district hospital in Phetchaburi participate in this medical abortion project.

Religion

Thai society adheres to the Buddhist religion, which emphasizes harmony, compassion, caring for others and responsibility (Hoffman, Demo, & Edwards, 1994). Buddhists believe that the present life is a link in a continuous chain of rebirths that depend on deeds (*karma*) performed in this life or in previous lives (Choowattanapakorn, 1999). In other words, carrying out good deeds brings good fortune, while doing bad deeds has evil consequences. According to traditional Thai Buddhist beliefs, an expectant father should not kill animals because killing is sinful and might harm the unborn baby (Sansiriphun et al., 2010). Buddha taught “*Sad lok yom pen pai tam karma*,” which means that people are responsible for their own deeds. The core ideology of family roles and duties has remained relatively constant in Thailand due to the country’s adherence to Theravada Buddhism (Yoddumnern-Attig, 1992). Becoming a Buddhist monk for a short period of time is an important traditional practice among Thai men, and is considered to be a way to repay one’s parents “*bunkhun*” for giving birth to a child, or to express one’s debt of gratitude. In addition, it is a rite of passage marking adulthood for a man, after which his parents consider him to be a “mature or a ripe man” (Limanonda, 1995). Some Thai teenage fathers reported being upset about having had a child before they could be trained as a monk.

Education in Thailand

The formal education system of Thailand is based on the 6:3:3 model, comprising six years of compulsory education, three years of lower-secondary education, and three years of upper-secondary education preparing students for college or for vocational/technical training. The 1999 Education Act extended the compulsory education to nine years, to be implemented by 2004. Most schools in Thailand are operated by the government or local administrative council, or are privately run. Informal education is adapted to meet the needs of specific groups that do not have the opportunity to study in the regular school system. Informal education is incorporated into the daily lifestyle of a person who chooses to continue learning throughout his/her lifetime.

In 2006, the Ministry of Education implemented reforms allowing pregnant students to continue their formal schooling (Thorarin, 2006). This can be beneficial for teenage girls who become pregnant; however, because teenage pregnancy goes against social norms, and tends to cause shame and spoil the family reputation, parents usually do not want their daughters in school while they are pregnant (Suwansuntorn & Laeham, 2012). Moreover, it is not

common to see pregnant students at a formal school, so some participants must have decided to leave school because of their feelings of shame. Nong Chum Saeng School in Thayang district, Phetchaburi province, is one of five schools helping pregnant students continue their formal education by allowing credits to be transferred from the previous school, thereby enabling students to study on their own, with some special class participation arrangements (UNFPA Thailand, 2011).

Sexuality education in Thailand

Sexuality education is defined as an “age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, and non-judgmental information” (UNESCO, 2009, p.1). “Sexuality education” is preferred to “sex education” because it is a more encompassing term (Clarke, 2010). In Thailand, sexuality education is mandatory, and it is explicitly mentioned in the 2001 Thai Basic Education Curriculum (B.E. 2544) under the heading “Life and Family” (Thailand’s Compulsory Education Curriculum, 2001). Sexuality information has been provided in health education classes. In 2003, the Teenpath project was developed by the Program for Appropriate Technology in Health (PATH), an international non-governmental organization based in Bangkok. PATH is the main source of content for sexuality education in Thailand. The content consists of six dimensions including human development, relationships, personal skills, sexual behavior, and society and culture (Boonmongkon & Thaweessit, 2009). Formerly, Comprehensive Sexuality Education (CSE) was considered a core strategy in the 2007–2011 national AIDS Plan, in which the Ministry of Education was expected to play a major role (UNESCO, 2014). UNESCO have reached 1,304 out of 8,000 secondary schools in Thailand, 354 out of 415 public vocational schools, and 200 out of 400 private vocational schools with their CSE program (UNESCO, 2014). PATH also is collaborating with 10 Rajabhat Universities to provide CSE to students in the faculty of education (Teenpath, 2008). Reaching out with CSE is one factor in reducing teenage pregnancy (HITAP, 2013).

Although sexuality education has been provided, the quality and amount of information varies between teachers and schools, the main focus is on physiology, and the target group is students 16 years of age and older (Vuttanont, 2010). Moreover, it is not comprehensive enough to meet the needs of teenagers. A survey of 1,000 teenagers nationwide carried out by the College of Population Studies reported that lack of proper sex education was an important factor in the rising number of teenage pregnancies (Rakamneuykit & Prajaubmoh, 2013). In addition, most Thai parents have not taught their children about sexuality or discussed it with them, because of restrictions imposed by Thai culture, the fact that providing sex education is

not a duty of parents, and the generational gap between parents and children (Sridawruang, Pfeil, & Crozier, 2010b). Although, students were taught and encouraged to adopt a positive attitude toward sexual and reproductive health, including condom use, their attitudes about safe sex and their ability to negotiate sex did not improve after three months (Fongkaew, Settheekul, Fongkaew, & Surapagdee, 2011). A quasi experimental study in Thailand reported that the Culturally Sensitive Sex Education Skill Development program had beneficial effects on attitudes and perceived self-efficacy. Teachers became more positive toward sex education, and more confident in teaching sex education (Thammaraksa, Powwattana, Lagampan, & Thaingtham, 2014). Moreover, the students preferred to learn about sexuality through a varied methodology, including such things as short movies, drama or role playing. Teachers also reflected over the fact that the methods used to teach sex education did not suit the students and were difficult for students to understand (Chaiwonroj, Buaraphan, & Supasetsiri, 2014). Furthermore, a school-based pregnancy prevention model used a multi-level collaboration between families, schools, individuals, and the community in developing a program to address teenage pregnancy (Chaikoolvatana, Powwattana, Lagampan, Jirapongsuwan, & Bennet, 2013).

Sexuality education in Thailand emphasizes biological and physiological aspects of sexuality rather than reproductive health. Furthermore, the curriculum lacks CSE and does not reach teenagers who leave school. There is still a need for cooperation from various sectors.

Sexual and reproductive health and rights of teenagers

Governments around the world signed on to the goals of the International Conference on Population and Development (ICPD) in 1994 to promote and protect sexual and reproductive health and rights (United Nations, 1994). The ICPD Program of Action, states that

Information and services should be made available to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, sexually transmitted diseases, and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. (United Nations, 1994. International Conference on Population and Development, Cairo, 1994. Program of Action, Para: 7, Article 41)

The Thai Department of Health began a project in 1997 titled "All Thai citizens, of all ages, must have [a] good reproductive life" (Ministry of Public

Health, 1998, p.11). The success of Thailand in reducing its birth rate is linked to effective family planning programs which provide birth control and maternal and child health care, especially for married women (MoPH, 2005; Tangcharoensathien, Tantirass, Teerawattananon, Auamkul, & Jongudomsuk, 2002). Generally, reproductive health services are provided in the public health sector. In 2009, the Department of Health launched a youth-friendly health services project (YFHS) to support national reproductive health policy and strategy during 2010–2015, and 878 public hospitals participated in the project (Bureau of Reproductive Health, 2015). Public health care facilities were cited as the last choice among facilities to visit, and were usually utilized only when health problems had become critical (Tangmunkongvorakul et al., 2012). In addition, around 40% (n=26,430) of teenagers buy condoms at the drug store, and only 25% reported that they received them from healthcare providers (Bureau of Epidemiology, 2013).

Thailand still lacks an integrated sexual and reproductive health plan; instead various components are carried out by different ministries and departments (MAP Foundation, 2015). In 2012, 11.7% of mothers aged 15–19 had given birth more than once or were pregnant for a second time. Repeated teenage pregnancy implies a failure of the reproductive health services (Termittayaprasith & Peek, 2013). The teenagers suggested that sexual and reproductive health services should be combined into a one-stop service with convenient opening hours and located close to school, and that facilitators should keep clients' information confidential, have good interaction with the young clients, and understand and have positive attitudes towards sexually active young people (Anusornteerakul, Khamanarong, Khamanarong, & Thinkhamrop, 2008; Tangmunkongvorakul et al., 2012). The expansion of PHCs and universal financial protection have clearly improved the utilization and equity of sexual and reproductive health services (Tangcharoensathien, Chaturachinda, & Im-em, 2015). However other key actions are needed, especially the provision of accessible and supportive family planning services for youth, including universal health coverage for emergency contraception and access to safe abortion (Tangcharoensathien et al., 2015).

Thailand's neighboring country Vietnam, where abortion has been legal since 1945, also has provision of quality care. A study showed that healthcare professionals had strongly disapproving attitudes toward adolescent premarital sex and abortion. In addition to these attitudes, barriers to quality abortion care and counseling were identified, such as lack of confidentiality, difficulty generating trust, inconvenient services, and a lack of reliable equipment (Klingberg-Allvin, NGA, Ransjö-Arvidson, & Johansson, 2006). Services for teenagers faced challenges related to availability, accessibility, acceptability and quality (Backman, 2012).

Reproductive health services are poorly integrated with various other sectors. Services for teenagers must meet the needs of teenagers, and therefore they need to expand their availability and accessibility for this group.

Healthcare providers

The major classes of healthcare professionals that work with parents and their families are nurses and midwives. In Thailand, nursing and midwifery are integrated. The Thailand Nursing and Midwifery council (2011) defines the scope of nursing practice, and the professional practice of midwifery in particular caters to women both during pregnancy and post-delivery, and to their newborns and families. This definition is built upon guidelines from the WHO, the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM). In Thailand, the number of nurses and midwives is insufficient. Between 2010 and 2019, the nurse to population/patient ratio is expected to be 1:400, but there is a shortage of nurses and midwives estimated to around 43,250 positions (Srisuphan & Sawaengdee, 2012). Health care professionals are the most important resources providing information to teenage parents from pregnancy to the postpartum period, including on how to provide for their baby's well-being (Dallas, 2009). Although physical care of teenagers and adults is similar, teenagers need more support and information during the pregnancy and postpartum period (Montgomery, 2003). Research in western countries has concluded that teenage parents receive emotional and material support from healthcare professionals (Dallas, 2009; Shakespeare, 2004; Wahn & Nissen, 2008). Moreover, Schaffer and Mbibi (2014) reported that healthcare providers offered a great variety of information to the teenage parents on topics including growth and development, parenting, how to play with children, nutrition, sleep safety, breastfeeding, and birth control. Support from professionals was a resource that facilitated teenagers' transition to parenthood in Thailand (Neamsakul, 2008; Pungbangkadee, 2008; Sriyasak, Åkerlind, & Akhavan, 2013).

Healthcare providers are the backbone of efforts to improve health and well-being, in addition to being the most important source of information about pregnancy, childbirth, the postpartum period, and infant well-being.

Theoretical perspectives

The four theories chosen for this dissertation are transition theory (Meleis, 2010), gender theory (Connell, 2009), attachment theory (Ainsworth & Bowlby, 1991), and social support theory (Schaffer, 2004). Transition and gender theory provide the major scaffolding for discussion. Attachment theory

and social support theory added pieces to support reciprocity in the main discussion.

Transition theory

Afaf Meleis’s transition theory was selected because the studies centered on the transition to teenage parenthood. A theoretical elaboration of transition was constructed using concepts of roles and role transitions (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). This theoretical journey was influenced by symbolic interactionism, which is a philosophical view on how people interact effectively, and how the dynamic self is formed as a result of a series of experiences and interactions (Meleis, 2010). Moreover, this theory was also influenced by Florence Nightingale’s focus on environment, health and well-being (Meleis, 2010). Transition theory is based on four concepts: (1) nature (type, patterns and properties of transition), (2) transition conditions (process facilitators or inhibitors related to the person, the community, and society), (3) patterns of response (process indicators and outcome of the transition, and (4) nursing therapeutics (Meleis, 2010). (Figure 4)

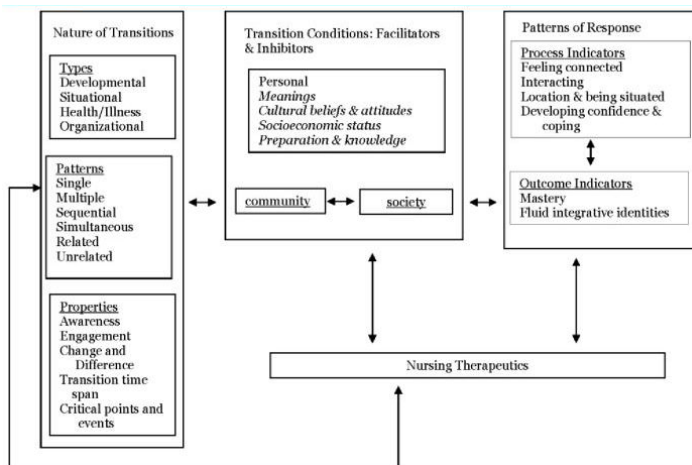


Figure 4. Meleis’ transition theory. Adapted from “Experiencing transitions: An emerging middle range theory,” by A. I. Meleis, L. M. Sawyer, E. Im, D. K. Hifinger Messias, and K. Schumacher, 2000, *Advances in Nursing Science*, 23(1), p. 17.

Gender theory

The issue of parenthood seems to be crucial to how sex and gender are related. Father roles and men's role in the family are intertwined with the practices and cultural conceptions of masculinity. There are links in research between masculinity and fatherhood. Two main scholars who discuss masculinity as having a singular form, and consider masculinity to be a more static and defined concept with normative expectations, are Nock (1998) and Townsend (2002). Townsend (2002) outlines four facets of fatherhood in his "package deal": economic provision, protection, emotional closeness, and endowment. Townsend (2002) discusses the exclusive nature of masculinity, arguing that men who do not meet the package deal also fail in masculinity. For Nock (1998), the exclusive nature of masculinity is represented in three historical implications of what masculinity entails: "[a man] should be the father of his wife's children, he should be the provider for his wife and children, and he should protect his family" (p. 6). Other scholars discuss the concept of multiple masculinities, which are not fixed but continually shift according to the cultural context (Coles, 2009; Connell, 1987, 1995; Kimmel, Hearn & Connell, 2005; Messner, 2004). Connell (1987, 1995) distinguishes between the culturally dominant forms of masculinity or "hegemonic masculinity" and "subordinated" or "marginalized" forms. Coles (2009) focuses on multiple hegemonic masculinities, suggesting that each man subscribes to his own ideal form of masculinity based on the different roles/statuses and attitudes he holds. The notion of hegemonic masculinity has been further developed; see e.g. Hearn (2014) who addresses the hegemony of men in seeking "to address the double complexity that men are both of a social category formed by the gender system and dominant collective and individual agents of social practices" (p.10). According to Hearn (2002), fathers and fatherhood are "intimately connected with the social production and reproduction of men, masculinities and men's practices" (p. 245).

Connell discusses several dimensions of gender to analyze characteristics of gender composition. Two of these are the structure of power relations and production relations (Connell, 2009). In this dissertation, "power relations" refers to the power of husbands over wives, and fathers over children, and to related ideas that are still accepted such as the idea of the father as head of the household (Connell, 2009). According to Hobson (2002), "men's authority in the family and male breadwinning are at the core of masculinity politics" (p. 5). The term "production relations" refers to the gendered division of labor between men and women (Connell, 2009). The findings suggest that although caregiving can be interpreted culturally as a feminine duty (Doucet, 2004; Miller, 2011), paternal masculinities were shaped by a masculine father (Eerola & Mykkänen, 2013).

Models of fatherhood

Lamb (2010) provides an account highlighting changes in fatherhood in the 21st century and conceptualizes paternal involvement as comprising three parts: engagement, accessibility, and responsibility. Engagement concerns fathers' direct contact with their children through shared activities. Accessibility refers to fathers' availability for interaction with their children. Responsibility refers to the role of fathers in ensuring that their children's needs are taken care of, such as by taking the child to day care or providing for the child financially.

As Hobson (2002) emphasize, the analytical role of their "fatherhood triangle" is "to capture the complex interplay between institutions and practices" (p.10). The father, fatherhood, and fathering are three elements, each linked to different dimensions of fatherhood today. The father can be seen as a biological father or a social father and this distinction is often connected to the privileged position of the biological father. Fatherhood shows what rights, duties, and responsibilities are connected to fatherhood and also what it means to be a father in a particular society. Fathering refers to a set of practices connected to fatherhood (Hobson, 2002).

Drawing on Connell's (1992, 1995) classic theoretical formulation, several studies have mentioned the relationship between masculinity, paid work and housework (Cooper, 2000; Hoang & Yeoh, 2011; Townsend, 2002). Connell and others (Brines, 1994; Connell, 1995; Show & Gerstel, 2009) suggest that men's involvement in gender relations at home, and especially in parenting, provides an important (re)construction and expression of various masculinities. Masculinity can be exemplified by two major models for how men combine family and paid work (Gerson, 2010; Show & Gerstel, 2009): the neotraditional model of masculinity, in which men put their breadwinning first and rely on their partners for caregiving (Gerson, 2010); and the egalitarian model, which entails sharing child care or household responsibilities and paid work equally with their partner. Men living by the latter model want to have a modern lifestyle regarding gender issues (Cooper, 2000; Damaske, Ecklund, Lincoln, & White, 2014).

Attachment theory

The analytical framework of attachment theory, jointly developed by Ainsworth and Bowlby (1991), defines attachment as a person's affection for a specific other. According to Bowlby's (1982) attachment theory, infant attachment behaviors include a communicative system of cries and facial expressions that allow the infant to signal danger to the caregiver, who can then protect the infant. Attachment is a long term process and has been found to take up to seven months to develop. It can take place with more than one individual; therefore, a baby can have more than one attachment (Bowlby, 1988). Bowlby tended to focus on the mother–infant attachment, but the father–infant attachment is also of importance. Although Bowlby focused on mothers, these attachment behaviors can evolve with any primary caregiver. It is now recognized that the father–infant attachment is just as important for a child's growth and development as mother–infant attachment, albeit in different ways (Fletcher, 2011).

Social support theory

Social support theory is a middle-range theory that describes the structures, functions, and processes of the social relationships surrounding an individual (Schaffer, 2004). Social support can be defined as a well-intentioned action that is done willingly for a person with whom there is a personal relationship and that produces an immediate or delayed positive response in the recipient (Hupcey, 1998). House (1981) proposed four kinds of social support: (1) emotional, (2) instrumental, (3) informational, and (4) appraisal support. Emotional support is the most important, and comprises sympathy, concern, love, and trust. Instrumental support includes activities that help to satisfy individual needs, such as offering work help, service, money and time. Informational support means providing a person with information that the person can use in coping with personal and environmental problems, such as providing advice or suggestions, direction or information. Appraisal information is described as providing feedback that affirms self-worth and allows the recipient to see him/herself as others do (House, 1981).

Research on social support for teenage parents

Several studies have addressed the fact that teenage mothers receive family support, especially from their own mothers, who help them to perform the maternal role and reduce stress (Blunting & McAuley, 2004; Heh, 2003; Letourneau & Barnfather, 2004; Quinlivan, Luchr & Evans, 2004). Family support is important and influences parenting behaviors and practices.

However, in some studies grandmothers of the newborn children expressed that they were forced to take on a level of responsibility for which they were unprepared (Sadler & Clemmens, 2004). The relationship between the teenage mother and grandmother also influences the provision of both tangible and emotional support to the young parent (McKinley, Brown, & Caldwell, 2012; Oberlander, Black, & Starr, 2007). Nevertheless, the child's grandparents play an important role in a teenage parent's life (Borcherding, SmithBattle & Schneider, 2005). Notably, because teenage parents have a low income or are unemployed, they depend on their family to be able to perform their parental role (Dallas, 2004). A Thai study revealed that the availability of support is one condition that helps the teenage mothers use appropriate strategies to deal with conflicting needs while taking care of their babies (Neamsakul, 2008; Pungbangkadee, 2008; Sriyasak et al., 2013).

Rationale for the studies

The transition to parenthood is a period of multiple changes. Pregnancy and child care seem to be stressful period in the transition to teenage parenthood (Petch & Halford, 2008). Studies in the area of teenage motherhood have explored female experiences during pregnancy, early motherhood and childrearing (Muangpin et al., 2010; Neamsakul, 2008; Phoodaangau, Deoisres, & Chunlestskul, 2013; Pungbangkadee, 2008; Sriyasak et al., 2013). Further, studies on parenting have devoted more attention to mothers than fathers. Few studies have examined the differences between how teenage and adult first-time fathers construct their roles in Thailand. There is a need to explore and understand teenage fathers and teenage mothers' own experiences from the point of view of teenage fathers and teenage mothers during their pregnancy and early parenthood. Healthcare providers may help teenage parents to enhance their satisfaction with care given during pregnancy, labor, and early parenthood. Knowledge and understanding about teenage parenthood is limited in the existing literature. This dissertation intends to contribute to an increased understanding about teenage parenthood, and healthcare providers' experiences in caring for teenage parents in Thailand.

AIM

The overall aim of the dissertation is to contribute to a deeper knowledge and understanding of teenage parenthood, as experienced by Thai teenage parents and healthcare providers.

The specific aims are:

- Paper I To compare Thai teenage and adult first-time fathers' perceptions of father roles in terms of their sense of competence, childrearing behavior, and father-child relationship.
- Paper II To gain a deeper understanding of how teenage fathers reason about becoming and being a father from a gender-equality perspective.
- Paper III To gain a deeper understanding of Thai teenage parents' perspectives, experiences and reasoning about becoming and being a teenage parent from a gender perspective.
- Paper IV To describe Thai healthcare providers' experiences of caring for teenage parents and views on teenage pregnancy and childbirth in Thai society.

METHODS

Design

Study I had a cross-sectional, comparative design and used a quantitative method. Study II had an explorative design and used grounded theory methodology. Study III had a descriptive design and the method used was focus-group discussions. An overview of the dissertation is presented in Table 2.

Quantitative research uses deductive reasoning to generate predictions which are then tested against empirical data. The findings are thus based on the reality of the situation rather than on the researchers' perspective (Polit & Beck, 2012). Qualitative research is a broad approach to studying phenomena (Marshall & Rossman, 2016).

Table 2. Design, study group, methods and instrument of the studies included in this dissertation.

Study	Design and methods	Study group	Instruments
I (Paper I)	Cross-sectional, comparative design, quantitative method	Teenage fathers ≤ 19 (n=70, group A), adult fathers aged ≥ 25 (n=70, Group B)	Questionnaire, 3 validated instruments
II (Paper II and III)	Exploratory design, qualitative method: Straussian Grounded theory methodology	25 teenage couples (n=50)	individual interviews with both mothers and fathers, before and after childbirth
III (Paper IV)	A qualitative method with focus-group discussions	4 focus groups with health care providers (n= 21)	Interview guide

Paper I

Study setting

The empirical data collection for paper I was undertaken during April and October 2013 in a province in western Thailand. This rural area has one of the highest adolescent birth rates in the country. The birth rate among teenagers in this province increased from 48.4 to 59.3 per 1,000 teenage women during 2003–2013 (Termpittayapaisith & Peek, 2013).

Participants and data collection

Thirty-two PHCs were randomly selected in a province in western Thailand, and consecutive sampling was performed among teenage fathers ($n = 70$) and adult fathers ($n = 70$). The inclusion criteria for participants were: (i) being a teenage father aged ≤ 19 years, or being an adult father aged ≥ 25 years; (ii) being a first-time father; and (iii) having a baby between two and six months old, without any congenital diseases or serious health problems. The sample size was calculated using a power analysis (Polit & Beck, 2012). A power calculation was performed to minimize the chance of a false-positive finding or type I error (Cohen, 1992). The effect size was determined on the basis of previous means scores in reported results from studies of fathers' relationships with their children in Thailand (Chakuntode, 1996). To detect differences between teenage and adult fathers, an estimated level of competence was set to an alpha value of 0.05 and a power of 80% to yield a statistically significant result.

The first author met with the directors of the PHCs to inform them of the study procedure and request permission to conduct the study. The nurse and/or a village health volunteer identified potential participants who met the inclusion criteria and provided information verbally and in writing. If the participants agreed to participate, the study was explained, and signed consent was obtained. Participants were asked to complete the questionnaire in a comfortable place at the PHCs or in their homes if they preferred. The questionnaire took approximately 10–15 minutes to complete, after which it was sealed in an envelope and placed in a locked box.

Measurement instruments

The questionnaire (Paper I)

The questionnaires used in Study I consisted of two sections. The first section focused on the characteristics of the fathers and babies. The fathers' characteristics included age, education level, occupation, income, family size, intention to have a baby, experience in childrearing, equality in childrearing. The characteristics of the baby included type of delivery, birth weight, complications after birth, and age. The second section addressed three dimensions of the father role, including the father's sense of competence (FSC), the father's childrearing behavior (FCB), and the relationship between father and child (RFC). All questionnaires had previously been validated using samples of Thai-speaking first-time fathers (Chaekuntode, 1996; Soomlek, 2000). The instrument package comprised four self-reported questionnaires. In this study, face validity was strengthened through pilot questionnaires filled in by one teenager and one adult first-time father.

The FSC questionnaire was translated from English into Thai ((Gibaud & Wallston, as cited in Soomlek (2000)). It consists of 17 statements about the perception of recently becoming a father. Possible total scores for all items range from 0 to 68; the higher the score, the better the father's sense of competence. In this study, the overall Cronbach's alpha coefficient was 0.75.

The FCB 25-item scale was developed by Salong (2009) to measure the father's behavior regarding physical care of his child, preventing harm and developmental care. Possible scores for all items can range from 0 to 100. The higher the score, the better the father's childrearing behavior. In this study, the overall Cronbach's alpha coefficient was 0.79.

The RFC questionnaire was developed by Bill (1980) and modified by Chakuntode (1996). It consists of 20 items on the father's perception of the body of the infant, attachment to the infant, physical contact with the baby, perception of characteristics of the infant, and self-esteem. The total score for this questionnaire ranges from 0 to 80. The higher the score, the better the relationship between the father and the child. The Cronbach's alpha coefficient for this study was 0.72.

Data analysis

Analysis of the data from teenage fathers in Paper I served to support the results in this dissertation. Descriptive statistics were used to describe the demographic characteristics. A sum-score was calculated for each of the questionnaires, and the Mann-Whitney U-test (Polit & Beck, 2012) was used when the data distribution were skewed (skewness FSC = .643, FCB = -.184, RFC = -.663). Variables on nominally and ordinaly scaled levels were calculated with the Chi-square. A p-value below 0.05 was considered statistically significant.

Papers II, III

Study setting

The empirical data collections for papers II and III were performed in a province in western Thailand (the same as in Paper I) from April 2013 to June 2014.

Participants and data collection

Inclusion criteria for participants were that they were heterosexual couples under 20 years of age expecting their first child. The selection of a heterogeneous group of teenage parents-to-be (n = 50) continued until saturation was reached, as described by Glaser and Strauss (1967). Participants were selected from among pregnant couples who visited the district hospitals and PHCs, who resided in a province in western part of Thailand, and who cohabited.

The interview guides were developed based on our research question (*What were Thai teenage parents' perspectives, experiences and reasoning about becoming and being a teenage parent in a gender perspective?*). Three pilot studies were undertaken to test, and if necessary modify the questions in the interview guide, in a group similar to the sample. At all interviews – conducted by the first author in Thai – the researcher initiated a conversation with a general question such as: “Could you please tell me the story of how you became a teenage parent?” All the semi-structured interviews were digitally recorded and transcribed verbatim. Names and places were changed. Taking theoretical sensitivity into consideration (Glaser & Strauss, 1967), the interview questions were modified throughout the study according to the emerging concepts. Examining the data from different angles enabled us more easily to develop a preliminary model. To gain richer data, some new

questions were added to the interview guide, such as questions concerning preparations for parenthood. During the interviews, a probing technique was employed, raising questions like “Could you describe more about that?” “Could you give me an example of that?” and “What does that mean to you?”

This study was designed to investigate Thai first-time teenage parents from when they were expectant parents until the baby was 5–6 months old. The second trimester was the time when they began bonding with the fetus (Draper, 2002); the period after childbirth was chosen to give participants time to become accustomed to parenthood, since parental involvement for first-time fathers has been shown to increase gradually between 3–6 months postpartum (Ohashi & Asano, 2012).

Data analysis

The processes of collecting and coding data took place in parallel, as is characteristic of grounded theory. The procedures for data analysis followed the work of Strauss and Corbin (1990). Interviews were transcribed verbatim into Thai, and NVivo10 was used to organize data (QSR, 2010). Two data analyses were made from two different research questions (*How do Thai teenage fathers reason about becoming and being a father from gender equality perspective?* (Paper II), and *What are Thai teenage parents’ perspectives, experiences and reasoning about becoming and being a parent in a gender perspective?* (Paper III)). See Appendix. The first step in the analysis was open-coding; the primary author reviewed the transcripts and field notes and wrote memos on concepts that emerged between the initial defining of categories and the first draft of the completed analysis. A professional interpreter translated the open-coding from Thai into English. The non-Thai speaking authors read and commented on parts of the interviews. The process of open-coding was double-checked by both Thai co-authors to reduce the common risk of translation distortion (Squires, 2008). Similar concepts were grouped through data reconceptualization into a more abstract level called a category (axial coding).

The axial coding provided a holistic view of the findings, describing “causal conditions, actions, intervening conditions, and consequences” (Strauss & Corbin, 1990, pp. 96–97). A “causal condition” is an event that leads to the occurrence of some phenomenon. “Action/interaction” refers to the strategies devised to handle a phenomenon under a specific set of perceived conditions. “Intervening conditions” help to facilitate the strategies taken within a specific

context. “Consequences” are outcomes or results of actions and interactions. Constant comparative methods of analysis were performed while coding and analyzing the data; the author looked for patterns by comparing incident with incident, incident with category, and participant with participant. During the second step, selective coding was performed to select the concepts relating to the core category. In the last step of forming two preliminary models (Figure 5 and 6), the constant comparative method was used to fit closely related categories together to create a preliminary model. Both memos and diagrams were useful in all stages of the analytical process.

Paper IV

Study setting

The empirical data collection for paper IV was performed in a province in western Thailand (the same as in Papers I–III) during January to May 2015.

Participants and data collection

The participants were recruited through one provincial hospital and three district hospitals (two small and one medium-sized district hospitals). The inclusion criteria were as follows. Participants had to be Thai healthcare providers with at least one year’s experience of caring for teenage parents, who work in antenatal care, postpartum care, or family planning, or at a delivery ward and/or a reproductive health unit for young people. Four focus groups were held, with a total of 21 healthcare providers (4–6 healthcare providers in each group).

First, the researcher informed the director about the study and asked for permission to conduct it. The researcher then met the head nurse of each hospital to distribute information about the inclusion criteria for participants. The department heads distributed verbal information to their staff and informed them that participation was voluntary and data would be kept confidential. Finally, the researcher and participants set a date, time, and convenient place for the focus-group discussion (FGD). A FGD with a semi-structured interview guide was conducted in another district hospital as a pilot study. The findings were then used to improve the subsequent FGDs. The interview guide served to facilitate the FGD process.

Focus groups are useful for exploring participants’ knowledge and experiences and clarifying their views on a specific topic that would be less accessible if using direct questions in an in-depth interview (Farnsworth &

Boon, 2010; Wong, 2008). A focus group is commonly described as an in-depth semi-structured discussion group led by a group leader called a moderator (Patton, 2014). The group size varies depending on the context, but the most common size is between 4 and 15 participants (Krueger, 1988). A small group may be recommended, depending on the sensitivity or depth of the topic (Prince & Davies, 2001). The three steps of FGD described by Krueger and Casey (2015) were followed. The first author was the moderator (leading the discussion) and the assistant was a colleague who served as an observer (taking notes throughout the session). The assistant did not participate in the group discussions. The moderator gave an introduction and informed the participants about the reason why they were there: to give their opinions and share their experiences about the issue. After that, informed written consent was obtained from the participants (Holloway & Wheeler, 2010), and they then introduced themselves. The moderator's role was to stimulate the participants in the group to feel free to talk, to listen and to follow the interview guide, and to keep the discussion focused on the aim of the study. Finally, the moderator summarized the main contents of the study and thanked the participants. All the sessions were digitally-recorded and transcribed verbatim by the first author. Field notes from the focus groups were used to facilitate the preliminary analysis. Each session lasted between 60 and 90 minutes.

Data analysis

In order to capture the experiences of the healthcare providers, the focus group transcripts were subjected to latent content analysis (Graneheim and Lundman, 2004; Krippendorff, 2013). In the first step, each Thai interview transcript was read and reread several times individually until it was fully understood. The aim of the study was kept in mind while reading the transcripts and NVivo 10 was used to organize data (QSR, 2010). Meaning units, which are the words, statements, and paragraphs that reflect the core meaning of the participants' answers, were identified (Holloway & Wheeler, 2010; Streubert & Carpenter, 2011). The 146 meaning units with relevance to the aim were identified and translated from Thai into English by the third author, who is experienced in qualitative methods and midwifery. The non-Thai-speaking authors read and commented on part of the interviews. The process of coding was conducted independently by the first and the third authors, and cross-checked by all authors to reduce the common risk of translation distortion (Squires, 2008). In the second step, the meaning units were condensed, while preserving the meaning of content, and the text was reformulated using the participants' concepts and finally coded. During the last step, similarities and differences between the groups of codes (32 codes)

were linked and compared to form eight sub-themes, which in turn were organized into three themes. Sub-themes were combined together into themes.

Ethical considerations

The study was approved by the Ethical Committee of the Public Health Office in a province in western Thailand (PB0027.005/3539; PB0027.005/43) and by the Swedish Ethical Board in Uppsala (Dnr. 2012/556; Dnr. 2015/017). All participants took part voluntarily, and had the opportunity to ask questions before providing informed consent. For participants under 18 years age without an official marriage license, written consent was requested from their parents or guardians. Participants were also informed that they could withdraw at any time without giving an explanation, but none chose to do so. A code number was assigned to each participant for identification purposes when analyzing the data (Polit & Beck, 2012). All questionnaires are stored in a computer file, and data are reported on a group level. Furthermore, all participants were asked for permission to publish the findings of the study, with the understanding that the names and identifying characteristics of all participants were withheld.

When talking about their life situation, participants may have felt uncomfortable answering certain questions. The participants could choose not to answer any question, and they could withdraw at any time without giving an explanation. Furthermore, if the interview made the participants feel upset, then they could contact a professional for counseling, recommended by the researcher. All participants received a small gift as a token of appreciation for their time.

RESULTS

The findings from the four studies about Thai teenage parents and the healthcare providers' care are synthesized under two main headings: the process of transition to parenthood among Thai teenage parents; and healthcare providers' care for teenage parents.

THE PROCESS OF TRANSITION TO PARENTHOOD AMONG THAI TEENAGE PARENTS

The description of Thai teenage parents' perspectives, experiences, and reasoning about becoming and being a parent was facilitated by combining some of the categories in the preliminary models in studies I and II.

Unintended parenthood

Most of the teenage parents did not intend to become a parent (II, III), and the rate of unintended teenage fatherhood was 74% (52 out of 70 teenage fathers participating in the study (I)). However, three teenage couples intended to get pregnant, and wanted a baby to form a family (II). The main reason for the unintended pregnancies was that most of the participants were unconcerned about risks and failed to use contraceptives (II, III). The decision to keep the baby was based on various reasons including a religious belief, called "bap", where the teenage parents-to-be feared the consequences of this sin, and especially feared losing the prospect of future success in life; fear of undergoing an illegal abortion; acceptance of the pregnancy by their family (II, III) (Figures 5, 6); and societal expectations to take responsibility (II).

Parenthood as a turning point

The teenage parents reflected on the adaptation to become a parent. The teenage parents had to adapt their behaviors and lifestyle; by changing their relationships with their families and partner, they helped prepare themselves to become parents. Moreover, the young couples were concerned about childrearing (III), and 24.3%, or 17 of the 70 teenage fathers, had childrearing experience (I). Bonding with the fetus during their partner's pregnancy gave the men a sense of being a father, as did taking care of their partner during pregnancy and participating in childbirth (II).

Support from family

Strong support from their families assisted the young people in becoming teenage parents. Teenage parents reported various forms of support from their families both during the pregnancy and after the baby was born. The support could be characterized as emotional, physical, financial, material, and informational (II, III). For example, the teenage parents received economic support from both their families. The teenage couples got help from both families, but it seems as though the teenage mother's mother was the primary source of emotional support.

Becoming a parent

After the birth of the child, the teenage parents were involved in parental activities and reestablished their goals in life. They were also concerned about family planning. 39 out of 70 teenage fathers (55.7%) reporting routinely or often talking or playing with the child, which appears to contradict the finding that 40 out of 70 teenage fathers (57.2%) reported never or only infrequently giving their child a bath and a shampoo (I). The main concern of most of the teenage parents was to be a caregiving mother or a breadwinning father (I-III).

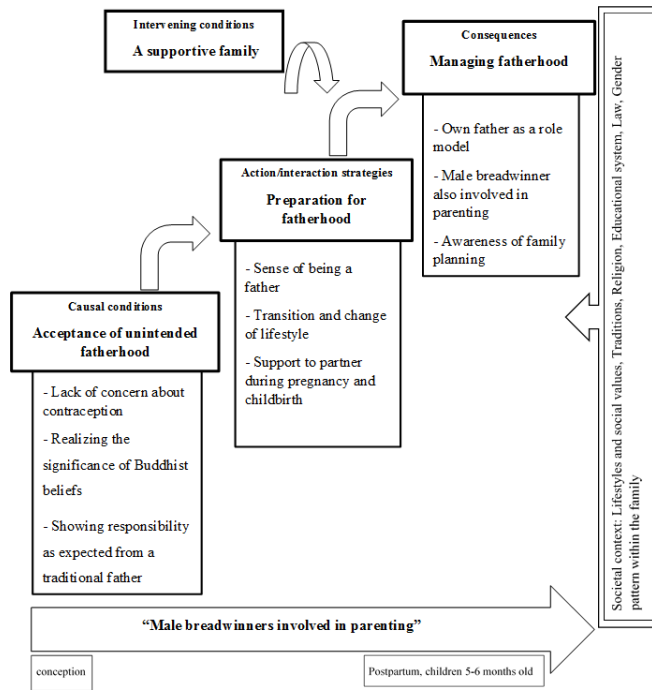


Figure 5. The process of transition to fatherhood among Thai teenage fathers

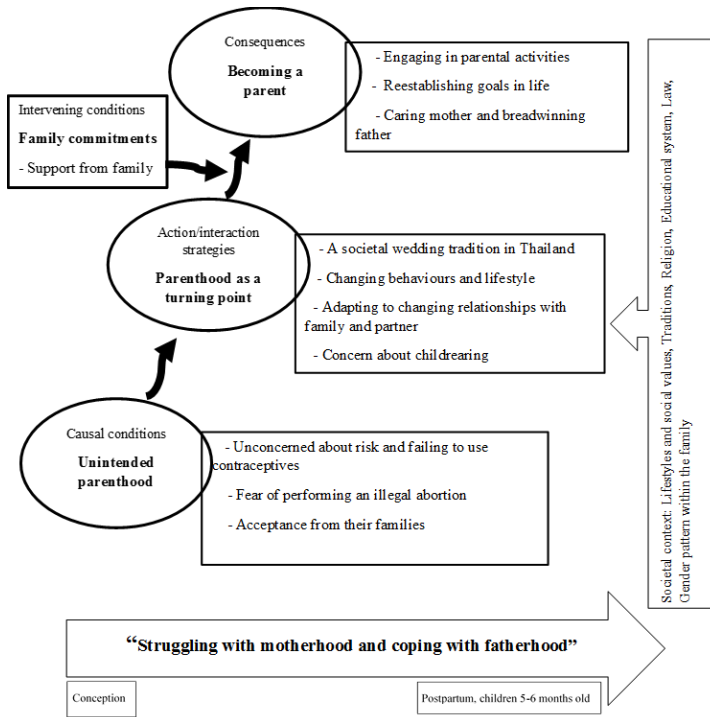


Figure 6. The process of transition to parenthood among Thai teenage parents

Teenage and adult father roles

The mean age of the teenage fathers was 18.09 years and that of the adult fathers was 30.84 years. The fathers' age had an impact on education and income, teenage fathers having lower financial and educational levels than adult fathers. A significant difference between the teenage and adult father groups was found for adequate income and saving money after the child was born. Only one-fourth of the teenage fathers had planned to have a baby, compared to two-thirds of the adult fathers (I).

The teenage fathers scored lower than adult fathers on all three questionnaires: father's sense of competence, childrearing behavior, and the father-child relationship (Table 3).

A major finding was that nearly 20% of the teenage fathers disagreed or strongly disagreed with the statement that they had adequate skills and abilities to be a good father. Moreover, nearly one-quarter of the teenage fathers never, or only infrequently talked or played with the child. However, nearly one-third of the teenage fathers completely agreed with the statement: "When the baby was born, you got the feeling of being a real man."

Most of the teenage fathers helped take care of their partner during pregnancy by giving emotional support as well as practical support in the form of healthy food. Their reason for doing so was concern for the unborn baby's health. The young fathers also participated by taking their partner to the hospital when she was in labor and taking care of her during the postnatal period (II).

Table 3. Comparison of the father role between teenage and adult first-time fathers

Instrument	Teenage fathers n= 70 n (%) Mean score	Adult Fathers n= 70 n (%) Mean score	Man Whitney U test (Z)	p-value
The father's sense of competence (total score=68)	58.21	82.79	-3.590	0.000***
Low (≤ 28.33)	5 (7.1%)	1 (1.4%)		
Moderate (28.34 – 56.67)	65 (92.9%)	67 (95.7%)		
High (≥ 56.68)	-	2 (2.9%)		
The father's childrearing behavior (total score=100)	60.73	80.27	-2.852	0.004**
Low (≤ 41.67)	1 (1.4%)	-		
Moderate (41.68 – 83.35)	53 (75.7%)	36 (51.4%)		
High (≥ 83.36)	16 (22.9%)	34 (48.6%)		
The father-child relationship (total score=80)	60.78	80.22	-2.839	0.005**
Low (≤ 33.33)	-	-		
Moderate (33.34 – 66.67)	12 (17.1%)	6 (8.6%)		
High (≥ 66.68)	58 (82.9%)	64 (91.4%)		

** p-value < 0.01 *** p-value < 0.001

HEALTHCARE PROVIDERS' CARE FOR TEENAGE PARENTS

Three themes captured the experiences of caring from the healthcare providers' point of view: (a) Provision of comprehensive care; (b) Reflections on improving quality of and access to care; and (c) Concern about young parents.

The healthcare providers reported that they provided care for teenage parents based on safe motherhood guidelines. The participants mentioned that they provided the same services to adult groups, but stressed the importance of providing teenager-focused care and emotional support to the teenagers visiting them. They also considered the teenage years to be a tough time to become a parent (IV).

The healthcare providers made suggestions to improve the quality of care, especially concerning sexual and reproductive health for young adults. Ways of improving the quality of health care services included making it more easily accessible, reorganizing sex education to better meet the target group's needs, and improving collaboration between different parties such as sub-district administrative organizations, schools, hospitals, and parents (IV).

The healthcare providers mentioned causes of teenage pregnancy, especially a lack of contraceptive use. Participants also mentioned that teenagers had easy access to the Internet, and that it is quite hard to ensure that the sexual information they access is accurate. A lack of correct information about contraceptives led to teenage pregnancies (IV).

During the time that the teenage parents attended the antenatal care clinic, intrapartum care clinic, and postnatal care clinic, they reported that the healthcare providers offered informational and physical support (II, III). Teenage parents also reported receiving health care advice, prevention advice, and nursing care from the healthcare providers. The healthcare providers expressed that they understood that the teenagers needed appropriate care, an educative approach, emotional support, and prevention advice to avoid repeated pregnancy (IV).

DISCUSSION

The results will be discussed in the following order: results related to theoretical perspectives; results related to the research field of Health and Welfare; results related to implications for clinical practice and methodological considerations.

Results related to theoretical perspectives

Transition is viewed as a process that occurs over time, and the concept of transition is widely used by healthcare professionals when working with people who seek or need healthcare guidance during a transition process. The findings in this dissertation have similarities and differences to the theory developed by Meleis et al.(2000).The author compares and discusses the two preliminary models (Figures 5 and 6) with the transition model (Figure 4), and three topics are addressed: the nature of transition; transition conditions (facilitators and inhibitors); and patterns of response.

Nature of Transitions

The nature of transitions defines the types, patterns, and properties of transitions. Four types of transition are related to development (e.g. adolescence, pregnancy and parenthood), health-illness (e.g. HIV infection, weaning from mechanical ventilation), situation (e.g. the transition into or out of a social role), and organization (e.g. nurses changing roles in the hospital) (Meleis, 2010). There are many patterns of transition, for example, single, multiple, sequential, simultaneously related, and unrelated transitions (Schumacher & Meleis 1994). Patterns of transition include multiplicity and complexity; many people experience multiple transitions at the same time rather than experiencing a single transition; hence transitions cannot be understood in isolation from the context of daily life (Meleis et al., 2000). The transition to teenage parenthood is a “developmental” and “situational” type of transition, and consists of “multiple, sequential, and related” patterns as the teenage parents progress from the moment when they first learned about their pregnancy, through the multiple stages of pregnancy, labor and birth, to childrearing. The health-illness type, organization type, single pattern of transition, and unrelated pattern of transitions are not relevant to this dissertation.

Meleis et al., (2000) point out five properties of transitions: (1) awareness, (2) engagement, (3) change and difference, (4) time span, and (5) critical points or events. Awareness is associated with perception, knowledge and consciousness of the transition experience. Engagement is described as the degree to which a person shows involvement in the transition. The mothers-to-be were aware of their lifestyle, and engaged in changing it in various ways: nurturing themselves, promoting fetal health, protecting the fetus from harm, and modifying their eating habits (III). The fathers-to-be also prepared themselves for fatherhood by changing their behaviors and adapting to the new situation (II). They hoped that doing so would make their baby safe and healthy. Change and difference are essential properties of the transition; they are similar words but cannot be used interchangeably or synonymously with transition. The way of adapting consists of changing behaviors, helping each other or offering help, keeping calm and patient, and accepting each other's identities. By doing things like this, the young couples won more acceptance and sympathy from others (II–III). Transition time span is described as a flow and movement over time in all transitions. The time span varied for each teenage parent in this dissertation; the time was limited, because the parents were interviewed when the child was 5–6 months old. Critical points and events are prominent events that may be related to the transition, such as the birth of a child. Unintended parenthood is described as a critical turning point in the lives of teenagers as they became teenage parents (II–III). The main reasons why the participants decided to keep their baby were fear of undergoing illegal abortion; wanting to keep the baby because it was a part of them, “their flesh and blood”; and receiving acceptance from their families (II–III). In this study (III), all of the teenage parents were also devout Buddhists who believed that abortion is destruction of human life and a serious sin called “bap”; therefore none of them wanted to undergo an abortion (Whitaker & Miller 2000).

Transition Conditions: Facilitators and Inhibitors

Transition conditions include facilitating and inhibiting conditions. Facilitating conditions make something go well, and inhibiting conditions are hindrances in the transition process (Meleis et al., 2000). Conditions of the transition comprise three parts: person, community, and society (Meleis et al., 2000).

Personal conditions comprise four parts. (1) *Meaning* is an attribute of events in the transition process and may facilitate or hinder a healthy transition (Meleis et al., 2000). An example of (2) *cultural beliefs and attitudes* is that teenage parenthood is stigmatized in Thai culture, and is viewed as

problematic and a serious social problem (Health Intervention and Technology Assessment Program [HiTAP], 2013; Jahan, 2008; Nicaise, Tonuthai, & Fripont, 2000). In the interviews for this dissertation it was described that teenage parents performed a social ritual which is a part of a wedding ceremony (II–III). This tradition helped people to accept the pregnancy and to forgive the pregnant teenagers for the “mistake” they had made. Having a wedding ceremony not only symbolizes social acceptance of the girl and her parents, but also is a way for women to gain a sense of intrinsic value and win respect from the boy’s family (Muangpin et al., 2010). (3) *Socioeconomic status, education and income* depend on the teenage parents’ age; teenage parents have lower financial and educational levels, so they have to rely on their families (I–III). This agrees with previous findings linking teenage fathers with low socioeconomic status (Xie, Cairns, & Cairns, 2001). (4) *Preparation and knowledge* facilitate a smooth transition. Teenage parents wanted to learn more about how to care for their child and raise it. Sources of knowledge were healthcare providers, the baby’s grandparents, the Mother and Child Health record book, and parenting classes (I–III). According to Schaffer (2004), informational support is helpful in problem solving and contributes factual data during the decision-making process.

Community conditions include support from family, which was the transition condition that made the strategies for dealing with stress effective. Strong support from their family assisted the participants in becoming teenage parents. Most of the teenage parents had easily available support (II–III). Their extended families helped them meet the costs of living when they could not earn enough money. Furthermore, they were also assisted for a longer period of time when they lacked the self-confidence to perform basic activities in childcare. A Thai study shows that social support was a helpful resource for promoting a successful transition to teenage motherhood, especially during the baby’s first month, as the mothers lacked confidence in taking care of their infants (Neamsakul, 2008; Pungbangkadee, 2008; Sriyasak et al., 2013). However, support from the family can be a hindrance in the transition process. Some teenage parents were unaware of the meaning of being a parent, because when they received family support, they handed over the responsibility for taking care of their child to their parents. The concept of “societal conditions” in the transition model is not applicable to this dissertation.

Patterns of Response

Process and outcome indicators are both described as patterns of response (Meleis et al., 2000). Process indicators include feeling connected, interacting, being situated, developing confidence and coping. The majority of the teenage

parents expressed bonding with their fetus and feelings of strong emotional connection to their child when engaging in parental activities (I–III). The teenage mothers and fathers focused on different parental activities. The mothers’ child care activities mainly included physical care and feeding, and promoting their child’s development; they also did housework. The fathers promoted their children’s development by playing with them (II, III). Outcome indicators, in transition theory, include mastery and fluid integrative identities (Meleis et al., 2000). Self-confidence in taking care of the child was an aspect of mastery for the teenage parent. In addition the skills and abilities that young parents thought they needed to be good parents depended on their perception of their own competence to perform the parental role (Ferketich & Mercer, 1995). Becoming a parent meant that they could embrace and enact parental roles. However, it took time for some participants to gain enough self-confidence to practice certain skills, such as basic infant care. The teenage parents’ skills varied, depending on their social network or background. In practice, nearly all teenage fathers put the traditional breadwinning role first, and the teenage mothers took on the responsibility of performing child care and unpaid housework, as traditionally expected. Paschal, Lewis-Moss, and Hsiao (2011) reported that most US teenage fathers have a desire to provide financially for their children and are willing to behave like “good fathers”, despite being economically poor.

A comparison between transition theory (Figure 4) and the two preliminary models (Figures 5 and 6) highlights concepts of relevance to this dissertation; see highlighted text (Figure 7). The process indicators “interacting and being situated” are not relevant to the process of becoming a teenage parent. The outcome indicator “fluid integrative identities” has been described in terms of identity reformation, and as dynamic rather than stable (Meleis et al., 2000). This concept is abstract and difficult to apply in practice. However it is not applicable to this dissertation; the term “nursing therapeutics” is also not relevant here.

A comparison of the preliminary models in Figures 5 and 6 with the transition theory in Figure 7 shows that “unintended parenthood” in the causal condition model corresponds to “critical points and events” in the transition model. The category “family commitments” in the intervening condition model is comparable to community in the transition conditions (facilitators and inhibitors). “Parenthood as a turning point”, viewed as an action/interaction strategy in the model, is the same as “developing confidence and coping” in patterns of response in transition theory. The category “being a parent” in the model corresponds to the outcome indicator “mastery” in transition theory.

Transition theory has been developed and used in many countries, especially as a central concept in nursing. Some concepts of transition theory can be used to describe “Becoming a Thai teenage parent”. However, transition theory lacks the emotional or mental component which is an important aspect of holistic health. In addition, becoming a parent is a complex developmental and situational transition, something which requires an understanding of numerous variables influencing the whole concept which transition theory cannot fully explain.

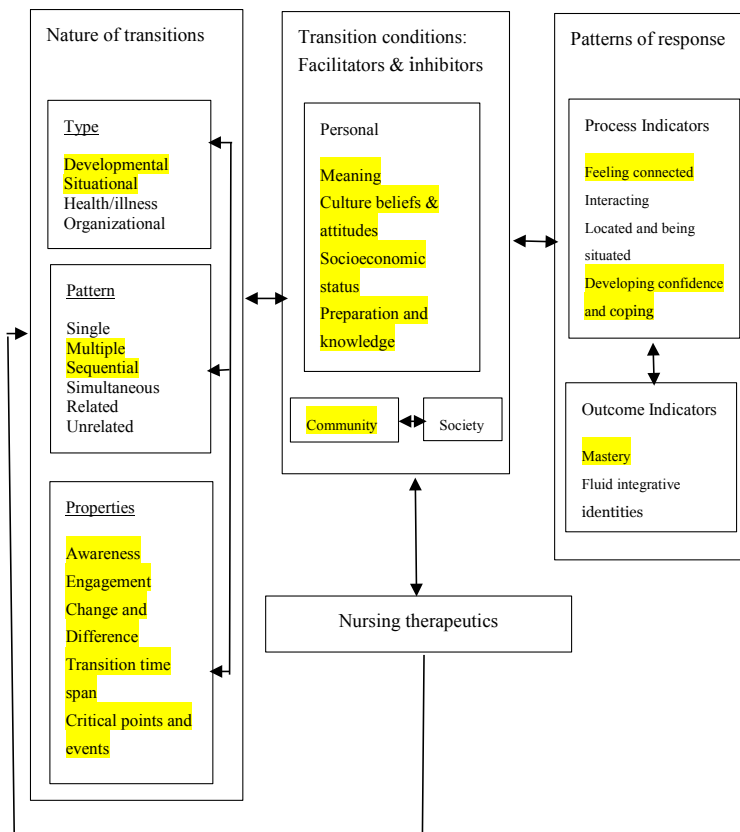


Figure 7. A comparison between Transition theory with the preliminary model: Struggling with motherhood and coping with fatherhood

Gender theory

After the birth of their child, the main concern of most of the teenage parents was to be a caring mother or a breadwinning father (II–III). This is in line with Connell's (2009) notion of the production relation, here reflecting the unequal gender division of paid and unpaid work. It is also in line with Hoang and Yeoh's (2011) finding that men were the main financial providers. The expected gender role for women in Thailand is to be a good mother and to make personal sacrifices for her child (Liamputtong, Yimyam, Parisunyakul, Baosoung, & Sansiriphun, 2004). In the present day, one of the most important aspects of this division is the gendered division of labor. However, most of the male participants did not think that caring for their child or performing housework would reduce their masculinity (II). This is in accordance with the neotraditional model of masculinity where men primarily are concerned about their breadwinning role and rely on their partners for caregiving (Gerson, 2010). Normally, many less educated, low-to-middle-class fathers must work long hours to provide for their families (Marks & Palkovitz, 2004). However, most of the teenage fathers reported that men are not "chang tao na" (the front leg of the elephant, leader), and women are not "chang tao lung" (the rear leg of the elephant, follower) (III). They thought that men and women have equal rights, and that men do not have more power than women. In this study, power relations (Connell, 2009) refer to aspects of men's power over women that are still accepted, such as the idea of the father as being the head of the household. Because most teenage mothers stayed at home, and therefore unavoidably were the primary caretaker and did the housework, teenage men and women, in their roles as parents, became unequal. As a result, teenage fathers played quite a small role in childrearing. Most teenage fathers accordingly gave more attention to the traditional gender role of breadwinning than to deepening their involvement in childrearing (Sriyasak, Almqvist, Sridawruang, & Häggstrom-Nordin, 2015). In Thai society, as in many Asian countries, the notion of fathers as breadwinners is still dominant (Chin, Hall, & Daiches, 2011; Chirawatkul et al., 2011; Yeung, 2013). Thus, even if the findings indicated some degree of involved fatherhood, the researcher interpreted the young parents' stories as describing a reproduction of gender inequality in work and child care.

Teenage fathers had lower self-esteem than adult fathers (I), which may be related to their low involvement in caring for their child. These teenage fathers seemed to be accessible to their child, but were not directly engaged, using Lamb's (2010) conceptualization. In contrast to our findings, a Chilean study found that teenage fathers were more involved in parenting, both during pregnancy and after birth, than older fathers (REDMAS, Promundo & EME 2013). A national policy in Chile uses universal or targeted programs to

involve men in childbirth and in daily care, including school-based initiatives and community mobilization (Barker, Contreras, Heilman & Singh, 2011). In 2008, a Thai government campaign introduced parenting classes, but Thai public hospitals still do not permit fathers to be present during birth; they only allow men to make prenatal visits or visit the postpartum wards (Ministry of Public Health in Thailand, 2012). Thai health authorities do not seem to place enough importance on fathers' involvement in early childrearing.

A major finding was that about two-thirds ($n = 70$) of the teenage fathers completely agreed or partly agreed with the statement that when the baby was born, you got the feeling of being a real man (I). The teenage fathers felt that they should take responsibility, as is expected of a traditional father, and accept the unintended pregnancy (II–III). All the teenage fathers participating in these studies represented traditional hegemonic masculinity, since they were closely connected to paid work and Thai traditions. Hearn (2002) states that fatherhood is related to male identities. Fathers and fatherhood are connected with social production and reproduction of men, masculinities and men's practice. Men have traditionally been expected to construct their identities as fathers through the hegemonic norms of masculinity and its connection to paid work (Townsend, 2002). The primary difference between fatherhood and motherhood seems to lie in the biological differences between men and woman. But in fact it is also strongly connected to cultural coding of masculinity and femininity.

Attachment theory

Attachment is a long-term process whereby a child develops affection for a specific other, and children can have more than one attachment (Bowlby, 1988). The teenage fathers showed less concern about childrearing behavior (II). This is consistent with Hoontanee's (2007) finding that teenage fathers interact less frequently with their children than adult fathers. This was also confirmed in answers about physical care, preventing harm, and developmental care. Most teenage fathers scored low on childrearing behavior and had not planned to have a baby, perhaps indicating they were not yet ready to be fathers. Thus, as stated by Paschal et al. (2011), teenage fathers try to manage the difficulties involved in handling two roles: the teenager role and the father role. Furthermore, our results indicate that the attachment to the child, at least in the beginning, might be less strong for teenage fathers than adult fathers.

Social support theory

The child's grandparents were important sources of support for the teenage parents from pregnancy to childrearing (II–III). The teenage parents reported receiving various forms of support from their family, both during pregnancy and after the baby was born. Families provided physical, emotional, material, informational, and financial support. The Social Support Theory is applicable, especially the three concepts about informational, instrumental, and emotional. However, appraisal did not appear as clearly as the other concepts in the focus group discussion. Healthcare providers accounted for the bulk of informational support to teenage parents (IV). Hupcey and Morse (1997) found that professionals performed professionally supportive actions such as teaching, being role models, encouraging, and counseling. Social support played a vital role in the transition to parenthood. As Western studies have reported, support from the family is helpful in enabling teenage parents to achieve competence in their parental role (McKinley et al., 2012; Oberlander et al., 2007). The findings from this dissertation correspond with those from a Thai study reporting that support was a helpful resource helping the teenage mothers provide care when they were under stress and lacked confidence in taking care of the infant (Neamsakul, 2008; Pungbangkadee, 2008; Sriyasak et al., 2013).

The results related to the research field of Health and Welfare

Getting adequate access to SRHR is very difficult for most adolescents. The availability, accessibility, acceptability and quality of service coverage all need improvement to guarantee reproductive health and rights for all adolescents; achieving this is a challenge facing healthcare workers providing these services (Backman, 2012; Guttmacher institute, 2015; UNFPA, 2013).

The theme *provision of comprehensive care* illustrated participants' experiences of taking care of teenage parents. The main approaches used in caring for teenage parents were teenager-focused care with an emphasis on emotional support, understanding and listening to teenagers' voices, and being concerned about repeated pregnancies. This is in line with Montgomery's (2003) finding that while physical care for teenagers and adults is similar, teenagers need more support and information during the prenatal and postpartum period. Many studies report that healthcare professionals are the most important sources of support to teenage parents (Dallas, 2009; Shakespeare, 2004; Wahn & Nissen, 2008). Healthcare providers are one of several sources of support for teenage parents, but in this study, it seems as

though the healthcare providers were the primary source of informational support.

Healthcare providers reflected on ways to improve the quality and accessibility of care offered by healthcare providers in order to meet the needs of teenage parents (IV). These findings are supported by results from Thai studies examining the limitations of reproductive health services; for example, service hours do not suit everyone, facilities are located in inconvenient settings, and centers do not offer one-stop service (Anusornteerakul et al., 2008; Tangmunkongvorakul et al., 2012).

Participants stated that medical abortion might solve unwanted pregnancy problems, but the procedure was not confidential and it was difficult to reach the target groups (IV). Nevertheless, reproductive health services for teenagers or safe sex behaviour in society are necessary. In addition, the quality and amount of information about sex varies between teachers and schools, and is often tailored to an older teenage group (Vuttanon, 2010). Respondents stated that personnel at some schools still thought that sex education might encourage teenagers to be sexually active and that people in the community might believe that the school had a problem with teenage pregnancies if sex education was taught. Thus, as reported by Sridawruang et al. (2010), traditional Thai culture has a double standard, considering premarital sex as unacceptable for young women (“good girls”), while young men, on the other hand, have the privilege of sexual freedom. Teenagers mentioned the practice of comparing “sex scores” between friends, which was more common among males than females (Vuttanon, 2010). According to Backman (2012), teenage services need to combine availability, accessibility, acceptability and quality. It is important to meet the needs of teenagers, and to combine support from different parties such as sub-district administrative organizations, schools, hospitals, and parents in order to address teenage parenthood.

The healthcare providers were concerned about the young parents. Participants mentioned that teenagers had easy access to the Internet, but had misconceptions about contraceptives and their use. According to Tipwareerom, Powwattana, and Lapwongwattana (2013) adolescents in Thailand scored low when asked about knowledge and skills in using a condom, and, moreover, attitudes towards condom use were negative. The healthcare providers brought up effects of teenage parenthood. Not only did pregnancy affect the teenagers themselves, it also had a long-term impact on

their families and society. Teenage parenthood can have consequences, both physiological and psychosocial. This is in agreement with Isaranurug et al. (2007) and WHO (2007), who found that being a pregnant teenager means being at greater physical, mental, social and economic risk than adult women. Teenagers should receive comprehensive sex education and learn skills to handle sexual situations in order to avoid unintended pregnancy.

The results related to implications for clinical practice

Expanding comprehensive sexuality education policy for teenagers

Most of the teenage parents were unconcerned about the risk of becoming pregnant and had not used contraceptives or had used them only sporadically (I–III). Healthcare providers also mentioned that teenagers had easy access to the Internet, but lacked correct knowledge and had misconceptions about contraception (IV). Even though Comprehensive Sexuality Education (CSE) was a core strategy in the 2007–2011 national AIDS plan (Ministry of Education), it was not reached in all secondary schools in Thailand (UNESCO, 2014). Ministries and involved parties should give particular attention to human rights as a basis for CSE, and make sure that CSE reaches teenagers both in school and out of schools. Moreover, CSE must reach teenagers who are 10–14 years old and are in puberty. Our findings indicated that personnel at some schools still thought that sex education might encourage teenagers to be sexually active and that people in the community might believe that the school had a problem with teenage pregnancies if sex education was taught (IV). Therefore, it is necessary for the Ministry of Public Health and the Ministry of Education in Thailand to work together to provide a clear message about teenage pregnancy, and their responsibility to provide CSE should be addressed at national, provincial, and local levels. This may also include decisions to keep pregnant girls in school and encourage them to return after having had their child.

Strict law enforcement to reduce teenage parenthood

According to Thai law it is illegal for anyone to have sexual intercourse with a person under the age of 15. Involved parties must strictly enforce the law and refuse to protect offenders. This means that guardians, parents, and teachers should be held legally responsible for girls under 15 who become pregnant.

Improving Sexual and Reproductive Health and Rights of teenagers

WHO has lunched the Sustainable Development Goals 3.7, for the period 2016–2030, in order to ensure universal access to sexual and reproductive healthcare services (WHO, 2015b). Findings in this dissertation also demonstrate that healthcare providers suggested improving the quality of care, especially concerning sexual and reproductive health for young adults. In addition, around 40% (n=26,430) of teenagers buy condoms at a drug store and only 25% report receiving them from healthcare providers (Bureau of Epidemiology, 2013). Therefore, to reduce the incidence of teenage pregnancy, the national health policy should address the right of all young people, and especially girls, to access health care services, with special focus on sexual and reproductive health and right. This means ensuring that sexually active teenagers should be educated on sexual and reproductive health, have access to contraceptive counseling, and be encouraged to use effective contraceptives. It is important to teach young men to practice safe sex and encourage them to be responsible in sexual relations with their partner.

According to the Ministry of Public Health (2015), legal medical abortion is possible, though subject to strict restrictions. Teenagers under the age of 18 need parental consent. Healthcare providers stated that the medical abortion procedure was not confidential and it was difficult to reach the target group (IV).

Nurse-midwifery practice

Our findings provide healthcare professionals with a deeper understanding of teenage parents' experiences of becoming and being a parent, and may increase their adaptation of care for teenage parents and inspire them to tailor their care specifically to teenagers' needs from early pregnancy to parenthood. Specifically, health care professionals need to develop teenage parenting classes both in the antepartum and postpartum periods. In 2008, a Thai government campaign introduced parenting classes, but Thai public hospitals still do not permit fathers to be present during birth. Men are only allowed to attend prenatal visits and visit postpartum wards (Ministry of Public Health, 2012). Thai health authorities do not seem to place enough importance on fathers' involvement in early childrearing. However, there is an increase in men's involvement in childrearing as part of an overall change in Thai family roles (Sansiriphun et al., 2010). Ways need to be found to encourage teenage fathers and healthcare professionals to work together to promote good relationships between fathers and children, with the aim of raising public awareness and fostering positive values in society regarding fatherhood.

The preliminary models developed in this dissertation could be adapted for use in intervention studies for teenagers from pregnancy to parenting. These could be, for example, nurse-midwifery interventions to promote the transition to becoming teenage parents, or community participation in developing sexual and reproductive health service for Thai teenagers with the aim to reduce the teenage birth rate. Families play a vital role in helping teenage parents to successfully pass through this transition. Professionals are recommended to provide health education for teenage parents and their families, especially from pregnancy until the childrearing period. Services for this particular group should continuously and systematically be provided to enhance the quality of care for teenage parents and to promote the infants' well-being and future development.

Nursing education

The findings of this dissertation have useful implications for nurse-midwife education in the fields of SRHR, parenthood and child nursing. The nursing curriculum could place more emphasis on health promotion. Nursing instructors can apply knowledge gained from the findings to teaching the nursing students. Topics should focus on SRHR, the teenage father role, and teenage parents, and be integrated with the Thai context.

Methodological considerations

Paper I

Validity and reliability are ways of demonstrating the rigor of quantitative research findings (Black 1999; Twycross & Shields, 2004). A reason for giving the instruments FSC, FCB, and RFC to teenage fathers in our study was that the scales had previously been used in studies in Thailand, and their content validity and reliability were high (Chakuntode, 1996; Chunpradub, Chupradit, & Bhasaprates, 2008; Salong, 2009). Another reason for our choice of the parenting sense-of-competence scale for studying fathers in Thailand was the validation of this instrument by Suwansujarid, Vatanasomboon, Gaylord, and Lapvongwatana (2013). Internal consistency of items such as individual questions in a questionnaire can be measured using statistical procedures such as the Cronbach's alpha coefficient (Cronbach, 1951). Cronbach's alpha values in the three questionnaires (FSC, FCB, and RFC) were 0.75, 0.79, and 0.72. Acceptable values of Cronbach's alpha range from 0.70 to 0.95 (Bland & Altman, 1997; Tavakol & Dennick, 2011).

In this study, face validity was strengthened through pilot questionnaires filled in by one teenager and one adult first-time father. Self-reported measures are suggested to be essential when the purpose is to obtain subjective assessment of experiences (Bowling, 2001). A self-reported questionnaire was chosen as it was considered to be consistent with the aim of the study. To get a high response rate, the first author visited nearly all the PHCs in order to contact personnel and inform them about the study. With the exception of some demographic questions, the respondents answered every question about the father role in the questionnaires. The reason for the latter could be the respect accorded to healthcare providers in Thai culture, or pressure to participate, because the healthcare providers or village health volunteers reminded the participants to check the questionnaires before putting them in the envelope.

Generalization is a major standard of quality in quantitative research (Polit & Beck, 2012). The study group consisted of teenage fathers (≤ 19 years) and adult fathers (≥ 25 years) ($n=70$), and at each PHCs the group participants had an equal chance of being selected (Sapsford, 2007). This study focused on first-time fathers only, and was confined to a single province in western Thailand. The results may be comparable to similar regions in Thailand (e.g. rural regions with a high adolescent birth rate). However, the results should be interpreted with caution when it comes to urban areas in Thailand. Therefore, more studies in other regions are needed to obtain a more complete picture of fatherhood in Thailand. Our study contributes to the knowledge and understanding of teenage first-time fathers, a topic not previously studied in Thailand.

Papers II–III

Grounded theory is useful for describing complex phenomena and providing an understanding and description of people's personal experiences of phenomena (Bryant & Charmaz, 2007; Creswell & Cook, 2012). Lincoln and Guba (1985) have suggested four criteria to establish trustworthiness; these are credibility, dependability, confirmability, and transferability. Credibility was confirmed, as the researcher read the transcript and coded the data independently before discussing codes and preliminary categories with the Thai field supervisor (who has extensive experience of grounded theory) until consensus was reached. To further enhance credibility, before the second interview the analysis process was discussed with team authors until agreement was reached. Dependability was achieved through member checking, where participants were asked to give feedback on the transcript from the first interview. The study was designed to collect data from the same

teenage parents at different points of time. This was done in order to determine the congruence of the studied phenomenon over time.

To enhance the confirmability of the results, the researcher kept the raw data, memos, field notes, data reduction and analysis transcripts, data reconstruction and synthesis products, process notes, and existing relevant literature to aid in confirming the findings.

Using theoretical sampling helped us to obtain transferability, which concerns whether findings in a study can predict and explain similar situations. In Study II, cohabiting teenage parents-to-be were recruited in a rural area with one of the highest adolescent birth rates in Thailand. The construction of the emerging model could have been different if teenage parents living in other contexts had been interviewed (e.g. living in an urban area, living in an area with low teenage pregnancy birth rates, or living in a nuclear family). Another limitation was that the participants all lived in extended families; further, they all lived in the same geographical area in Thailand.

Paper IV

The focus-group technique is a type of qualitative research methodology for producing qualitative data. In order to establish the key considerations about validity, a pilot focus-group discussion was undertaken at a district hospital with members of the target population who did not participate in the actual focus groups (Dreachslin, 1999). The researcher acted as the moderator of the focus-group discussions. Nassar-McMillian and Borders (2002) state that it is necessary for the researcher to run focus groups, because the researcher is knowledgeable about the subject and therefore is best equipped to keep the sessions on track and help the group maintain its focus. Four homogeneous groups with 4–6 participants each were included in this study. The respondents could feel free to talk about their experiences of caring for teenage parents. Small groups of 4–6 participants may be productive since all members in the group feel encouraged to take part in the discussion (Prince & Davies, 2001). Jinks and Daniels (1999) found that larger groups were difficult to control, and it is difficult to achieve equal participation in the discussion. It is recommended that focus groups ideally should be conducted with a comparatively homogeneous group (Dreachslin, 1999) in order to elevate the equality of contributions to discussion among participants (Boddy, 2005; Gibbs, 1997). Through this process, much information was gained from the healthcare providers in different clinical settings. Healthcare providers had a

chance to contribute, exchange ideas, and discuss the issue from the point of view of their own experiences. Venues for group sessions must be created in a comfortable, relaxing, and productive atmosphere (Masadeh, 2012).

The trustworthiness of a study comprises credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1999). Credibility was achieved when the researcher read the transcript and coded the data independently before discussing codes and preliminary themes with the Thai co-supervisor (who is experienced in qualitative research and in the Thai midwifery field) until agreement was reached. Dependability refers to the consistency and stability of the data over time. In this study, the researcher used the same interview guide for each group during data collection. After each group discussion was finished, the moderator and note taker shared and discussed the information until consensus was reached. Dependability was confirmed by discussing codes and themes with team researchers until consensus was reached. Transferability refers to whether findings can be applied to other settings or groups (Polit & Beck, 2012). This study was conducted in one province in western Thailand; therefore the results may not be transferable. However, this study can provide valuable insight into Thai healthcare providers' opinions about teenage parenthood. Ultimately, however, it is the reader who decides whether or not these findings are transferable to another settings (Graneheim & Lundmand, 2004). Finally, to ensure confirmability, before finishing a focus group discussion, the moderator summarized the discussion for the participants, who could confirm the accuracy of the summary or recommend that portions be removed. Citations from the original text are presented under the various themes to illustrate the participants' statements. The researcher has kept the raw data and analysis products to strengthen the confirmability of the findings.

Pre-understanding

The researcher serves as the major instrument in qualitative research (Charmaz, 2006; Rew, Bechtel, & Snapp, 1993). The researcher and participants interact and co-construct knowledge (Streubert & Carpenter, 2011). In the qualitative studies presented here, the researcher was the major research instrument and was involved throughout the research study. The researcher originates from a rural area of Thailand and has extensive experience as a nursing instructor. To enhance self-awareness and minimize bias, a reflective journal was kept throughout the data collecting process and analysis to remind the researcher of biases and to enhance the study's rigor (Charmaz, 2006). As a woman interviewing male participants, the researcher could have difficulty understanding the other's perspective. The first author

has undertaken research within the area of teenagers and has led parenting classes with both men and women. These experiences were beneficial for her ability to listen to and talk with men who were, or were about to become teenage parents. Further, all the co-authors have previous experience of doing and publishing research on families using grounded theory. These experiences have led to an awareness of the importance of data variation and an open mind when analyzing the empirically generated findings.

CONCLUSION

The findings in this dissertation may contribute to the knowledge and understanding of teenage parenthood in the Thai context.

Teenage fathers differed from adult fathers in having a lower income and savings after the child was born, and having lower educational levels.

Only one-quarter of the teenage fathers had planned to have a baby, compared to two-thirds of the adult fathers.

The teenage fathers scored lower than adult fathers on all three questionnaires: the FSC, the FCB, and the RFC.

Nearly one-fifth of the teenage fathers disagreed or strongly disagreed with the statement that they had adequate skills and abilities to be a good father.

Nearly one-quarter of the teenage fathers never, or only infrequently talked or played with the child.

Nearly one-third of the teenage fathers completely agreed with the statement: "When the baby was born, you got the feeling of being a real man."

Both positive and negative experiences associated with teenage parenthood were described by Thai teenage parents.

The core category "struggling with motherhood and coping with fatherhood" comprises descriptions of the process from when the teenagers first learned about the pregnancy until the child was six months old. The teenagers had failed to use contraceptives, which led to an unintended parenthood. Their parenthood became a turning point in their lives, as the teenagers started to change their behaviors and lifestyle during pregnancy, and modified their relationships to partner and family. Family commitments were a facilitator,

through support given by their families. Finally, becoming a parent necessitates finding ways to deal with the parental role, by engaging in parental activities and reestablishing life goals.

Most of the teenage parents reproduced traditional gender roles by being a caring mother or a breadwinning father.

Strong support from their families helped smooth their transition to being teenage parents.

The reflections by the healthcare providers about their experiences of caring for teenage parents

The healthcare providers viewed themselves as caring for teenage parents by using teenager-focused care and prevention to help them avoid repeated pregnancy.

The healthcare providers suggested easier access to reproductive health care, improved sex education, and better collaboration between different parties as ways to improve the quality of and access to care.

The healthcare providers were mainly concerned about factors contributing to teenage pregnancy, and the impact teenage pregnancy might have on an individual and structural-societal level.

Future research

The following recommendations for future research are made from the findings as well as the limitations of this dissertation.

More studies in other regions are needed to obtain a more complete picture of fatherhood in Thailand, and to make it possible to develop suitable strategies for promoting healthy father roles.

More studies on young fathers in Thailand are required. It is important to deepen the understanding of young fathers' experiences of childrearing.

Future research could take an exploratory approach and use a cross-cultural perspective, employing the preliminary model in different contexts.

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Summary in Swedish Svensk sammanfattning

Syftet med avhandlingen var att bidra med kunskap om och en fördjupad förståelse för thailändska tonårsföräldrars upplevelse av att bli förälder, samt vårdgivares reflektioner om sina erfarenheter av vård och upplysning när det gäller tonårsföräldrar.

Resultaten baseras på tre studier vilka resulterat i fyra artiklar, genomförda med både kvantitativa och kvalitativa ansatser. Data samlades in mellan 2013 och 2015 i en provins i den västra delen av Thailand. Artikel I: data baserades på tre självrapporterade validerade frågeformulär vilka fylldes i av 70 tonårsfäder och 70 vuxna fäder. Deskriptiv statistik, Mann-Whitney U-test och Chi-två-test användes för att analysera kvantitativa data. Artikel II och III: semistrukturerade intervjuer genomfördes enligt grundad teori i en heterogen grupp med 25 tonårspar (n=50) innan och efter deras första barns födelse. Artikel IV: fyra fokusgruppdiskussioner genomfördes med 21 vårdgivare och latent innehållsanalys tillämpades för att analysera kvalitativa data.

Resultaten visade att tonårsfäder i genomsnitt hade lägre poäng än vuxna fäder på självskattningsskalor som mätte faderns känsla av kompetens, faderns barnuppfostransbeteende, och relationen mellan far och barn (Artikel I). Tonårsmammorna uttryckte hur de kämpade med fysiska och sociala förändringar, som exempelvis kroppsförändringar, amning och att behöva avsluta sin skolgång, medan tonårsfäderna gav exempel på hur de hanterade sitt framtida ansvarstagande genom att arbeta hårdare för att spara pengar för framtida familjebehov (Artikel III). Mor-och farföräldrar fungerade som viktiga stödpersoner från graviditeten till barnuppfostran. Genom att ta hand om barnet och genom att ge råd och instruktioner, hjälpte de tonårsföräldrarna att hantera sin situation. De flesta tonårsföräldrar reproducerade traditionella genusmönster genom att vara en vårdgivande mamma och en familjeförsörjande pappa (Artikel II-III).

Vårdgivarna var engagerade i unga föräldrars situation och ansåg sig tillhandahålla allsidig vård och omsorg. Men de hade förslag om förbättrad kvalitet genom tillgänglighet till reproduktiv hälsovård och förbättrad sexualundervisning.

De unga föräldrarnas berättelser innefattar hur de kämpade och hanterade förändringen i sina liv då de blev oplanerat gravida, accepterade sitt föräldraskap och slutligen blev föräldrar. En stödjande familj spelade en väsentlig roll i övergången till föräldraskapet.

Insatser för tonårsföräldrar bör inledas och organiseras systematiskt för att förbättra vårdkvaliteten för tonårsföräldrar och främja barnets välbefinnande och framtida utveckling.

Avhandlingen kan bidra till en djupare förståelse för tonårsföräldrars erfarenheter av att bli och vara förälder. Vidare kan den inspirera vårdpersonal att skraddarsy insatser utifrån tonåringars specifika behov avseende sexuell och reproduktiv hälsa, med fokus på preventivmedelsrådgivning, tidig graviditet och föräldraskap.

Summary in Thai

บทคัดย่อไทย

จุดมุ่งหมายของวิทยานิพนธ์เพื่อทำให้เกิดความรู้ ความเข้าใจด้านประสบการณ์การเป็นพ่อแม่วัยรุ่นในบริบทไทยและสะท้อนความรู้สึกของผู้ให้บริการสุขภาพด้านประสบการณ์ในการดูแลพ่อแม่วัยรุ่น

ผลการวิจัยมาจากการศึกษาสามเรื่อง เป็นการวิจัยแบบผสมผสานวิธีเชิงปริมาณและเชิงคุณภาพ เก็บรวบรวมข้อมูลในจังหวัดหนึ่งในภาคตะวันตกของประเทศไทยระหว่างปีพ.ศ. 2556-2559 ทำให้มีบทความจากการวิจัยจำนวนสี่เรื่อง บทความวิจัยเรื่องที่ 1 ใช้แบบสอบถามจำนวน 3 ชุดสำหรับการรายงานผลตนเองสำหรับบิดาวัยรุ่นไทยครั้งแรกอายุต่ำกว่าหรือเท่ากับ 19 ปีจำนวน 70 รายกับบิดาผู้ใหญ่อายุมากกว่า 25 ปีขึ้นไปจำนวน 70 รายวิเคราะห์ข้อมูลใช้สถิติเชิงพรรณนาการทดสอบ Mann-Whitney U-test และไคสแควร์ (Chi-Square) บทความวิจัยเรื่องที่ 2,3 เป็นการวิจัยเชิงทฤษฎีจากข้อมูลพื้นฐาน (Grounded Theory) กลุ่มตัวอย่างเป็นวัยรุ่นที่กำลังจะเป็นพ่อแม่ ($n = 50$) เก็บข้อมูลระยะก่อนคลอดและหลังคลอดบทความวิจัยเรื่องที่ 4 สันทนาการกลุ่ม 4 กลุ่มกับผู้ให้บริการสุขภาพจำนวน 21 รายโดยใช้การวิเคราะห์เชิงเนื้อหา

บิดาวัยรุ่นมีค่าคะแนนต่ำกว่าบิดาผู้ใหญ่ในเรื่อง ความสามารถการเป็นบิดา พฤติกรรมการเลี้ยงดูเด็กและความสัมพันธ์ระหว่างบิดาและบุตร (บทความวิจัยเรื่องที่ 1) มารดาวัยรุ่นมีการเผชิญกับการเปลี่ยนแปลงทางร่างกายและสังคมเช่น การเลี้ยงลูกด้วยนมแม่และการออกจากโรงเรียนบิดาวัยรุ่นยกตัวอย่างการแสดงความรับผิดชอบเพื่ออนาคตด้วยการทำงานอย่างหนัก ใช้จ่ายอย่างประหยัดเพื่อเก็บออมสำหรับอนาคต (บทความวิจัยเรื่องที่ 3) พ่อแม่ของวัยรุ่นเป็นแหล่งสนับสนุนทางสังคมที่สำคัญ ซึ่งมีส่วนช่วยพ่อแม่วัยรุ่นในการรับมือกับบทบาทใหม่ส่วนใหญ่การดูแลครอบครัวเป็นหน้าที่ของมารดาวัยรุ่นช่วยการหาเลี้ยงครอบครัวเป็นหน้าที่ของบิดาวัยรุ่น (บทความวิจัยเรื่องที่ 2,3) ผู้ให้บริการด้านสุขภาพมองตนเองว่าให้การดูแลอย่างครอบคลุมนอกจากนี้ยังสะท้อนถึงความสำคัญของการเข้าถึงการดูแลสุขภาพการเจริญพันธุ์และการการสอนเพศศึกษาให้มีประสิทธิภาพ (บทความวิจัยเรื่องที่ 4)

จากการวิจัยสะท้อนให้เห็นถึงความพยายามและ การเตรียมรับมือกับการเปลี่ยนแปลงของ
ชีวิตของพ่อแม่วัยรุ่น ตั้งแต่เกิดตั้งครรภ์โดยไม่ได้ตั้งใจการยอมรับการเป็นพ่อแม่วัยรุ่นซึ่งการ
สนับสนุนจากครอบครัวมีความสำคัญ

การจัดบริการส่งเสริมสุขภาพควรจัดบริการเฉพาะและ เป็นระบบเพื่อเพิ่มคุณภาพของการ
ดูแลสำหรับพ่อแม่วัยรุ่นและเพื่อส่งเสริมให้ทารกมีพัฒนาการที่ดีในอนาคตและมีความสุข
มีชีวิตและมีความสุขเป็นอยู่ที่ดี

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APPENDICES

Appendix A: Data analysis diagram of Teenage father

Appendix B: Data analysis diagram of Teenage mother

Appendix C: Paper I-Paper IV

Appendix A: Data analysis diagram of Teenage father

Data analysis diagram of teenage father

Causal conditions

Figure 1 Reason to be a teenage father

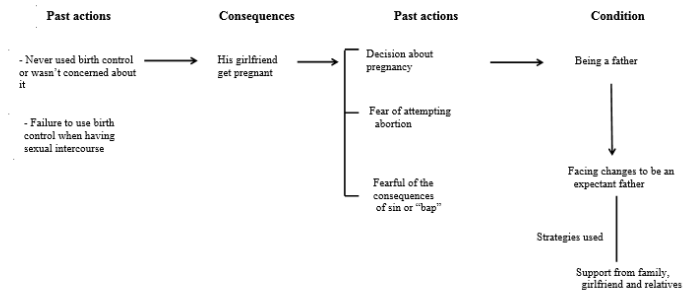


Figure 2 Realizing the significance of Buddhist beliefs

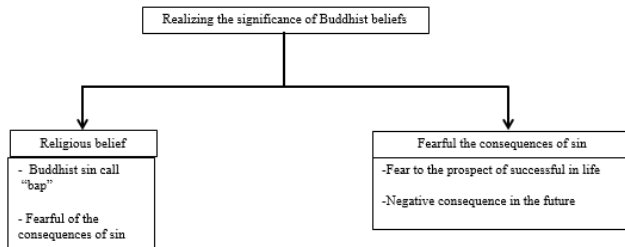


Table 1: Showing responsibility as respected from a traditional father

Responsibility for oneself	Responsibility for his girlfriend
<ul style="list-style-type: none">- Focus on studying and working- Changing bad habits	<ul style="list-style-type: none">- The fetus as one's own flesh and blood- Approval from girlfriend's family

Action/interaction strategies

Figure 3 Transition and change of lifestyle

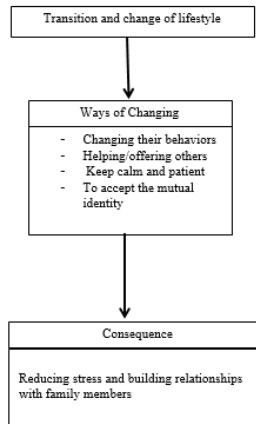


Figure 4 Support to partner during pregnancy

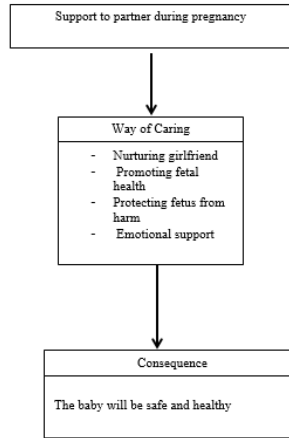


Figure 5
Preparation to fatherhood

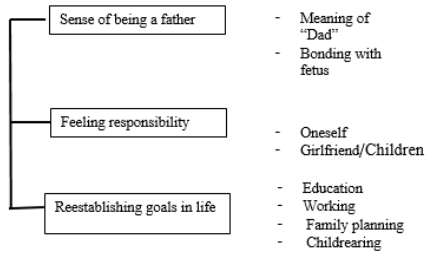
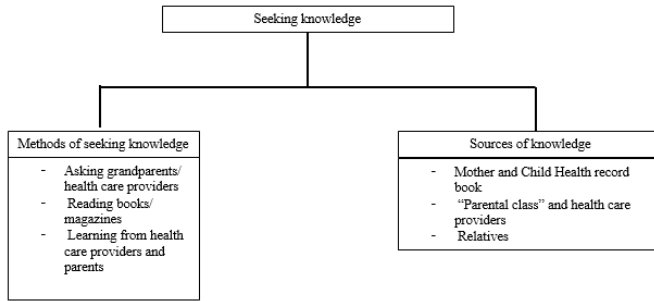
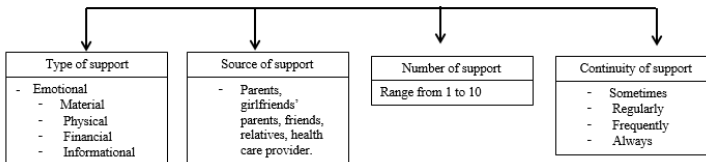


Figure 6 Seeking knowledge



Intervening conditions

Figure 7 Getting support



Consequences

Figure 3
Becoming a father

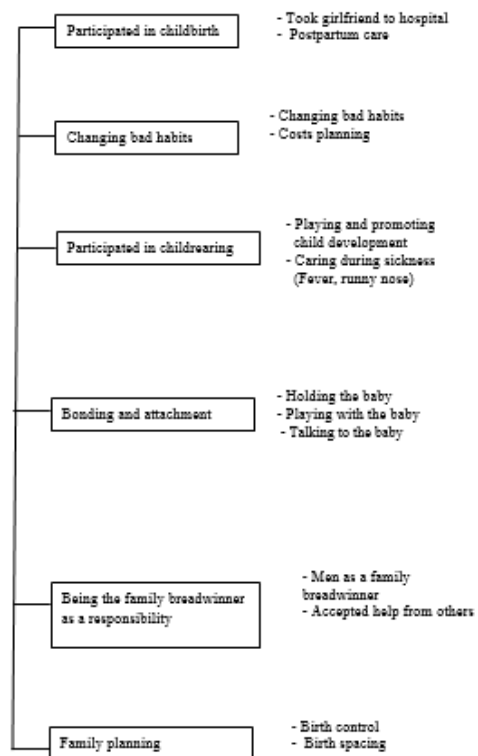
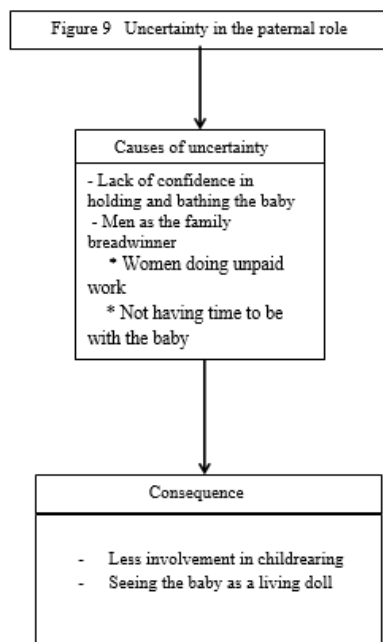


Figure 9 Uncertainty in the paternal role



Appendix B: Data analysis diagram of Teenage mother

Data analysis diagram of teenage mother

Causal conditions

Figure 1 Reason to be a teenage mother

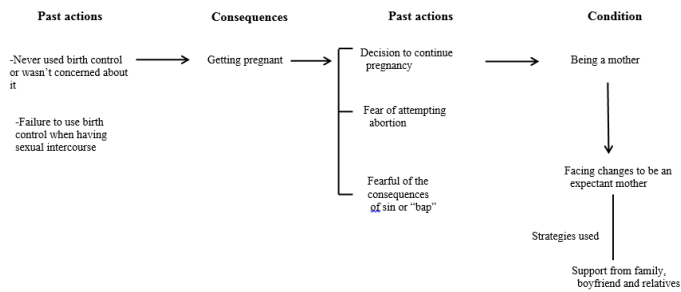
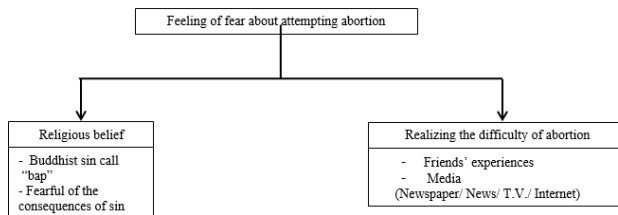


Table 1: Acceptance from family

Reaction of her family	Reaction of boyfriend and his family
<ul style="list-style-type: none"> - Disclosed the pregnancy - Unexpected depth of love from her mother/family 	<ul style="list-style-type: none"> - The fetus as one's flesh and blood - Approval from boyfriend and his family

Figure 2 Feeling of fear about attempting abortion



Action/interaction strategies

Figure 3 Changed behavioral and lifestyles

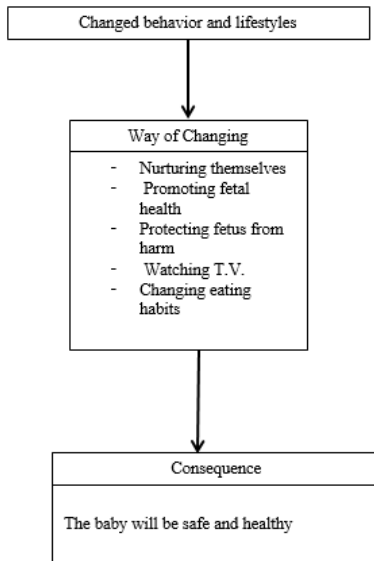


Figure 4 Adapting to changed relationship with family and partner

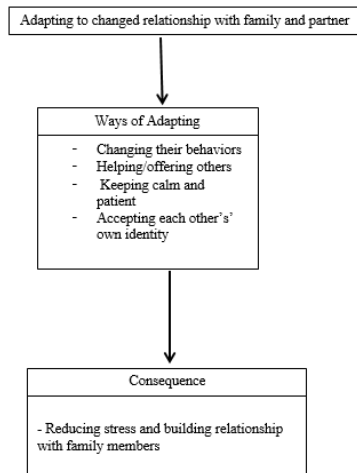


Figure 5 Concerns about childrearing

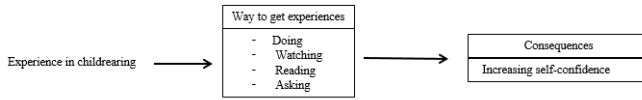


Figure 6 Gaining knowledge

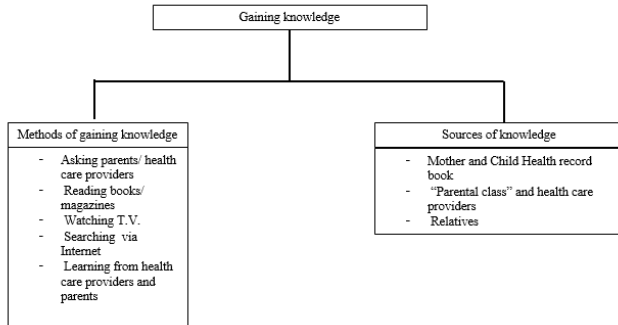
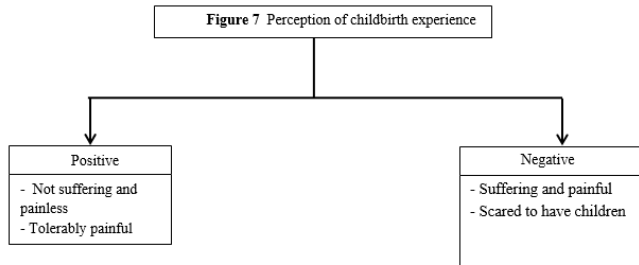
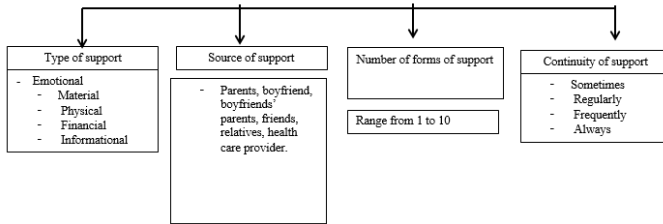


Figure 7 Perception of childbirth experience



Intervening conditions

Figure 8 Getting support



Consequences

Figure 9
Becoming a mother

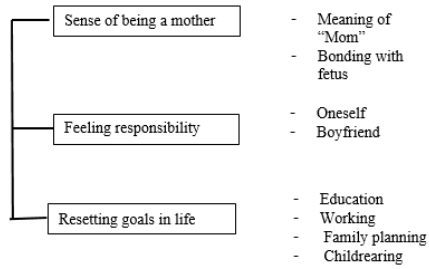


Figure 10
Constructing a warm family

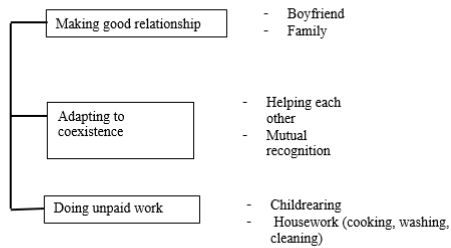


Figure 11
Engaging in maternal activities

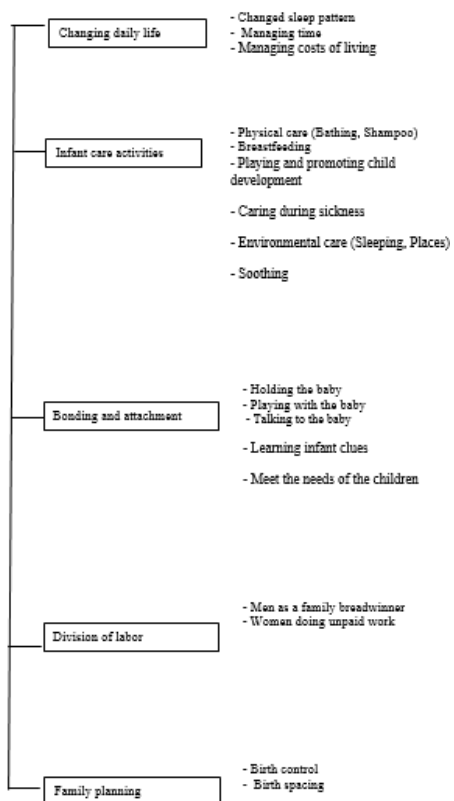


Figure 12
Being confident as a mother

Factors leading the achievement

- Infant temperament and behavior
 - . Docile child
 - . Healthy baby and normal conditions
- Maternal instinct
 - . Child caring
 - . Protective child
- Learning maternal role
 - . Mother and relatives
 - . Following belief
 - . Imitation maternal role
- Satisfaction in maternal role
 - . Supported from family
 - . Happy to perform the maternal role
 - . Feeling proud of the baby
- Marital satisfaction
 - . No/less arguments
 - . Managing within the family
- Timing
 - . Still not stable in childrearing (Child age less than 1 month)
 - . Settled in childrearing (Child age more than 1 month)
 - . Trial and error

Consequence

- Appropriated child development
- Increased body weight