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THAI ADOLESCENT MOTHERS: PERSPECTIVES ON SEXUALITY EDUCATION AND EDUCATIONAL OPPORTUNITIES

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ABSTRACT

This qualitative research aimed to answer the following questions: 1) What are the reasons behind Thai adolescents' failure in contraceptive use, despite their school-based sexuality education and participation in teen pregnancy prevention activities? 2) What are the factors supporting Thai adolescent mothers continuance in education? Data were gathered by conducting in-depth interviews with twenty adolescent mothers from Nakhonsawan in 2018. Each respondent was younger than 19 years at the time of the interviews. Content analysis was then used to interpret the collected data. The result revealed that majority of the mothers reported their school-based sexuality education as being one-directional, and mainly taught using a lecture method. On the other hand, the out-of-class pregnancy prevention activities were regarded as enjoyable and participatory. Nevertheless, the failure to increase adolescents' awareness of contraceptive methods persisted, consequently leading to unplanned pregnancies. Two out of the 20 adolescent mothers were able to continue studying while raising their children. However, this was with support from parents, teachers and peers. In this regard, collaborative planning between parents and teachers is necessary to support adolescent mothers' education continuity. School-based sexuality education using a lecture method failed to enable the students to translate their knowledge into practice. Meanwhile, support from parents, teachers and peers formed a critical factor that endorsed the opportunity for adolescent mothers to continue their formal education.

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1. INTRODUCTION

Each year, 16,000,000 adolescent females aged 15 to 19 years, and 2,500,000 females under the age of 16 from developing countries give birth (World Health Organization, 2018; United Nations Population Fund, 2015; Neal et al., 2012), particularly in West Africa where the adolescent birth rate has been observed to be as high as 115 births per 1,000 girls. This estimated number is followed by the adolescent birth rate at 45 per 1,000 girls in the Latin America, Caribbean and Southeast Asia regions (United Nations Department of Economic and Social Affairs, 2017). Additionally, the adolescent birth rate in rural areas is three times the

number in urban areas (Every Woman Every Child, 2015). In Thailand, a study on adolescent females aged 15 to 19 years during the period from 2000 to 2012 detected a continual increase in the Thai adolescent birth rate, which grew from 31.1 births per 1,000 girls in 2000 to 53.4 births per 1,000 girls in 2012. Thereafter, the birth rate began to decline from 2013 to 2015, reaching 44.8 births per 1,000 girls in 2015. The number remained significant, despite the anticipated downturn. The estimation was more evident in the northeastern, central, and northern region of Thailand (Bureau of Reproductive Health, Department of Health, 2015; UNICEF Thailand, 2015). In 2018, Nakhonsawan, which is a part of the lower northern and upper central regions of Thailand, observed a fall in the adolescent birth rate at 35.46 births per 1,000 girls. Nevertheless, the number remained higher than the national average at 35.32 births per 1,000 girls when compared with the estimation at regional or national health levels (Jongjit, 2018: 10).

The main factors contributing to adolescent pregnancy problems are: lack of understanding of sexuality education and lack of skills and knowledge in the use of contraceptives. With additional factors, including these social and economic factors: problems of family relations, poverty, substance abuse, and sexual abuse or rape. The consequences of adolescent pregnancy and childbirth can affect the teen mother and her child. For example, risk of premature birth, risk of a low birth weight child. Children's health and development problems arising from a lack of parenting knowledge. Social consequences for unmarried adolescents can include stigmatization, rejection, or violence by partners, parents, and peers. Moreover, teen pregnancy and childbearing often require girls to drop out of school, it could also be detrimental to girls' future educational and employment opportunities (World Health Organization & UNAIDS, 2015; World Health Organization, 2016; 2018; Raj and Boehmer, 2013).

Ashamed, most adolescent mothers abandon their studies and drop out of school after learning of unplanned pregnancy. A few have reported rejection by peers, teachers and communities, or that their parents had forbidden them from continuing their education out of fear that the young mothers would bring shame to their families. In addition, a few adolescent mothers dropped out of school to raise their children and support their families financially (UNICEF Thailand, 2015: 8). Although a variety of reasons, including marriage, were stated in a published study by Thailand's Ministry of Education on the factors influencing students' dropout decisions, pregnancy was not one. Furthermore, failures by many school administrators to record the statistical data on their school's pregnancies has consequently resulted in the number of pregnancy-related dropouts being misrepresented (UNICEF Thailand, 2015: 12). Sexuality education, formerly named sex education, was introduced into the primary and secondary education curriculum in 1978. The quality of the subject has been continually revised and improved since then (Thaweesit and Boonmongkon, 2012). Another arrangement included a collaboration among the Ministry of Education, the Ministry of Public Health and non-governmental organizations. For instance, the Path2Health Foundation, which was supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Thai Health Promotion Foundation (ThaiHealth) have promoted out-of-class adolescent pregnancy prevention activities (Boonmongkon et al., 2016: 1). Section 6 of the Act for Prevention and Solution of the Adolescent Pregnancy Problem 2559 B.E. currently states that all educational establishments shall offer learning and teaching on sexuality studies that is age-appropriate to their students or pupils (Ministry of Public Health, Legal Affairs Division, 2020). A study by the United Nations Children's Fund (UNICEF), Thailand, further revealed that 99% of schools offered a sexuality education in their curriculum. However, the study hours varied. Some schools offered sexuality education as a self-contained subject spanning 18 sessions per semester. Some schools offered sexuality education as a part of health education. Consequently, the teaching and learning of the subject required only two to four sessions out of a total of 18 sessions, each taking approximately 50 to 60 minutes. Other schools incorporated sexuality education within subjects such as social studies, science and guidance. Each session lasted from five to ten minutes in turn. The topics addressed by sexuality education could range from contraceptive methods for adolescents, sexually transmitted diseases and AIDS, to human physiology and sexual development. Meanwhile, teachings on sexuality education primarily focused on a point of view that emphasized the negative consequences of sex rather than promoting students' analytic and critical-thinking skills. Nevertheless, the lecture method employed by most teachers failed to offer students opportunities to develop analytical thinking skills or ask questions. In contrast, an activity-based pedagogy was adopted by only a minority of teachers (Boonmongkon et al., 2016: 7-8, 18). Regardless of Thai teenagers' experience in sexuality education and their related out-of-class activities, Thailand's adolescent birth rate has remained high in comparison to that of other East Asian countries at 7 births per 1,000 girls (World Health Organization, 2018).

The reasons behind this inconsistency between Thai adolescents' comprehensive school-based sexuality education combined with their participation in out-of-class pregnancy prevention activities and their contraceptive failure are therefore of interest. The factors supporting Thai adolescent mothers' educational continuance are of further note. This research was conducted in Mueang Nakhonsawan District, and Mae Wong

District of Nakhonsawan Province with the intention of forming a systematic review of Thailand's sexuality education and out-of-class pregnancy prevention activities. In addition, the research aimed to establish a support system for adolescent mothers to enable them to continue their formal education.

2. RESEARCH METHODOLOGY

2.1 Research design

This was a qualitative research. Data were gathered by conducting in-depth interviews and content analysis was then used to interpret the collected data.

2.2 Participants

The key informants were adolescent mothers from two districts in Nakhonsawan, each a pilot district under the Teenage Pregnancy Prevention and Solution Project financially supported by the Thai Health Promotion Foundation (ThaiHealth). Ten of the informants were from Mueang Nakhonsawan District (5 from Wat Sai Sub-district and 5 from Nong Krot Sub-district). The other 10 informants were from Mae Wong District: (5 from Mae Wong Sub-district and 5 from Khao Chon Kan Sub-district). To conform to the research's selection criteria, the key informants had to be adolescent mothers under 19 years of age at the time of their first pregnancy or child birth. The sampling process was assisted by four sub-district staff who were either registered nurses or sub-district health personnel from the Teenage Pregnancy Prevention and Solution Project. The four sub-district staff ascertained that each selection criterion was met and that each key informant had given their consent to participate in the research. The research was certified by the Research Ethics Review Committee for Research Involving Human Research Participants of Nakhonsawan under Certification of Approval (COA) No. NSWPHO-028/61.

2.3 Definition

As defined by this research, adolescent mothers were females younger than 19 years of age at the time of their first child birth or first pregnancy.

2.4 Data collection

Four sub-district staff members from the Teenage Pregnancy Prevention and Solution Project in Nakhonsawan assisted in recruiting the target group. This process was based on the research's inclusion criteria. In addition, sub-district staff (Director of Health Promotion Hospital or Public Health Scholar) coordinated a meeting between the researcher and the target group for data collection. In-depth interviews were conducted at the arranged time at each key informant's home, assisted by sub-district staff. Each interview was conducted until all the relevant data was obtained, taking about 1-1.5 hours. Collection took place in June-July of 2018.

This research employed an interview form as its data collection instrument. The instrument was designed by the researcher and contained both closed-ended and open-ended questions. The closed-ended questions were used to gather general information about each participant whereas the open-ended questions addressed the objectives of the study. The data collection was also guided by an interview guideline created prior to the field study. Interviews were documented as field notes with audio recordings for later analysis. Researchers are also instrumental in in-depth interviews, observing key informants, analyzing and synthesizing data.

Self-introduction and a request for permission to record audio by the researcher occurred at the onset of the one-on-one interviews which involved the adolescent mothers, the researcher and the note-taker. After the field research, further enquiries or requests for additional information on a few specific topics were addressed through phone interviews with some of the key informants. Each audio recording of the interviews was transcribed verbatim and validated against the corresponding field notes to ensure accuracy.

2.5 Data analysis

This research used a content analysis approach to interpret the recorded interviews. Data-reduction was applied to both the audio recordings and transcription through conscientious analysis. Next, the information was coded into manageable, thematic content categories. Later on, the quotes or opinions from the interviews were interpreted based on the derived categories. This summed the findings with the intention of answering the research questions while providing an authentic assessment of the situation.

3. RESULTS

Of the 20 key informants, 17 were in junior high school, high school, vocational certificate program and high vocational certificate program, when they became pregnant. One was in primary school. Two were studying an upper secondary school curriculum in a non-formal or informal education program. The key informants had an average age of 18 years on the date of the interview. One was younger than 15 years of age. The first sexual intercourse happened at an average age of 16 years old. Meanwhile, the earliest first sexual intercourse and pregnancy were reported in a girl as young as 13 years of age. Eighteen key informants had delivered a child whereas two had not. Repeat pregnancy was observed in four of the adolescent mothers. Nevertheless, only five adolescent mothers were able to continue their studies while raising their children. Of these five, three adolescent mothers studied in a non-formal or informal education program. One adolescent mother was in senior high school and another was in vocational school. None of the key informants had ever had an abortion. Most of the adolescent mothers had met their boyfriends or male friends through their peers, school, or social media such as Facebook.

3.1 Reasons behind Thai adolescents' failure in contraceptive use

What are the reasons behind Thai adolescents' contraceptive failure, regardless of their experiences in school-based sexuality education and participation in pregnancy prevention activities?

Seventeen of the 20 adolescent mothers confirmed that sexuality education, including the topic of contraception, was taught at their schools. Furthermore, 13 of the informants reported having previously participated in the collaborative pregnancy prevention activities by the Ministry of Education and the Ministry of Public Health. This practice was extended to out-of-class activities by other non-governmental organizations to promote both theoretical and practical contraceptive knowledge. Concerning the reasons behind all pregnancies among teenagers aged younger than 19 years of age, it was clear that the contributing factors varied. However, with regard to sexuality education, this research analyzed the related factors through adolescent mothers' perspectives and opinions. The approach was intended to reflect the problems and limitations that rendered both school-based sexuality educations and out-of-class pregnancy prevention activities ineffective.

Here, we discovered that, regardless of their previous experience in sexuality education, there was a misunderstanding of contraception among this group of adolescent mothers. A few had never used any contraception. To them, sexual intercourse was spontaneous and unprepared at best. A few others, having regarded the intercourse as only their first, downplayed the possibility of pregnancy. Other adolescent mothers continued to engage in unprotected intercourse with their boyfriends, despite having stopped taking contraceptive pills after they had exhausted their supplies. This was due to the belief that the pill remained effective as quoted:

> *"I knew nothing then, because health education had not yet covered this topic. But my boyfriend knew, he was an adult, so he used condoms. I was 14 when I first had sex. I was too young to know about any contraception."* (Second Key Informant, 18-year-old, 7-month-old child)

> *"On our first time, neither of us had the protections; we had not thought about it. It was only one time and should have been all right."* (Ninth Key Informant, 18-year-old, 2-year-old child)

> *"I had sex with my boyfriend without taking a birth control pill because I had always taken them in the past. The effects should have continued to protect me. After all, it was only last week when I had taken my last pill, so having sex without the pill should have been fine."* (Twelfth Key Informant, 17-year-old, 10-month-old child)

Moreover, it was noted that school-based sexuality education had not only failed to provide an adolescent-friendly consultation, but also information on safe induced abortions. During early pregnancy, a few adolescent mothers had considered having an induced abortion. However, they were discouraged by the questionable safety of the procedure, the notion that abortion is a sin, and their lack of access to information about safe and lawful abortions. None of them had sought consultations from other youth-friendly services such as adolescent clinics (Clinic Wai Sai), youth-friendly clinics or hotlines such as 1663. This was due to the lack of awareness of the existence of these services. Nevertheless, the few key informants who knew of the youth-friendly services had similarly failed to access these services. This was as much due to fear as not knowing how to begin. Consequently, seeking consultations from close peers was more preferable as quoted:

> "*I began thinking about getting an abortion from the first moment I knew I was pregnant. I was searching for ways, but I did not do it. The Internet was where I looked up abortion procedures*." (Fifteenth Key Informant, 20-year-old, 4-year-old child)

"*When I first learned I was pregnant, I wanted to get rid of it, but I did not dare. I was afraid of committing a sin… At first, my neighbor let me try this medicine, a solution, but it stank so I did not take it. Nothing about the medicine clearly stated that it was a haemagogue. It was from a conversation among friends that I knew*." (Sixteenth Key Informant, 16-year-old, 10-month-old child)

"*… I was not ready; I was afraid of the plaguing troubles afterwards and that my parents would be crushed. I mean, had I known it was safe, I would have easily gotten an abortion without telling anyone, keeping it just between me and my boyfriend. I didn't know anything then. It was like I was facing a dead end. I had not tried school either, because I was not really familiar with the teachers. So, I didn't know who to turn to. Even as close as I was to my parents, I still couldn't tell them."* (Fifth Key Informant, 21-year-old, 2-year-old child)

One of the key observations as reflected by most of the adolescent mothers was about their sexuality education. The teaching was noted as being one-directional, mainly taught through lectures and failing to encourage critical thinking skills. In turn, most of the students were bored. The absence of practical sessions led to a lack of comprehension on the subject, lack of awareness and, consequently, the students' inability to apply their knowledge in practice. The adolescent mothers in this study further suggested that, for any pregnancy prevention activities to succeed, the sessions should encourage discussions among students or between students and teachers on topics concerning contraception. Moreover, students should participate in practical sessions rather than only listening to lectures or taking notes. Nevertheless, a few adolescent mothers also cautioned that, although greater understanding about contraception was observed with activities, their failure to protect themselves was a result of their disinterest, because the subject had not been regarded as a problem at the time as quoted:

"The teachers' method was boring. They just went through the subject, nothing much about it, standing at the front of the class and giving lectures. I was listening from my seat. … I would rather like the class to be taught through practical learning. Practical sessions made the learning interesting." (Seventh Key Informant, 20-year-old, 3-month-old child)

"The activity helped me understand, but I was not really paying attention. I was only half-listening. I had not faced the problem then because, at the time of the activity, I did not have a boyfriend." (First Key Informant, 18-year-old, 10-month-old child)

"… I had no idea what hardships would follow the delivery. Topics concerning the burdens of motherhood should be covered in the teaching. I would have liked to know what other hardships were to be expected." (Fourth Key Informant, 20-year-old, 3-year-old child)

3.2 Supporting factors for Thai adolescent mothers' educational continuance

Based on the in-depth interviews, most of the adolescent mothers did not continue their education after give birth since parenting had become their priority. Fifteen of mothers dropped out of school in order to prepare for the birth and care of their children. Only two participants continued their formal education, whereas three others were engaged in non-formal or informal education and programs. Support from parents, teachers and peers was noted for the adolescent mothers who continued with formal education.

Teachers' assistance was reported from an early stage of pregnancy. Teachers offered advice that helped the adolescent mothers continue their studies. This ranged from a suggestion for bigger school uniforms and encouragement to ignore insults to input on the period when adolescent mothers should take maternity leave for delivery. On the other hand, having homework from each class missed by the mothers home-delivered allowed the adolescent mothers to keep up with their studies with the help of close peers who delivered and retrieved the homework. In terms of parents, their roles began from the first moment they learned of their child's pregnancy. Parents, teachers and schools helped coordinate and plan solutions addressing the teenage mothers' academic possibility. In addition, they helped their children apply for maternity leave and raise their grandchildren when the mothers returned to school. Peers were another deciding factor concerning adolescent mothers' ability to continue their formal education. With help from peers to deliver and retrieve their homework, two adolescent mothers were able to keep up with their classes. This was stated in the interview as quoted:

"My teachers helped me. I was able to consult them about my problems. From my pregnancy to the birth of my child, they suggested I wear bigger clothing, covering my baby bump. I could also drop my studies and continue later. They told me to ignore what other people said, just continue studying. Whatever others might be saying, they told me to ignore them. Now, I know I should have focused more on my studies. Before the baby, I skipped class sometimes; sometimes, I did not. After all, if I do not study— do not have a degree— what job can I have? Without my teachers, I would not have continued my education. I was too embarrassed to face my friends and I could not bring myself to go to school. But my teachers have always told me to ignore my friends' words. After the delivery, I missed school for three months. During those three months, my teachers brought me my homework from all of the classes I had missed. I would work on the homework.

If I could not do it, I phoned to ask. My homeroom teacher did not teach all the subjects, there were others, but they brought me homework from all of the subjects." (Sixth Key Informer, 17-year-old, 2- year-old child)

"The first person both my mother and I reached out to was the school counsellors. My mother questioned them on what could be done, now that I was pregnant; if I should drop out or leave school for now. They said it would be a waste of my study time and I would not be able to catch up. My friends would move to a higher level of study before I did; and I would have to study with my juniors. The teachers told me not to drop out. Instead, I was told to take a one-month leave of absence for the delivery and to feed the baby. My mother could help with the child during the day when I returned to school…During that one-month leave, if there was classwork or homework, my friends would take photos of their notes and send them to my phone. I would work on them at home and submit them later." (Eighteenth Key Informant, 16-year-old, 1- month-old child)

4. DISCUSSION

Ninety-six percent of elementary, secondary and vocational schools in Thailand have offered sexuality education in their curriculum since 1978 (Boonmongkon et al., 2016: 7; Thaweesit and Boonmongkon, 2012). In some schools, sexuality education is a self-contained subject and spans 18 sessions. In others, sexuality education is part of health education and requires only two to four sessions out of a total 18 sessions. Each of the sessions takes approximately 50-60 minutes. Other schools incorporate sexuality education within subjects such as social studies, science and guidance. The topic itself is addressed before each of the subjects and lasts from five to ten minutes (Boonmongkon et al., 2016: 7-8). Apart from school-based education, the Ministry of Education and the Ministry of Public Health have also collaborated with non-governmental organizations to promote out-of-class adolescent pregnancy prevention activities (Boonmongkon et al., 2016: 1). For instance, the Path2Health Foundation and the Thai Health Promotion Foundation (ThaiHealth). However, the adolescent birth rate remains high.

The findings from this research support a claim that the teacher-centric sexuality education teaching strategy focused on the lecture method failed to offer an opportunity to stimulate critical thinking among the students and to help them question their assumptions. Despite the long class sessions and years of study, sexuality education was unable to help some attendees who might have already possessed enabling factors for adolescent pregnancy (relationship and communication issues in the family, lack of access to information on reproductive health, contraceptive illiteracy, lack of access to contraception, incorrect use of contraceptive methods, peer-pressure from sexually active peers, sexual violation, rape and forced sex, negative attitudes and behaviors among parents and teachers, sexual norms, various forms of media, alcohol, drugs, poverty and social stigma about abortion (UNICEF Thailand, 2015: 15-16; United Nations Population Fund, 2014: 19)) such as the key informants from this study. Although each of the informants had had a school-based sex education and participated in out-of-class adolescent pregnancy prevention activities, they were unable to apply their knowledge in practice, consequently leading to pregnancy at ages younger than 19 years. It is possible that the lecture method primarily taught by most teachers was regarded as boring. In turn, most of the students were unenthusiastic about participating in class. As a result, they were unable to put the knowledge from their sexuality education into practice in daily life. Similarly, while activities involving both students and teachers might have included brainstorming sessions, small-group activities, or group discussions in front of the class, the activities did not foster an environment for critical thinking, nor did they make the students feel truly involved (Boonmongkon et al., 2016: 31, 41). Data from the interviews further revealed that, for sexuality education to be applicable in real-life among modern teenagers, the learning process should foster proper understanding of contraception. Moreover, it should be a student-inclusive activity. The activity should offer opportunities to practice, facilitate the exchange of opinions between students and teachers, and help both male and female students realize the hardships faced by adolescent parents. In addition, the activities should grant access to information about consultation channels offering help on unplanned pregnancy and safe induced abortions.

When faced with unplanned pregnancy, the major contributing factor affecting adolescent mothers' ability to continue their formal education was support from parents, teachers and peers. Teachers, peers, and parents must, therefore, collaboratively plan support for adolescent mothers. Prepartum, adolescent mothers may continue their education. However, they also need to stay home to give birth and breastfeed their children during the first three months postpartum. Thus, friends need to support them by delivering and retrieving homework, allowing adolescent mothers opportunities to catch up with their classes. When adolescent mothers return to school at the end of their maternity leave, the task of child rearing should fall to their parents.

Meanwhile, adolescent mothers need to leave a one-day supply of expressed breast milk for their parents. This pattern is similar to that of working mothers with preschool children. Nevertheless, for this approach to succeed, adolescent mothers must be committed to continuing their education and possess the strength to overcome most pressure. Encouragement from families, teachers and peers has major importance in empowering adolescent mothers. This coincides with the findings of the United Nations Population Fund (2014: 34) which suggest that teachers schedule private consultations with adolescent mothers. These sessions will not only prepare young mothers for perseverance against future impacts, but also encourage them to complete their education. In addition, personal factors concerning the prevention of adolescent pregnancy include parents, peers, teachers, community members and those who shape the laws and regulations at the national level.

5. CONCLUSION AND RECOMMENDATION

For the sexuality education to be applicable in real-life among modern teenagers, the learning process should foster proper understanding of contraception. Schools and Thailand's Ministry of Education need to review the teaching of sexuality education. It should be a student-inclusive activity. The activity should offer opportunities to practice, facilitate the exchange of opinions between students and teachers, and help both male and female students realize the hardships faced by adolescent parents. In addition, the activities should grant access to information about consultation channels offering help on unplanned pregnancy and safe induced abortions.

Moreover, schools must organize a system to access student pregnancy information. It is necessary to keep the information confidential so that the pregnant student does not feel embarrassed. A counseling system for adolescent mothers and their parents should also be created. Providing support for adolescent mothers by teachers and peers in assignments and exams during the first 3 months of parenting. All teachers should be aware of adolescent motherhood and understand the problems of adolescent mothers. In addition, teachers should understand how to help adolescent mothers to further their education.

The limitation of this research is the lack of data collection from parents, teachers and peers who are the main supporters for adolescent mothers. Future studies should conduct in-depth interviews about attitudes and approaches to helping adolescent mothers in order to create a system to assist adolescent mothers in schools in the future.

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