CHAPTER I

INTRODUCTION

The first chapter summarizes why this study is important to focus on unplanned pregnancy of young people, consequences of unplanned pregnancies, the health seeking behavior, and way to solve problems. This chapter particularly presents research questions, objectives of the study, hypothesis, conceptual framework, and expected outcomes of the study.

1.1 Background and Rationale

Worldwide, there are an estimated 15 million adolescents age 15 to 19 who give birth, approximately for up to one-fifth of all births each year. Furthermore, each year 1 million to 4.4 million adolescents in developing countries undergo abortion, and most of these procedures are performed under unsafe conditions (RHO, 2002) due to unplanned pregnancies. These pregnancies lead to their health problems in two ways: first, many unplanned pregnancies can threaten the young women's health or well being; they may face a medical, psychological, social problem and lack resources to support themselves during pregnancy and raise a child. Second, if young women do not have access to or cannot afford safe abortion services, many unplanned pregnancies are terminated using unsafe procedures that can lead to the women's death or disability.

To understand the problem of unplanned pregnancies among young women, context surrounded this issue includes unsafe abortion, legal situation of abortion in Thailand, sexual health and risky of unplanned pregnancies among young people, consequences of abortion, and impact on health services are presented.

Unsafe Abortion Requires Worldwide Awareness

Unsafe abortion is defined as a procedure for terminated pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO, 1993) which therefore exposes the women to an increased risk of morbidity and mortality.

In 1994, during the Cairo International Conference on Population and Development (ICPD), Participating governmental organizations agreed that:

> *"In no case should abortion be promoted as a method of family planning. All government and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health aspect of unsafe abortion as a major public health concern and to reduce the resource of abortion through expanded and improved family – planning services. Prevention of unplanned pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unplanned pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for management of complications arising from abortion. Post abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions."*

In Thailand, the term "abortion" refers to both induced termination of pregnancy and to spontaneous abortion (miscarriage). These are different types of event. In common usage, the term "abortion" without qualification is usually intended to refer to induced abortion. For clarity, the term "pregnancy termination" is used, except to refer to the concept of induced abortion as defined legally. Moreover, in Thailand induced abortion without medical conditions is an illegal. So, this is one reason leading women

to hide her abortion from the public by seeking services from unsafe places. For this instance, women with unplanned pregnancy who opt for abortion are still risky to unsafe abortion.

Legal Situation of Abortion in Thailand

Induced abortion is a crime under the Articles 301-305 of the 1957 Penal Code of Thailand. Both the women and the person terminating the pregnancy are subject to legal penalty. The women can be sentenced to three years in prison and a fine of 6,000 baht (US$ = 467; 1US$ = 39 baht). Heavier prison sentences and fines are prescribed for the person who conducts the pregnancy termination. However, attempted but unsuccessful termination of pregnancy is not punishable under some circumstance, which allows women who have had the operations to be treated in hospital. The other major exception to the law is that medical practitioners are permitted to terminate pregnancies in case of rape or if continuation of pregnancy will endanger the health of the women. During the last few decades' abortion law was debated worldwide, as well as in Thailand. At present, there are some movements of many non-government organizations (NGOs) especially those working in women issues. Some groups of people from governmental organization are calling in for reform abortion law. Until now, nothing in the law has been changed (Gray et al., 1999).

However, changing law takes a long period of time. Prevention and care for long and short-term plan can help solve the problem of the unplanned pregnancies.

Sexual Health and Risk of Unplanned Pregnancy

Along with increase exposure to unplanned pregnancy, Sexually Transmitted Infection, and Human Immunodeficiency Virus (STI/HIV), young women who engage in sexual activity outside of marriage may face stigmas, family conflicts, problems with school and the potential need for unsafe abortion. Married adolescents and youth who become pregnant may not encounter the same social risk as the unmarried women, but they may face the same complications from STI/HIV and the health risk of early pregnancy, which will cause both physical and psychosocial problems.

Among Thai youth who are sexually active, the median age at first sexual encounter is between 16 to 18 years. The median age for girls was higher compared to that of boys. More than half of those who have had sex had unprotected first sexual intercourse. Moreover, it was found that a relatively small proportion of males had commercial sex workers (CSW) as their first partner as compared before the HIV/AIDS epidemic (UNESCO/Thailand, 2001). During that time, men tended to go to CSW. Now this has changed to their girl friend(s). There is clear evidence from many studies showing that sex is initiated at a younger age and sex partner are either friends or lovers of similar age (Boonmongkon et al., 2000). Thus, this situation puts their girlfriend(s) at a high risk of unplanned pregnancies, and STI/HIV.

Among female adolescents, they revealed that unplanned pregnancy was a major problem (Boonmongkon et. al., 2000; Porapakkham et al., 1985 and Deemar, 1980 as cited in Soonthornthada, 1996). Findings from a study of sexual experience of school adolescents in Bangkok showed that 35 percent of sexually active male adolescents stated that their girlfriends become pregnant and 4 out of 5 pregnancies ended with abortion. Moreover, 30 percent of sexually active girls stated that they had had abortion (Porapakkham et al., 1985 and Deemar, 1980, as cited in Soonthornthada, 1996). A study by Soonthornthada (1996) found that out of school adolescents (factory workers) were more likely to accept abortion when compare with school adolescents. Thus from reviewing many studies, it is found that female out of school youth is more vulnerable to unplanned pregnancy, unsafe abortion, and STI/HIV than school adolescents.

In Thailand, abortion rates among the youth are increasing. The number treated for complications from illegal abortion has increased. More than half of these complication cases were among clients aged 24 and younger. Of all illegal abortion cases among unmarried women, 48.6 percent were performed on age 20-24, and 40.5 percent on those ages 15-19 (Warakamin and Boobthai, 2001). Furthermore, studies estimated that one out of three pregnancies are unplanned (Chayowan and Nodel, 1992) and 200,000-300,000 women at the reproductive age terminated their pregnancies each year (Koetsawang, 1993). Adolescents are more likely than adults to hide a pregnancy,

seeking late term abortions, and having a procedure performed by untrained providers under unsafe conditions, often leading to permanent disability or death (Sertthapongkul et al., 1993; Koetsawang, 1993).

Consequences of Abortion

Complications from unsafe abortions are a major cause of death among these young women. Because these young women's knowledge in limited, they lack confidence and can not afford to access the health care system, which often results in complications. Apart from physical consequences, psychological trauma can occurs to many women, which is unseen and immeasurable.

Physical Consequences

The women may induce unsafe abortions by herself, by non-medical person or by health workers in unhygienic conditions. Such abortions may be induced by insertion of solid objects such as root, twig, or catheter into the uterus, an improperly performed dilatation and curettage procedure, ingestion of harmful substances, or external massage. In the northeastern part of Thailand, one method which often performs by non-medical personnel is massage at the uterus (Warakamin & Boonthai, 2001; Chaumpruk, 1981). Abortifacient products, known as a menstruation inducers are widely used throughout Thailand. The mortality and morbidity risks of induced abortion depend on the facilities and skill of abortion provider, the method used and certain characteristics of the women herself, such as her general health, presence of sexually transmitted infection (STI) or other reproductive infection (RTI), age, parity, and the stage of her pregnancy. According to the conditions in which the unsafe abortions are performed and the methods used, a variety of severe complications may occur.

Warakamin & Boonthai (2001) found that 28.8 percent of cases admitted in the hospitals had severe complications including cause of sepsis and perforated uterus, which were found to be 21.6 and 0.4 percent respectively. These severe complications may be fatal if left untreated. The study also found 14 cases or 0.11 percent of all the cases admitted results in death.

Psychological Consequences

Major & Gramzow (1999) found that apart from physical consequences, women who feel stigmatized about their pregnancy are more likely to feel a need to keep it hidden from family and friend. Secrecy was related positively to suppressing thoughts of abortion and negatively to disclosing related emotion to others. More importantly, suppression was associated with experiencing intrusive thoughts and distress. Both suppression and intrusive thoughts, in turn, were positively related to psychological distress over time.

Impact on Health Services

Spontaneous abortion or uncomplicated case is rarely a fatal and seldom presents complications. It may require up to 3 days of hospitalization, complicated cases may need a stay of up to 5 times longer. The treatment of abortion complications in hospital uses a disproportionate share of resources, including hospital beds, blood supply, medication, as well as access to operating theatres, anesthesia and medical specialists. Thus, consequences of unsafe abortion place great clinical, material and financial demands on the scarce hospital resources of many developing countries (WHO, 1997). In Thailand, it is calculated that cost per case of severe complication per abortion is 21,024 baht (Warakamin & Boonthai, 2001).

1.2 Causes of Unplanned Pregnancy

Unplanned pregnancies are caused by several factors including the nature of transition from childhood to adulthood; lack of knowledge, moral, values, and education at home and in school; relationship with parents; gender inequalities situation; inadequate reproductive health resources for providing information, education, and communication to the young people. Moreover, all these factors intern effect on health seeking patterns and access to health care of the young women.

Transitional from Childhood to Adulthood

Physical and Emotional Development. Adolescence is a transitional phase from childhood to adulthood. While becoming physiologically mature during this transitional period, they become less dependent on their parents and more involved with peers. They begin to form identities as individuals and develop further capacity for interpersonal relationships with others. Moreover, it is a critical period that lays the foundation for reproductive health of the individual's lifetime. It is also a period when *"sexuality"* emerges in the form of physical body changes. Feeling, psychological changes including emotions and consciousness about one's sexuality and these of the opposite sex also occur at this time. It is also a phase of life where one searches for self-identity, is vulnerability to sexual risk behavioral including unplanned pregnancy (AIDC, 1999).

Lack of Knowledge, Moral and Values, Education at Home and in School

Many young people lack accurate knowledge of reproductive health anatomy, physiology and the pregnancy process including the consequences of unprotected sex. Also, they might lack knowledge of pregnancy prevention and access to family planning methods due to several factors, such as, social taboo on unmarried young women seeking for contraceptive methods.

A large-scale study by Maungman et al. (1983) in Bangkok found that schooled females had different knowledge and attitude about sex than out of school female youth. School adolescent had higher level of basic knowledge about reproductive biology, conception, and awareness of sexuality than out of school adolescents. A subsequent study in 1996, conducted among in and out of school youth revealed that among the sexually active out of school youth, less than half used contraceptives while having sex. Among the non-users, some of them reported that they did not use any method of birth control due to lack of adequate knowledge while some of them feared side effects (Soonthornthada, 1996)

Another source of information revealed that parents and teachers rarely talk and openly discuss sexual knowledge, values, and moral with their children. This may lead youth to lack of concern for the outcome of irresponsible sexual behavior and to seek information from many unreliable and harmful sources such as pornography, magazine, Internet sites and etc. to educate themselves. Although, some issues on sexual health have begun to be taught in some school effective sex education requires trained personnel which is lacking at the present time.

Gender Inequality

In Thailand, young women are more restricted than men in their personal movements because of concerns over their virginity and chastity. After puberty, daughters are not allowed to go out alone. Daughters are kept under strict supervision, while brothers take advantage of their social and sexual freedom. Young men gain status if their peers believe they have seduced many women, whereas young women lose their reputation if people hear that she slept with a man (Boonmongkon et al., 2000; Gray & Pungpuing, 1999; Sainsbury, 1997; Ford & Kittisuksathit, 1996).

This inequality situation puts young women at a disadvantage in controlling sexual relations and contraceptive use. Social experiences and pressures define what is or is not acceptable for a young woman to do. These make it difficult for them to protect themselves from unplanned pregnancy. The inequality among man and woman include social taboos and power over women often prevents her from using contraceptives. Opposition from their partners/lovers is one of the most common reasons women give for not using barrier contraception.

Stigmatizing Young Women in Utilizing Reproductive Health Resources

In Thailand, there are limited reproductive health service resources for young people. In the last decade, the existing government health services were for adults, which their operations based on the assumption that the adolescent group did not require reproductive and sexual health services. The use of health care services is complicated and stigmatizes adolescents who come to use the services for their sexual

health problems (Limsampan, 1997 ; Pracharat, 1990 as cited in Boonmongkok et al., 2000).

Health Seeking and Access to Reproductive Health Care

The main obstacle for women in Thailand in seeking abortion once they are faced with unplanned pregnancies is that it is illegal. There are no public health facilities that provide abortion if the pregnancy does not result from specific conditions as stated in the law. There are some private professionals who provide such services, but the cost is high. Prohibitively most young women cannot afford it, thus, they will seek alternative services from other sources, such as, traditional healers, and drugstore personnel. Drugstore personnel are more popular than traditional healers among young people because they do not need to answer questions nor reveal their identity but the most important is easy access to products that young women believe can terminate their unplanned pregnancy (PATH, 2001b).

Drugstores are an important source of health services for Thai communities. When faced with mild illness, most of people tend to go to a drugstore as their first choice. In the Northern part of Thailand, a study revealed that 66 percent visited drugstores (Chuamanocharn et al., 2000), where as 80 percent in Bangkok (Punyawuthikrai et al., 2001) and 97.7 percent in the Northeastern part of Thailand respectively (Kanchanaraj et al., 2001). Young people also share the same pattern of health seeking that is they will seek services from drugstores as their primary resource especially when they have to seek for sexual health products; abortifacient for terminating pregnancy; or when faced with any sexual health problems.

Another study in 1998 by PATH/Thailand in Had Yai, Songkla province, revealed that vocational school students utilizing drugstores as the common place to seek health services; particularly in regard to sexual and reproductive health issues. The research showed that youth prefer to seek reproductive health advice from drugstores rather than from the government health care service, because they cannot be identified by medical record showing name, marital status, etc. Youth also wish to avoid confronting sometime-negative attitudes of healthcare providers towards unmarried

adolescents, particularly females, seeking FP services, diagnosis and treatment of Sexually Transmitted Diseases (STDs), pregnancy tests, etc.

Peers also influence young people to seek services. When young women missed their menstruation, they usually consult their female friends who would recommend that they get a pregnancy test from the drugstore or private clinic in town. No young women utilize the government health services for a pregnancy test because they were afraid that their secrecy about their sexual relations would be revealed to the public (Boonmongkon et al., 2000).

1.3 Ways to Solve Problem

Unplanned pregnancy is one of the most difficult life experiences among young women. Women are often confused, and then seek for help and support. When the problem occurs, the woman has three choices including parenting the baby, make a plan for adoption, or terminate the pregnancy. However, to choose one of the options, it is hard for the young women to make a decision.

Thus, to implement or initiate any strategies to help solve the unplanned pregnancy problem, it is important to understand thoroughly how young women making decision, and seeking for help - or health services; when, where, how and why they decide in that ways. Moreover, it is worth to explore additional information on what type of reproductive health services are available for the women with unplanned pregnancy. What type of services that women were seeking help from, whether they meet the needs of these young women. By explore the information from the service side, it provides a holistic picture of health seeking patterns of young women with unplanned pregnancies.

After reviewing many studies on this issue, so far, there is not a single study that addressed, in a holistic manner, health-seeking patterns among young women on unplanned pregnancy. Moreover, research on abortion failed to take into account the role of unplanned pregnancy, which is an important determinant of abortion. The aim of

this study is to formulate a theoretical model of health seeking patterns of service utilization among young women with unplanned pregnancy. Findings are expected to support policy and decision makers in designing interventions and services to help young women to make the transition from adolescent to adulthood without physical and psychosocial trauma from unintended pregnancy. Moreover, this explanatory model will help implementers and providers understand the decision making process, why and how women made decision to solve their problems which in turn can provide more appropriate interventions and services that serve the needs for young women.

1.4 Conceptual Framework of the Study

There are many theoretical models on health seeking behavior that attempt to explain utilization of health services. Furthermore, there are many determinants that affect the decision- making options of women with unplanned pregnancies, and their health seeking behavior. However, there has been no definitive conclusion about which factors or variables influence their decision-making options, or their seeking of health care utilization. This is because health behavior involves a number of social and behavioral factors including attitude, perception, beliefs and interpersonal relationships with peers, partners, and family members, as well as the influences of culture, norms, law, and health delivery system and policies.

Thus, the study conceptual framework of this study is derived from a combination of factors recognized to be important determinants for the decision-making process of options for women with unplanned pregnancies from Ratchukoon (1998) *"A Model on Decision-making Process for Terminating Pregnancy"*.

In addition, the *"Symbolic Interaction Theory"* plays special attention to the symbols individuals use to interpret and define themselves, the actions of other people, and all other things and events. This theory helps us understand how young women interact with themselves when facing the problem of unplanned pregnancy. Moreover, Kleinman's theoretical framework (1975) called *"The Health Care System"*. According to Kleinman, the health care system is a type of cultural system, which integrates all

health related components of a society. These components can include the patterns of belief about what causes health problems; the norms that govern choice and the evaluation of treatment and care; power of relationship; interaction settings, and institutions. Kleinman also proposed structural components of the health care system, he divides his model into three overlapping parts: the popular, the professional, and the folk sectors. Moreover, the study's conceptual framework also takes into account some selected sexual and reproductive health variables of the young people. In addition to services characteristics, indicators that are used for measuring the youth friendly services are selected from Nelson's study (2000).

In conclusion, based on the theoretical models and literature reviewed on health seeking behavior, sexuality, and reproductive health, this study classifies determinants of health service utilization into four sets of factors. These three sets of factors are including: **1) personal history.** The variables include age at first sexual intercourse, age at latest unplanned pregnancy, number of sexual partner, and number of unplanned pregnancy; **2) individual psychosocial factors.** The variables used are attitude towards sexuality, contraception, service facilities and providers, and consultation while having trouble; and **3) relationship factors.** The relationship variables used are relationship with parents, partner, and peers.

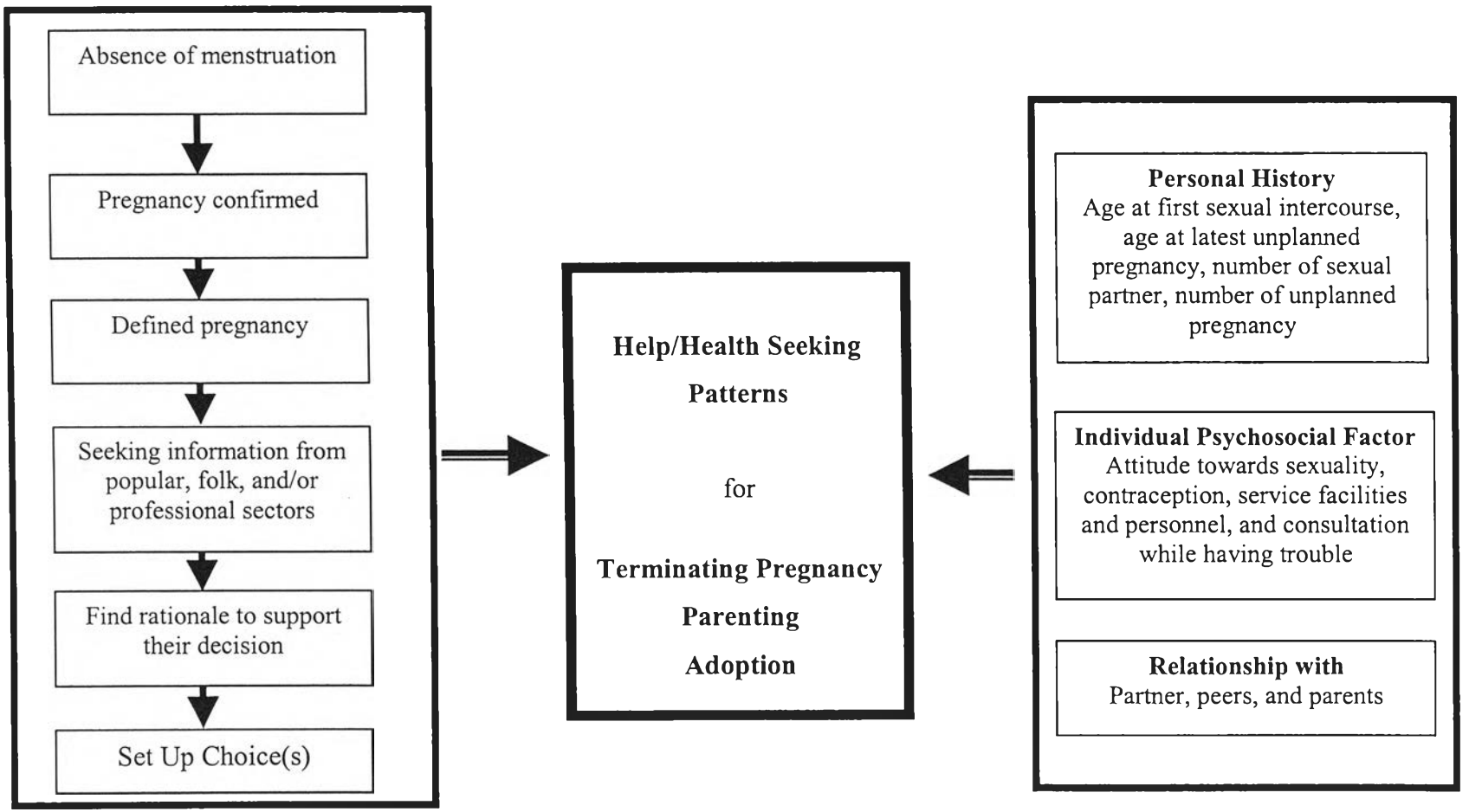

Figure 1.1: Conceptual Frame Work of the Study

1.5 Purpose of the Study

This study is intents to understand what factors influence the unplanned pregnancy options considered by young women. When, where, why and how women with unplanned pregnancies seeking for health services, and patterns of health seeking behavior, their access to health care, and their reasons for using or not using available health services. These results provide valuable insights regarding how best to improve the utilization of existing interventions by influencing health behavior and care seeking choices. The dissertation employs both qualitative and quantitative methods to answer the research questions. The qualitative approaches are employed to provide in-depth information to explain a woman's decision-making process to utilize the service facilities to ultimately formulate a theoretical model of help- or health- seeking patterns of women with unplanned pregnancies. Moreover, the qualitative data are used to guide tool development and explain the statistical data that are secured in the Phase II, the quantitative approach. In addition, the quantitative data analyses from Phase II in this study are help to identify influencing variables towards choices of the young women with unplanned preganancy.

Research Questions

Based on the study's conceptual framework, this study has the following research questions.

1. What are the decision making processes and health seeking patterns of the young women who choose for abortion, parenting, and adoption?, and
2. What factors influence the unplanned pregnancy options considered among young women? and,
3. What are the characteristics of service facilities that meet the needs of young women?

Research Objectives

1. To explore decision-making processes of the young women with unplanned pregnancy who choose for abortion, parenting, or adoption.

2. To explore health-seeking patterns of the unplanned pregnancy women who choose for abortion, for birth, or adoption.
3. To identify influencing factors that lead to the unplanned pregnancy options considered among young women.
4. To explore the characteristics of service facilities that influence utilization of unplanned pregnancy services among young people.

1.6 Key Themes and Main Issues for Phase I

Phase I, the main part of this dissertation focused on the collection and analysis of qualitative information to understand when, where, how and why women with unplanned pregnancies seeking for health and social services, their patterns of seeking services, and the gaps between their needs and the services available. This information was utilized to develop hypothesis to explain their health seeking patterns, which, in turn, was utilized in the quantitative aspects of Phase II. For these reasons, there is no hypothesis for Phase I. However, key themes and main issues are proposed as follows:

1.6.1 Definition of pregnancy and their interaction

- Definition of unplanned/unwanted pregnancy by women.
- What will happen if women keep the baby to full term?
- Interaction and feelings among women and their significant others, when facing unplanned/unwanted pregnancies.
- Feeling towards the fetus, and pregnancy.

1.6.2 Process of decision-making, seeking for services and their interaction

- When and why women define the pregnancy as unplanned/ unwanted.
- Sources of information and person that women go for consulting.
- Process of decision making of women who opt for abortion, adoption, or parenting and feeling towards the choice.
- Rationale behind the selected choices

- Choice of services and care seeking patterns of women who select each option.
- Rationale behind the choice of services
- Interaction and feeling towards themselves and service providers.

1.6.3 Social culture and stigmatization on sex, sexuality, and culture

- Reaction of others towards sex, sexuality and pregnancies of young women with unplanned pregnancies and ways the women response to the reactions.

1.7 Hypotheses for Phase II

In Phase II, based upon the review literatures, and findings of Phase I, the research hypotheses generated for quantitative methods to identify and explore the factors (15 factors) that influence choices (abortion, parenting, or adoption) of the young women with unplanned pregnancies. The research hypotheses are as follows:

1. **Age of the first sexual intercourse** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned pregnancies.
2. **Age of the latest unplanned pregnancy** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned pregnancies.
3. **Number of sexual partners** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned pregnancies.
4. **Number of unplanned pregnancies** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned pregnancies.
5. **Attitude towards sexuality** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned pregnancies.

6. **Attitude towards contraception** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
7. **Attitude towards unplanned pregnancy** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
8. **Attitude towards service facilities and personnel** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
9. **Consult partner while in crisis** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
10. **Consult parents/relatives** while in crisis is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
11. **Consult friends while in crisis** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
12. **Making decision without consultation while in crisis** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
13. **Relationship with partner** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
14. **Relationship with parents** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.
15. **Relationship with friends** is a factor influencing among the choices, i.e., abortion, parenting, or adoption of the young women with unplanned.

1.8 Hypothesis Testing

There are two hypotheses, the null hypothesis denoted Ho, which is against the alternative hypothesis, denoted H_1. For this study, special consideration is given to the null hypothesis. The null hypothesis related to the statement being tested, whereas the alternative hypothesis related to statement to be accepted if the null hypothesis is rejected. The final conclusion once the test has been carried out is always given in terms of the null hypothesis. It is well understood that there is every close connection between the confidential intervals and the test of the hypothesis. Hence, to test the significant a p-value of less than or equal 0.05 for discriminant analysis was calculated.

1.9 Expected Outcomes

The specific outcomes of the study are expected as follows:

- To understand woman's decision – making process and her utilization of services and patterns in order to provide information for policy development, program managers, service providers, teachers, family, and adolescences.
- To provide more in-depth understanding of the relevant factors which facilitate or obstruct the use of certain types of health services by women with unplanned pregnancy. The results also help understanding the low utilization of the government health care facilities.
- To provide valuable insights regarding how best to improve the utilization of existing interventions by influencing help/health care seeking choices, which may lead to danger for women's health.
- Results use as case study to advocate policy development, decision makers, women's NGOs for revision of abortion law, unfair regulation in school and labor force, and decrease in restrictions criteria for doctors to perform induced abortion.

1.10 Organization of the Thesis

The remaining of the dissertation is organized as follows. Chapter II literature reviews with aim at identifying the knowledge gaps, initiate research questions, and develop conceptual framework of the study with based on literature review and theoretical models. The main issues include the most relevant literature related to sexual activities and reproductive health among young people especially in Thailand. Moreover, it follows a review of consequences of unsafe sex, unplanned pregnancy, and abortion; situation of reproductive health services for young people. Finally, the remaining of this chapter summarizes the main theoretical models of symbolic interaction theory, sociologically based health care seeking theories and the anthropologically based health care seeking theories. These theories provide explanation of interaction of women with themselves and others, and the possible explanations of why such components may be important for affecting service utilization.

The next chapter, Chapter III discusses the research methodology used, including research design, study population and sample size, instruments and pre-testing, variables and measurement, data collection and management, data analysis, and ethical considerations.

The proceeding chapters present the main findings of the research effort: decision making processes, interactions of women and others, and help/health seeking patterns of young women with unplanned pregnancies by employing qualitative methods (Chapter IV); availability of reproductive health services at all level of health facilities (Chapter V); influencing factors towards choices of the young women who opted for abortion, parenting, or adoption (Chapter VI).

The final chapter, Chapter VII, discussions and conclusions, places the study findings with context of the literature, acknowledges scope and limitations, answers the researcher questions, deal with hypotheses testing, formulates recommendations including required further study.