CHAPTER VII

DISCUSSION AND CONCLUSIONS

This chapter presents a summary, discussion, future researches, study limitation, and recommends of health systems strategies to prevent unplanned pregnancies and provide friendly services for young women with unplanned pregnancies.

7.1 Discussion of the Findings

This research was based on the findings of the qualitative and quantitative studies of the decision-making processes and the help-or health-seeking patterns of young women with unplanned pregnancies who were in shelters and low-income communities in Bangkok. The issues addressed in this were: 1) examining the factors that may directly or indirectly influence the choices of young women with unplanned pregnancies; 2) examination of the decision-making processes of young women with unplanned pregnancies; 3) examination of help- or health-seeking patterns and service utilization; and 4) exploration of the characteristics of youth-friendly reproductive health services and the availability of existing reproductive health services. The study utilized data at two levels--individual, and service facilities personnel--from a qualitative research and quantitative research approach through cross sectional studies. Data collection was conducted during the period October 2002 to March 2003 for the qualitative data, and November 2003 to March 2004 for the quantitative data. Since studies of influencing factors for the choices of the women with unplanned pregnancies are not available, comparisons with past studies to establish the consistency of the findings is not possible. Thus, the findings will mainly be discussed in the results.

7.1.1 What factors influence the choices of young women with unplanned pregnancies?

In order to identify the factors affecting the choices of the young women with unplanned pregnancies, discriminant analysis was used. There were 6 out of 15 variables in three broad categories of factors that influenced their choices, which were identified by using univariate tests (p-value $\leq$ 0.05), mean scores of significant variables, and the structure matrix of canonical functions. The influencing factor from the personal history variable was age at the latest unplanned pregnancy. The individual psychosocial variables were attitude towards unplanned pregnancy, attitude towards contraception, making a decision without consultation, and consulting with partner. The relationship variable was relationship with partner. For the parenting group, there were four variables that strongly discriminate the parenting group from the other two groups, i.e., age at latest unplanned pregnancy, attitude towards contraception, attitude towards unplanned pregnancy, and making decision without consultation. The results indicated that the parenting group tends to have higher scores towards the four variables than those in the abortion and adoption group. When considering the variables on consultation with partner, and relationship with partner, which were significantly discriminated the adoption group against the abortion and parenting women. For the abortion group, two variables, i.e., attitude towards unplanned pregnancy, and relationship with partner that shown significantly discriminate the abortion group from adoption and parenting group. The abortion group tended to have low attitude scores towards unplanned pregnancy, but higher scores on relationship with partner when compared with the other two groups. The results of the discriminant analysis yielded 69.2 percent predictive accuracy. This result was satisfactory compared with the 33 percent chance accuracy (i.e. classification by chance alone would yield 33% accuracy).

The following is an explanation of these influencing factors, derived from in-depth interviews, and focus group discussion (FGD) results:

Age of the Latest Unplanned Pregnancy

Age of the latest unplanned pregnancy was the most important influencing variable towards choices of the young women with unplanned pregnancies.

Moreover, it can explain by using qualitative results, which indicated that the young women preferred to have a baby when they were around 20-21 years old. If the women were younger, they might not be ready for the responsibility of a new family because of unemployment and having no money to raise the baby. Also, in the in-depth and structured interviews found that the majority of the pregnancies were among the early and mid-adolescents, who were the women who tended to terminate the pregnancy, rather than keep the baby to term and raise it. However, if the pregnancy termination was not successful, they tended to put the baby up for adoption.

Attitudes towards Unplanned Pregnancy

Attitudes towards unplanned pregnancy was statistical significant to influence choices of the young women with unplanned pregnancies. If the women had positive attitude towards the unplanned pregnancy, they tended to raise the baby. Whereas the women who had negative attitude towards unplanned pregnancy tended to terminate pregnancy. Also, the in-depth interview results indicated that if they failed from terminate pregnancy, they would put the baby up for adoption or raise the baby themselves.

Attitude towards Contraception

Attitudes towards contraception was statistical significant enough to influence choices of the young women with unplanned pregnancies. The women who had negative attitude towards contraception (condoms and/or contraceptive pills tended to terminate pregnancy, where as the women with positive attitude tended to raise the baby. However, among the women who failed from terminated pregnancy would put the baby up for adoption, or raising the baby themselves without solution.

The in-depth interview results indicated that majority of the early and middle adolescent acted like their peers, and if their peers did not use contraceptives, they did the same. Some women believed that having sex occasionally could not cause pregnancy, thus, they did not protect themselves by using any method of contraception. Once, unplanned pregnancy occurred they tended to terminate pregnancy, if it was fail they might put the baby up for adoption. However, late adolescent or the married women were more independent from their peers and had more experience of sexual intercourse, so their attitudes were different, as mentioned above. Some of them did not use contraceptive pills due to side effects, or they had no time to access services at government facilities. Some of them believed that having sex occasionally could not cause pregnancy. Also, once they faced with unplanned pregnancy, they tended to raise the baby themselves.

Making Decision without Consultation

Making decision without consultation was statistical significant as a factor that influenced choice of the young women with unplanned pregnancies. The women who made decision by themselves without consultation tended to raise the baby. However, the women consulting their partner tended to terminate pregnancy.

The results of the in-depth interviews indicated that the women who made a decision (abortion, parenting, or adoption) by themselves, were the women who had no relationships with their partners and lived alone. Hence, they made the decision without any influence from their parents or partners. The results also indicated that once they had failed to terminate the pregnancy, they tended to raise the baby by themselves instead of putting the baby up for adoption.

Consulting Partner while in Crisis

Consulting partner while in crisis was statistical significant enough to influencing choices of the young women with unplanned pregnancies. The in-depth interviews indicated that most of the young women who had relationships with their partners would consult their partners in decision making. However, due to their being young and not ready to be responsible as parents, they tended to decide to terminate the

pregnancy after discussion. However, if terminating pregnancy failed, they tended to raise the baby themselves.

Relationship with Partner

Relationship with partner was statistical significant enough to influencing choices of the young women with unplanned pregnancies. In the in-depth interviews, the women who had no relationship or negative relationships with their partner would try to terminate pregnancy first and if it was not successful, they would put the baby up for adoption rather than raising the baby themselves.

The following is an explanation of the factors which were not statistical significant with the explanation derived from in-depth interviews, and focus group discussion (FGD) results:

Age of the First Sexual Intercourse

Age of the first sexual intercourse was not statistical significant enough to influence choices of the young women with unplanned pregnancies. It could be described that sexual intercourse was usually found in the women who raised the baby, terminated pregnancy, or put the baby up for adoption. So, there was no difference at the age of the first sexual intercourse among them.

Number of Unplanned Pregnancy

Number of unplanned pregnancy was not statistical significant to influence choices, i.e., parenting, abortion, or adoption among the young women with unplanned pregnancies. It could be described that majority of the young women had their first pregnancy, therefore, number of pregnancy would not effect on their decision.

Number of Sexual Partner

Number of sexual partner(s) was not statistical significant to influence choices, i.e., parenting, abortion, or adoption among the young women with unplanned pregnancies. It could be described that women who raised the baby, terminated pregnancy, or put the baby up for adoption commonly had sexual partner(s). So, the

number of sexual partner(s) could not affect in influencing choice of the young women with unplanned pregnancies.

Attitude towards Sexuality

Attitude towards sexuality was not statistical significant enough to influence choices of the young women with unplanned pregnancies. It could be explained that positive or negative attitude towards sexuality was commonly found among the young women who raised the baby, terminated pregnancy, or put the baby for adoption. Also, the attitude towards sexuality could not affect in influencing choices of the young women with unplanned pregnancies.

Attitude towards Service Facilities and Personnel

Attitude towards service facilities and personnel was not statistical significant enough to influence choices of the young women with unplanned pregnancies. It could be explained that among the three groups, (abortion, parenting, and adoption) there was no difference of attitude towards service facility and personnel.

Consult Parents/Relatives

Consult parents/relatives did not pass tolerance test. It was due to consult parents/relative had small tolerance (less than 0.001) and it was not permitted to enter the analysis.

The tolerance is a measure of degree of linear association between the influencing variables. Small values for the tolerance indicate that the variable of consult of parents/relatives is almost linear combination of the other influencing variables.

Consult Friends

Consult friends was not statistical significant enough to influence choices of the young women with unplanned pregnancies. It could be explained that even the women consulted their friends but at the end most of them made decision by themselves. Also, the quantitative results indicated that 82 percent of the young women made decision by themselves. To make decision whether to keep the baby to term or to terminate

pregnancy was not easy because it was dealing with several complicated factors with could not rely on their friends' opinion.

Relationship with Friends

Relationship with friend(s) was not statistical significant enough to influence choices of the young women with unplanned pregnancies. It could be explained that good or poor relationships with friend(s) had no affect to the decision of the young women with unplanned pregnancies. Friend(s) usually provided a support role while the women was in crisis.

Relationship with Parents/Relatives

Relationship with parents/Relatives was not statistical significant enough to influencing choices of the young women with unplanned pregnancies. The in- depth interview results revealed that if the women lived with their parents/relatives, and the parents/relatives showed that they were supportive and accepted the women's situation, the majority of them would seek a place for their daughter to terminate the pregnancy, because the parents were concerned about their daughter's future and would made the decision for them. However, if they failed to terminate the pregnancy, they tended to raise the baby, instead of putting the baby up for adoption.

7.1.2 What are Decision-making Processes of the Young Women with unplanned Pregnancies?

Decision-making Process

Based on the in-depth interviews, the decision-making processes of the young women with unplanned pregnancies would start from the time that the pregnancy was confirmed. Before making a decision, the women would define the pregnancy, then seek consultation from the popular sector (partner, parents, and friends). After they had gained more information, they would come to terms with the self-conflicts about their roles, and make a choice. The following are the decision-making processes of low-income young women to solve the problem of an unplanned pregnancy:

1. Suspicion and confirmation of pregnancy. The women suspected that they were pregnant in the following ways: 1) knowledge and experience based on signs and symptoms; 2) fetal movement; and 3) physical change. Many of them at this stage would consult their partners, friends, or parents about missing menstruation before or while seeking confirmation of the pregnancy. After they suspected the pregnancy, most of the primigravida visited private clinics, whereas the same proportion visited drugstores/grocery stores to purchase a pregnancy test kit to test themselves and to confirm the pregnancy. However, some cases did not trust the self-test and visited private clinics for final confirmation. A few cases did not seek any confirmation because they had experienced pregnancy before. A few cases visited government hospitals or community health centers for pregnancy tests, because they planned to come back again for antenatal care, delivery, and/or post-natal care. Moreover, a few women did not realize that they were pregnant because they had irregular menstruation patterns from the onset of puberty. However, when time passed by, their physical status had changed, so they realized that they were pregnant.

2. Self-definition of pregnancy. After the women had passed through the "shock period", they thought about the pregnancy and tried to define it. Although they were all in the same situation, with unplanned pregnancies, there were variations in the degree of acceptance of the pregnancy, which was due to differences in the individuals, partners, parents/relatives, peers, and communities. The self-definition of pregnancy was reflected in the terms they used to define it, which included unwanted, unintended, unplanned, and unexpected. The terms given revealed that all of the women reflected on being physically and psychologically unprepared for pregnancy.

3. Consulting other people (popular sector). After the women had defined their pregnancy, most of those who had separated from their partners would consult friends at school or at work, or relatives they trusted. They would select the person who could make them feel better or give them some advice. They preferred to consult people with similar experiences who were older or in the same age group, because they could understand their situation easily. Some women who lived alone tended to make decisions by themselves. Some of the single women revealed that they did not like to

tell their parents about the pregnancy because they were afraid that they would disappoint them. The married women preferred to consult their parents. If the relationships of the participants and the parents were more close and friendly, they tended to consult them. However, some married women revealed that they did not want to tell their parents because they already had many problems and they did not want to bother them. However, if their parents asked, they would only divulge some information, not all of the problems. After the women gained support and information from the person they consulted, it was surprising that most of them made decisions by themselves. A few cases followed their parents' decision.

4. Choosing options. After the women with unplanned pregnancies gained information and recommendations from consulting others, there were two decision-making options, terminating the pregnancy and continuing the pregnancy. The majority needed to terminate the pregnancy, while a few cases needed to continue the pregnancy. In making the decision, both options were painful for the young people. The women who chose to terminate their pregnancies faced self-conflict and other external factors, while the women who continued their pregnancies were insecure because they were unsure how to cope with present and future situations. It was important to note that the young women could change their minds, which depended on their partners and their parents. If these significant people supported them, they tended to keep the baby to term, but if they did not care, or showed no responsibility, the young women tended to terminate the pregnancy. The factors that influenced the choices of the young women included: 1) society and community; 2) family member; 3) partner; 4) friends; 5) women's situation; 6) women's experiences of sex, pregnancy, perception, and rumors; 7) access to information; and 8) affordability.

5. Compromise with self-conflict and finding a rationale for support. Not only the listed external and internal factors influenced the decision; in addition, the women needed to prevail over internal self-conflicts towards terminating the pregnancy, which may be attributed to Thai norms and culture, in which women are taught to be caretakers for family members, and mothers. Society expects that any woman who falls pregnant will be a mother, without looking at their circumstances.

Moreover, as Buddhists, many women have been taught that terminating pregnancy is sinful because it is the killing of an innocent life. With the negative consequences of keeping the baby to term, which were due to socio-economic and internal conflict problems, most of the women decided to terminate the pregnancy after weighing up the outcomes and the long-term effects on their lives, which would be those of mothers responsible for their babies' futures. However, some women decided to keep their babies to term. The following are the rationales, based on terminating the pregnancy and keeping the baby to term:

- **Rationale for terminating the pregnancy.** Once the women decided to terminate the pregnancy, they would gain support from a person they trusted, get more relevant information, or interact with themselves to overcome their feelings about terminating the pregnancy, which included 1) terminating a pregnancy was immoral, 2) terminating a pregnancy was risky for their life, and 3) terminating a pregnancy was losing a loved one.

- **Keeping the baby to term.** A few cases among the women with unplanned pregnancies decided to keep their babies to term, because many of them failed to terminate their pregnancies. A few of them did not attempt to terminate the pregnancy. The women who decided to keep the baby to term would weigh the positives and negatives of pregnancy. They tried to adjust themselves to appreciate keeping the baby, by thinking about morality, the mother's role, and the health risks of abortion. The moral issue was mentioned the most by the women who had decided to keep the baby to term. The longer the pregnancy period, the more the women could adjust their attitudes, because the baby could react to them as the pregnancy term increased. So, they felt attached to the baby, especially the women who lived in shelters, because they had a chance to care for other people's babies, and thus realized how hard a time their mothers had endured raising them. In addition, they were among other women who were in the same situation. They compared and shared their experiences with others, which made them rethink, based more on logic than emotion. The following are the young women's reactions towards keeping the baby to term: 1) seeking a place to hide during the pregnancy, and 2) putting the baby up for adoption after delivery.

The study by Ratchukoon, S. (1998) concluded the process of decision making to solve unplanned pregnancy among women of reproductive age in Bangkok included: 1) access information from various sources, including their own experiences, and especially information on costs, supports, beliefs, norms and values; 2) set up choices; 3) make the decision to carry the pregnancy to term or terminate the pregnancy; 4) in the case of terminating the pregnancy, there were two choices--safe and unsafe abortion; 5) find a rationale to support their decision and accept their choice; 6) attempt to terminate the pregnancy or continue the pregnancy; 7) if terminating the pregnancy, seek assistance from trained personnel resulting in safe abortion, or seek assistance from untrained personnel resulting in unsafe abortion; 8) if terminating the pregnancy, seek assistance from untrained personnel or attempt an abortion on their own, resulting in an unsafe abortion; 9) have an unsafe abortion possibly resulting in complications; 10) unsuccessfully terminate the pregnancy; 11) if unsuccessful, continue the pregnancy.

When compared with the study by Ratchukul, S. (1998), it appeared that the main process of decision-making of the study among low-income young women with unplanned pregnancies were consistent with Ratchukul's study. The study suggested that, in terms of the decision-making process to solve the problem of an unplanned pregnancy, women had similar patterns of thought.

7.1.3 What are the Help- or Health-seeking Patterns of Young Women with Unplanned Pregnancies?

As evidenced in the above discussion, the in-depth interviews indicated that once the pregnancy was confirmed, they would feel worried and seek help or consultation from the popular sector first, which included the partners, parents, and friends. After they had gained more information and interaction with themselves, their partners and/or parents, they would make the decision by themselves, which was based on their status, attitudes, relationships and the consultation outcomes. If they decided to keep the baby to term, they would not seek further service from the professional sector but might consult the popular sector to seek support. The majority who decided to terminate their pregnancies would seek further professional services, especially at

drugstores, which were most popular among low-income young people seeking abortifacient products for self-terminating the pregnancy. It was popular because there would be less interaction with the providers. Few of the young people utilized government health facilities due to the abortion laws, beliefs and stigmatization that deterred the individual and the family member from seeking services there.

However, if the women failed in their use of abortifacient products, they tended to seek more efficient facilities, such as private clinics. Some of them were successful, but some were not. The unlucky women would try as hard as they could to seek ways to terminate their pregnancies until they felt that it was not possible to do as planned, and then they would abandon the attempt with no hope for the future.

Regarding the health-seeking patterns of the low-income young women with unplanned pregnancies, it was observed that the women started with simple self-medication, then moved towards more complex efforts i.e. taking higher doses or mixing abortifacient regimens, beating, jumping up and down, or visiting private clinics to terminate the pregnancy. However, because of premarital sex, which is a major cause of unplanned pregnancy, it was different from other health problems. The women's ability to seek and utilize certain help- or health-services is socially controlled by laws, regulations, culture, and norms. However, none of these factors were studied, but they do impact upon the choices of young women with unplanned pregnancies.

To examine this research question more extensively, it is important to compare the help- or health-seeking patterns among young women with unplanned pregnancies. According to Kleinman's (1980) healthcare system framework, the professional sector consists of modern medicine, while the folk sector is, in general terms, traditional medicine. The popular sector is the sector where health problem are first defined and help- or health-seeking behaviors are initiated. It is also the sector where multiple layers of factors (individual, family, society/peers, and community) interact to shape and influence these help, or health, beliefs and behaviors. Hence, the findings for help or healthcare seeking in this study are consistent with Kleinman's theoretical framework of the healthcare system.

7.1.4 What are the Characteristics of Service Facilities that Meet the needs of Young Women with Unplanned Pregnancies?

Expectations of Women with Unplanned Pregnancies of the Types and Characteristics of Services needed

The provision of sexual and reproductive health services (SRH) to young women with unplanned pregnancies need to be sensitive to the characteristics of service provision, because values, norms, and culture control their help- or health-seeking behaviors. Thus, to have them change their utilization to the existing service interventions, they need to be involved in all of the processes of service provision. According to the in-depth interviews and observations at the shelter, unplanned pregnancy was not a physical illness; hence, women in this situation need more psychological support and counseling. While they were in a crisis situation, they had nobody to counsel them, and many of the young women mentioned that if they had got counseling they might have arrived at a better solution and pass through the crisis more smoothly. They also said that they needed shelter to hide in while their belly was getting big. Moreover, they needed support setting up with the baby as a single mother, because many of them faced an unfaithful man and were abandoned. The following are details of each type of service needed:

Counseling once pregnancy is confirmed. The in-depth interviews indicated that before knowing about the shelters, many women expressed the same view, that they had nobody to advise them how to manage when they were in trouble. If they had someone to counsel them they might have better solutions instead of living under a dark cloud. They said that telephone counseling was more convenient and comfortable for them before they came in to utilize the services. Most preferred female counselors with a friendly manner.

Shelter to hide in while the belly was getting big. During the first trimester of pregnancy, most of the women still hid their pregnancy in large clothes because their belly was not very big. However, during the second to third trimester, their belly was

getting big. The in-depth interviews indicated that the bigger the belly was, the more stress the women felt. As there are a limited number of shelters throughout the country, shelter is available only in the big cities and Bangkok. Moreover, few women know about the shelters, thus, some of the young women with unplanned pregnancies ran away from their community to new places where nobody knew them. The women with bigger bellies who still lived in the community would feel embarrassed. Hence, if there were more shelters available, the women would endure less stress and could cope with their problems. Moreover, the in-depth interviews with the women in the shelters revealed that the shelter is a good place where women who have the same problem can share, support, and learn from each other's experiences. It helps them feel stronger and ready to return to their communities.

Nursery care a few months after delivery. The in-depth interview results revealed that the women who failed to terminate their pregnancies would be very worried about the baby's future, because they had no income and had been abandoned. Hence, many of them felt worried about how to manage their lives after they delivered. Many women said that they needed a place to nurse their baby at least for 3 months, so that they could earn income and set up the new life first; then they would be ready to take care of the baby. However, the results from the in-depth interviews with the social workers at the shelters revealed that the women needed to wait in a queue for a nursery room for their baby, because there were limited numbers of free nursery care services available.

Support for setting up a new family. The in-depth interviews and structured interviews indicated that the majority of the women had had their first unplanned pregnancy. Moreover, due to inexperience, youth, immaturity, and lack of income, many of them needed support at the beginning of setting up the new family.

Counseling to prevent recurrent unplanned pregnancies. Apart from the services and activities provided at the shelters, explained above, the in-depth interviews indicated that the women expected counseling, which was very important. If they were

in a shelter, they preferred to have face-to-face counseling. The counseling would support them and prevent them from recurrent unplanned pregnancies.

The in-depth interviews of the young women with unplanned pregnancies indicated that friendly administrative processes included: 1) a private area for history taking, 2) anonymity, 3) no identity card required, 4) no need for the parents or caretakers to approve of using the service. The minimum requirement was confidentiality, to make the young women feel relaxed and comfortable to utilize the services with a good impression.

Apart from the types and characteristics of services needed, public relations and information dissemination to potential users about the services should be widely available, so that the women would have more alternatives to taking abortifacient products or visiting a private clinic to terminate the pregnancy, even when they did not want to.

Existing Reproductive Health Services available for Women with Unplanned Pregnancies

The in-depth interviews with the providers revealed that they felt that there was an increasing prevalence of premarital sex among young people. Thus, this phenomenon caused many young people to seek pregnancy termination services, or self-treatment using abortifacient products, because induced abortion is considered a crime, other than induced abortion performed by a medical practitioner in cases of pregnancy resulting from rape, contraceptive failure, fetal abnormality, or protecting the woman's health. Moreover, in the case of the HIV-positive mother who did not want to continue her pregnancy, she was eligible for an induced abortion. However, if a case did not satisfy the criteria, the hospital would have a committee make the decision. Only physicians under the above mentioned circumstances regularly performed induced abortions at both government and private hospitals. The existence of such laws, however, cannot prevent illegally induced abortions. Consequently, illegal abortions have been performed secretly. If the women failed to terminate the pregnancy, a few

shelters in Bangkok do provide support during pregnancy and postpartum care. Moreover, if the women want to put the baby up for adoption, government organizations, religious organizations, or non-governmental organizations provide the service by screening the new family or the adopters of the baby. The following are services available for women with unplanned pregnancies:

Traditional birth attendant (TBA). The in-depth interviews with the TBA revealed that the methods of terminating pregnancy by the TBA, using traditional uterus massage, was more invasive than taking abortifacient products or utilizing other modern methods provided by the professional sector. Moreover, it did not guarantee a successful outcome. Thus, TBA customers were decreasing and were not popular in Bangkok.

Drugstores. The in-depth interviews with the young women found that drugstores were a source of abortifacient products. Besides the wide availability of drugs for regulating menstruation, which were misused, they did not need a medical prescription to purchase these products, the cost of the abortifacient products for self-treatment was low, and drugstores were plentiful. Moreover, they offered anonymity and were not perceived as being symptomatic of an illness. Hence, drugstores became a popular health resource for young women with unplanned pregnancies.

Private clinics. The in-depth interviews indicated that once the women faced unplanned pregnancy, if they could afford the cost of terminating the pregnancy, they would seek a place to do so. However, since it is illegal in Thailand, the women knew the place by word of mouth, without knowing whether it was a safe or unsafe place.

Government and private hospitals. Pregnancy terminations performed in government and private hospitals were done under medical conditions or hospital criteria, as mentioned above because it is illegal.

Shelters. The ultimate hope for the women who failed to terminate their pregnancies was a shelter. However, there are few shelters in Bangkok for women who

are in a crisis situation, while the numbers of women facing unplanned pregnancies are more than for other reasons. The results of the in-depth interviews revealed that many women who failed to terminate their pregnancies visited a shelter by themselves. They knew the shelters from word-of-mouth, the media, or various printed materials. Most of the shelters located in Bangkok allowed the women to stay until delivery, or a few months after delivery to permit them to get ready to raise the baby. The shelter's staff helped some women who were not ready to raise a baby, and also helped them select a suitable family for adoption. Most of the shelters tried to assist the women to avoid terminating the pregnancy or abandoning the baby after delivery. Moreover, some shelters set up a project to assist women set up a new family after they came back to their community, to ensure that the women could help themselves in the real world.

Based on the in-depth interviews, it was found that there was an informal referral network among the professional sector, such as drugstores, private clinics and hospitals, which referred cases of women who wanted to terminate their pregnancies to a shelter. The religious communities also referred women with unplanned pregnancies to religious shelters. This kind of referral network needs to be further strengthened.

7.2 Policy Implications

Based on the in-depth interviews and discriminant analysis, solutions for various health systems emerge from this study, which are listed as follows:

7.2.1 Pharmacist Association, Pharmacy Association, Drugstore Club of Thailand, and other related Pharmacy Organizations

Local business/drugstore as a focal point for increasing access to prevention and care for young women with unplanned pregnancies. Based on the in-depth interview study of the help-or health-seeking patterns of the young women with unplanned pregnancies, most of the women did not seek help or services from the formal government healthcare system. Thus, the provision of comprehensive unplanned pregnancy prevention and care services should be established through collaboration from both private and public sectors. Drugstores should be an initial source of

collaboration and referral, since the majority of the young women with unplanned pregnancies sought abortifacient products, menstruation regulators, and other essential products from this source.

The most important is that drugstore should be the best option for providing primary prevention services, education, and information for both unmarried and married youths. Information towards emergency contraception, and other related contraceptive technologies to the potential users to prevent unplanned pregnancy should be provided through this channel.

7.2.2 Health Department, Ministry of Public Health

Healthcare providers in all levels of health facilities need to screen for unplanned pregnancies. In the in-depth interviews with the providers of obstetric services, it was suggested that nurses or clinicians should assess young people's pregnancies, and make more detailed decisions in determining planned or unplanned pregnancies. In addition, in assessing the women decision-making on the choices for unplanned pregnancies, they should consider whether to continue or terminate the pregnancy, so that the provider can provide appropriate counseling and support, which will increase women's decision-making capacity in areas of life, sex, and pregnancy.

Establishing comprehensive sexual and reproductive health systems. Health Department should play as an umbrella's role for all organizations dealing with sexual and reproductive health (SRH) provision. The organization should collaborate by segmentation to provide a comprehensive SRH package, to make a broader contribution in delivering SRH services and preventing unplanned pregnancies among young women, such as counseling and testing for pregnancy, STI/HIV; diagnoses for abnormal vaginal discharge or menstruation; treatment and care for STI/HIV; post-abortion care; and contraceptive technologies.

Clinics or small hospitals may be better targeted to provide secondary services and care, including antenatal care, delivery, postpartum care, and well-baby care. Tertiary care, including general hospitals, university hospitals and large private

hospitals that are well-equipped and have medical specialists, should provide more complex health services, including diagnosis, delivery, treatment services, and any complications or abnormal pregnancy or delivery.

Moreover, all organizations should provide couple counseling and information to prevent unwanted pregnancies in the future. Most important is that the services should ensure that all women who in different situations are effectively referred to facilities with services and encourage the use of such services. For example, youths who visit drugstore personnel for abortifacient products might be given a referral to see a counselor(s) at a women's organization or at a shelter. In this way, "friendly service" could be linked to several types of healthcare facilities.

The referral network should include drugstores, clinics, community health centers, hospitals and shelters. Moreover, the beneficiary group, the school and home, should be strengthened to network with the service facilities, so that it can be assured that women with unplanned pregnancies and other SRH problems are fully assisted. All the organizations need to work together to develop formal acceptable practice guidelines or protocols to help ensure that each organization provides specific services as indicated in the protocol and have clear criteria for referral.

Training of providers. The Health Department should provide training of service providers at all level of service facilities on delivery of gender-sensitive, gender equality, and quality of services (i.e., positive interpersonal relationship, confidentiality, privacy, in counseling and management, and referral).

Provision of emergency contraception, i.e., emergency contraceptive pills, and postcoital insertion of IUD. Based on the in-depth interviews and semi-structure interview, majority of the sexual intercourse had happen by chance. So, all level of health care facilities need to provide and made available of the emergency contraception to the person who are in needed.

Strengthening counseling services, which are essential for unplanned pregnancies women. In the in-depth interviews, most of the women mentioned that they needed counseling once the pregnancy was confirmed. Counseling services should provide both hotlines and face-to-face. Moreover, it should add on male and couple counseling to their routine services, which emphasize on female. They should have specially trained personnel to provide counseling to young people about unplanned pregnancy. They should also be able to provide comprehensive counseling to respond to women's emotional and physical needs, and their other concerns related to their trouble.

Adoption services. As shown in the in-depth interviews, abortion was most popular among the young people with unplanned pregnancies. One underlying reason was that many young people did not know that an adoption agency was available. For this reason, information about this agency should be provided to women who will potential want to have an abortion, so that they have one more choice for consideration. Moreover, the government needs to support and strengthen this type of service and make it available nationwide.

Male involvement in reproductive health. The in-depth interviews indicated that the majority of unplanned pregnancies were attributable to males, so that it is important to develop programs targeting males, aiming to change their attitudes and behaviors, to be more responsible for sex and its consequences.

Involve young people in all stages of program development. It is important to involve young people in all stages of program development because they can help ensure that the programs are relevant to young people's real needs. Moreover, they can help identify communication channels, activities, and messages to other young people in meaningful ways.

Evaluation. The umbrella organization should be responsible for evaluation of all components of the program, to determine the effectiveness of preventing current and future pregnancies among young people, and expanding upon those shown to be effective.

7.2.3 School Masters, and Teachers

Enhancing sex education in the school by collaboration with the home. The in-depth interview and structured interview results showed that unplanned pregnancy could occur at the age of 12, or older. Even though they are at a low risk compared to those who engage in risky behavior, such as drug taking, alcohol consumption, or smoking, it is important to prepare them to make responsible decisions when the rare opportunity to have sex occurs. Life-skills decision-making regarding sex, unplanned pregnancy, its consequences and prevention, should be taught in school by collaboration with the home before completion of grade 6. Sex education should be comprehensive and consistent. This will help the young people make decisions based on rationality, responsible choices made with an awareness of the available options. Strategies for school training are as follows:

Expanding the training of teachers. Teachers who train in life skills should be trained on a regular basis in transaction and teaching techniques.

Involving young people. Since peers have more influence on sexual behaviors, the school program should promote more active involvement of young people in all stages of program development to increase the effectiveness and marketing of its activities. Feedback should be sought from the young people regarding what kinds of support would be helpful for them to prevent unplanned pregnancies, and what things the providers should keep in mind when providing services or addressing issues of sexuality. All the responses would help improve the program and increase its acceptability among young people.

Encouraging the school system to work with the home. Since parents also impact upon their children's sexual behavior, the school program should support parents developing and nurturing their children. Moreover, the school system should work with the parents to assess the developmental needs of the young people and identify programs, resources, and tools to assist them in making responsible choices. In addition, they could share information to prevent substance abuse at all levels of childhood development, because substance abuse is likely to be associated with unplanned pregnancy.

Encourage the school system to work with the community. The community environment also impacts upon the sexual and reproductive health of young people. Thus, the school system should work with community leaders to assess and develop a youth-friendly environment.

7.2.4 Family

Parent-child relationship. As indicated in the findings that family played important roles on unplanned pregnancy among young women. Parents are the key people who play in shaping the perceptions, beliefs, and behavior of the young people towards adolescent sexual and reproductive health. If the relationship between the young people and parents is weak, then they will turn to their peers and follow their advises. However, if the relationship is strong the young people will turn to their parents whenever they have problems.

To create a good relationship among them, parents need to change of attitude, including understanding their own sexuality in the a way that enabled them to relate positively with their children on sexuality; and understanding of sexuality and adolescent psychology, communication, and counseling skills.

7.2.5 Representative of Shelters

P.R. the services to the potential users. Based on the findings from in-depth interviews, there were a few young women who knew about the shelters services. Majority of them were refereed from private clinics, churches, or words of mouth. If they knew about shelters' services, it would help them released from the crisis, and had more choice.

Create shelter's image as a second home for the women. The shelters should create images as a second home for the women. Also, it should be a place for all young women who want to get information, education, counseling, and cares towards women issues.

Continue to support the women who want to raise the baby themselves. The women with unplanned pregnancies who want to raise the baby themselves need a follow-on support at least for 3 months. Due to they are young and less experience on caring the baby, thus, the shelter needs to create a systems to help support and follow-up after the women go back to their family, or community.

Create the self-help group in the shelter and continue to strengthen the network. During the women who face the same crisis are at the shelter, it is important to create a friendly environment by having them get together, and sharing experiences. Counselor at the shelter should play as a facilitator at the beginning in establishing group activities. After they are settled, the facilitators should let them manage the group by themselves.

7.2.6 Decision Makers, Policy Development, and Women' s NGO(s)

Provision of one stop comprehensive services. The health care facilities should provide a comprehensive one-stop service for the young women with unplanned pregnancies to reduce crisis that they may encounter at the long processes.

Established youth friendly shelter nationwide. At present, all the shelter s provide services for the women at all age group. However, majority of the unplanned pregnancy women are in the adolescent stage. Thus, it is worth to create youth friendly environment and services for the young women while they are staying at the shelters.

Relief regulation in educational system. Based on the findings from in-depth interview, the main reason of terminated pregnancy was that the young women were student. So, to relief regulation in educational system would help those adolescents having more choices rather than terminating pregnancy.

Revise of business or labor rules and regulations. The business, labor rules, and regulation, which are unfair, and discriminatory, i.e., deterrence of pregnancy during employment, no paid for maternity leave need to be revised.

Revise of the abortion law. The most important in issue of unplanned pregnancy is that the abortion law, which is unfair to the women, need to be revised. Also, the law needs to decrease in restrictions for doctors to perform induce abortion and less stringent conditions than the existing one. Moreover, it should allow the women to access to induce abortion if needed. This effort will decrease risks of unsafe abortion especially those performed by "quacks" and self-management using several of abortifacient product regimens.

7.3 Future Research

7.3.1 Initiate more research targeting married and unmarried males. Since this study and other related study were target mainly female, whereas their partners mostly caused the unplanned pregnancies. Hence, there should be more research initiatives into the male side of the decision-making process regarding unplanned pregnancy.

7.3.2 Research should select young women in rural communities. As indicated in this study that there is limited number of shelters available in Bangkok. For this reason, it is worthwhile examining the decision-making process and exploring the health-seeking behaviors of young women with unplanned pregnancies in rural areas, to increase understanding of their help- or health-seeking patterns. The results should help the government better to understand their needs and be able to plan and provide better services according to those needs.

7.3.3 Prospective study to follow-up on outcomes and impact. Since this study was a cross sectional study, thus, a prospective study should be conducted to follow-up the cases of unplanned pregnancy among the young people so that planners and implementers understand the consequences in the whole process, so that they can provide better services according to the needs identified.

7.4 Conclusions

Once the young low-income women were faced with an unplanned pregnancy, they were stressed and concerned about how to manage their lives. For most of them, terminating their pregnancies was their first choice. Traditional beliefs about abortifacient products are still strong among young low-income women. However due to limited knowledge, lack of information, inexperience, and money, many of them used them to solve the problem. They normally started with a simple regimen first, and if it were not successful, they would move onwards to stronger regimens based on beliefs from word of mouth.

Self-medication through drugstore products was the dominant source of care for personal problems that entailed stigmatization, such as unplanned pregnancy. Even though most of the women realized that self-medication was not as effective as visiting a clinic with professional personnel, it was a way to control the skyrocketing cost of abortion, which was very high performed after the first trimester. Many of them failed after trying several regimens of abortifacient products. They were exhausted from trying to do so without success. This was not only a waste of time and resources but they also suffered psychological trauma while doing so. Some of them turned to utilizing modern medicine at a private clinic and were successful, but some were not because the pregnancy term exceeded the medical criteria or it was too expensive. Hence, they turned to keeping the baby to term without hope about what to do in the future.

When faced with an unplanned pregnancy, most of the early adolescents would terminate it. If termination of the pregnancy failed, they preferred to put the baby up for adoption, whereas the middle and late adolescents could not make definite decisions immediately after pregnancy was confirmed. Instead, the partner played an important role in continuing or terminating the pregnancy. According to the discriminant analysis, which was conducted to identify factors affecting the choices of the young women with unplanned pregnancies, it was found that apart from age at the latest unplanned pregnancy; it the young women made their decision to choose abortion, parenting, or

adoption based on their attitudes towards contraception and unplanned pregnancy, the relationship with the partner, consultation with partner and making decision without consultation while in the crisis situation. The results indicated that the parenting group tends to have higher scores towards the four variables (age at latest unplanned pregnancy, attitude towards contraception, attitude towards unplanned pregnancy, and making decision without consultation) than those in the abortion and adoption group. When considering the variables on consultation with partner, and relationship with partner, which were significantly discriminated the adoption group against the abortion and parenting women. For the abortion group, two variables, i.e., attitude towards unplanned pregnancy, and relationship with partner that shown significantly discriminate the abortion group from adoption and parenting group. The abortion group tended to have low attitude scores towards unplanned pregnancy, but higher scores on relationship with partner when compared with the other two groups. A total of 69.2 percent of cases were correctly classified in the study.

Knowing the influencing factors for the choices of young women with unplanned pregnancies permits prediction of the women's decisions and their utilization of services with some degree of confidence. Hence, the decision makers, planners, and implementers can understand, plan, and provide prevention and care, so that it can lead them to better decision-making regarding their choices for abortion, parenting, or adoption.

Abortion law and other related regulations are played an important role to solve the consequences of unplanned pregnancy. The abortion law needs to decrease in restrictions and be inflexible for doctors to induce abortion. Also, the business rules and regulations, which are unfair and discriminative to women, i. e., layoff women during pregnancy, and no paid for maternity leave, need to be revision.

Moreover, since drugstores are widely used by young low-income women, more attention should be paid to this sector providing reproductive health services. The government should support, collaborate, and cooperate to bring better health services to young people.

In addition, personnel working with young pregnant women should assess whether the pregnancy is planned or unplanned, so that they can provide information and counseling to help them reduce the physical and psychosocial trauma occasioned by unplanned pregnancy in a friendly manner.

7.5 Limitations of the Study

7.5.1 Sampling technique. Abortion and other sex related topics are very sensitive, thus, respondents were recruited based on their willingness. Respondent selection was not based on random sampling and cannot represent the young women in the general population.

Also, this study only purposive selected young woman with unplanned pregnancy who had lived in the shelters and the women who were identified by their peers who used to terminate their pregnancies in the communities, consequently, comparisons of choice by location are not possible.

In addition, the cases of terminated pregnancies were recruited from the communities and the NGO network, whereas the women choosing parenting and adoption were recruited from the shelters. According to the predefined definition "choices" were the decisions of the young women with unplanned pregnancies at the time data collection took place. Thus, the women who had failed to terminate their pregnancies were at the shelters to hide themselves, whereas the women who were successful in terminating their pregnancies tended to stay in their communities.

7.5.2 The additional information from the service sectors. The additional information collected from service sectors, some providers might not cooperate and disclose the information regarding services management for women with unplanned pregnancy. In order to fulfill the provider information, thus, some providers might be the persons who are in the same sectors and can reveal their experiences either from their own or from the person they know. Also, to get a good collaboration, the recruitment was through reproductive health network.

7.5.3 Methodology Limitation. Due to the discussion topics were sensitive, dealing with feelings towards unplanned pregnancy and sexual health, and the participants were on this situation, discussion initially was difficult and it took time to "open up". Moreover, the FGD technique could not elicit profound or plentiful information because of the nature of the topics and the environment, so that the samples did not dare to disclose their opinions or feelings in the presence of others. Thus, the FGD technique was good for assessing the attitudes that the young women expressed in public. However, the advantage of this technique was that it gained a sense of trust among the samples and the researchers for the next appointments, for individual in-depth interviews.