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# SITUATION ANALYSIS OF ADOLESCENT PREGNANCY in Thailand

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Synthesis Report 2015



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# Acknowledgements

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# Abbreviations

DoH	Department of Health
IUD	intrauterine devices
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
Mol	Ministry of Interior
MoPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
NGO	non-government organization
NSO	National Statistics Office
OSCC	One Stop Crisis Centre
PPAT	Planned Parenthood Association of Thailand
RHS	Reproductive Health Survey
THPF	Thai Health Promotion Foundation
VHV	village health volunteers

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# PROJECT OVERVIEW

## PROJECT OBJECTIVES

This situation analysis documents current trends in adolescent pregnancy/parenthood; summarizes key laws and policies impacting adolescent pregnancy in Thailand; identifies key drivers of vulnerability to inform prevention and care seeking efforts; maps potential partners; and identifies best practices (e.g., pregnancy prevention, interventions, and linkages to care and services) and entry points for a cross-sectoral approach. The findings of this study are intended for staff of the United Nations Children’s Fund, partner organizations, United Nations agencies and policymakers.

## BACKGROUND

The combination of increased adolescent pregnancy and decreasing contraception use in Thailand has caused local experts in numerous fields to take notice. While Thailand demonstrated great success in increasing contraceptive prevalence from 1969 to 2006, progress stalled from 2006 to 2009. Contraceptive prevalence decreased 2.5 percentage points (from 81.1 per cent in 2006 to 78.6 per cent in 2011) according to the UNFPA (Wassana, 2013). Similarly, adolescent fertility rates among 15 to 19-year-olds in Thailand rose from 39.7 per 1,000 in 1996 to 53.6 in 2011 (UNICEF EAPRO, 2013). It is also important to note that an estimated 129,541 girls between the ages of 15 and 19 became mothers in 2013, and an additional 3,725 girls under the age of 15 became mothers in the same year (Sivarnee, 2013). Adolescent pregnancy has increased to such a level in Thailand in recent years that for every 1,000 live births, 60 are to adolescent females (National Statistical Office of Thailand, 2012).

Conversations from a scoping visit conducted by the research team during February and May 2014 confirmed several reports from the literature regarding the factors influencing the high pregnancy rates among Thai adolescents. Firstly, **parents of pregnant adolescents** play a role in the decisions their children make. Some interviewees believe that the lack of communication about sex between parents and their adolescent children, as well as limited parental supervision, creates an environment where an adolescent may decide to have sex without the proper knowledge and without contraception. In situations where a pregnancy has already occurred, parents will often decide that their daughter must get married, or in some instances, help her find access to an abortion.

Another factor influencing pregnancy rates among adolescents is **gender roles**. Interviewees during the scoping visit spoke of how girls lack negotiating power. They believe this has influenced their ability to demand the use of contraception and in some cases, their ability to determine what happens to them after becoming pregnant, as their parents or the parents of the father limit their options. Mentioned by a few individuals and backed by findings from another study, stereotypical “good girls” (those who perform well in school and do not exhibit other risk behaviours) are more likely to be the ones to become pregnant since they do not have sufficient knowledge and skills to assert and protect themselves in sexual situations (Chirawatkul et al., 2012).

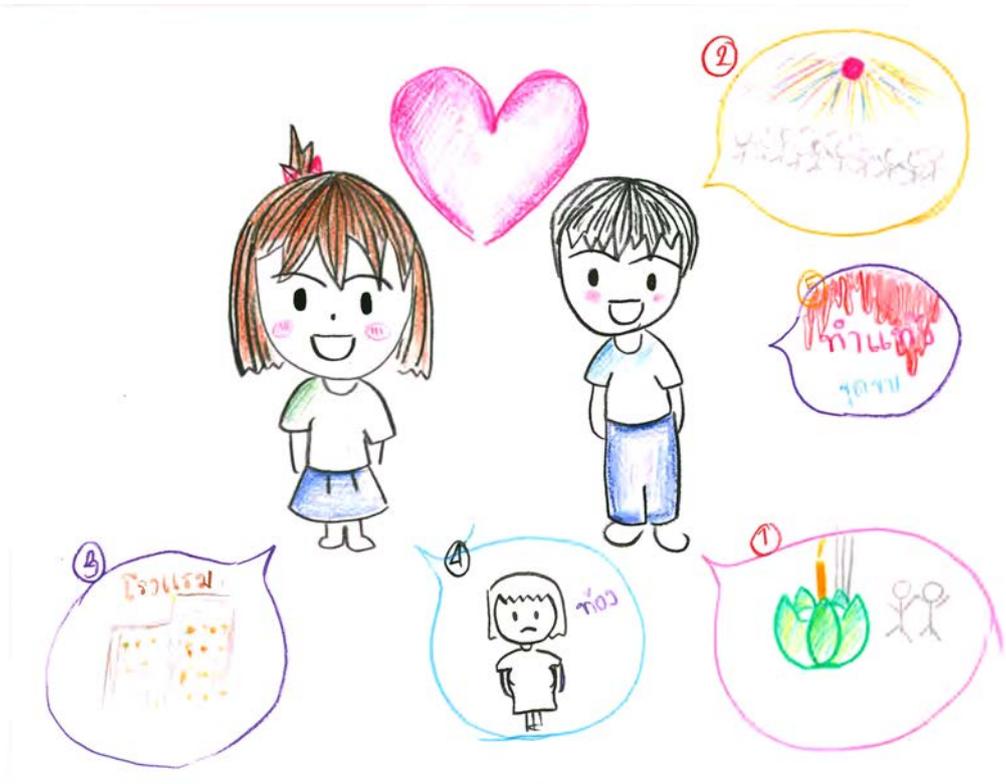
Thai officials and knowledgeable parties perceive that exposure to various forms of **media and messaging** around sexual activity, contraceptive use and relationships impact adolescents. They reported that global access to media portraying younger relationships and sexual experience (often outside marriage) may be changing youth behaviour and expectations. In contrast, interviewees also spoke of how national mass media censorship around condom marketing or campaigns associating condom use with HIV/AIDS may be affecting these changes in contraceptive use. Increased access to the Internet further allows adolescents to seek information and advice about sex, providing yet another source of messaging on the issue. Concern around Internet use was tied to the perception that youth were not receiving accurate facts about sex, as they were able to access information without proper supervision. Media is believed to support youth attitudes in favour of younger and extra-marital sexual relations, with the Internet serving as a means to learn more about sex. In contrast, censorship of condom marketing and unregulated information about reproductive health on the Internet may be decreasing contraceptive use or encouraging improper birth control methods. As a whole, this could point to greater rates of adolescents having sexual intercourse and using improper or no contraceptives, leading to pregnancy.

A final theme revealed in the scoping visit is the issue of **inconsistent policy implementation**. Interviewees across provinces reported varying levels of quality in youth friendly health services and sexual education within the school system. (Youth friendly health services are defined as clinics within hospitals or universities that have standard practices for adolescents and provide reproductive health services. These are also called “teen corners”.) Healthcare professionals’ beliefs influence access to services like long-term contraceptives and safe abortions. Options such as intrauterine devices (IUDs) or “the pill” could assist adolescents in preventing pregnancy. However, not all healthcare professionals will provide this option to adolescents. Likewise, despite situations in which abortion is legal, interviewees reported that a large portion of doctors are not willing to perform the procedure or prescribe the medication for medical abortion due to their belief system or social pressure on the issue. Sexual and reproductive health education implementation also varies greatly by school despite national requirements. Directors, teachers, and counsellor attitudes and beliefs seem to drive how and when this curriculum is implemented.

The literature review identified additional factors contributing to adolescent pregnancy. These included: a lack of awareness about where and how to access contraceptives, a lack of publicity for existing services, early sexual experiences, Western media portrayal of sexually active adolescents, access to technology, sexual abuse, peer pressure, drugs and alcohol, economic hardship, migration to urban areas, sex workers, economic status, differences in ethnic cultural norms between medical professionals and clientele, and physiological changes.

Of particular note in light of this study's findings, the literature review revealed research highlighting the role **stigmatization** plays in adolescent pregnancy and parenthood. In these Thai studies, families and communities commonly stigmatize pregnant adolescents if it is out of wedlock. Getting married reduced the youth's ostracization, especially if the adolescent father was able to financially support the family.

Increased knowledge of these factors and associated outcomes of adolescent pregnancy among policy makers are critical to understanding the problem of rising adolescent pregnancy rates in Thailand. Although the themes presented above represent some explanation as to why the issue has emerged, the voices and perspectives of young people and their parents across the country have been underrepresented. Including them as a primary source of data in this study, along with local and national key stakeholders, provides a better understanding of the situation and recommendations for change.



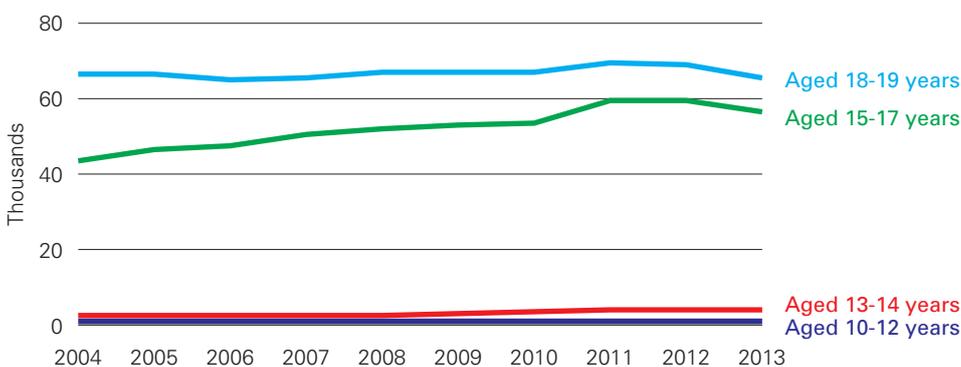
# FINDINGS

This summary of findings first describes the problem using available national statistics. Then, it delineates the reasons why adolescent pregnancy and parenthood should be considered a problem. Third, the summary identifies the ways in which Thailand currently uses data to determine if and when this issue is a problem. Next, it defines the factors contributing to the situation. Finally, this synopsis describes services and strategies currently used to address the problem.

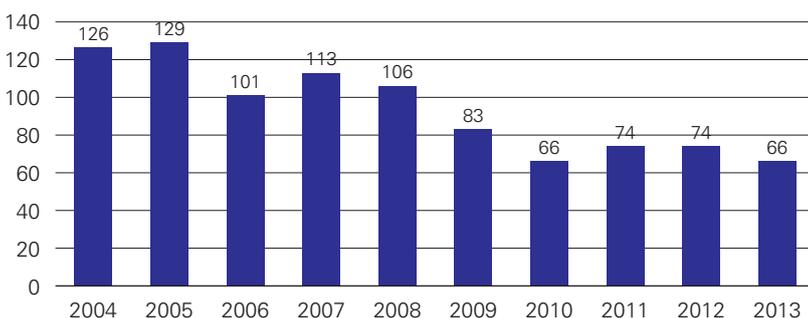
## Prevalence of adolescent pregnancy

This study used data from birth registration records to demonstrate the prevalence of pregnancy in Thailand for adolescents aged 15 to 19 years. Adolescent birth rates are highest for mothers aged 15-19 years, especially those aged 18-19, which is in the legal range of marriage. For adolescents aged 15-17, the numbers of births increased steadily from 2004 to 2011 with the most substantial increase between 2010 and 2011. After peaking in 2011, the number of births to adolescents aged 15-17 decreased from 2011 to 2013. For adolescent mothers aged 18-19, the number of births decreased over the 2004-2006 period. After rising steadily from 2007 to 2011, it declined again from 2012 to 2013. Figures 4 and 5 show the numbers of births to adolescent mothers aged 10-14 are relatively small, yet conversely trend over time. The number of births to adolescents aged 10-12 declined from 126 in 2004 to 66 in 2013. In contrast, for adolescents aged 13-14, births slightly increased in the same time frame, showing signs of a decline only after 2012.

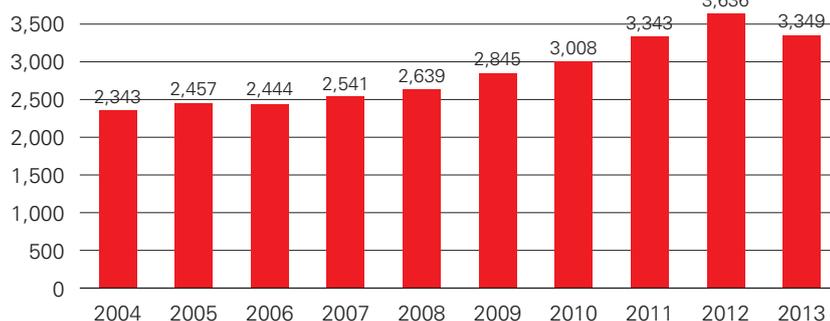
**Figure 1** The number of births to adolescent mothers aged 10-19 registered, 2004-2013



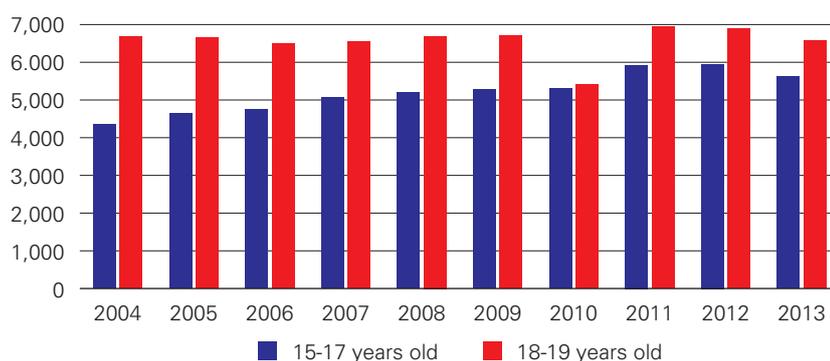
**Figure 2** The number of births to adolescent mothers aged 10-12 registered, 2004-2013



**Figure 3 The number of births to adolescent mothers aged 13-14 registered, 2004–2013**



**Figure 4 The number of births to adolescent mothers aged 15-17 and 18-19 registered, 2004–2013**



## Adolescent births: Trends by age

According to the Ministry of Public Health (MoPH), adolescent birth rates increase slightly from 2004 to 2011 and then decline from 2012 to 2013. For adolescents aged 15-19, the birth rate rises from 47 per 1,000 in 2004 to 54 per 1,000 in 2012; it begins to fall to 48.8 in 2013. Births to adolescents aged 10-14 follow a similar pattern, as they increase slightly from 1.0 per 1,000 in 2004 to 1.8 per 1,000 in 2012, and fall to 1.6 in 2013. In 2013, out of every 1,000 births to women aged 10-49 (n=747, 307), 4.6 are to younger adolescents aged 10-14 and 163.2 were to adolescents aged 15-19.

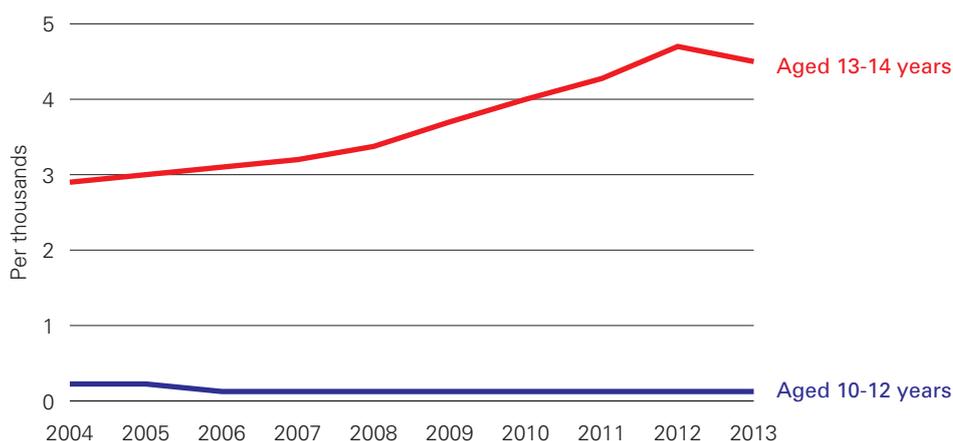
The proportion of births to adolescents aged 10-14 to all births to women aged 10-49 increases gradually from 3.0 per 1,000 births in the 2004-2007 period to 3.5 and 4.8 in 2008 and 2012, respectively. The increase is likely attributed to the increase in birth rates of adolescent mothers aged 13-14, as the proportion of births to this age group increases gradually from 2.9 per 1,000 births in 2004 to 4.7 per 1,000 in 2012 (see [Figure 5](#)). Conversely, the proportion of births to adolescents aged 10-12 declines from 2004 to 2013. After stabilizing at 0.16 per 1,000 births in the 2004-2005 period, the proportion falls to 0.13 per 1,000 in 2006 and appears to have stabilized again at 0.09 for the 2010-2013 period.

For the older age group, 15 to 19 years of age, the proportion of births to adolescents increases somewhat from 2004 to 2012, with 2013 seeing some decline. For adolescents aged 15-19, the increase steadily rises from 136.1 per 1,000 births in 2004 to 164.7 in 2012; it remains relatively stable at 163.2 in 2013. Births to a subset of this age group, adolescents aged 15-17, follow a similar pattern as they increase steadily from 53.8 per 1,000 births in 2004 to 76.3 in 2012, and remain relatively stable at 75.3 in 2013.

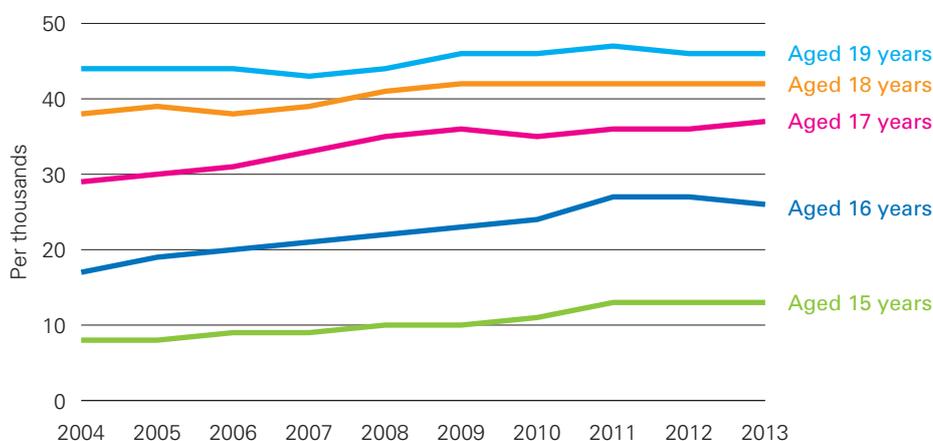
By comparison, the proportion of births to adolescents aged 18-19 were relatively stable, varying between 82.0 and 89.0 per 1,000 births over the same period.

The proportion of births to adolescents increases with age, with the largest increases occurring between ages 15-16 and 16-17 (see [Figure 6](#)). From 2004 to 2013, the proportion of births to the 10-14 age group ranges from 3.0 to 4.8 per 1,000 births, 53.8 to 76.3 for the 15-17 age group, and 82.0 to 89.0 for the 18-19 age group. While the proportions of births to adolescents appear to increase steadily with age according to these age groupings, narrowing the age ranges reveals variation in the rates at which the proportions of births increase. Disregarding the change from the 10-12 to 13-14 age groups, the largest difference in proportion of birth in 2013 is between ages 15 and 16. In 2013, the proportion of births is 13 per 1,000 births *more* for 16 year olds than 15 year olds. The second largest increase in that year is between ages 16 to 17; whereby the 17-year-old adolescents have 11 per 1,000 births more than 16-year-old adolescents. Moreover, 16-year-olds have the greatest increase in births from 2004 to 2013, increasing by 9 per 1,000 births over the nine years. The variation in the rate at which the proportions increase may have implications for age-targeted interventions.

**Figure 5 Proportion of total births (among women aged 10-49) that were to adolescent mothers aged 10-14 years**



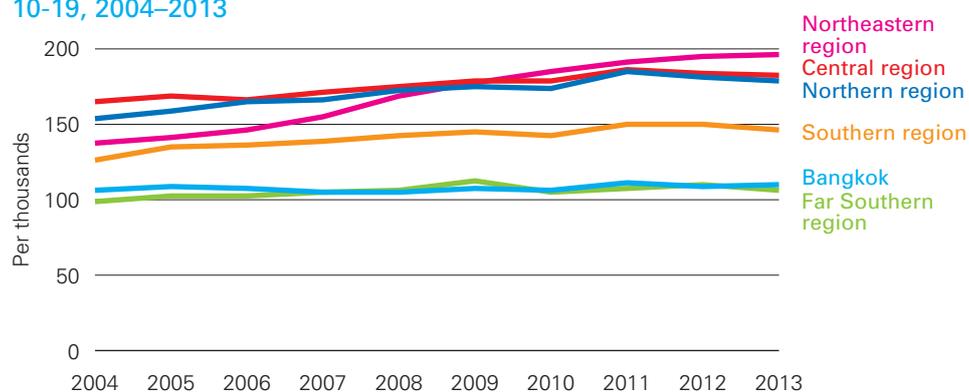
**Figure 6 Proportion of total births (among women aged 10-49) that were to adolescent mothers aged 15-19 years**



## Adolescent births: Trends by region

Figure 7 shows the trends in the proportion of births among adolescents by region from 2004 to 2013. The regions featured in the trend comparison include Bangkok, the Central Region, the Northern Region, the Northeastern Region, and the Southern Region. Multiple regions show a pattern of increasing proportions of births to adolescent mothers aged 10-19 between 2004 and 2012, followed by a decline in 2013. The Northeastern region, Bangkok and the southernmost provinces (called "Far South", which comprises of the Yala, Pattani and Narathiwat provinces) are exceptions to this trend. The proportion of births in the Northeastern region increases quickly over time, whereas Bangkok and the Far South remain relatively low and stable over time. Bangkok and the Far South also have the lowest average proportion of adolescent births of all the regions across the 10-year span.

**Figure 7 Proportion of births within the region that were to adolescents aged 10-19, 2004–2013**



In 2013, births to adolescent mothers aged 15-19 accounted for 163.2 per 1,000 births. By region, there is some variation in the proportion of births that were to adolescents. The Central, Northern, Northeastern and Southern regions have higher proportions of births to adolescents than Bangkok. For each region, the proportions of total births in 2013 (among women aged 10-49 in each region) to births to adolescents aged 15-19 are as follows: 191.5 per 1,000 births in the Northeastern region, 176.2 in the Central region, 173.6 in the Northern region, 142.8 in the Southern region, 105.2 in Bangkok and 104.8 in the Far south.

## Repeat births: Trends by age

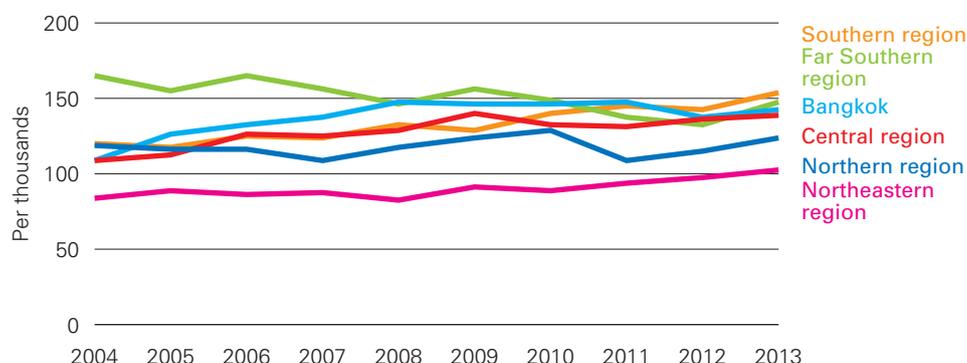
According to the MoPH, over the nine-year period between 2004 and 2012, repeat birth rates among 15-19 year olds increases from 4.9 per 1,000 adolescents aged 15-19 to 6.4 and subsequently decreases slightly to 6.2 from 2012-2013. In contrast, repeat births among younger adolescent mothers (aged 10-14) declines between 2009 and 2013, from 0.20 per 1,000 to 0.10.

## Repeat births: Trends by region

As shown in Figure 8, data for most regions demonstrate a general trend from 2004 to 2013 of increasing proportions of repeat births to adolescent mothers aged 15-19. All regions have seen increases in repeat births since 2004, except for the Far South. In 2013, among 15 to 19-year-olds, the Southern region has the highest proportion of repeat births to total births, with 154.2 repeat births per 1,000 births. For this same year and age group, the Northeastern region has

the lowest proportion of repeat births to total births, with 102.4 repeat births per 1,000 births. It is surprising the Northeastern region has the lowest proportion of repeat births to total births, yet the highest proportion of overall births to adolescents. In addition, Bangkok and the Far South have some of the highest proportions of repeat births to total births and the lowest proportions of overall births. Further research could explore this inverse relationship.

**Figure 8 Proportion of repeat births within the region that were to adolescent mothers aged 15-19**



## Pregnancy outcomes

The main consequences of adolescent pregnancy and parenthood are economic and social in nature, as adolescent parents face increased barriers to educational achievement – which ultimately impede professional success – and social stigma in their public and private lives.

In particular, pregnant adolescents and adolescent mothers face numerous barriers to continuing education, many of which are interrelated. These barriers include: being forced out of school, not receiving the support necessary to continue attending school, and not wanting to experience stigma from peers, teachers, and parents of other students. Policymakers should consider the implications this problem has for individual economic success, and on a larger scale, economic development and human rights.

Social stigma against unplanned pregnancies creates an unsupportive environment at home, in school, and in the community for pregnant and parenting adolescents. Adolescent females in particular often face stigmatization from the people closest to them, which can incite familial problems.

Pregnant adolescents, female and male adolescent parents, adolescents who terminated a pregnancy, and both male and female students all frequently describe financial difficulty due to additional expenses during pregnancy and after delivery. Parents of adolescent parents also note the financial impact of an adolescent pregnancy. Often, the grandparents end up caring for the baby, resulting in additional financial responsibilities for them. Some key informants recognize the difficult economic implications of adolescent parenthood. One key informant states, “When they become parents, they should receive services like other people. They’re short of money because they’re not ready to be parents. They don’t have money, jobs and everything else. What service do you expect them to get?”

I was about to graduate in another month, but when the principal knew I was pregnant he said I have to drop out. It’s like they’re taking away my opportunities and forcing me to start all over again.

Pregnant adolescent, Rayong

They (my family) could not accept it because they said I’m still a kid, they wanted me to get higher education. They said, ‘we told you to take birth control.’

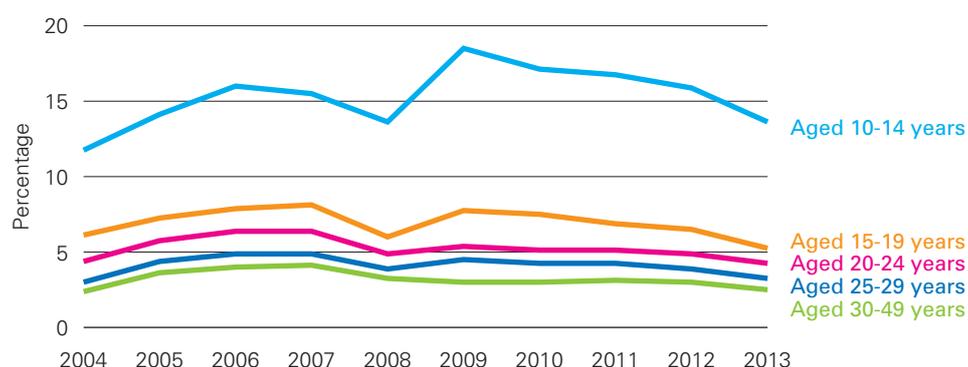
Female adolescent parent, Rayong

Adolescents frequently mention emotional distress as a negative consequence of becoming pregnant. This can include feeling embarrassed, worried, sad, scared or unprepared for the pregnancy and the associated implications. In particular, adolescent females comment how these emotions are connected with family relationships and relationships with their partner. Some reported being worried that their parents would not let them stay with their boyfriend, while another said she was scared that her boyfriend would leave her with the baby. Likewise, both males and females underpin the feelings of shame linked to the wider social stigma associated with adolescent pregnancy.

The greatest health concerns for pregnant adolescents result from the increased risk of life-threatening complications associated with unsafe abortion. According to hospitalization data from the MoPH, hospitals in Thailand from 2004 to 2013, the percentage of abortions per live births averages around 4.7 per cent. This percentage peaks at 5.7 per cent in 2006, then declines steadily to 3.8 per cent in 2013. Figure 9 shows that most of the age groups follow this trajectory with the exception of the 10 to 14-year-old age group. For these young women, hospitalization rates due to abortion peak in 2009 at 18.5 per cent, then decline steadily to 13.6 per cent in 2013. This age group (10 to 14-years-old) shows the highest rate of abortions, with an average of 15.3 per cent over the ten-year period: This is five times higher than the age group with the lowest abortion rate (25 to 29-years-old). This rate may be explained by the fact that females under the age of 15 are legally able to access abortions.

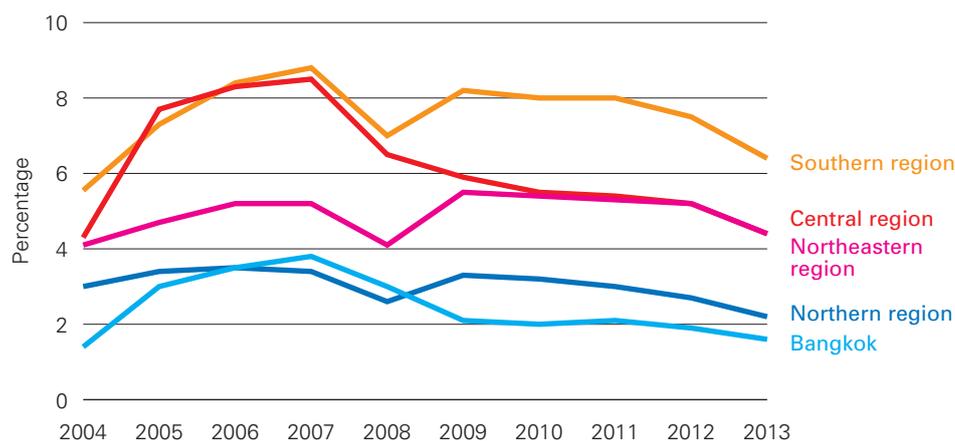
The next age group with the highest rate of abortion is 15 to 19-years-old, with an average of almost 7 per cent over the ten-year period. Interestingly, the 30-49 age group exhibits the third highest abortion rates with a ten-year average of 5.2 per cent. This may be due to having reached their desired family size and wanting to retain their present number of children. Of note is that these rates likely underrepresent the number of abortions. Data on abortions are only available through MoPH hospitals; many other facilities provide this service but are not required to report it to a public agency. As well, these numbers likely reflect mostly legal abortions and not those conducted outside the bounds of Thai law.

**Figure 9 Trend in percentages of females who had an abortion by age group, 2004–2013**



As shown in Figure 10, from 2004 to 2013, abortion rates declined in all regions. Figure 10 also illustrates that abortion rates vary by region. The highest average rates are in the Southern region (7.5 per cent), three times higher than the region with the lowest rates, Bangkok (2.4 per cent). The Central region rates of abortion is the next highest with an average of 6.2 per cent, followed by the Northeast and the North at 4.9 per cent and 3.0 per cent, respectively.

**Figure 10 Trends in percentages of females aged 10-49 who had an abortion by region, 2004–2013**



In term of the health complications of the infants, low birth weight is an elevated concern among infants born to adolescent mothers. In an analysis of Thailand’s 2004-2013 birth registration records, infants born to adolescent mothers are significantly more likely to be at a low or extremely low birth weight (from 12.3 to 17.5 per cent) than infants born to adult mothers. The younger age group, mothers aged 10-14, are twice as likely to birth infants at low birth rates than mothers aged 20-29 (17.5 per cent versus 9.3 per cent; OR=2.06). This younger age group is also at higher risk of giving birth to infants with low birth weight (17.5 per cent) than their slightly older counterparts, mothers aged 15-19 (12.3 per cent). The difference between infants born to older versus younger mothers is even more marked for those born at extremely low birth weights.<sup>1</sup> Although extremely low birth weight is far less common than low birth weight, infants born to younger mothers aged 10-14 are over four times more likely to have extremely low birth weight than mothers aged 20-29 (0.6 per cent versus 0.1 per cent; OR=4.36) and mothers aged 15-19 are twice as likely (0.3 per cent versus 0.1 per cent; OR=1.94).

Marriage among adolescents is both a cause and consequence of pregnancy. Qualitative responses from regional key informants across Thailand indicate that pregnant adolescents often get married to their partner in order to “save face” or to avoid legal complications if a male is brought to court. A few individuals noted that the pressure to get married when pregnant is especially prevalent in more rural areas, supporting Multiple Indicator Cluster Survey (MICS) data. These observations support the notion that marriage is an outcome of pregnancy. On the other hand, regional key informants also observe that some cultural groups and rural communities regard early marriage as “normal”. Informants commenting on this cultural norm mention the following communities and cultural groups: small villages, hill tribe people (such as Akha and Hmong) and Muslims. For example, one key informant says “For the hill tribe society...like the Akha and Hmong, they think it’s a good thing to get married young and have children early because the children can help with the farm work...”

<sup>1</sup> Extremely low birth weight (ELBW) is defined as birth weight of less than 1,000 grams.

In small villages it's a common thing to see children aged 12-13 getting married. It's considered normal. But we see things differently, so we consider it a social problem, something not normal.

Regional key informant,  
Khon Kaen

Further evidence of the prevalence of young marriage is available through the 2012 MICS data. In it, 14.7 per cent of Thai women aged 20-49 report they were married before age 18. These rates vary across regions, with the highest rate in the Northeast region (19.1 per cent) and the lowest rate in Bangkok (11.6 per cent). Of women aged 15-49, 2.7 per cent report marrying before age 15. Regional differences in marriage rates before the age of 15 are minimal; they range between 2.4 per cent in Bangkok to 2.8 per cent in the Northern and Central regions.

## National statistics

A review of national statistics and the monitoring system in Thailand reveals the current systems for tracking adolescent pregnancy and parenthood are insufficient.

Major limitations of the current monitoring system include infrequent data collection, limited data sources and a lack of data on indicators based on risk and protective factors, service utilization and supply rates for various agencies and providers, pregnant and parenting adolescents aged 10-14, and unmarried pregnant and parenting adolescents.

## Existing data

Four Thai Ministries collect data pertaining to adolescent pregnancy and parenthood. This section provides an overview of the relevant data on the subject.

The National Statistical Office (NSO) conducts three main assessments that contribute to knowledge of adolescent pregnancy and parenthood in Thailand: the Population and Housing Census, MICS and a Reproductive Health Survey (RHS). The census collects data every 10 years with the lowest level of aggregation available being regional. NSO collaborated with the Office of the National Economic and Social Development Board in 2008 to administer a Child and Youth Survey.

MICS is an internationally-recognized survey developed to collect information on children and women at the household level (approximately 27,000 households). The last survey was administered in 2012, with the one before that conducted in 2006. This survey captures general demographic characteristics as well as reasons for having a child, reproductive health (e.g., contraceptive use and unmet needs), HIV/AIDS prevalence and family violence. The non-demographic characteristics are only captured for women aged 15-49.

NSO's RHS has occurred at approximately 10-year intervals until 2006. The most recent survey was administered three years later in 2009. This RHS yielded a sample of approximately 30,000 households throughout the country. Relevant variables included in the survey are: premarital services, age of first marriage, number of live births, birthing location, breast-feeding, breast examination, cervical cancer screening and family planning.

The MoPH collects hospitalization data from their health care facilities throughout Thailand. For individuals with HIV/AIDS who receive services through a MoPH facility, data related to risk factors for this condition, including sexual intercourse, is collected. Additionally, the Ministry receives data on the causes for hospitalization in their facilities; this includes pregnant women and

those who have had an abortion at the clinic. One limitation of this data is that age of women and where they live is not necessarily included with the reason for care. Additionally, these data are only supplied to the Ministry from MoPH facilities; women may choose to use many other health care options available to them. As national key informants reported, agencies operating under the MoPH implement the Youth Risk Behaviour Survey collecting information about adolescent sexual behaviour and contraception use. Data are collected and analysed every two years and is used to guide and assess programmes to promote safe sex and control HIV transmission. Scoping visit key informants called into question the reliability of the data from this survey.

The Ministry of Interior's (MoI) Bureau of Registration and Administration issues birth registration for all babies born in Thailand and the mother's age. Of the relevant data collected in this registration process, this system collects the baby's nationality, birthweight and address. Likewise, it also gathers the names and ages of both parents, their nationality and address(es). Records are issued at the Provincial Registrar Office and computerized at this point.

The Ministry of Education (MoE) has information on reasons for why students drop out of school. This includes "marriage" as a reason, but does not include pregnancy. However, schools may not always know the true reasons why students leave school. Key informants state that school administrators may not always accurately report this information, even in cases where the reasons are known.

Lastly, key informants listed the National Institute for Child and Family Development at Mahidol University in Bangkok as an institution with relevant and public data on adolescent pregnancy and parenthood. As a research institute, they are limited in the regularity of their data collection efforts to those related to currently funded projects. Nevertheless, they conduct project-based research on issues related to adolescent pregnancy and make their findings publicly available.

Aside from the census and birth records, data are collected at irregular intervals or in a manner that does not capture sufficient national, regional, or local level analysis. The National Health Security Office, MICS and RHS could serve as the most powerful data sources from which effective analysis could occur. However, in recent years, no analysis has been executed on a regular schedule. Hospitalization data from the MoPH also has the potential to be accurate and useful for multiple levels of geographical analysis. Yet, until a secure infrastructure is in place to acquire these data beyond just MoPH facilities, an understanding of adolescent pregnancy and parenthood will be partial.

## Service utilization indicators and sources

According to secondary research sources, hospitals report service utilization rates to the MoPH. Providers include Health Promoting Hospitals located in sub-districts, district hospitals located in all districts and provincial hospitals situated throughout the country. The data reported include the total numbers of pregnant women at antenatal care, deliveries, abortions, infants born at low birth weight, haemorrhage cases and information about health care facilities providing medical abortions. Additionally, the Ministry of Social Development and Human Security (MSDHS) reports the number of calls from the One Stop Crisis Centre (OSCC), the number women in shelters who are pregnant and the number of women in shelters "after delivery".

The data these agencies collect are not available for analysis. Without these or other similar data, the study is unable to quantitatively discuss the supply and demand for adolescent pregnancy and parenting healthcare services.

## Status of monitoring systems

Monitoring systems exist in Thailand to review information related to pregnant adolescents and adolescent parents. The consistency of the practices and the use of the information collected are unknown in many cases. The MoPH and MSDHS provide the majority of the monitoring on the key indicators: births to adolescent women, abortion rates and contraceptive use. Additional monitoring is done on secondary indicators related to pregnant adolescents and adolescent parents.

Three Thai ministries have some monitoring in place specific to pregnant adolescents and adolescent parents. The MSDHS and MoPH both use the data from the Bureau of Registration and Administration to monitor prevalence and trends in adolescent pregnancy. The former conducts additional area-based surveys as needed, while the latter provides the majority of oversight on this topic. In addition, according to national key informants, MSDHS also annually compiles data on abortions.

As referenced in their 2014 report, “Policy and monitoring system, adolescent pregnancy”, the MoPH also monitors repeat births to women under the age of 15 and between 15 to 19-years-old. Further monitoring activities include their hospital data on contraceptive services after delivery and abortion cases. This Ministry also reviews the distribution of establishing youth friendly health services and regulates the standards set out for them. A new monitoring practice being implemented in 2015 is data collection at each of the 12 Regional Health Promotion Centres. The goal is full implementation in five years, with data being reported on the number of districts implementing and meeting standards of the Bureau of Reproductive Health’s project on the Promotion of Network Participation to Improve Sexual and Reproductive Health among Teenagers and Development of Guidelines/Mechanisms in the Implementation of the “Reproductive Health District (RHD)”.

Through interviews with national and regional key informants, other government branches and non-government organizations (NGOs) were identified as agencies monitoring indicators related to pregnant adolescents and adolescent parents. Several informants felt that the current systems in place were adequate for understanding trends in this area. Yet, one informant advises “There should be a monitoring mechanism to control and ensure compliance with the Acts.”

At a local level, key informants spoke of regional or provincial reports being sent to larger government branches. For example, health service providers in different regions described reporting abortion, repeat pregnancy and other data (such as contraception use rates) to the provincial public health office or to the Medical Council of Thailand. According to public data, MoPH facilities collect this information along with the patient’s age. Public health offices also report on surveillance of adolescent behaviour in schools once a year. Youth friendly service providers record information such as the number of people using their services, as well as their sex and their age. Vocational studies institutes send results of assessments in life skills and sexuality education to the national level, which is then used by the Office of the Public Sector Development Commission to assess annual bonuses of civil servants. However, these data were criticized by several respondents as being unreliable. Similarly, as the MoE receives

student grades, it is able to review grades in sexuality education. Provincial Shelters and OSCCs report the number of cases they receive. This can include cases of pregnant adolescents, particularly those who have been abused and/or sought shelter.

Two NGOs stood out for their monitoring practices during key informant interviews: the Thai Health Promotion Foundation (THPF) and the Planned Parenthood Association of Thailand (PPAT). THPF has a database and surveillance system on adolescent behaviour. This system includes data on adolescent pregnancy, abortion rates broken down by age group and contraception use by males and females. Data are reported once a year. PPAT records and reports monthly numbers of people who have used their services, types of services provided and problems encountered.

## Current methods for data analysis

Little information is available related to practices in place to analyse Thailand's administrative and survey data. National key informant interviews describe using some existing monitoring and surveillance to assess and improve their work. An example supplied was using student examination data from the Vocational Education Commission of the MoE, as well as data from the Behaviour Survey (from the MoPH) to assess the effectiveness of sexuality education and life skills development in schools and whether adolescents can access youth friendly services. While driven on a project-by-project basis, the National Institute for Child and Family Development at Mahidol University was noted for their analysis of data, particularly in adolescent pregnancy. Their capacity for widespread and regular analysis of national data for public consumption or policymaking is unknown.

## Thailand's key relevant indicators from public data

Thailand's public data provide information on risk factors and pregnancy rates, although these numbers are limited by the number of years in between each sample. NSO's MICS and RHS capture short- and long-term indicators relevant to adolescent pregnancy and parenthood. (Short-term indicators are those related to risk and protective factors, as well as indicators related to the pregnancy itself. Long-term indicators are those related to parenthood, birth rates, antenatal and post-natal care.) Information related to the number of pregnancies not carried to term is not part of either survey and could be helpful in understanding this topic.

The Youth Risk Behaviour Survey conducted through Mahidol University, is a third source of data that could potentially aid in tracking adolescent pregnancy and parenthood indicators. However, the frequency with which data are collected through this survey could not be detected, nor could the list of 111 items included on the survey. The general areas explored through this survey include:

- Demographic data
- Traffic safety
- Sadness, suicidal ideation and attempts
- Cigarette smoking
- Psychosocial and learning data
- Violent behaviour
- Age of initiation of each risk behaviours
- Alcohol use

- Illegal drug use
- Contraception use
- Sources of health education
- Sexual behaviours
- Learning problems

This study attempted to reveal some of the relevant data on adolescent pregnancy and parenthood that are publicly available at a national level. To this end, the researchers relied on MICS, RHS, global school-based student health survey, some hospitalization data, birth records and death records. Qualitative responses from key informants indicated additional areas where data were collected for government purposes. However, little exact indicators were noted. Given this limited purview and access to data, few conclusions can be drawn as to what indicators are missing. Nevertheless, of the current information available, several gaps stood out: (1) Data on reproductive health did not include adolescents aged 10-14; (2) data on many reproductive health choices did not include unmarried females; and (3) data did not report the frequency of use of reproductive health services.

## Factors contributing to the situation

The factors highlighted in this summary are those the research team determined could be addressed through interventions including policy and programme reform, public campaigns and staff training. These factors include: cultural norms among adolescents, social stigma, negative attitudes, lack of adult supervision and healthy recreational venues and gender norms. Many of these factors are likely interrelated.

Key factors contributing to adolescent pregnancy include:

- Lack of knowledge and misinformation around sex, reproductive health, and contraceptive methods contributes to adolescent pregnancy. Challenges in this realm span from not knowing how to use condoms and birth control pills to having inaccurate beliefs about what it takes to conceive a child. For example, some respondents point out that it is not uncommon for adolescents to use methods such as counting seven days before and after menstruation or the “withdrawal method”. Research presented in the First National Health Assembly Agenda in 2008 corroborates this finding, as it states the second most frequently cited reason for unplanned pregnancy is the lack of adequate knowledge of birth control. Moreover, it finds the third most common reason is that birth control was ineffective; this could also be an indication of inadequate information on effective use. Some national key informants attribute the deficient understanding and communication about sex to cultural stigma against contraception and adolescent sexuality, which they say may also limit the accessibility of contraception. Likewise, based on a variety of respondents’ reflections, cultural norms may be colouring misconceptions related to adolescent pregnancy. Namely, that provocative dress encourages adolescent pregnancy.
- Young male and female respondents explained that irregular or non-use of contraceptives on the part of both females and males contributes greatly to adolescent pregnancy. They named various reasons for this, including forgetting, being carried away by emotions, not having enough time, and feeling that condoms reduce pleasure for the male. Parents also commented on the limited contraceptive use, but did not have an explanation. Building on this finding, some female and male respondents mention some adolescents

No matter which geographical area, the reason for most unplanned pregnancies is lack of education and information.

1633 Hotline staff,  
Bangkok

lack concern about pregnancy because they can have an abortion or use the morning after pill. The research presented in the National Assembly Agenda described above suggests it could be valuable to further explore the connections between irregular use of contraception and its ineffectiveness, as well as connections between the non-use of contraception and inadequate or incorrect information.

- Adolescents' perception of normal, healthy sexual relationships between adolescents contradicts Thai-majority values of abstinence until marriage.
- Social stigma against unplanned pregnancies and adolescent sexuality is a barrier to youth learning about accessing contraception and other reproductive health services.
- Negative attitudes and behaviours of teachers, parents and service providers are barriers to adolescents' access to health and social services, as they discourage open communication and requests for help.
- Adolescents have few after school and recreational programming opportunities. At the same time, adolescents often lack adult supervision because of their parents' work circumstances, leaving them on their own without productive activities.
- Gender norms and social stigma perpetuate adolescents' ignorance about reproductive health and shared responsibilities in a relationship. Young females are discouraged from seeking information and services about reproductive health while being expected to shoulder the responsibility of pregnancy prevention and the consequences should they get pregnant. Young males are encouraged through media and peer pressure to increase their sexual prowess and yet typically do not share the burden of pregnancy prevention and parenting.
- Other factors such as media, alcohol, early marriage, poverty, age law for marriage, and stigma on abortion are contributing factors to adolescent pregnancy

After about seven months we started to sleep together. I didn't take birth control pills. My boyfriend used condoms sometimes, but sometimes we didn't think about it. After a year or so I got pregnant...

Female adolescent parent, Bangkok

Their friends encourage them to try it...because these days if teens have a boyfriend or girlfriend they have to have sex.

Female student, Bangkok

## Access to information and services

The greatest barriers for accessing information and assistance on the issue are often related to stigma. This stigma is present even among those who could provide education and services, furthering opportunities for access.

Qualitative and quantitative analyses show districts, communities and schools have not uniformly implemented current policies related to adolescent pregnancy and parenting, suggesting some organizations and areas are operating under outdated policies. In particular, this study finds adolescents' level of access to reproductive health information through health care providers and schools is not uniform throughout the country. Adolescents who do have access to information are not consistently receiving information due to their own embarrassment or reticence on the provider's part, which are both linked to stigma and other cultural barriers. Informants also agreed that youth friendly health and counselling services are currently insufficient and inconsistently implemented.

**Figure 11 Sources of sexual education for female adolescent parents**

According to Chirawatkul study (2012)	According to current study (2015)
Female friends (69%)	Friend (50%)
Boyfriend (69%)	Parent (48%)
Textbook (54%)	School (43%)
Teacher (51%)	Doctor (36%)
Television (48%)	Nurse (19%)
General book (41%)	Books (19%)
Male friends (36%)	Internet (14%)
Mother (36%)	Other family member (14%)
Internet (30%)	Sibling (14%)
Sexuality education movie (30%)	Television (10%)

Source: Chirawatkul, S., et al (2012). "Working with Young Adolescents on the prevention of and dealing with Teenage Pregnancy". Unpublished manuscript. World Health Organization's Collaborating Centre for Research and Training on Gender and Women's Health. Khon Kaen University, Thailand.

## Array of services

The following paragraphs provide a brief overview of the Thai Government's efforts to meet the needs of adolescent girls and boys during pregnancy and after delivery. The MoPH provides health services for young people during and after pregnancy. Currently, they offer reproductive health services counselling and special programmes for youth. The Ministry also has plans to establish youth friendly health services in all public hospitals and is working to further integrate and build capacity among local organizations using prevention models. In addition, the MoPH regulates medical abortions. Termination of a foetus that is less than nine weeks of gestation is allowed on the basis of several criteria: (1) medical need, (2) legal need (e.g., rape), (3) female is under 15 years of age (and unmarried), and (4) the child is at risk of severe foetal abnormalities or genetic diseases. Medical abortion is now registered with the Food and Drug Administration, but its use and accessibility are limited. The Department of Health (DoH) is the only organization that can purchase drugs for terminating pregnancies directly from the company; drug companies are prohibited from direct sales to health care facilities. The DoH maintains direct oversight of facilities applying for and receiving drugs used to terminate a pregnancy.

The DoH recently submitted a request for medical abortion to be on the national drugs list in order for users to get financial reimbursement from their insurance; however, the approval process takes about two years. In the meantime, in order to obtain approval, the drug must be in the safety-monitoring programme through which it will be evaluated at the end of the programme. Once approved, these drugs would be more widely accessible in health facilities.

The MSDHS provides social support services to young parents. For emergencies, MSDHS operates the 1300 Hotline, which manages and transfers all calls to the appropriate agency. For example, callers with needs related to health issues are sent to the MoPH; rape and/or violence are sent to the police; child labour to the Ministry of Labour; and female trafficking to the MoI. MSDHS supports Provincial Shelters for Children and Families, which accepts pregnant women who want to continue to term and continue their stay after a delivery

for up to three months. These shelters can further refer pregnant females to shelters more specific to their needs if desired. This branch of government also assists in adoption, foster and kinship care. Additionally, special programmes and training are provided to adolescents, occupational training to those who are pregnant or new moms, and awareness raising campaigns for other youth.

Key informants provided the names and descriptions of services available to adolescents experiencing unplanned pregnancies or parenthood, which included a variety of public and private options; some services are delivered through the State (getting more widespread coverage), while others are available at an NGO. Pregnant adolescents have some access to abortions and financial assistance through the Choice Network. Counselling, contraception advice and antenatal care are all part of youth friendly health services developed in some public hospitals across many urban centres. Some NGOs provide similar opportunities at their facilities, the most well-known being PPAT.

The services intended for adolescent parents are primarily post-natal healthcare, with some coaching and counselling on preventing repeat births and caring for the child. Regional key informants across Thailand describe home visits as targeting pregnant and parenting adolescents. Shelters support adolescent mothers with some options for fostering and adoption, but they are not specifically for youth. Other services specific to parents seem to be available on an ad hoc basis depending on the region, often based on what local NGOs provide. A few regional key informants mentioned job or education counselling, although the degree of assistance in this area seemed minimal. It is unclear if this limited list of services for parents is due to ignorance or an actual lack of options.

In addition, key informants discussed place- and region-specific services. In some cases, they describe where the service was found, and in other cases, regional specificity was identified in analysis based on the region in which the informant was located. Lastly, informants list three NGOs providing services to pregnant and parenting adolescents.

## Services known to adolescents

While both male and female adolescents know of places that assist youth experiencing unwanted pregnancies, the majority of them have never accessed any of these services. Pregnant adolescents, female and male adolescent parents, and female and male general students most commonly mention larger facilities, including hospitals, the Sub-District Health Promoting Hospitals and private clinics. While parents and general students mentioned hotlines (1300 or 1663) as a means to gain information and referral services, they commonly indicated not being familiar with the types of services provided. A few adolescents list postnatal home visits, adoption assistance, provincial shelters, websites or residential care facilities. Although, far fewer adolescents than key informants mention these services. Adolescents note two resources that informants did not, Village Health Volunteers (VHVs) and the Paveena Foundation. Only female students in Satun list teen corners in schools, hospitals, clinics or marketplaces. Other than this, adolescents did not mention youth friendly health services, which suggests a lack of knowledge and awareness about these services.

All of the adolescent groups mention services where adolescents can access abortions when the pregnancy is unwanted. Most respondents note that clinics, especially illegal clinics, provide abortions. Some mention public hospitals as a resource for abortions; one female adolescent parent specifically mentioned the name of a local clinic that she knew to provide legal, safe abortions (name omitted to protect from potential repercussions). The two adolescents who had an abortion also indicate that traditional medicine and traditional healers are often used as the first resource in cases of unplanned and unwanted pregnancies.

## Sources of information about available services

The most commonly mentioned sources of information about services were parents or other relatives (mentioned by pregnant adolescents, female and male adolescent parents, and adolescents who had had an abortion). Female adolescent parents also mentioned learning about services available to them from the following places and people: the Internet, nurses or doctors, friends, Sub-District Health Promoting Hospitals, husbands and/or boyfriends, hospitals, and VHVs. Male adolescent parents also mentioned learning about services available to them from hospitals and friends. Adolescents who had had an abortion mentioned learning about traditional medicines from friends and about illegal clinics where they can get an abortion from neighbours.

## Relevance of services to needs of adolescents

Adolescent respondents hone in on the insufficiency of quality healthcare services, rather than speaking to the relevance of health and social services related to pregnancy prevention, pregnancy and parenthood. Also of note is that youth mentions of social services were minimal, with a couple references to adoption and fostering and child care. However, male and female parents say they have a need for financial support and training on resources, how to care for the child, and how to be a parent. One female parent in Chiang Rai poignantly illustrates the need for hospitals to accommodate women with transportation issues. She describes, "When it's almost time to deliver, I want them to let you stay at the hospital because for people in the mountains, if you are 2 cm dilated, they tell you to go and wait at home and there may be no one to take you back to the hospital."

While some adolescents describe positive experiences with healthcare services, the majority explain the ways in which the quality of health services is not meeting their needs. Nearly all types of adolescent respondents (pregnant adolescents, male and female adolescent parents, and female students) point to limited privacy and confidentiality in public health centres. Only one female student in Satun spoke of experience with youth friendly services in particular; the rest did not specify, indicating either their ignorance of the option or the non-existence of youth friendly services at the facility. Adolescent parents, males and females alike, say staff at hospitals and clinics are unfriendly and have negative attitudes. Several female adolescent parents describe hospital staff as inattentive, and they, along with pregnant adolescents, state the hospitals and public health centres are overly crowded and slow. Several male students from Satun mention that public health service providers do not provide enough information.

Two adolescents, one from Khon Kaen and one from Rayong, shared stories about their experiences having abortions, highlighting the problem of staff providing insufficient information. The adolescent from Khon Kaen had an abortion at an illegal clinic; she describes having to pay 20,000 Thai baht, a very high cost for a young person who might not have the means to pay. She also highlights the inattention and mistreatment she experienced, saying the staff did not give her any information. The adolescent from Rayong describes her abortion service at the public hospital as polite and convenient; yet she shares staff did not give her sufficient information, particularly about contraceptives, and she did not feel comfortable enough to ask questions. This adolescent became pregnant again, which underscores the need for youth friendly counselling and post-abortion advice on contraception.

Some informants, including pregnant adolescents, adolescent parents and general students, think that hospitals, Sub-District Health Promoting Hospitals and VHVs provide good, confidential and convenient services.

## Coverage of adolescent friendly health services

The MoPH has two key national initiatives to expand reproductive health services for adolescents: the Reproductive Health District and youth friendly health services. In 2011, the MoPH started the Reproductive Health District initiative to increase the capacity of various organizations to address reproductive health services, particularly adolescent pregnancy. The national strategy is to enlist individual Thai districts in the initiative, with the end goal of enlisting all 878 districts by 2017. At the end of 2014, approximately 300 districts (34 per cent) were enlisted in the initiative.

Since 2008, the MoPH has been implementing an initiative to expand the coverage of youth friendly health services across all regions in Thailand. MoPH data indicate that, as of the end of 2014, there were 426 youth friendly health services clinics. Three of these clinics are housed in universities; the rest are situated in MoPH hospitals. The MoPH aims to have 855 of these clinics throughout Thailand, and thus the initiative has achieved almost half (45.5 per cent) of its goal in six years. Supply and demand data on these particular facilities are not available. Yet, of the single youth who had accessed a youth friendly clinic, she states that it was “easy to access” and a “good experience”.

While youth friendly services are increasing, they are unequally distributed within or across districts and remain largely concentrated in urban areas. National and regional key informants describe the coverage of youth friendly counselling and health services as currently insufficient, with many adolescents not having anywhere to go for reproductive health services. Respondents across the different regions mention youth friendly services in urban centres of Bangkok, Rayong, Chiang Rai, Khon Kaen and Satun. However, regional key informants say services, especially those that are youth friendly, are not accessible to those living in more remote areas, including hill tribe areas. Other qualitative data also indicate services for safe abortion are unequally distributed across the country. Some provinces do not have any clinics offering safe abortions, and the clinics are usually located in cities. Informants call additional attention to the insufficiency and unequal distribution of services in many areas for abortion if the pregnancy is over 12 weeks.

Among the services adolescents list that they can access, the Township Public Health Office and hospitals are described for parents; providing pre- and post-natal check-ups and vaccinations. For a few parents, private clinics, VHVs and MoPH post-natal home visits offer additional assistance like family planning. None of these places are identified as youth friendly or for adolescent mothers.

## Barriers adolescents face to accessing services

Key informants and adolescents discuss many of the same barriers to health services, from poor confidentiality to inadequately trained staff (see [Figure 12](#)). National and regional key informants, but not adolescents, highlight barriers specific to minority cultural groups, whereas only adolescents point to their lack of time, laziness and the inconvenience of services as reasons for not accessing services.

**Figure 12 Barriers to accessing adolescent friendly health services according to informants<sup>2</sup> and adolescents<sup>3</sup>**

Barriers mentioned by both national and regional key informants and adolescents	Additional barriers according to key informants	Additional barriers according to adolescents
<ul style="list-style-type: none"> <li>• Insufficiency of confidentiality on administrative and interpersonal levels</li> <li>• Inadequately trained and/or skilled adolescent friendly human resources</li> <li>• Lack of awareness and knowledge of services</li> <li>• Social stigma against adolescent sexuality and feelings of shame</li> <li>• Social stigma against abortion</li> <li>• Lack of interest in receiving services, especially boys</li> <li>• Cost of care</li> </ul>	<ul style="list-style-type: none"> <li>• Insufficiency of youth friendly reproductive health services</li> <li>• Barriers specific to minority cultural and ethnic groups</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of time or laziness</li> <li>• Inconvenience or inefficiency of services</li> </ul>

### Irregular confidentiality, on both administrative and interpersonal levels

Patients under age 18 must have their parents' signature to access health care services. Key informants and adolescents emphasize the barrier that the requirement for parent consent creates. Many adolescents do not want their parents to know they are using reproductive health services. This requirement is a barrier for both general services, as well as legal abortion services. Some key informants also describe poor privacy in hospitals as a barrier to service access. Youth responses also show that adolescents lack trust in service providers. They fear providers will not keep information confidential and are particularly anxious that providers will share information with family and other community members. This fear is compounded in smaller, close-knit rural communities.

<sup>2</sup> National key informants, regional key informants, and hotline staff

<sup>3</sup> Adolescents include pregnant adolescents, female and male adolescent parents, adolescents who had an abortion, and female and male general students

**Insufficiently trained and skilled adolescent friendly human resources** Key informants and adolescents name inadequately trained staff as a barrier to accessing services. Key informants say existing services are typically not youth friendly and that the dearth of quality care is exacerbated by the negative attitudes of staff. One key informant links negative staff attitudes to a lack of clear guidelines for staff providing services to adolescents, which causes staff to rely more on their personal beliefs and values. Adolescents add that hospital staff are not attentive, and one respondent shares they are afraid of male doctors. Taken together, these perspectives indicate that current medical staff are insufficiently responsive to the needs of adolescents.

**Lack of awareness and knowledge of services** Key informants suggest the general lack of information and publicity about reproductive health services likely explain adolescents' limited knowledge about the types of service that exist and where or how to access them. This also includes ignorance of youth friendly services. For instance, there is little information publicized about ad hoc funding that may be available to cover a portion of abortion fees available in Bangkok and its vicinity through the Choice Network and AIDS Access Foundation. Moreover, the geographical constraints of this financial assistance further limits access. Some key informants as well as adolescents share that lack of knowledge, combined with social stigma against adolescent sexuality and pregnancy, can lead adolescents to resort to traditional medicines instead of seeking health services.

**Social stigma against adolescent sexuality and feelings of shame** Informants indicate negative attitudes within society about teenagers having sex and getting pregnant contribute to adolescents' fear of being stigmatized as well as cultural barriers – especially for girls – to accessing youth friendly services. Adolescents explain their feelings of shyness, embarrassment, shame and fears of stigma and condemnation are a main barrier to accessing services, even those purported to be “adolescent friendly”. This corroborates adult informants' perception that adolescents do not try to access services because they are ashamed.

**Social stigma against abortion** Informants and adolescents say abortion not being culturally accepted is another barrier. Although medical abortion is available in some specific circumstances, social taboos reinforce unsatisfactory information about where and how to access it. Adolescents say their family members disapprove of it and informants point out that staff in public health services frequently oppose abortion and stigmatize people who inquire about it.

**Disinterest in receiving services, especially among boys** Adolescents report many people their age are disinterested in using reproductive health services, explaining some adolescents may not think they need reproductive health services or do not think they are important. Some adolescent girls specify that boys are especially disinterested in such services. Others state they do not need services because they can access information elsewhere, such as the Internet. Key informants confirm that adolescents' lack of interest in using services is a barrier, especially for boys.

**Cost of care** Key informants and adolescents share examples that reveal the perceived and actual cost of care is a barrier to access. Adolescents share they are afraid of the costs of using services, and key informants describe welfare and social aid as insufficient, especially for adolescent parents. Further research could explore the actual costs of various services to adolescents as compared

Thai culture by itself is a barrier to the preventive work on teenagers' issues. We're not comfortable with speaking (about sex) to educate, both with families and in school. So, the preventive knowledge is totally missing.

National key informant,  
Bangkok

I think we need public relations and we need service centres that are really teen friendly, not just in the name. At some places the personnel still use inappropriate words or have attitudes that are not appropriate.

Regional Key Informant,  
Chiang Rai

to the perceived costs of services. If a discrepancy exists, there may be a need for increased public awareness around the issue. Key informants also report that while limited funding for adolescents who cannot pay for abortion fees sometimes exists through NGO fundraising efforts, it can only be provided to those within Bangkok and its vicinity. They also remark that there is little information about this opportunity.

**Insufficient youth friendly reproductive health services** Only national and regional key informants identify a dearth of adolescent friendly services as a key barrier to this age group accessing reproductive health services. They explain that services exist, but that they are rarely targeted towards or adjusted for adolescents. Adolescent participants in the study did not explicitly identify the scarcity of adolescent-specific services as a barrier to their access. Instead, they described the ways in which current services are not youth friendly as barriers, which implies they also perceive a lack of youth friendly services as a barrier.

**Barriers specific to minority cultural and ethnic groups** National and regional key informants highlight barriers specific to minorities groups including hill tribe groups, Muslim communities and undocumented immigrants. They explain lack of documentation prevents some people from accessing reproductive health services. They also specify abortion services are more difficult to access and often more expensive for adolescents without documents and/or ethnic minority groups. Other informants report people living in hill tribe and ethnic minority areas face unique barriers due to their cultural beliefs, language differences and the remoteness of their communities. Lastly, informants state Muslim adolescents also face barriers related to cultural beliefs and practices, such as the perception that contraception is sinful.

**Lack of time or laziness plus inconvenience or inefficiency of services** Interestingly, adolescents, but not adults, voice not having time or being lazy, as well as inefficiency of services as barriers to accessing services. For instance, only adolescents comment on the slow, crowded service at the hospital or refer to the services as “inconvenient”. This may suggest a generational difference in the value placed on convenience.

## Types of birth control used

Twenty per cent of survey respondents participating in this study indicate they have never used birth control. One data source in the literature review found 83 per cent of students age 10-19 used birth control when having sexual relations, while another found 79.4 per cent of students or their partners used birth controls. The numbers across this study and other independent research are similar enough to suggest some accuracy, though they do not reflect the frequency with which students use birth control. Specifying the population of concern, adolescent mothers and a precise occasion (in this case, the first time having intercourse), yields a lower percentage, as only 60 per cent of adolescent mothers used birth control methods at their first intercourse. Among married adolescent females *without children*, 67.3 per cent used birth control methods, which is 10 percentage points lower than for married adolescent girls with *at least one child* (78.7 per cent).

Condoms are the most popular form of contraceptive. Students report using condoms more than other forms of birth control. One study found 66.4 per cent use condoms, and another found 60.4 per cent used condoms the last time they had sexual intercourse. However, one of these studies finds the second most

common method is withdrawal (14.1 per cent), and another finds it is the birth control pill (32.3 per cent). Among married women, birth control pills are the most common form of contraception (43 per cent indicate they use birth control pills), followed by injectable birth control. Preferences were the same for both females with and without children.

Survey responses in the current study show 54 per cent of adolescent respondents who had sexual intercourse have tried (or been in a relationship with someone who tried) oral contraceptives, 38 per cent have tried male condoms, 25 per cent have tried injectable methods and 21 per cent have tried the emergency contraceptive pill. Though prompted about a number of other methods, only three people or fewer had tried other contraceptive alternatives (e.g., female condom, NuvaRing, patch, implant or IUDs).

## Availability of contraceptives

The NSO's RHS in 2009 finds that 15 per cent of respondents have received advice on family planning from health care providers. For Thai women aged 15-49, the MICS indicates 6.9 per cent have unmet contraceptive needs.

Key informants generally describe contraceptives as easy to access, especially since forms of contraception like condoms and pills can be accessed at convenience stores and pharmacies. They list a number of venues where people can access contraceptives; the most commonly mentioned places include convenience stores, pharmacies, hospitals (at different levels), NGOs, schools, Provincial Health Offices, VHVs and vending machines in public places such as gas stations or bars. An array of organizations provides free condoms including hospitals, clinics, provincial public health offices, Sub-District Health Promoting Hospitals, NGOs, VHVs and some schools. The wide availability of contraception brings a challenge – since condoms and pills are available in many non-clinical settings, adolescents can purchase contraception without receiving appropriate information. As discussed among professionals during the 2015 Choices Forum, a collaborative programme between the MoPH and MoE to provide free (per the law) distribution of contraceptives through condom vending machines at schools, is also challenged due to the concern that abuse may occur with free distribution.<sup>4</sup> Respondents in the current study most frequently indicate they get contraception from the pharmacy (69 per cent), the community health clinic (41 per cent) or the convenience store (39 per cent).

Respondents typically only use three forms of contraceptives: condoms, oral contraceptive pills and emergency contraception pills (called the morning-after pill). A small number of female adolescent parents also mention using injectable methods and IUDs, but female adolescent parents are the only group that lists these methods. Given female students did not mention IUDs or implants, this may suggest their ignorance of long-term methods of contraception. This is unsurprising in the context of the findings that the sexuality education curriculum rarely covered long-term birth control.

Probably some girls don't dare to tell anyone or talk about it (contraception). They are ashamed for others to know.

Adolescent who had an abortion, Rayong

<sup>4</sup> Discussion during the session "Utilization of approved medical abortion for pregnancy termination: from Policy to practice" by Dr. Boonrit Sukarat, Bureau of Reproductive Health, Ministry of Public Health. Presented at the 36th meeting of Choices Forum at the Nation Health Security Office (NHSO) on February 24th, 2015.

Some organizations give out information and give out free condoms, but one thing I've seen is that when a teen goes to get free condoms, they don't give them out because they say the teen is too young. That happens a lot.

Hotline staff,  
Bangkok

The problem is insufficient information, thorough information, real facts about the kinds of contraception and how to use them, or how often or how much. Misunderstandings lead to unplanned pregnancies.

Hotline staff,  
Bangkok

## Barriers to accessing contraceptives

Although the availability of contraception appears widespread, qualitative data reveal that the barriers to adolescents accessing contraception are parallel to those in accessing reproductive health services. These barriers range from social stigma and lack of knowledge to cost and disinterest in use.

**Social and cultural stigma** Stigma against contraception and/or adolescent sexuality emerges as a key barrier to accessing contraception. The 2008 National Health Assembly Agenda points to stigma as the main culprit delaying the MoPH's efforts to expand coverage of national birth control services to single adults and adolescents. The agenda cites the response some leaders took when considering sexuality education: "The provision of sexuality education and means to prevent sexually transmitted diseases and pregnancy is tantamount to facilitating sexual looseness and so it should not be done." Social stigmas against adolescents using contraception exist in many cultures across Thailand, including Thai, Muslim and hill tribe cultures.

**Lack of knowledge** As a barrier to access, lack of knowledge about sex and contraceptives is closely tied to two other factors: (1) the insufficiency of youth friendly reproductive health services and (2) adolescents feeling ashamed about seeking out contraceptive services and information on reproductive health. A dearth of youth friendly reproductive health services, however, is mentioned primarily by national key informants, regional key informants and 1663 Hotline staff. Only one female student (from Satun) specifically mentioned youth friendly centres in Thai public hospitals as places to access contraception. This may illustrate that adolescents are very much unaware that these types of services could be provided, and thus, they are not aware that there is a gap in services upon which to comment. Adolescents feeling ashamed about seeking out information is likely a reflection of the social and cultural stigmas attached to adolescent sexuality and contraceptive use.

**Disinterest** Adolescents, particularly boys, do not care or want to use contraceptives. This also includes not planning and not carrying contraception. It is difficult to separate these issues from stigma and/or lack of knowledge, as some adolescents may project disinterest in using contraception when instead it may be they do not want to face social stigma or admit to not being knowledgeable about contraceptive options.

**Lack of anonymity and convenience** Individuals in multiple regions across Thailand cite condom vending machines as an example of a convenient and anonymous means to access prophylactics. One adolescent parent says this would enable individuals to get contraceptives late at night after other stores had closed. Several regional key informants note that the limited number of vending machines providing contraceptives is a barrier to access. This was noted as especially true for more rural areas like the hill tribes in the North where contraceptives are even more difficult to access. One key informant related the dearth of vending machines to cultural stigma.

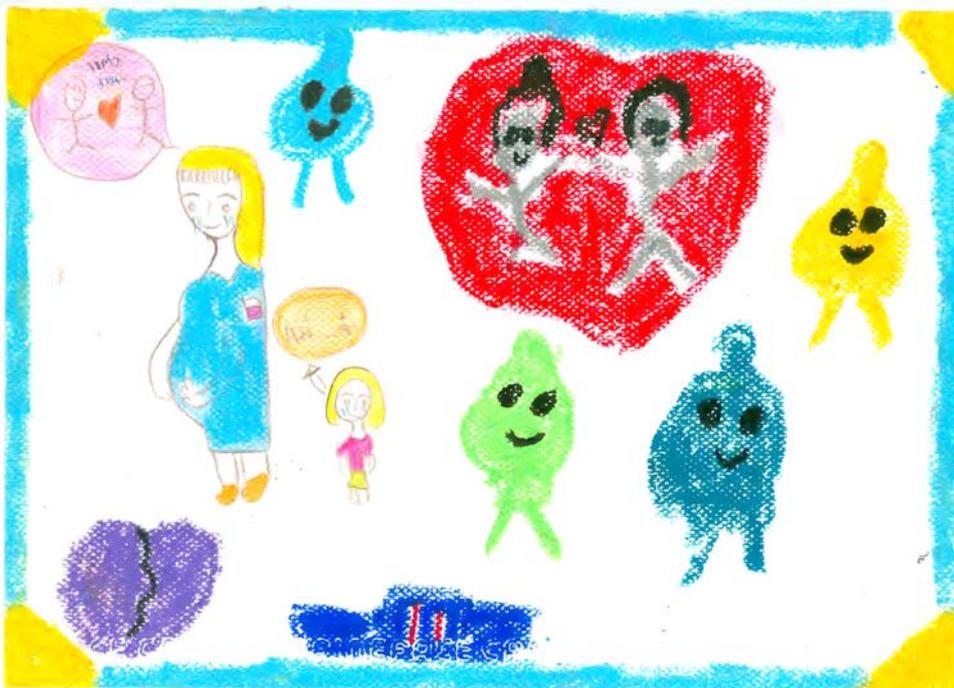
**Cost** Cost is also a barrier to access, that of condoms and birth control pills. Regional key informants in multiple locations believe the expense of regular contraceptives is out of reach for many adolescents.

## Strategies to address adolescent pregnancy

Informants agree that current government efforts do not have a clear shared goal and lack coordination. Prevention programming at the community level is largely limited to a school-based education which often does not follow national standards.

This study finds neither health care professionals nor teachers are typically prepared to effectively communicate with or teach adolescents about sexual health. This conclusion is drawn from the finding that staff are generally not prepared to confront and overcome their personal biases toward sexual activity among adolescents. These factors contribute to adolescents' incomplete or incorrect understanding of reproductive health and sex.

In addition, life skills instruction in schools appears to inadequately prepare youth to acquire necessary life skills such as communication, negotiation and being a responsible person. The perseverance of unbalanced relationships is an indicator that life skills education is not working as it should. For instance, many young women have challenges negotiating reproductive health issues, such as contraceptive use and starting a family. Additionally, many young men do not take responsibility in contraceptive use or engage during pregnancy and parenting.



# RECOMMENDATIONS

The recommendations put forth in this report are informed by the key findings of this study. These suggestions incorporate insights captured from adolescent participants, key informants, researchers and project staff to provide realistic solutions to address adolescent pregnancy. Recommendations are grouped into the following categories: (1) coordination, (2) accountability, (3) strategies, (4) education, (5) social and medical services, (6) community engagement, (7) communication and public awareness, and (8) monitoring and national statistics. Where applicable, recommendations are also organized under subthemes within each category. Pertinent contextual information introduces each recommendation (or set of recommendations), as well as the recommendations present in a bold font and a bulleted list.

## Coordination

### COORDINATING STRATEGIES

Establishing a national committee composed of representatives from the various government agencies that meets intermittently is a common practice in the Government of Thailand. In the context of adolescent pregnancy and parenthood programming, multiple agencies oversee different aspects of these services. For instance, the Office of the Basic Education Commission oversees sexuality education, multiple agencies oversee activities in communities, and the Public Health Department provides reproductive health services for adolescents. This study finds that current government efforts to address adolescent pregnancy and parenthood are insufficient because there is no central coordinating agency. As a result, committees focus on a number of issues and face competing priorities. In order to address the problem of adolescent pregnancy in Thailand, the Government should establish a single unit, potentially under the Prime Minister's Office, to focus exclusively on this issue.

In addition, current government efforts addressing pregnancy do not have a clearly stated shared goal, a necessary component of collaborative efforts. A single unit could work to coordinate common goals and objectives for addressing adolescent pregnancy and parenthood, creating a shared policy framework with integrated strategies among the multiple ministries and departments working in this field. Lastly, additional funding would arm organizations with the capacity to implement prevention approaches that address risk and protective factors. Additional funding could also be used to promote public/private partnerships between entities that serve adolescents.

The recommendations below can build upon the sixth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): provide mechanisms to drive the strategy at all levels. The Strategic Plan could be used to leverage areas of overlap.

- **Establish a single government unit to address adolescent pregnancy in an integrated manner**

- Coordinate common goals and objectives for addressing adolescent pregnancy and parenthood
- Centralize the funding stream for adolescent pregnancy and parenthood
- Increase to current funding for adolescent pregnancy and parenting programmes

## COORDINATING ACROSS SETTINGS

This study finds that adolescents did not know about and did not feel comfortable using reproductive health services. To reach adolescents in school, the Government could foster local partnerships between medical providers and schools. Bringing highly trained medical professionals into classrooms could improve clinic outreach efforts, increase adolescents' knowledge of services and help navigate the stigmatizing attitudes of some teachers. To reach pregnant and parenting adolescent women who are not in the school system, medical providers could partner with social service providers and target places of work.

The recommendations below can build upon the fourth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop system of assistance, protection, and social welfare for teen pregnancy. The Strategic Plan could be used to leverage areas of overlap.

- **Develop a coordination plan between medical providers, schools, and social service providers.**

## USING EXISTING STRUCTURES AND PLANS

Effective strategies are responsive to the needs of different communities and their contexts. Strategies should respond to gaps in local services and be documented in a format that can be readily passed along to the appropriate national ministry for consideration. Local governments can use existing organizations to provide the structure for implementing modifications to existing programmes or new programmes.

- **Inform the Local Administrative Organizations about the situation of adolescent pregnancy and parenting and the strategies to address the issue.** Request that these organizations consider incorporating relevant strategies into their Community Development Plans.
- **Use the structure provided by the existing national Strategic Plan for Teen Pregnancy Prevention and Solution FY 2015-2024 to implement recommendations from this study that overlap with strategies included in the plan**

## Accountability

### HOLDING SCHOOLS ACCOUNTABLE

This research finds that sexuality education curriculums are taught to varying degrees, depending on the school, with some schools not teaching any curriculum. Moreover, the study finds that some school staff's attitudes show their personal biases about adolescent pregnancy, parenthood, and sexuality. These attitudes likely create an unsupportive learning environment, as students do not feel comfortable asking questions when they sense stigma around the subject.

The recommendations below can build upon the first strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): promote the life skills and the learning of sexuality education for teens. The Strategic Plan could be used to leverage areas of overlap.

- **Improve accountability mechanisms for schools providing sexuality education to promote supportive environments that foster learning.**  
Accountability mechanisms should include quality oversight of the following:
  - Sexuality education standards that acknowledge youth have the power to choose when to be sexually active;
  - Teacher qualifications and training; and
  - Counselling and referral services.

## HOLDING ADMINISTRATION ACCOUNTABLE

This study finds that many adolescents have not used youth friendly services, likely because of the barriers to access described in this report. Youth friendly health and counselling services should be adapted to the needs of adolescents, which includes creating proactive outreach services and acknowledging engaging in sexual behaviours as a social norm among many adolescents. Additionally, this study finds that some youth cannot access services because of their young age or their citizenship status. Agencies should adopt anti-discrimination policies and the Government should ensure incentives or disincentives are in place to promote compliance. Moreover, current consent requirements are a barrier to accessing services for adolescents under age 18, as some adolescents do not feel comfortable telling their parents they would like reproductive health information or services (such as consultations about contraceptives).

Lastly, findings from this study suggest that youth socialize in unsupervised settings in the community, which could contribute to opportunities to engage in sexual behaviour. Two specific regulations that could curb this problem include: ensuring businesses are outside the designated perimeter around schools and ensuring adherence to age requirements for entry.

The recommendations below can build upon the fourth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop system of assistance, protection, and social welfare for teen pregnancy. The Strategic Plan could be used to leverage areas of overlap.

- **Improve monitoring structures and oversight of social and health service agencies to ensure adherence to non-discrimination policies, particularly with regards to age and citizenship status, and youth friendly approaches that acknowledge youth have the power to choose when to be sexually active**
- **Reform parental consent policy** not by changing the law specifically, but rather by identifying instances or caveats where parental consent may not be necessary
- **Enforce youth related regulations related to high risk establishments, such as bars, clubs, and “love hotels”**

## HOLDING OTHER HUMAN RESOURCES ACCOUNTABLE

This study finds that some front-line staff lack the skills and attitude necessary for creating a youth friendly environment in service settings. Additionally, informants said there is a need to train staff in referral options and procedures. Front-line staff and officials would benefit from oversight to increase their understanding of problems related to adolescents and ensure they treat adolescents with dignity and respect.

The recommendations below can build upon the third strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop system of quality and friendly sexual and reproductive health services. The Strategic Plan could be used to leverage areas of overlap.

- **Create accountability mechanisms for service referral processes to ensure social and medical service front-line staff and officials give youth the assistance they require**

## Strategies

### TARGETING SUB-POPULATIONS

Birth rates for adolescents aged 15, 16 and 17 are increasing at the fastest rates, which could inform intervention strategies if deemed appropriate to target a specific age group. However, stakeholders planning interventions should be mindful of the advantages of intervening “downstream”, or initiating interventions prior to puberty. To create region-specific strategies, local governments could review the findings about the factors contributing to adolescent pregnancy highlighted in this study, and then discuss and determine which are most salient in their community. Stakeholders planning interventions should be mindful that some minority and ethnic groups may have higher birth rates due to cultural differences. For instance, this study finds that adolescent pregnancy and parenthood is widely accepted and valued in some cultures.

- **Give priority and special attention to younger age groups**
- **Start discussions of sexual, reproductive health and life skills topics with youth prior to puberty** in order to equip youth with the skills and knowledge needed to navigate relationships and their bodies
- **Consider the particular factors contributing to the higher adolescent birth rates outside of Bangkok** and develop interventions for these regions. If prioritization of regions for programming is needed, the Northeastern region has the highest proportion of adolescent birth rates.
- **Research and select adolescent pregnancy prevention or intervention programmes culturally appropriate to the minority and ethnic groups in Thailand**

### ADDRESSING BARRIERS TO ACCESSING CURRENT PREGNANCY PREVENTION SERVICES

This study finds a number of barriers impeding effective implementation of current initiatives aimed at reducing adolescent pregnancy. In the case of health services, some of the barriers to access are related to supply, such as partial implementation of the stated goal to increase youth friendly services, limited coverage of services in remote areas, lack of trained staff and social stigma from staff. Barriers on the demand side of access to health services include lack of awareness of services, lack of privacy and confidentiality, perceived and

actual cost, and social stigma combined with disinterest. The preceding barriers also inhibit access to specific health services, especially abortion services and services supplying contraceptives. In the case of sexuality education, this study explores barriers related to supply, but not demand. This study finds the supply-related barriers to access include variation in the content, quality and frequency of sexuality education across settings, as key informants and youth say course delivery is inconsistent, and even non-existent in some cases. As stakeholders modify and implement strategies to address these barriers, they should ensure strategy design and implementation reflect cultural and social norms, as well as other factors affecting local environments.

- **Stakeholders should address barriers to the supply of, and demand for, existing adolescent pregnancy prevention initiatives when modifying and implementing interventions to address adolescent pregnancy**

## USING PARTICIPATORY PROCESSES

Participatory processes are a best practice for programme and policy planning because they ensure strategies resonate with the targeted age groups, or geographical and cultural communities. Involving stakeholders from the targeted groups will lead to more effective outcomes and incorporate democratic principles into the decision-making process.

- **Encourage involvement of stakeholders like youth and community members in planning for new or modifying existing adolescent pregnancy or parenthood programmes, services or policies**

## Education

Recommendations related to education are meant to encompass vocational schools, non-formal education and general schools.

## DEVELOPING HUMAN RESOURCES

This study finds teachers and other public employees behave in ways that indicate they are in need of increased knowledge, awareness and skills for addressing issues around adolescent pregnancy, parenthood and sexuality.

The recommendations below can build upon the fourth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop system of assistance, protection, and social welfare for teen pregnancy. The Strategic Plan could be used to leverage areas of overlap.

- **Increase teacher and administrative capacity through trainings.** Findings from this study indicate training needs in the following areas:
  - Reducing biased attitudes and behaviours of staff;
  - Long-term contraceptive options in addition to short-term options;
  - List of resources for obtaining the variety of contraceptives and improving reproductive health; and
  - Referral options and procedures.

## BUILDING ON EXISTING SEXUALITY EDUCATION POLICY

Sexuality education must evolve to respond to the cultural norms among adolescents. In particular, programmes should recognize that youth who choose to be sexually active need to be knowledgeable about methods to prevent pregnancy. This study finds that pregnancy occurs between the ages of 10 and 14, indicating this age group is sexually active. Therefore, sexuality education should start prior to age 10 and continue through age 18 and should be appropriate and practical for each age group and gender.

Findings from this study also indicate that interactive curriculum options are most effective. Teachers should integrate more interactive curriculum options to increase learning and engagement. Lastly, programmes like the path2health foundation are respected for their pedagogy and curriculum and may be useful for modelling larger national standards.

The recommendations below can build upon the first strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): promote the life skills and the learning of sexuality education for teens. The Strategic Plan could be used to leverage areas of overlap.

- **Reform sexuality education content and pedagogy extending beyond pregnancy prevention.** Sexuality education curriculum should emphasize:
  - Developing life skills, with particular attention to communication and negotiation skills;
  - Youth choice and self-respect;
  - Long- and short-term contraceptive options;
  - List of resources for obtaining a variety of contraceptives and improving reproductive health;
  - Shared responsibility of partners in parenting and using contraception
  - Impacts of pregnancy and sex literacy; and
  - Continue to cover the biomedical aspects of sexuality education.
- **Sexuality education should start prior to age 10 and continue through age 18**
- **Ensure curriculum is age and gender appropriate.**
- **Integrate more interactive curriculum options to increase learning and engagement**
- **Use lessons learned through the path2health foundation when developing national sexuality education standards and materials**
- **Increase budget with a clear administrative mechanism for sexuality education and life skills. Funding should go towards:**
  - Increased teacher training and capacity building;
  - Greater integrated methodology; and
  - Continuation of technical support for teachers who teach comprehensive sexual education. Examples of technical support include: classroom observation by education supervisors, a forum for sexual education teachers to share and reflect on experiences, and technical updates on related issues.

## SUPPORTING PARENTING MOTHERS IN SCHOOLS

This study finds that many adolescent mothers do not continue their studies for a number of reasons, including not being allowed back in school, not feeling welcomed back to school and not having time because they are caring for their child. It is important for adolescent mothers to have the opportunity to continue their education, both from human rights and economic development perspectives.

The recommendations below can build upon the fourth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop systems of assistance, protection, and social welfare for teen pregnancy. The Strategic Plan could be used to leverage areas of overlap.

- **Develop and disseminate special education plans and social support mechanisms for youth who do become pregnant or parents, with the goal of keeping these adolescents on track to finish high school.** Specific planning areas should include:
  - Maternity leave policy and expectations, with support for young mothers;
  - Systems for allowing pregnant females to miss class for doctor and counselling visits; and
  - Requirements and timing of end-of-year exams to allow adolescents to continue to the next level.
- **Ensure school counsellors with appropriate expertise are available and trained on issues pregnant or parenting adolescents face in order to assist adolescents in navigating the process.** Counsellors can also work in a preventive role with adolescents who are not pregnant.
- **Ensure schools are up-to-date on social and health services available to pregnant or parenting teens in the community, and that they are communicated and referred to these resources**

## Social and medical services

### ADDRESSING BARRIERS TO SERVICE UTILIZATION

This study finds that youth are not regularly using reproductive health services for a variety of reasons. The main barriers include a lack of youth friendly staff, lack of awareness that services exist, and a general lack of youth friendly services. Currently there are two key strategies working to increase adolescents' utilization of reproductive health services: Adolescent Friendly Health Services and the Reproductive Health District campaign. These strategies have not been fully implemented. Further research could determine whether there are differences in service utilization among adolescents as a result of these strategies.

The recommendations below can build upon the third strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop system of quality and friendly sexual and reproductive health services. The Strategic Plan could be used to leverage areas of overlap.

- **Conduct nationwide trainings for social service and medical professionals to increase knowledge and action of more youth friendly practices.** Trainings should cover:

- How to confront and overcome personal biases around adolescent sexuality
  - Expectations for youth friendly customer service;
  - How to guide adolescents in making responsible decisions about when to have sex;
  - Expectations for conversations about contraceptive options (e.g., they should always include long-term options in addition to short-term options);
  - When to make exceptions to the parental consent policy; and
  - Best practices for referral processes and service options available to youth.
- **Provide strategies and plans for social and health services agencies to do community outreach to youth in order to increase their knowledge of services available to them.** Health officials and social workers should be incentivized to offer convenient and non-official service hours for adolescents (e.g., from 4 p.m. to 8 p.m. or over the weekend) through a revised compensation system.
  - **Ensure communities have access to a variety of quality social and health services by assessing existing services and increasing facilities in rural areas.** Ensure the menu of services includes:
    - Counselling;
    - Financial support;
    - Child care;
    - Health information and services;
    - Education;
    - Career development;
    - Foster families and adoption for children of teenage mothers; and
    - Contraception, particularly for females who have been pregnant before.

## Community Engagement

### BUILDING COMMUNITY WHILE FINDING SOLUTIONS

For interventions to be successful, they must be pertinent to the unique needs and cultures of local communities. Additionally, participatory processes are built on democratic decision-making processes, which are presumed to create more engaged communities.

The recommendations below can build upon the second strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): promote role of the family and community as the caregiver, build relationships and communication in terms of healthy sexuality for teenagers. The Strategic Plan could be used to leverage areas of overlap.

- **Create community groups made up of knowledgeable and engaged stakeholders in adolescent pregnancy and parenthood (including youth themselves) to select, fund and provide oversight over local prevention programmes**

## CREATING SAFE RECREATIONAL AREAS

This study finds many adolescents are unsupervised while socializing in their dormitories, homes, and at establishments. This could be a signal that there is a shortage of supervised recreation areas and after-school activities. Creating additional opportunities for recreation in a supportive, safe, and supervised environment would contribute to positive physical, mental and social development.

- **Develop positive physical environments, such as recreation areas, where adolescents may pursue activities**
- **Fund and promote after-school and other recreational activities for adolescents**
- **Extend the learning system beyond the school walls and into the community, homes, and other residences, such as private dormitories**

## Communication and public awareness campaigns

### ADDRESSING PERVASIVE CULTURAL STIGMA

Given the high stigmatization surrounding adolescent sexuality in Thailand and the social norms constraining the use of reproductive health services and education, Thailand will need to challenge these attitudes and behaviours at a national level. Cultural stigma against adolescent pregnancy was a key finding under many of the research questions explored through this study.

The recommendations below can build upon the fifth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): communication for promote understanding of healthy sexuality in society. The Strategic Plan could be used to leverage areas of overlap.

- **Design and implement a public awareness campaign targeted at all individuals living in Thailand, with the goal of reducing stigmatization around adolescent sexuality, pregnancy and parenting.** Communication objectives include:
  - Increasing awareness that adolescents engaging in sexual behaviour is a social norm among youth;
  - Increasing community members' knowledge about services and websites that provide information about making responsible decisions about when to have sex and how to have sex safely if both partners have made that decision;
  - Increasing the degree to which all members of the community communicate about the reality of adolescent sexuality and behaviours;
  - Reducing the expectation that questions about reproductive health imply sexual experience, particularly among women;
  - Reducing male expectations that frequent sexual activity is masculine;
  - Increasing joint partner responsibilities in contraceptive use and parenting;
  - Increasing parent-child communication about sexual activity; and
  - Considerations for modes of communication (use social media, the Internet and other mobile application friendly options to meet youth at their level, and communicate using channels that will appeal to other generations).

- Engage existing community social groups in conversations and campaigns to decrease the social stigma against unplanned adolescent pregnancies and parenting. Examples of social groups include: community leadership, credit unions, farmers associations, women’s union and health volunteers.

## Monitoring systems and national statistics

### IMPROVING THE MONITORING SYSTEM

The current monitoring systems for risk and protective factors of adolescent pregnancy and parenthood in Thailand are uncoordinated and not comprehensive. Although there are two surveys that collect data relevant to the subject, data are not collected on a frequent basis.

The recommendations below can build upon the fourth strategy of the Strategic Plan for Teen Pregnancy Prevention and Solution (2015-2024): develop systems of assistance, protection and social welfare for teen pregnancy. The Strategic Plan could be used to leverage areas of overlap.

- **Conduct a full national gaps analysis of government data** collected on adolescents related to risk and protective factors for pregnancy, current status of the problem, service utilization and supply, and outcomes
- With a gaps analysis in hand, convene the appropriate and relevant ministries to **prioritize the changes and additions to the current data collection system**
- **Implement the RHS and relevant MICS questions on an annual basis** to ensure a regular source of data tracks indicators on the issue. Expand targeted respondent pool to include youth aged 10 to 14
- **Provide a national database for other medical, non-MoPH facilities to submit hospitalization and clinic use data.** Include age of patients with reasons for care and begin collecting information on pregnancy, not just abortion or births
- **Conduct further research** to determine what factors contribute to the differences in birth rates between the Bangkok Metropolitan Area and the rest of the country

# Appendix

## Study methods

This study was designed and implemented using the following strategy: First, the researchers conducted a literature review on the issue of adolescent pregnancy and parenthood. This informed the design and data collection of a scoping mission conducted in Thailand. The researchers collected preliminary data on the topic from a variety of key informants. The findings from these data, along with the literature served to guide the design of this situation analysis.

Both quantitative and qualitative data were collected from a variety of respondents across Thailand for this study. Institutional Review Board approval for the study was obtained from the Office of Research Administration at Thammasat University. Additional quantitative data from other Thai studies and public agencies were obtained and analysed to answer some of the research questions. This report combines the findings from these primary sources and integrates some of the insights from the literature and scoping visit.

## Study participants

The table below displays the total number of respondents who provided information through interviews and focus groups for this study.

**Figure 13 Total participants by region**

Informant/Respondent type	Bangkok	Rayong	Chiang Rai	Khon Khaen	Satun	Total
Key informants – National	12					12
Key informants – Local	8	8	8	8	8	40
Adolescent parents female (focus groups)	6	11	12	10	12	51
Adolescent parents male (focus groups)	3	4	6	2	5	20
Adolescent parents female (interviews)	2	2	2	2	2	10
Adolescent parents male (interviews)	1	2	2	2	2	9
Pregnant adolescents (focus group and interviews)	2	11	9	11	12	45
General students female (focus group)	12			12	12	36
General students male (focus group)	12			12	12	36
Ethnic minority groups female (focus group)			7			7
Ethnic minority groups male (focus group)			2			2
Non-Thai migrants female (focus group)	24					24
Non-Thai migrants male (focus group)	18					18
Parents of adolescent parents (focus group)	5	9	8	12	12	46
Adolescents who terminated a pregnancy (interview)	0	1		1		2
<b>Total</b>	<b>105</b>	<b>48</b>	<b>56</b>	<b>72</b>	<b>77</b>	<b>358</b>

The table below presents the number and type of adolescent respondents that completed the survey administered after the interviews and focus groups.

Figure 14 Survey respondents by type

Survey respondent type	Total
Female adolescent parents	61
Male adolescent parents	29
Pregnant adolescents	45
Female general students	36
Male general students	36
<b>Total</b>	<b>197</b>

## QUALITATIVE DATA COLLECTION AND ANALYSIS METHODS

Qualitative data collection combined focus group discussions and in-depth interviews. Primary data collection took place at each of the five provinces for up to 13 days each, including focus groups with: (1) adolescent mothers and fathers (with groups divided by gender); (2) pregnant adolescents; (3) parents and caregivers of adolescent parents; and (4) female and male general students (with groups divided by gender). One additional focus group was also conducted with staff of the 1663 Hotline run by an AIDS ACCESS Foundation with support by the THPF and National Health Security Office. This was done to compensate for difficulty in identifying and conducting in-depth interviews with adolescents who had an abortion. In addition to the focus groups outlined here, in-depth interviews were conducted with the following groups in order to obtain more information and discuss potentially sensitive issues on a one-to-one basis: (1) female adolescent parents; (2) male adolescent parents; and (3) adolescents who had an abortion. Regional key informant interviews with service providers, NGO staff, community-based organization staff, local officials, health professionals, community health workers, teachers and peer educators were also conducted. In-depth interviews were also conducted with national key informants.

Additionally, in Chiang Rai focus group discussions were conducted with female and male adolescent parents from ethnic minority groups, with groups divided by gender. In Bangkok, focus group discussions were conducted with female and male Burmese migrant adolescents (with groups divided by sex).

Qualitative analysis used the constant comparison/grounded theory method, in which findings were analysed using emerging concepts and themes. The qualitative data gathered for this study included findings from interviews and focus groups. The analysis explored themes and ideas around the relevant research areas. Themes were identified to detect findings that are prevalent (common across multiple participants), insightful (unique to a few participants, but sharing a perspective that is important), or illustrative (in-depth comments that do a particularly good job of describing a concept or idea). Using data collectors and the research team, a group analysis process was used to reduce potential biases and overcome issues in translation of qualitative data. A more extensive description of this process is available in the Methodology section of the Appendix.

## QUANTITATIVE ANALYSIS METHODS

Quantitative analysis included summary statistics, cross-tabulations, correlations, regression analysis and tests of significance to determine major issues, themes, and findings. The quantitative data also includes secondary data analysis and limited data from the short questionnaire administered during data collection. These data were summarized using bullet points of key findings, or in tables and charts to provide a clear overview for ease of interpretation.

As secondary sources were used for this analysis, methods reflect an integration of re-analysis of (primary) raw datasets provided by the researchers or institution as well as secondary data review of published study materials. In addition, several research questions relied on legislation and other policy in place in Thailand. No analysis was needed in this search; instead, the response reflects a summary of available and public documentation.

## Study limitations

There are some areas of exploration included in the initial Terms of Reference that may be compromised by incomplete or inaccurate data. In particular, we know from interviews that the number of abortions performed at hospitals is under-reported as doctors fear scrutiny for performing the procedure. We also heard that some doctors feel it is a sin to record the procedure. In addition, the frequency of rape and statutory rape are believed to be under-reported.

Interviews also revealed that health services data typically do not include the province of residence for individuals using their services. This may impact the data as certain provinces may have a higher concentration of services available, and people may feel more comfortable seeking services outside of their province of residence.

Certain areas pertinent to this study do not have consistent data available at a national level. For example, many schools do not keep records of student pregnancies, reasons for drop-outs, or reasons for transfers. Even more, based on conversations during the scoping visit, it seems that some schools and communities may be inclined to deny a problem or instances of adolescent pregnancy to save face and protect their reputations. Similarly, there is little information available on the outcomes of children born to adolescent parents. Health records are currently compiled in a way that allows only for limited tracking of health outcomes for babies born to adolescent parents. Migrants and ethnic minorities also are a group of individuals who are important to the situation analysis but limited datum exists. Lastly, little is known about youth outside the school system.

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