

Self-Efficacy in Child Rearing and Quality of Life among Adolescent Mothers in the Northeast of Thailand

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ABSTRACT

Background

Incidence of adolescent pregnancy has been increasing continuously in Thailand. These adolescent mothers might face various problems such as social acceptance, poor knowledge of child rearing with affect their quality of life. However, there are insufficient studies quality of life and the associated factors of the adolescent mothers in the biggest region, the Northeast of Thailand.

Objective

To identify the level of quality of life and the association between self-efficacy, ability in child rearing and quality of life of adolescent mothers in the Northeast of Thailand.

Method

Cross-sectional study with systematic randomization 232 adolescents who gave a first singleton live birth in a hospital, with data collection done through a structured questionnaire administration. The multiple logistic regressions were used to determine the association.

Result

The majority of postpartum adolescent mothers were age 18 years old (52.59%). All participants were primiparous mothers. Almost all of adolescent mothers had senior relative within family assisting in child rearing (90.95%). Nearly half of them (46.98%) had high scores of quality of life on living and child rearing. Most of the mothers perceived self-efficacy during pregnancy or pre-childbearing in moderate level (87.93%). However, only 36.64% had high level of self-efficacy on living and child rearing. Majority had moderate to high scoring of stress on living and child rearing (65.52%). Only 32.06% received high scoring of social support on living and child rearing. The multiple logistic regressions were used to measure association of significant factors by backward elimination. Factors associated with quality of life in postpartum adolescent mothers were no stress (adjusted odds ratio: AOR = 4.37, 95% CI; 2.29 to 8.30, p-value < 0.001), high level of self-efficacy (AOR = 4.01, 95% CI; 2.04 to 7.88, p-value < 0.001), and high level of social support (AOR = 3.31, 95% CI; 1.74 to 6.31, p-value < 0.001).

Conclusion

Social support, self-efficacy and stress have strong influences on quality of life of the postpartum adolescent mothers. Therefore relevant sectors should develop system to improve social support and child rearing competency of adolescent since pregnancy and postpartum.

KEY WORDS

Adolescent, child rearing, postpartum, quality of life, self-efficacy

INTRODUCTION

Adolescent pregnancy remains a significant global public health problem. About 16 million adolescent girls give birth every year and three million of them undergo unsafe abortions.¹ A childbearing during adolescence has a negative impact on the future well-being of mother and infant.² Previous studies have reported an increasing risk of adverse maternal and perinatal outcomes in adolescent mother.³⁻⁵ The risk factors associated with biological immaturity of adolescent mother included physical and psychoemotional factors, poor socio-environmental factors, social and cultural backgrounds and the quality of health care services.^{3,4,6-8} Adolescent maternity lacking proper preparation during postpartum period can have a significant new physical, psychological, emotional, social, and economic responsibilities into maturing process which was being transition and ends up having direct impacts on her quality of life.^{9,10}

Quality of life is a multidimensional, dynamic and subjective concept that broadly covers all the positive and negative aspects of life encompasses the physical, mental, and social functioning on health and well-being or the ability to function, and/or either satisfaction or achievement.^{11,12} Adolescent mother having dissatisfaction in new maternal role had associated with negative attitude and avoidance child rearing convey to a low maternal self-efficacy and less quality of life.¹³⁻¹⁵

According to Bandura's theory, self-efficacy is mother's confidence in her ability performance to regulate her motivation, thought process, emotional state, and social environment to affect a given behavior on living and child rearing.¹⁶ The Northeast of Thailand is the biggest region of the country with one third of both of land area and population but is the poorest region. There have been and continuously increasing trend of adolescent pregnancy in the region. There are inadequate studies that examine the early postpartum self-efficacy, ability in child rearing and quality of life among adolescent mothers. This study therefore aimed to identify self-efficacy, ability in child rearing and quality of life among adolescent mothers in the Northeast of Thailand.

METHODS

This cross sectional analytical research aimed to determine quality of life and its associated factors in postpartum adolescent mothers in the Northeast of Thailand. Data collection was performed between March and April of 2016. Eligibility criteria were age 18 to 19 years which gave first singleton live birth and child rearing on herself within 6 weeks postpartum period and no serious obstetric complications related to the current birth or any physical or mental constraints. Exclusion criteria were serious obstetric complications, or serious neonatal complications during or after childbirth as well as delivering an infant

with congenital abnormalities, fetal death, or infant death. Among a total population of 40,773 adolescent mothers (in 2013), who delivered their babies in public hospitals in the Northeast of Thailand and met the inclusion criteria were considered. A sample of 232 was selected by using systematic random sampling with reference to the hospital record of proportional to size of the adolescent mothers getting services in respective public hospitals.

In addition, those postpartum adolescent mothers were contacted by the research team and asked to complete a questionnaire during hospitalization and/or community-based care or during follow-up in a breastfeeding/postpartum clinic of a public hospital in the Northeast of Thailand. All of these questionnaires were directly self-administered by postpartum adolescent mothers.

Data collection was conducted through a structured questionnaire, consisted of six parts: 1) the maternal socio-demographic, obstetric questionnaire and breastfeeding data. 2) the perceived self-efficacy during pregnancy or pre-childbearing.^{16,17} 3) the ability of self-efficacy on postpartum period.^{17,18} 4) the social support.¹⁹ 5) mental health on stress.²⁰ 6) the quality of life of postpartum adolescent mothers on WHOQOL-BREF-THAI.²¹⁻²³ The questionnaire validity was reviewed and judged by three experts in this area. The final questionnaire was revised to improve its validity. This tool was pre-tested in 30 postpartum adolescent mothers at postpartum unit, public hospital in Northeastern Thailand. Its reliability was determined by Cronbach's alpha, yielding a score of 0.85, which was judged acceptable.

The dependent variable is the quality of life (WHOQOL-BREF-THAI).²¹⁻²³ This variable is obtained from an item directed to adolescent mothers' overall perception of quality of life and their health within 6 weeks postpartum which cover four domains (physical, psychological, social relationship, and environment).

Descriptive statistics was used to describe the quality of life situations and other independent variables. The number and percentage were used to describe the categorical variables. The mean and standard deviation together with median and the range (Minimum: Maximum) were used to present the continuous variables. As the design of quality of life on Thai version, systematic sampling weight was used. For the study objective, simple logistic regression was administered to estimate the association between each potential related factor with quality of life and presented as unadjusted odds ratio and its 95% confidence interval (95% CI) of each parameter. Multiple logistic regressions was used to estimate the magnitude of association of factors and quality of life by adjusting the covariates, and reported as adjusted odds ratio together with its 95% CI. Statistical significance was declared if the two-sided p-value was less than 0.05. All analyses were performed using Stata statistical software (Version 13.0, Stata Corp LP, College Station, TX, USA).

The study was approved on March 9, 2016 by the Khon Kaen University Ethics Committee in human research, Thailand (approval number: HE592031) in accordance with the guidelines of Helsinki Declaration and the International Conference on Harmonization for Good Clinical Practice (ICH GCP). All participants did not provide written informed consent prior to study commencement.

RESULTS

Participant characteristics

Descriptive statistics of 232 adolescent mothers were shown in Table 1. The majority of them were aged 18 years old (52.59%) with same mean and median. Most of them were married or living with a partner (84.05%), had a good relationship with her spouse/partner (65.09%), a high school education (75.0%), living within their own families or husband/partner's families (95.26%) and received good family support (96.12%). In addition, the average monthly family income was 7,331±2,595 Baht.

Furthermore, only 39.66% were intended to be pregnant however 37.93% were prepared for pregnancy. All participants were primiparous mothers (first time delivery mothers). The mean gestational age at delivery was 36.87±1.22 weeks in which 81.03% were normal child deliveries. Followed by 18.96% were undergone caesarean section. The average child birth weight was 2,929.31±234.49 grams. The prevalence of low birth weight (<2,500 grams) was (13.36%). Almost all of adolescent mothers had senior relative within their family for assisting in child rearing (90.95%). Nearly half of them (46.12%) had intended to give exclusive breastfeeding for 6 months and/or above. Most of mothers using breastfeeding were because of benefit and nourishment nutrition of breast milk (75.86%). Health personnel were most advocator breastfeeding (66.81%). Only 33.19% was supported for breastfeeding by the family members. The health care provider provide knowledge of breastfeeding to adolescent mothers were more likely to benefit from breast milk for feeding their child's (80.60%). Adolescent mothers having the early onset of first breast milk within less than 3 days was only 38.79%. About 79.31% of postpartum mothers yielded the baby sucking first breast milk within 2 hours after childbirth. Most of neonates had good sucking from breast milk (87.50%). Adolescent mothers aliment their child with partial feeding with breast milk and formula was 78.88%. There was only 14.66% of women constrained exclusive breastfeeding. The reason of adolescent mothers to discontinue breastfeeding was that they must return to work full-time or part-time (67.24%) and had insufficient breast milk (26.29%) (Table 1).

Descriptive statistics of the measured variables

Descriptive statistics of the measured variables for 232 adolescent mothers were shown in Table 2. Postpartum adolescent mothers having perceived self-efficacy during

pregnancy or pre-childbearing in moderate level were 87.93%, whereas others having that in low level and high level were 28.02% and 12.08% respectively. The mothers having high level of self-efficacy on living and child rearing were only 36.64%, whereas mothers having that in low to moderate were 63.36%. Postpartum adolescent mothers received high level of social support on living and child rearing were only 32.06%, but mothers received social support in low to moderate level were as high as 67.24%. Postpartum adolescent mothers had moderate to high level of stress on living and child rearing were 65.52%, whereas 34.48% had low level of stress. Nearly half of postpartum adolescent mothers (46.98%) had high scores of quality of life on living and child rearing, likewise slightly over half of mothers (53.02%) had low to moderate level of quality of life.

Quality of life and Independent Factors among postpartum adolescent mothers: bivariate analysis

Simple logistic regression was used to determine the association of individual independent variables and quality of life. The factors that have p-value not more than 0.25 were then proceed to the multivariable analysis. These factors were age, marital status, monthly income, educational level, readiness for pregnancy, gestational ages at childbirth, and intension to breastfeeding, the early onset of first breast milk, and method of feeding, human resources to supporting breastfeeding (Table 3).

Factors associated with quality of life in postpartum adolescent mothers: multivariable analysis

The multiple logistic regressions were used to estimate the magnitude association of significant factors by backward elimination of which factors were adjusted for the effect of all other factors (Figure 1). Adolescent mothers having no stress to low level of stress had the strongest influence on quality of life on living and child rearing at postpartum period when compared to those with had high stress (adjusted odds ratio: AOR = 4.37, 95% CI; 2.29 to 8.30, p-value < 0.001). Other significant factors on QOL of adolescent mothers were having high level of self-efficacy on living and child rearing (AOR = 4.01, 95% CI; 2.04 to 7.88, p-value < 0.001) and social support (AOR = 3.31, 95% CI; 1.74 to 6.31, p-value < 0.001).

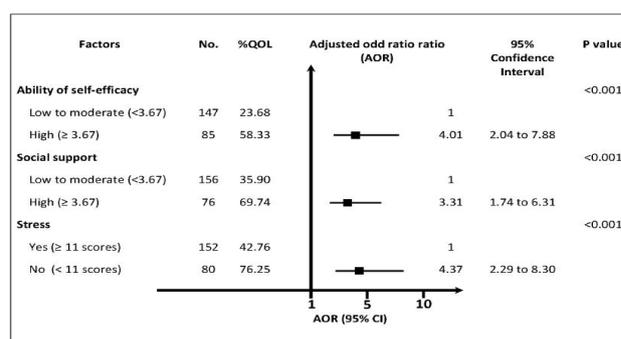


Figure 5. Factors influencing quality of life in postpartum adolescent mothers: multivariable analysis.

Table 1. Descriptive characteristics of postpartum adolescent mothers. (n=232)

Demographics Characteristics	Number (n=232)	Percent (%)
Age (years)		
18	122	52.59
19	110	47.41
Mean (SD)	18.53 (0.50)	
Median (Min : Max)	19 (18:19)	
Marital status		
Separated	37	15.95
Married or living with a partner	195	84.05
Spouse/partner relationship		
Good	151	65.09
Medium	51	21.98
Poor	30	12.93
Educational level		
Primary school	40	17.24
High school	174	75.00
Diploma	18	7.76
Living condition		
Living within their own family or husband/partner's family	221	95.26
Only living with husband/partner	11	4.74
Family support		
Received good family support	223	96.12
Not received good family support	9	3.88
Monthly household income (Baht)		
Less than 5001	37	15.95
5000 to 10000	117	50.43
10001 or greater	78	33.62
Mean (SD)	7,331.89 (2,594.90)	
Median (Min : Max)	8,000 (3,000:15,000)	
Wanted pregnancy		
Wanted	92	39.66
Unwanted	140	60.34
Readiness for pregnancy		
Ready	88	37.93
Unready	144	62.07
Obstetrics characteristics and breastfeeding data		
Gravidity (number of pregnancies)		
1	172	74.14
2	58	25.00
3	2	0.86
Parity (number of deliveries)		
1	232	100
Gestational age at delivery (weeks)		
< 37	32	13.79
≥ 37	200	86.21
Mean (SD)	36.87 (1.22)	
Median (Min : Max)	39 (36:41)	

Mode of delivery

Normal labor	188	81.03
Caesarean section	44	18.96

Neonatal birth weight (grams)

< 2,500	31	13.36
≥ 2,501	201	86.64
Mean (SD)	2,929.31 (264.49)	
Median (Min : Max)	2,900 (2,110:3,780)	

Age of living child (weeks)

Less than 1	73	31.47
1	57	24.57
2	63	27.15
3 to 6	39	16.81
Mean (SD)	1.50 (1.53)	
Median (Min : Max)	1 (0:6)	

Child rearing plan

Parenting alone	13	5.60
Senior relative within family assisting	211	90.95
Senior relative assisting (living in different house)	8	3.45

Intention to exclusive breastfeeding (months)

Less than 1	14	6.08
1 to 3	54	23.28
4 to 6	57	24.57
> 6 to 12	27	11.64
> 12 or greater	80	34.48

Reason for breastfeeding

Benefit and nourishment nutrition of breast milk	176	75.86
Save costs	52	22.41
Comfortable	3	1.29
Value, traditional belief and cultural	1	0.43

Supporting to breastfeeding from human resources

Health care provider	155	66.81
Member in family	77	33.19

Knowledge of breastfeeding

Benefit of breast milk	187	80.60
Technical care	25	10.78
Problem of breastfeeding	2	0.86
Method of pumping and storage of breast milk	13	5.60
Suitable time on breastfeeding	5	2.16

Early onset of first breast milk

≥ 3 days	142	61.21
< 3days	90	38.79

The onset of first breastfeeding

< 2 hours	184	79.31
≥ 2 hours	48	20.69

Characteristic of sucking neonatal from breast milk		
Baby having good sucking	203	87.50
Baby having sucking difficulty	29	12.50
Method of feeding		
Formula feeding	15	6.47
Exclusive breastfeeding	34	14.66
Partial feeding (breast milk and formula)	183	78.88
Discontinue breastfeeding reason		
Returned to work full-time or part-time (Working outdoors)	156	67.24
Physical problem	4	1.72
Neonatal problem	5	2.16
Insufficiency breast milk	61	26.29
Intention of returning to study	6	2.59

Table 2. Descriptive statistics of the measured variables.

Variables	Number (n=232)	Percent (%)
Perceived self-efficacy		
High (3.68 – 5.00)	28	12.08
Moderate (2.34 - 3.67)	139	87.93
Low (1.00 – 2.33)	65	28.02
Mean ± S.D. = 2.86 ± 0.67 Median = 2.80 Min = 1.47 Max = 4.43		
Ability of self-efficacy		
High (3.68 – 5.00)	85	36.64
Low to moderate (1.00 - 3.67)	147	63.36
Mean ± S.D. = 3.52 ± 0.36 Median = 3.50 Min = 2.00 Max = 4.20		
Social supports		
High (3.68 – 5.00)	76	32.76
Low to Moderate (1.00 - 3.67)	156	67.24
Mean ± S.D. = 3.40 ± 0.45 Median = 3.48 Min = 2.36 Max = 4.36		
Stress		
Moderate stress to High stress (Score=11 or greater)	152	65.52
No stress to Low stress (Score= 0 to10)	80	34.48
Mean ± S.D. = 12.39 ± 4.51 Median = 12 Min = 0 Max = 24		
Quality of life		
High (score = 96 or greater)	109	46.98
Low to Moderate (Score = less than 96)	123	53.02
Mean ± S.D. = 90.63 ± 13.43 Median = 95 Min = 58 Max = 115		

DISCUSSION

This study provides a comprehensive analysis of the quality of life among postpartum adolescent mothers in the Northeast of Thailand based on maternal ability of self-efficacy on living and child rearing.

The overall prevalence of the high quality of life in the adolescent mothers was 46.98% (Table 2) which social relationship was the highest domain of high level of quality of life (59.05%) whereas environmental and psychological

Table 3. Factors influencing quality of life in postpartum adolescent mothers considering each factor based on simple logistic regression analysis: bivariate analysis.

Factors	Number (n=232)	%QOL	Odds ratio	95% CI	p-value
Age (years)					
18	122	41.8	1		0.096
19	110	52.7	0.64	0.38 to 1.08	
Marital status					
Separated	37	32.4	1		0.051
Married or living with a partner	195	49.7	0.48	0.23 to 1.02	
Monthly household income					
<10,000	197	50.3	1	1	0.001
≥ 10,000	35	77.1	4.73	2.05 to 10.95	
Educational level					
Primary school	40	30.0	1		0.001
High school	174	50.5	2.39	1.44 to 4.99	
Diploma	18	50.5	2.33	0.74 to 7.3	
Readiness for pregnancy					
Unready	144	36.1	1		<0.001
Ready	88	64.7	3.25	1.87 to 5.66	
Gestational ages at childbirth					
	232	N/A	1.48	1.20 to 1.86	0.004
Intension to breastfeeding					
< 6 months	125	56.8	1		0.001
≥ 6 months	107	35.5	0.42	0.25 to 0.71	
The early onset of first breast milk					
≥ 3 days	142	41.6	1		<0.001
< 3 days	90	74.4	2.34	2.30 to 7.32	
Method of feeding					
Formula	15	6.6	1		0.006
Exclusive breastfeeding	34	61.7	0.56	0.26 to 1.19	
Partial feed (breast milk and formula)	183	47.5	0.04	0.01 to 0.38	
Human resources to supporting breastfeeding					
Member in family	77	23.3	1		<0.001
Health care provider	155	58.7	4.46	2.51 to 8.64	
Perceived of self-efficacy					
Low to moderate (1- <3.67)	204	25.8	1		<0.001
High (≥ 3.67)	28	68.6	6.30	3.16 to 12.55	
Ability of self-efficacy					
Low to moderate (1- <3.67)	147	23.68	1		<0.001
High (≥ 3.67)	85	58.33	4.51	2.43 to 8.36	
Social support					
Low to moderate (1 - <3.67)	156	35.90	1		<0.001
High (≥ 3.67)	76	69.74	4.11	2.28 to 7.41	
Stress					
Yes (≥ 11 scores)	152	42.76	1		<0.001
No (< 11 scores)	80	76.25	4.77	2.64 to 8.69	

domains were only 37.93% and 33.62% respectively. Only 13.36% of physical domain was at high level of QOL. Quality of life can be defined as subjective well-being, having to competency on management of many life domain, and accessibility resources and opportunities.²⁴ The results of this study, therefore, indicated that many women sustain reasonable levels of quality of life despite the challenges they may encounter during the postpartum period by several physical and mental health problems such as urinary and fecal incontinence, constipation, infection, wound problem, pain at multiple sites, fatigue, stress, anxiety, living condition, breastfeeding experience difficulties or coping of their infants.²⁵ The physical health problems experienced by fatigue or tiredness and pain in various parts of body are the most prevalent at postpartum.²⁵ while new mothers were adapting with new roles and changes in the family environment. Notwithstanding, the other domains can solve problem and competent manage many life domains to live and child rearing too. The stress is part of psychological domain which affects to adolescent competence and/or behavioral and devotion to the child or to be limited. Our study showed that postpartum adolescent mothers who had no stress to low level of stress was only 34.48% but these are the strongest factor associated with quality of life on living and child rearing at the postpartum period (4.37 times higher when compared to those had high stress (adjusted odds ratio: AOR = 4.37, 95% CI; 2.29 to 8.30, p-value < 0.001)). Although adolescent mothers were only wanted pregnancy (39.66%), readiness pregnancy (37.93%), and primiparous (100%), but almost all mothers (95.26%) resided within their own family or husband/partner's family, received good family support (96.12%), were supported breastfeeding from the health care provider (66.81%), and only from member in family (33.19%) (Table 1). The study showed that the maternal had their regulated with a calm and kind emotion toward themselves, which may explain less stress in maternity promote self-caregiving, shaping mother's behaviors, expectations, and feelings during mother-child along with their quality of life.^{26,27} On the other hand, stress was shown to associate with poor quality of life among adolescent mothers.²⁸ Other forms of stress including psychological distress, the context of living condition, and low socioeconomic resources can influence adolescent mothers health and well-being.²⁸ Women perceived higher stress were associated with restrictions on mental and physical quality of life-related health (QLRH) such as fatigue, loss of energy, anxiety, depression, reduced functional status, limitation in work or activities and performance difficulties.²⁹ A study research highlights that stress can lead to altered biological process such as inflammation and results to poor physical health outcomes.³⁰ These findings suggest that the relationship between stress and physical or emotional well-being of adolescent mothers is complex. One possible explanation, the resilience on adolescent mothers demand (providing optimal care to the infant including breastfeeding, improving relationship functioning

with a father of the baby or family) to promoting quality of life of their mothers and related to their child. Mothers received more social and family supported and less stressful child care and life in general are associated with a longer of feeding, factors which by themselves are associated with high quality of life.⁹ When adolescent mothers have less stress and self-critical, and therefore, they may feel more confident in their ability to self-caregiving, and care for a child toward quality of life by the challenges of maternity. They are more motivated to display positive emotion and self-ability behaviors that include caregiving, protection, reassurance and promoting their child rearing.³¹

In this study, there was association between self-efficacy and quality of life among postpartum adolescent mothers. The study showed that the adolescent mothers who had high level of self-efficacy were 4.01 times more quality of life level in postpartum period when compared to those who had low to moderate level of self-efficacy (adjusted odds ratio: AOR = 4.01, 95% CI; 2.04 to 7.88, p-value < 0.001). While mothers who had high level of self-efficacy were only 36.64% at postpartum period (Table 2), mothers with high level of perceived self-efficacy were only 12.08% during pregnancy or pre-childbearing (Table 2). In general, self-efficacy is defined as the ability to successfully perform a maternal task.¹⁶ According to Bandura's social learning theory of self-efficacy, maternal beliefs in their ability to functioning control may eventually result in desirable maternal self-efficacy.³² Accordingly, self-efficacy reflects maternal ability to influence the infant and her environment in order to facilitate the proper development and child rearing especially, mother-child attachment is potential ability performance as adaptive process.³³ On the other hand, enthusiasm, compatibility, and devotion of maternal role lead to higher self-efficacy and directly affect the quality of life in adolescent mothers living and child rearing. When mothers received social support from spouse or partner, family, information, health personnel and/or social environment could be enhanced through emotional and psychological health to promoting adolescent maternal self-efficacy. As the above mention, the mothers were supported from their family or healthcare providers who played a pivotal role in maternity self-efficacy through enhancing the mastery experience.³⁴ As a result, the member in family and healthcare provider encouraged adolescent mothers could develop positive attitude and self-compatibility toward self-caregiving and capable of childcare for their quality of life. This is compatible with Leahy-Warren P and McCarthy.³⁵ that, the mother-child interaction is a unique form of relationship.

In the current study, the social support was also factor contributed to quality of life in postpartum adolescent mothers. The study showed that the adolescent mothers who received high social support were 3.31 times more likely to have high level of quality of life during postpartum period compared to those who had low to moderate social support (adjusted odds ratio: AOR = 3.31, 95% CI; 1.74 to

6.31, p -value < 0.001). This study found that the majority of adolescent mothers stayed with spouse or partner (84.05%), had good relationship with them (65.09%) and had been supported from family (96.12%) but only 32.76% had high scoring of social support. Their child rearing plan had been supported from senior relative within family assisting as living in the same household (90.95%) (Table 1). There are three categories of social support in postpartum adolescent mothers: 1) emotional support such as empathy, care, love, and trust. 2) Informational support such as giving the information that can be used to solve the problem like take caring baby, self-treatment and personal problems or other environment. 3) Instrumental support such as giving help to take caring baby and do the housework.³⁶ This indicated that adolescent motherhood requires lots of support in various forms such as physical, emotional, appraisal, financial, social or environmental, and from sources: partners, family, peers, health care provider or community.³⁷ Social support is also an essential component for the postpartum woman's physical, emotional well-being and interpersonal relationships, even though adolescent mothers may lack preparedness for transition into motherhood (unready pregnancy: 62.07% from table 1). Previous studies have reported that the mothers having high levels of relationship as well as social support from partners and families had higher quality of life.³⁸ The importance of satisfied of social support on adolescent mothers cause to adaptive in a maternal role, valuing children or take caring a baby as the best aspect of life.³⁹ Social support included formal structural support and functional emotional support has positive influence when mothers gave birth and as a predicted factor of avoiding postpartum depression.⁴⁰ In addition, it can help adolescent mothers to successfully navigate through the combined demands of adolescent development and their role as a new parent. This may be due to the fact that adolescent mothers are not readiness for pregnancy going through motherhood of their peers which difficulty opportunities are built connections and network of mothers.³⁰ Mother or mother-in-law can assist to helping problem-solving in adolescent mothers. Development of the family is important to facilitating adaptation of mother in family for postpartum period. In this study, the mothers who fed their babies by the onset of first breastfeeding less than two hours were 79.31% which their babies were found to be good sucking (87.50%) and easy child (46.55%). It was found that adolescent mothers' breastfeeding based on the reason of benefits of breast milk for their babies were 75.86%. This breastfeeding was also supported by both health care provider (66.81%) and member in family (33.19%). The result suggested that adolescent mother should be received promoting knowledge about maternal benefits of breastfeeding in order to optimize initiation and maintenance breastfeeding. Discomforts in adolescent mother during breastfeeding in this study were uterus pain (42.18%), breast engorgement (29.25%), episiotomy or incision pain (19.73%) and cracked nipple (8.84%). Mothers

intended to breastfeeding less than six months (53.87%) did not differ so much from mothers intended to exclusive breastfeeding six months and over (46.13%). Majority of mothers terminated breastfeeding because they had to return to work full or part time (67.24%) while others had not enough breast milk (26.29%). Although all adolescent mothers gave the first singleton live birth and reared their children within six weeks at postpartum period, they exclusive breastfeeding were only 14.66% whereas most of them intended partial feeding: breast milk and formula (78.88%) and few of them formula fed their child (6.47%). Because they were new mothers, senior relatives in the family played an important role in helping them and their baby, especially her mothers or mothers-in-law and grandmothers which are the important part of culture of the people of Northeast Thailand (E-sarn). Other significant factors affecting the feeding decisions are her partners and family lived in extended family members. In addition, the health personnel and health care system consisted of community based nurses, public health staff were also significant constructed and promoted adolescent mothers' health and their child by knowledge, attitude, and practice skills to more likely to maintain their health and child rearing. Adolescent mothers can make informed decisions and learn the skills needed to manage common problems and the skills that can increase their self-esteem and ability as mothers. However, culture has a dominant impact of maternal on living and child rearing when mothers received good relationship in family or another so encourage their quality of life. Diverse cultural must be considered in appropriate postpartum care. Aforementioned, adolescent mothers received diverse supporting domains from physical, psychological, social relationship and environment can be built ability performance during postpartum period for maintenance quality of life and their child care. The social support, therefore, is crucial supportive of adolescent mothers.

However, there were some limitations in this study. Firstly, this study was conducted in only late adolescent mothers and did not include early adolescent mothers that cannot consequently represent to all adolescent mothers. So the further study should be conducted to include all adolescent mothers in every region of Thailand. Secondly, the sample size was small and utilized only one site for data collection thereby a larger and more diverse sample of mothers is required generalization.

CONCLUSION

This study identified to the effects of self-efficacy, ability in child rearing on quality of life among postpartum adolescent mothers, and found that the stress, ability of maternal performance, and social support supported increasing the quality of life. The postpartum adolescent mothers have consisted of ability-performance with social support from family or others may be contributing in their

self-efficacy to living and their child care. Consequently, recommending the supporting and advocating adolescent mothers through by preparing physical, psychological, emotional and other necessities both during pregnancy as well as postpartum period provided by the resilience and multidimensional health educational programs each period to enhance the quality of life in this population.

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