

UNDERSTANDING PATHWAYS TO ADOLESCENT PREGNANCY IN SOUTHEAST ASIA

FINDINGS FROM

Malaysia



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JULY 2023

Prepared for UNFPA Asia Pacific Regional Office and
UNICEF East Asia and Pacific Regional Office by:

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Foreword

Adolescent pregnancy remains a pressing concern for girls in the Southeast Asia region, hampering their ability to pursue their dreams and aspirations. It is a profound violation of their human rights and imposes significant barriers to their personal, educational, social and economic development. The consequences of early pregnancies are vast, perpetuating cycles of inequality and impeding progress towards gender equality.

Globally, during the last decade there has been a steady decline in child marriage. In several countries in Southeast Asia, there has been either stagnation or an increase in adolescent pregnancy, often triggering child marriage or early union.

The United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) have joined forces to generate evidence on the patterns of adolescent pregnancy and child marriage in four countries in the region. The factors driving adolescent pregnancy and child marriage are different from other regions, as suggested by "[Beyond Marriage and Motherhood: Empowering girls by addressing adolescent pregnancies, child marriage and early unions](#)," UNICEF and UNFPA, 2022.

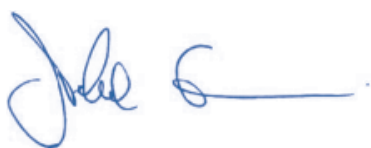
This report brings attention to the specific context, dynamics and influences that contribute to adolescent pregnancy in Cambodia, Indonesia, Malaysia and Lao PDR. The four in-depth country analyses identify the patterns that drive adolescent pregnancy across the region, including as determined by relationship or marital status, the extent of the girls' autonomy in decision making and whether the context of sex leading to the pregnancy was consensual.

The report finds that girls want to go back to school or continue their education but face challenges, including from their parents and partners. Girls said they wanted to seek help, but did not know where to go. Some girls are living with stigma, guilt, regret and a lack of knowledge about sexual and reproductive health and rights. These girls have the right to be informed about decisions that affect their lives. They need support, not stigma and blame.

Through this report, girls have expressed their thoughts and concerns, as well as their requests to decision-makers. They urge policymakers, advocates and stakeholders to recognize the significance of adolescent pregnancy in this region and its implications for girls like them.

UNICEF and UNFPA are committed to supporting girls to pursue their dreams and to prevent early and unintended pregnancies. It is our duty to come together, bridge the gaps in knowledge, and collaborate on strategies and interventions that prioritize girls' rights and opportunities.

We extend our deepest appreciation to all those who contributed to this report and, most importantly, to the girls who shared their voices. Thank you.



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Executive summary

Adolescent pregnancy remains a major public health concern in Southeast Asia. Adolescent pregnancy poses risks to the health and wellbeing of adolescent girls and their babies. In many contexts, adolescent pregnancy is closely linked to child marriage and early union. The adolescent fertility rate in Malaysia has been halved since the 1990s but has stagnated over the last few years (UN DESA Population Division, 2022). While this could be linked to child marriage and early union practices, publicly available and centralized data on child marriage in Malaysia are limited and so it is difficult to gauge the scale of child marriage in the country (Girls Not Brides, 2023). In addition, research suggests that the prevalence of adolescent childbearing may be underestimated as data on illegal abortion and abandoned babies among adolescents in Malaysia are not taken into account (Hazariah *et al.*, 2021; Suan *et al.*, 2015). There is limited research into the drivers of and pathways to adolescent pregnancy in Southeast Asia, and few studies capture the opinions and experiences of the girls themselves, which should be key in designing policy and interventions.

This study aimed to 1) understand the different drivers and pathways to adolescent pregnancy, and 2) co-develop, with adolescents, policy and programming recommendations to effectively address adolescent pregnancy. The findings of this study can help inform strategic investments and interventions that address specific pathways to and drivers of adolescent pregnancy, thereby enabling girls to make informed decisions for their relationships and life trajectories.

While this study on pathways to adolescent pregnancy was conducted in four countries, this specific report discusses study implementation and findings only from Malaysia.

Using a participatory, qualitative approach, the study design placed adolescent perspectives at the forefront, using primary data collected with adolescent girls aged 16–20 who experienced pregnancy or birth at age 18 or younger. Study implementation was guided by a working group led by the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), and two youth advisors from the study country. Data collection was conducted in three

states representing median (Selangor and Kuala Lumpur) and high (Pahang) adolescent fertility and premarital conception.

During the first round of data collection, an in-depth, timeline interview approach was used. Framework analysis was applied during preliminary data analysis, and candidate pathway typologies were developed based on girls' life stories and contributing factors in their pathway to adolescent pregnancy. During the second round of data collection, follow-up interviews were conducted with selected girls to validate and clarify study findings and interpretations and gather girls' recommendations for programmes and policy.

A total of 45 in-depth interviews were conducted with adolescent girls and six pathways to adolescent pregnancy were identified. These pathways were differentiated primarily according to the timing of first pregnancy relative to any union, that is, outside-union and within-union pregnancies. Outside-union pregnancy pathways all resulted in unplanned pregnancies but were differentiated further according to the context of sex that preceded pregnancy (consensual, pressured, forced) and whether or not pregnancy was followed by union. Within-union pregnancy pathways diverged according to who initiated the union, as well as pregnancy intention (planned, unplanned but wanted). Cross-cutting factors contributing to girls' pathways to adolescent pregnancy included lack of sexual and reproductive health (SRH) knowledge (including contraception), barriers to contraceptive access and use, girls' lack of agency and decision-making power in relationships, and social norms that support marriage as a means to protect a girl and her family's reputation.

During 10 follow-up interviews, adolescent girls offered several recommendations. They said that programmes and policies should focus on teaching girls about SRH and related topics. They would like to see the creation of a supporting, enabling environment for girls to access SRH information, services and supplies, and one that provide girls with guidance so they can have more say in their relationships. They recommended that girls receive targeted support following experiences of sexual violence, and they asked that parenting



classes and financial and moral support be provided to girls who are already pregnant or parents.

The study found diverse pathways to adolescent pregnancy among girls in Malaysia, some of which are not driven by marriage or cohabitation. The findings highlight the need to ensure that girls have the resources that they need to make informed decisions that affect their sexual and reproductive health before they become sexually active. This will entail assessing the delivery of timely and accurate SRH information in schools and providing comprehensive sexuality education in school and through non-formal, community-based programmes. It will likewise be imperative to address the social and legal barriers girls face to contraceptive access and use. This will necessitate the transformation of social norms and removal of age limits and requirements for parental consent so that unmarried adolescents can freely access contraceptives, whether through private establishments or public healthcare facilities. Finally, given that some girls' pathways to pregnancy were characterized by pressured and forced sex, it will be important to implement comprehensive sexuality education (CSE) and gender transformative programming (with girls

and boys) that address harmful gender norms, communication, consent and violence. It will also be important to ensure that girls have access to comprehensive sexual and reproductive health care to make the best-informed decisions, and receive targeted support and clear legal guidance following experiences of sexual violence, alongside access to a child-friendly justice process.

Future research could explore girls' decision-making and contexts following admission to shelter homes, as this was a critical component of many girls' experiences of pregnancy and unique to the Malaysian setting (relative to other countries where this study was also undertaken). Given the limited number of participants and locations included in this study, more qualitative research (i.e. with more girls in more locations) would enable more robust data analysis and help to identify other pathways to adolescent pregnancy that may be salient in the experiences of girls from socio-cultural and ethnolinguistic backgrounds not included in this study (e.g. Chinese and Indian). It would also be beneficial to gather quantitative data on the pathways to adolescent pregnancy at the national level so that national programmes and policies can be tailored to girls' specific contexts and needs.

Abbreviations

APRO	Asia Pacific Regional Office
CSE	Comprehensive sexuality education
EAPRO	East Asia Pacific Regional Office
FRHAM	Federation of Reproductive Health Associations, Malaysia
IEC	Information and education campaign
NGO	Non-governmental organisation
SRH	Sexual and reproductive health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Glossary

Adolescents

The World Health Organization (WHO) defines adolescents as “persons who are aged 10-19 years” (WHO, 2001). This definition will be used throughout this report.

Child marriage

UNFPA and UNICEF defines child marriage as “any formal marriage or informal union between a child under the age of 18 and an adult or another child (UNICEF, 2022).” This definition will be used throughout this report.

Consent

UN Women defines consent as “an agreement between participants to engage in sexual activity or enter into marriage. It must be freely and actively given and cannot be provided by someone who is under the influence of drugs or alcohol or by someone underage. Consent is specific, meaning that consent to one act does not imply consent to any others, and reversible, meaning that it may be revoked at any time (UN Women, 2010, 2023).”

However, in this report, girls’ descriptions of their sexual debut and subsequent sexual experiences are privileged. For this reason, consent to sex and marriage and union through “continuum thinking” was discussed, which draws on adolescent girls’ own constructions of consent (UNICEF and UNFPA, 2022; Whittington, 2021).

The following categories of consent to sex are used throughout this report:

- **Consensual sex:** The girl described that both she and her partner wanted to have sex, or her partner initiating or requesting sex and engaging in sexual negotiation with him, and eventually agreeing, or being “convinced” to have sex.
- **Planned/expected sex:** The girl did not explicitly state whether or not she wanted or agreed to sex but implied through her description that sex was planned or expected because of the circumstances, usually once the couple stated cohabitating or were married.
- **Pressured sex:** The girl mentioned that she did not want to have sex at the time and felt pressured by her partner. This included cases where the partner used threats of breaking up to “convince” the girl to have sex.
- **Forced sex:** The girl stated that she was forced, or described being in a situation where she refused, resisted, but was unable to fend off the partner’s advances. This included cases where the girl described being “too drunk” to consent or was unconscious during sex.

Sexual violence

UN Women defines sexual violence as “any sexual act committed against the will of another person, either when this person does not give consent or when consent cannot be given because the person is a child, has a mental disability, or is severely intoxicated or unconscious as a result of alcohol or drugs (UN Women, 2023).”

Background and rationale

Adolescent pregnancy remains a public health concern in several Southeast Asian nations. Pregnancy-related complications are a leading cause of death of girls aged 15–19 in low- and middle-income countries, and the third highest cause of death of girls in Southeast Asia. Adolescent pregnancy is also associated with lower educational attainment and poverty. While child marriage and early union is understood to be a driver of sexual debut and childbearing, recent data suggest that in many settings, adolescent pregnancy gives rise to child marriage and early union (Harvey *et al.*, 2022).

There is limited research into the drivers of and pathways to adolescent pregnancy in Southeast Asia, and few studies capture the opinions and experiences of the girls themselves, which should be key in designing policy and interventions.

In Malaysia, the adolescent fertility rate has been halved since the 1990s, but has stagnated over the last few years (UN DESA Population Division, 2022). While this could be linked to child marriage and early union practices, publicly available and centralized data on child marriage in Malaysia are limited (UNICEF Malaysia, 2021), making it difficult to gauge the scale of child marriage in the country (Girls Not Brides, 2023). In addition, research suggests that the prevalence of adolescent childbearing may be underestimated because data reporting on adolescent pregnancy is not standardized, and data on illegal abortion and

abandoned babies among adolescents in Malaysia are not taken into account (Hazariah *et al.*, 2021; Suan *et al.*, 2015).

Unmarried girls who get pregnant can be sent to live in maternity/shelter homes that have been operating in Malaysia for more than 50 years (Hazariah *et al.*, 2021; Siam *et al.*, 2013). Shelter homes are intended to act as a “zone of protection, supervision, rehabilitation, and training to the unwed young mothers (Saim *et al.*, 2016, p.186),” particularly in cases where the pregnant girl is below the age of 18 and deemed in urgent need of protection. While in shelter homes, girls have access to medical check-ups, vocational and sex education classes, extracurricular and religious activities, opportunities to work or volunteer, religious counselling and consultations on adoption (Hazariah *et al.*, 2021; Saim *et al.*, 2013). Admission into a shelter home can be initiated by the girl or her parents or family, and ideally would be done to help the girl and her family, such as by facilitating adoption or hiding the pregnancy (Saim *et al.*, 2016). However, prior research suggests that girls admitted to shelter homes do not necessarily experience positive experiences in health or well-being (Saim *et al.*, 2013; Saim *et al.*, 2019). There is a need to improve understanding of adolescent girls’ experiences of pregnancy within the context of shelter homes to better align interventions and approaches to girls’ needs and priorities.

Objectives

This research project was conducted in Cambodia, Indonesia, Lao PDR, and Malaysia, and aimed to:

1. Understand the different drivers of and pathways to adolescent pregnancy; and
2. Co-develop, with adolescents, policy and programming recommendations to effectively address adolescent pregnancy.

This report discusses study implementation and findings from **Malaysia only**.

The project was led by the Burnet Institute in partnership with the Federation of Reproductive Health Associations, Malaysia (FRHAM),¹ UNFPA Malaysia Country Office, UNICEF Malaysia Country Office, UNFPA Asia Pacific Regional Office (APRO) and UNICEF East Asia and Pacific Regional Office (EAPRO).

¹ <https://www.frham.org.my/>



Methods

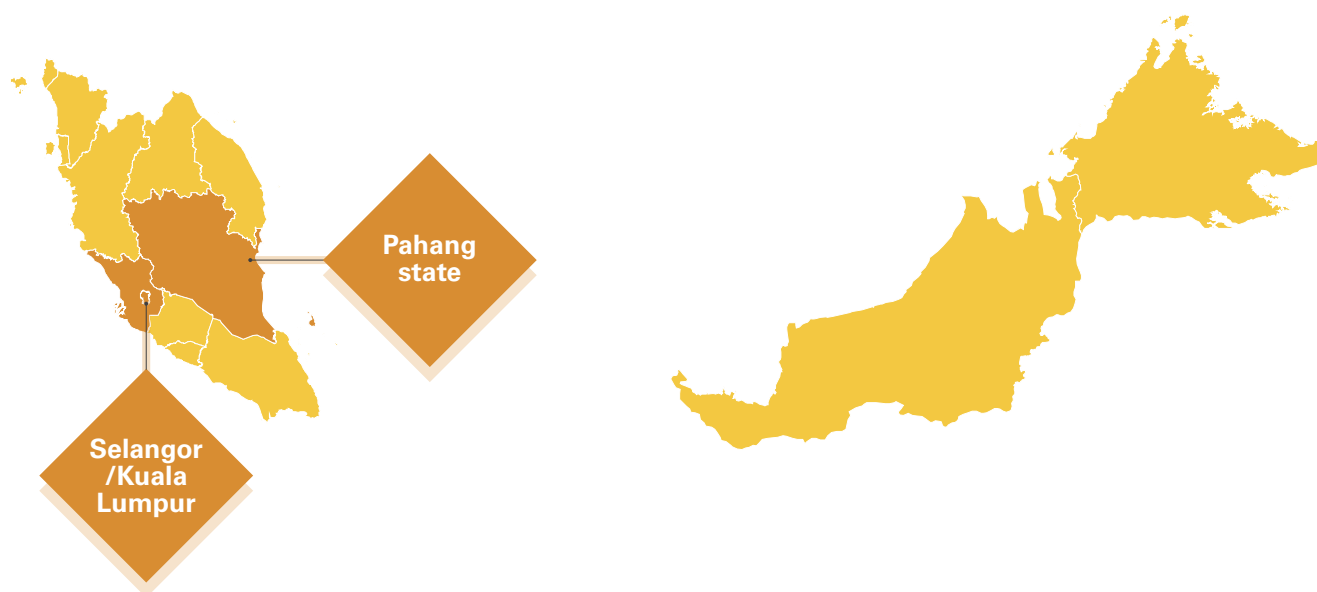
This research employed a participatory, qualitative approach to address the objectives. The design placed adolescent perspectives at the forefront using primary data collected with adolescent girls aged 16–20 who experienced pregnancy or birth at age 18 or younger.

Setting and site selection

A working group was established comprised of representatives from UNFPA, UNICEF and two youth advisors from the study country, Malaysian females aged 18–24 years old. The working group reviewed the methodology and study materials, provided guidance on site selection, and supported the interpretation and dissemination of study findings.

Through consultation with the working group and government stakeholders, two Malaysian provinces were selected for the study. Pahang was chosen to capture a setting of high adolescent fertility and premarital conception, and Selangor, containing the nation's capital city Kuala Lumpur, was selected as a setting of median adolescent fertility and premarital conception (see Figure 1). Site selection was based on the most recent adolescent pregnancy statistics by province in Malaysia,² as well as access to healthcare services and the presence of non-governmental organization (NGO) partners that were able to facilitate the identification of pregnant adolescents for recruitment. This was also done to ensure strong referral pathways to social and health services. Additional considerations were feasibility and cost, and the inclusion of both urban and rural settings within each province.

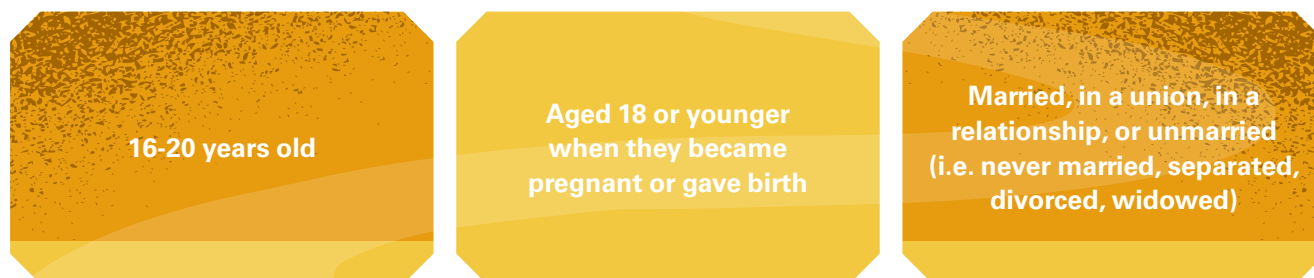
Figure 1. Map of Malaysia showing Selangor/Kuala Lumpur and Pahang state



² Reten Manual Statistik Remaja Hamil JKN 2012

Recruitment

Participants were sampled purposely, facilitated by partnering health care services and NGOs providing support to pregnant adolescents. The study aimed to recruit young women who were:



Written or verbal informed consent was obtained from all participants prior to participation.

Data collection 1: In-depth timeline interviews

In-depth interviews using participatory methods were conducted to understand the drivers and pathways to adolescent pregnancy from the adolescents' perspective. A timeline interview approach was employed. Interviewers received five days of training to familiarize themselves with the study objectives, timeline interview approach, interview topics, and key principles of research ethics, informed consent, personal privacy, protection of personal information, and distress and mandatory reporting protocols.

Interviewers used a semi-structured interview tool to guide participants to reflect on key life events and milestones in their journey to becoming pregnant. Interviewers were encouraged to draw visual timelines during the interviews to facilitate mapping out key life events in the girls' stories. Each interview was audio-recorded with the participant's consent.

Preliminary data analysis

Research team members fluent in Bahasa Melayu were trained to implement a blended inductive-deductive approach to preliminary data analysis. Specifically, framework analysis was used to analyse qualitative data collected through individual interviews. The data analysis process is outlined in Figure 2.

First, audio recordings of interviews were transcribed in the interview language (Bahasa Melayu) and the initial framework for analysis was developed. Interviews were summarized in English according to the framework. Second, Burnet and FRHAM team members modified the analysis framework to suit the local context,

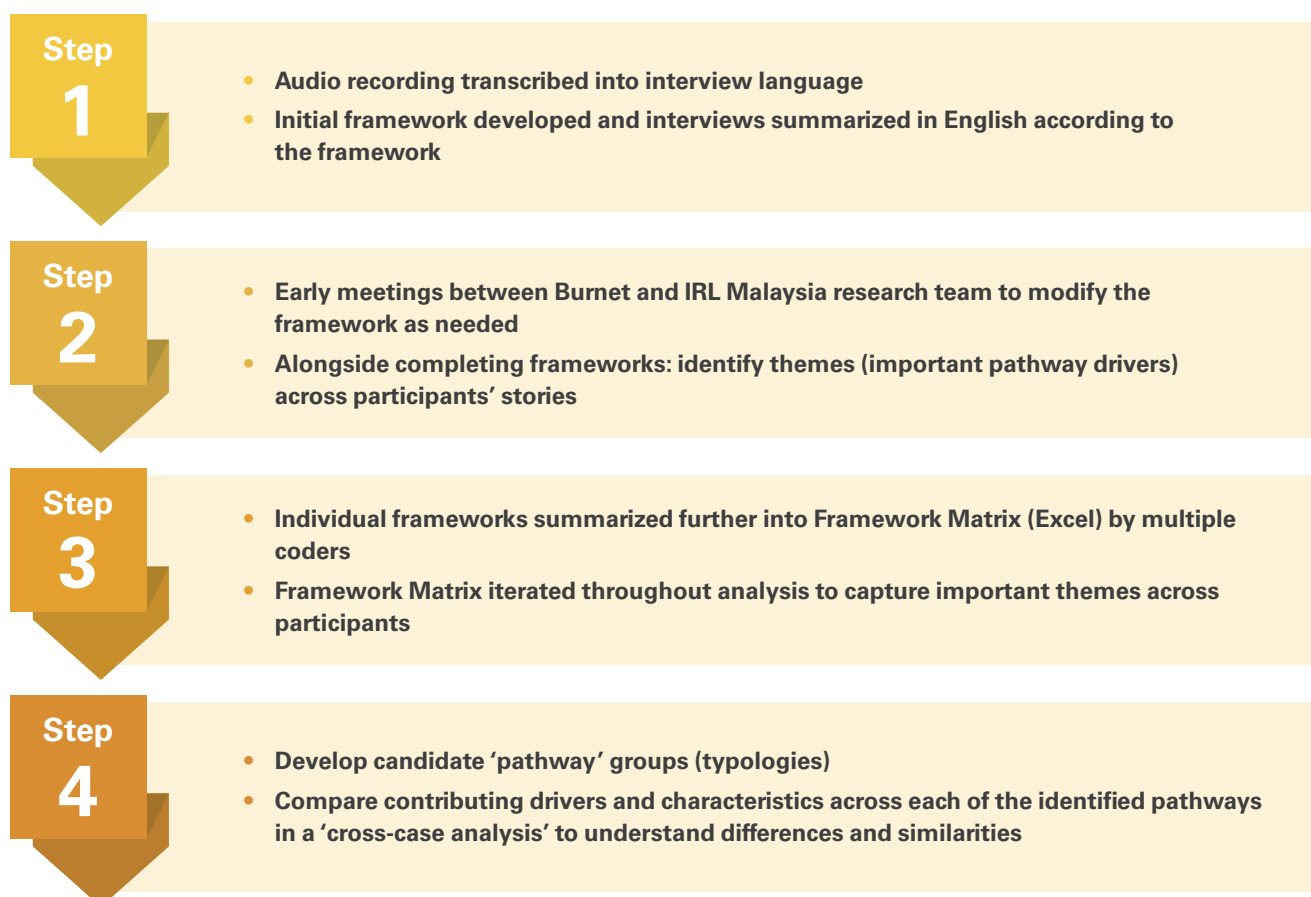
noting key life events and themes, and important pathway drivers across participant narratives. Third, multiple coders noted emerging themes from the analysis and developed the framework matrix in Microsoft Excel. Finally, candidate pathways (typologies) were developed. The contributing factors and characteristics across pathways were compared in a "cross-case analysis" to understand differences and similarities in girls' stories. No personal or other identifying data were included in summaries or other research outputs.

Data collection 2: Follow-up phone interviews

Following preliminary analysis of the data gathered through the in-depth timeline interviews, follow-up interviews were conducted with selected participants. These aimed to 1) validate and clarify the study findings and interpretations, and 2) gather girls' recommendations for programmes and policy.

Interviewers received three days of training to familiarize themselves with the follow-up interview topics. As part of the training, the study team, with the support of the study's youth advisors, developed short, engaging video clips to communicate the key study findings on four major topics: 1) knowledge about sexual and reproductive health plus contraceptive access and use; 2) girls' agency and decision-making power in relationships; 3) adoption and single parenthood following an unplanned pregnancy; and 4) pregnancy and marriage. During the training, interviewers also spent time reviewing key topics covered in the training for the first round of data collection, such as principles of research ethics, informed consent, and distress and mandatory reporting protocols.

Figure 2. Data analysis process (framework analysis)



Participants in the follow-up interviews were young women who 1) participated in the in-depth timeline interviews, 2) indicated their interest to be recontacted for the study's follow-up activities, 3) had access to a mobile phone, and 4) provided informed consent.

For the follow-up interviews, participants were sent the video clips and given time to watch them before the follow-up interviews began. Interviewers then used a semi-structured interview guide to facilitate validation of the study team's interpretation of findings, clarify any unclear points or contexts, and gather participants' suggestions and recommendations regarding priority strategies to support adolescent girls relevant to each of the four topics. After each interview, interviewers completed a summary sheet in which they documented participant's feedback on the study findings and their suggestions or recommendations.

Final data analysis

The findings from the follow-up interviews were integrated into the final data analysis and helped to validate and clarify findings from the first phase

of data collection. These are reflected in the findings presented below, and in the manuscript being prepared for journal submission on the study findings in Malaysia. Likewise, participants' suggestions and recommendations gathered during the follow-up interviews were incorporated into the presentation of findings to the working group and external stakeholders including government and non-government representatives from Malaysia. These will also be included in another manuscript for journal submission that will feature regional findings and recommendations for programmes and policies across the four countries included in this study.

Profile of participants

A total of 45 in-depth timeline interviews were conducted between May 2021 and April 2022 with girls aged 16–20, of whom 10 participated in follow-up interviews. The median age of the participants at the time of their interviews was 18 years. Selected participant demographic information is presented in Table 1.

Table 1. Sociodemographic characteristics of the participants

Characteristics	No. of participants
Age at interview	
16	5
17	12
18	10
19	9
20	9
Ethnic background	
Malay	30
Orang Asli	15
Province	
Kuala Lumpur/Selangor	19
Pahang	26
Site (Residence)	
Rural	16
Urban	29
Marital status at interview	
Single	25
Married	20
<i>Married before age 18</i>	13
Level of education	
Some primary school	7
Some secondary school	27
<i>Form 1</i>	1
<i>Form 2</i>	8
<i>Form 3</i>	7
<i>Form 4</i>	10*
<i>Form 5</i>	8
High school graduate	10
Some higher education	1

Characteristics	No. of participants
Engagement in paid work	
No	40
Yes	5
Previously or currently in shelter home	
No	22
Yes	23
Received antenatal care	
Yes	34
No/no information	11
TOTAL	45

* One participant was still in school

Participants were of Malay and *Orang Asli* (indigenous) ethnic backgrounds. More than half of the participants were from Pahang state, with the rest residing in Kuala Lumpur and Selangor state. More than half were not married at the time of the interview. Most girls (27) had at least some secondary education, with most having left school by Form 3, and 10 girls leaving in Form 4; seven girls had only primary education. Ten girls were high school graduates, and one girl had attended some higher (tertiary) education. Only five

participants were engaged in paid work at the time of their interviews, and about a third of participants were sent to live in shelter homes following pregnancy (18 were living in shelter homes at the time of their interviews, five previously lived in shelter homes but had since been discharged). Most girls (34) reported receiving antenatal care, with about half of these girls reporting that antenatal follow-ups were facilitated by the shelter homes in which they were living during pregnancy.



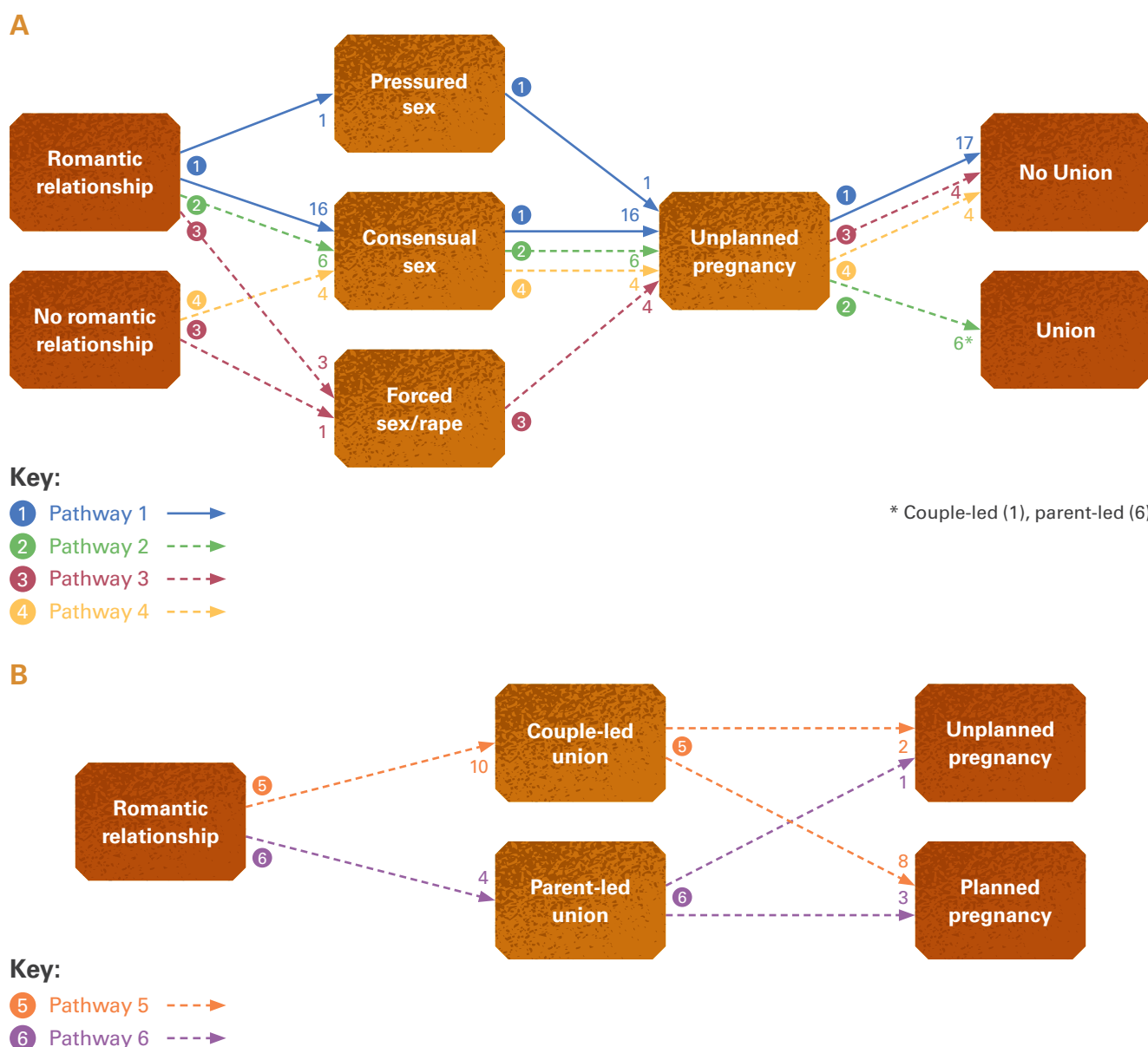
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Findings

The study identified six pathways to adolescent pregnancy, which are broadly mapped out in Figure 3. The pathways were differentiated primarily by timing of pregnancy relative to union, that is, outside- or within-union pregnancy. Within these broad categories, pathways were

further differentiated by the nature of sexual relationship that led to pregnancy (consensual, pressured or forced sex), pregnancy intention (planned or unplanned), and where applicable, who initiated union (couple- or parent-led).

Figure 3. Pathways to adolescent pregnancy in Malaysia



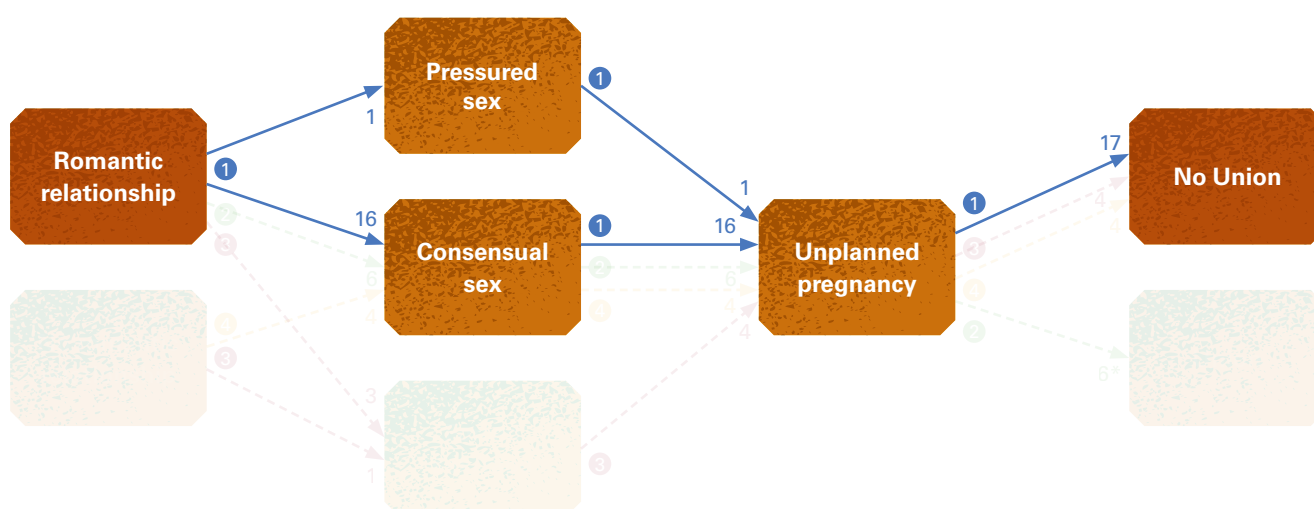
Outside-union pregnancy pathways

1. Romantic relationship leading to unplanned pregnancy and no union

The most common outside-union pregnancy pathway was through romantic relationships that led to sex and unplanned pregnancy but no union – girls either raised the baby on their own, or gave up or were planning to give up the baby for adoption (see Figure 4). This pathway was observed across the three study areas among 17 girls from urban (12 girls) and rural communities (5 girls). Sixteen of the girls were of Malay ethnic backgrounds, and one girl belonged to the *Orang Asli* indigenous group.



Figure 4. Malaysia pathway to adolescent pregnancy 1 – romantic relationship leading to unplanned pregnancy and no union



Sexual debut. Girls in this pathway started engaging in romantic relationships (i.e. having their first boyfriend) between the ages of 12 and 18. Most girls had their sexual debut with the partner who got them pregnant. Only two girls had their first sexual experience with a prior boyfriend, and one girl was raped by a stranger a year before meeting the partner who got her pregnant.

First sex with the partner who got them pregnant usually occurred when the couple had been in a relationship from a few weeks to a few months and girls described consenting or agreeing to have sex under varied circumstances. Girls who reported agreeing to sex described being motivated by love, curiosity, pleasure, feeling an obligation to their boyfriend, and fear of losing their boyfriend if they refused sex. One girl reported being pressured to

have sex. She recalled agreeing to have sex with her boyfriend because he had threatened to break up with her if she did not have sex with him, and she really liked him and did not want him to break up with her.

Contraceptive knowledge, access and use. Almost all girls in this pathway mentioned having some knowledge about the reproductive system, sex and pregnancy from science and health classes at school, but some emphasized that they received limited information. Others said they were not interested to learn about the topics or did not think the topics were relevant to them at the time.

Most girls had some basic awareness about contraceptives, such as condoms or pills, but this knowledge did not necessarily translate to use.

Most girls did not use modern contraceptives before they became pregnant. Only four girls reported using any modern contraceptive method before pregnancy – two used contraceptive pills while the other two used condoms. The girls who used pills discontinued use because they experienced side effects or were concerned about them. One of the girls who used condoms reported using them inconsistently, while the other used a condom during her first sexual encounter only, then opted for withdrawal in subsequent sex. Another girl reported not using modern contraceptives because her partner practiced withdrawal and she believed that it was effective.

Pregnancy. All pregnancies in this pathway were unplanned, and 12 of the 17 girls were sent to shelter homes by their families upon learning of their pregnancies. Most girls reported feeling sad, regretful, shocked, and afraid of how their parents might react to the news, but two girls reported transitioning to feeling happy knowing that they were fertile and were going to have their own child. Five of the 17 girls in this pathway considered abortion, three of whom attempted to induce abortion but failed. One of these girls sought abortion services at a clinic but was turned away, and another described trying several methods to induce abortion:

I tried to fall down from stairs, ate pineapple, drank Coke, and consumed [an] abortion pill to end the pregnancy but all were unsuccessful. (ML0311)

Relationship outcomes. Girls in this pathway had various relationship outcomes following unplanned pregnancy. All 17 girls in this pathway were unmarried at the time of their interviews.

Eight of the 17 girls became single parents – three by their own choice, and five due to circumstances beyond their control. Three of the eight girls who became single parents described having some say in deciding whether to pursue marriage with the partner who got them pregnant. One did not inform her boyfriend that she was pregnant and cut all contacts with him because she believed he would not take responsibility. Another girl received a marriage proposal from her boyfriend and his family, but her family disapproved of the marriage, and she decided to follow her family's decision.

The third girl received a marriage proposal from her boyfriend, but chose to enter a shelter home when her mother gave her a choice between marriage or entering a shelter home:

My mom gave me two options – whether to get married or to change for better [in a shelter home]. (ML0104)

Five of the eight girls who became single parents reported that this outcome was not by their own choice. For example, one girl described that her boyfriend wanted to elope on learning of her pregnancy, but she lost contact with him when her family sent her to live in a shelter home. Another girl's boyfriend left her on learning of the pregnancy. She was 16 years old at the time. At the time of her interview, this girl was happily married to someone else (married at age 19).

Two of the 17 girls in this pathway were pregnant and living in shelter homes at the time of their interviews. They had both been in a romantic relationship with their boyfriend for more than two years when they got pregnant, and on learning of their pregnancy, the couple wanted to get married. In both cases, the girl's family objected to marriage and decided to send the girl to a shelter home, thereby restricting the girl's communication with her boyfriend due to the rules at the shelter homes. Yet, both girls expressed that they and their boyfriend intended to resume their relationship – with the boyfriend's family's support – when they are discharged from the shelter home after giving birth.

Seven of the 17 girls in this pathway opted to put their baby up for adoption. All seven girls were sent to live in shelter homes following pregnancy, though one girl gave birth and gave up her baby for adoption before she entered a shelter home. Some participants indicated that their families placed them in shelters and the shelters facilitated adoption, but it was not clear if facilitating adoption was the main reason why girls' parents placed them in shelters in the first place. Where available, girls' descriptions suggest that they had little or no real say in the decision to enter a shelter home and to give their baby up for adoption. For example, in one case, the decision to place the girl in a shelter home was made after marriage talks between the girl and her partner's parents fell through and it became apparent that the boyfriend

was not willing to take responsibility for the girl and her baby. The baby was given up for adoption. In another case, a girl reported that the decision to give her baby up for adoption was made against her will, because her mother could not accept that she had an out-of-wedlock grandchild.

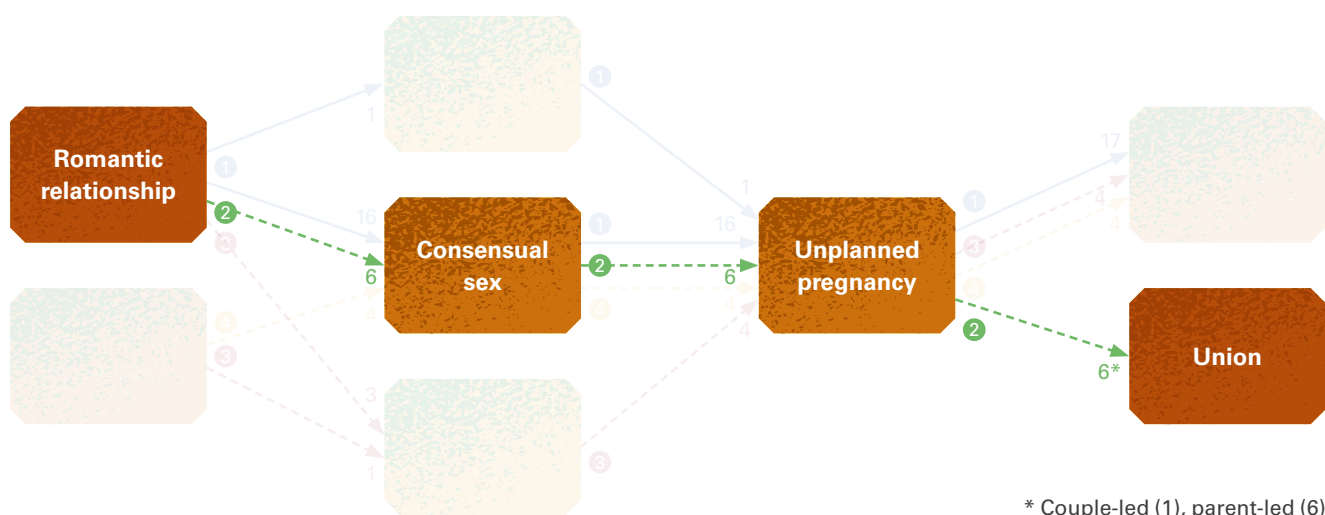
Education. Seven girls completed secondary school, while nine girls stopped attending secondary school before completing. One girl stopped attending after completing primary school as she was no longer interested in studying and wanted to work; at the time of interview, she had no intention of returning to school. Of the girls who left secondary school early, four left when they became pregnant and were sent to live in shelter homes. The other five girls left because

they were no longer interested in studying or struggled to keep up in class. Two girls expressed their intention to return to secondary school after delivery, while another girl wanted to enrol in a vocational course.

2. Romantic relationship leading to unplanned pregnancy and union

For six girls, the pathway to pregnancy was through romantic relationships and sex leading to unplanned pregnancy and union (see Figure 5). This pathway was observed across the three study areas among girls from urban and rural communities. Two girls were of Malay ethnic background, while the other four were of indigenous ethnic origin.

Figure 5. Malaysia pathway to adolescent pregnancy 2 – romantic relationship leading to unplanned pregnancy and union



Sexual debut. Almost all girls experienced their sexual debut with the partner who got them pregnant. Only one girl had her first sex with a prior boyfriend. All girls described their first sex with the partner who got them pregnant as consensual, motivated by love, and seeking fun and pleasure. One girl reported having consumed alcohol before having sex with her boyfriend, but she qualified that she and her partner had mutual romantic feelings and she did not feel uncomfortable or coerced.

Contraceptive knowledge, access and use.

Five girls out of the six reported having limited knowledge about the reproductive system, sex and pregnancy through health classes at school. Some girls had limited awareness of modern contraception methods such as condoms or pills, but others did not learn from healthcare workers

until after their first pregnancy and birth. None of the girls in this pathway used any modern method of contraception prior to pregnancy.

Pregnancy. All six pregnancies were unplanned but four were wanted – these girls described initially feeling regretful but later feeling happy about their pregnancy and wanting to keep their baby. None of the girls reported considering abortion.

Relationship outcomes. The decision to marry was parent-led for five girls (three of whom were married between the ages of 13–15) and couple-led for one girl (age 17). Parent-led marriages were intended to preserve the family's reputation and to compel the girl's partner to take responsibility for the pregnancy. Though these marriages were parent-led, all five couples agreed to the marriage arrangement and did not refuse on account of

the pregnancy. The couple-led marriage was also motivated by the couple's desire to marry on learning of the pregnancy. The girl elaborated that this was to avoid stigma of out-of-wedlock pregnancy, which was also influenced by social norms, as the girl reported that most of her friends got married at an early age (as young as 15) to avoid social consequences of adolescent pregnancy.

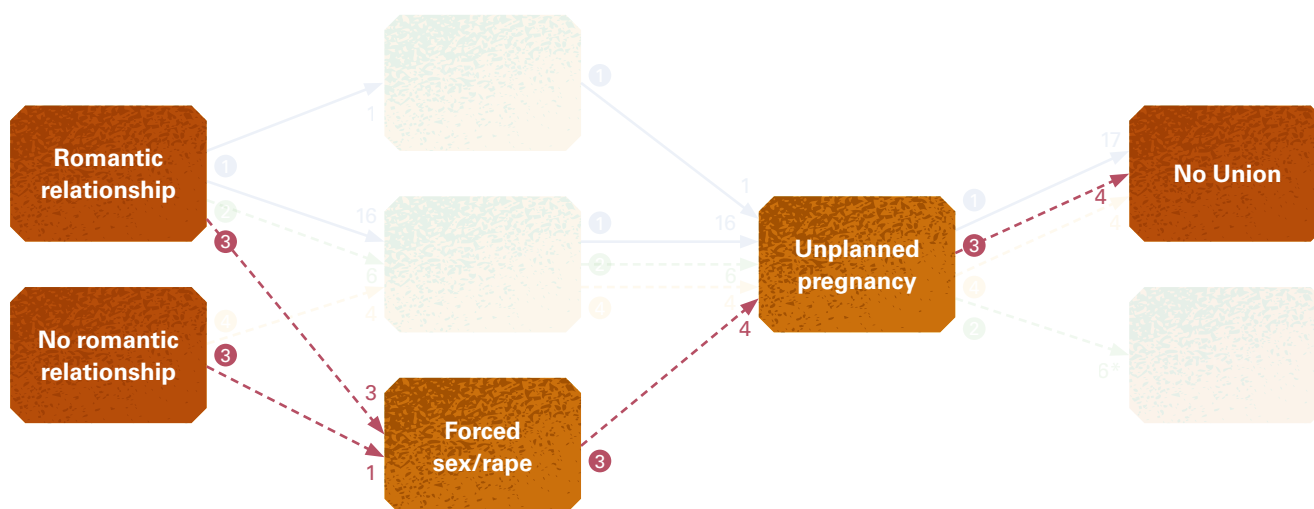
Education. All girls in this pathway had left school for other reasons before they became pregnant. Their reasons included loss of motivation (due to scolding by teachers and bullying by schoolmates), disinterest in school, and expulsion

due to disciplinary issues (truancy). One girl was a high-school graduate and had attended some higher (tertiary) education. None of these girls reported having any intention to return to school after the birth of their baby.

3. Forced sex leading to unplanned pregnancy and no union

For four girls, unplanned pregnancy occurred following forced sex or rape (see Figure 6). This pathway was observed in Selangor and Pahang, with two girls from urban communities, and two from rural communities. All four girls were of Malay ethnic origin.

Figure 6. Malaysia pathway to adolescent pregnancy 3 – forced sex leading to unplanned pregnancy and no union



Sexual debut. All girls in this pathway had their sexual debut with the partner who got them pregnant, and all reported being forced or raped. Three girls were raped by their boyfriends, while the other was raped by a stranger. One girl described being threatened by her boyfriend to have sex with him. Two girls described their boyfriend initiating sex and not being able to refuse or say anything during sex – one described feeling afraid and the other felt coerced because she knew her boyfriend would become angry if she refused. The fourth girl was picked up by a stranger who offered her a ride home while she was walking home alone one night. She was drugged, raped and left on the street afterwards. Only one girl reported filing a police report after being raped by her boyfriend but did not elaborate on the legal outcomes.

Contraceptive knowledge, access and use.

All four girls in this pathway mentioned learning about sex or reproduction and pregnancy through science and religious classes at school, though the extent of their understanding of the topics was unclear. One girl also reported learning through discussions with friends. Three girls had some basic awareness of modern contraceptive methods – all three had heard of condoms and two had also heard of contraceptive pills. One girl reported having no knowledge about contraception or sexually transmitted infections before she became pregnant, despite having learned about reproduction and pregnancy in school.

No contraception was used during sex and the girls had no control over the situation.

Pregnancy. All girls had unplanned pregnancies following rape and were living in shelter homes at the time of their interviews. Girls described feeling shocked, sad, guilty, regretful and afraid of how their parents would react to their pregnancy, but none of the girls reported considering abortion. Three girls were still pregnant at the time of their interviews, of whom one expressed her intention to give her baby up for adoption. The fourth girl had already given birth and described being happy to be able to care for her baby herself while in the shelter but felt she had to give the baby up for adoption as she believed she could not continue to raise the baby by herself.

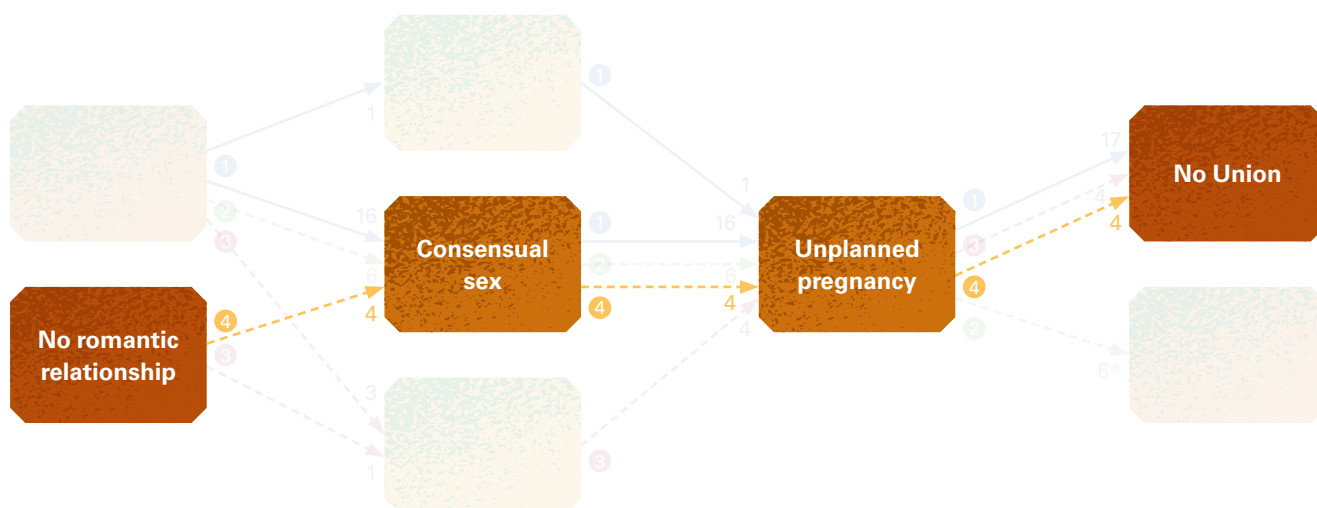
Relationship outcomes. All four girls were unmarried at the time of their interviews. One of them was in a new relationship where she reported feeling respected by her partner.

Education. Three girls left secondary school before completing (at Forms 2, 3 and 4), and one girl had completed secondary school. Of the girls who left school early, two girls left due to pregnancy, while the other had been expelled from school due to disciplinary issues (tardiness and sleeping in class). One of the girls who left due to pregnancy intended to return to secondary school after leaving the shelter home and was determined to go on to higher education.

4. Casual sex leading to unplanned pregnancy and no union

The fourth outside-union pregnancy pathway was characterized by casual sex leading to unplanned pregnancy and no union (see Figure 7). This pathway was observed in Pahang and Selangor, among four girls residing in rural communities, and one girl residing in an urban community. All girls were of Malay ethnic backgrounds.

Figure 7. Malaysia pathway to adolescent pregnancy 4 – casual sex leading to unplanned pregnancy and no union



Sexual debut. In this pathway, girls began engaging in romantic relationships between the ages of 9 and 14. One girl had casual sex with a friend who supported her during a stressful time (she was experiencing family issues), and another girl had casual sex with her cousin. Two girls in this pathway had multiple casual sex partners.

Three of the four girls described their sexual encounters as consensual, while one girl had difficulty recalling whether she consented to her first sex because she was undergoing stress at the time. One girl described having multiple sex partners and being motivated by pleasure:

I have never thought of getting pregnant. Never. I only think about pleasure. (ML0305)

Another girl maintained a “friends-with-benefits” relationship with her brother’s friend because she enjoyed his company, although he was not her only sexual partner.



Contraceptive knowledge, access and use.

Two girls of the four recalled learning about sex, reproduction and pregnancy at school. These girls also reported learning about sex through pornography and having some awareness about condoms and contraceptive pills. The other two girls did not mention receiving sex education at school and had little or no knowledge about contraception before they became pregnant.

One girl discussed attempting to access condoms at a store but not going through with her purchase because she felt embarrassed and was afraid that other people would judge her. She recalled not feeling any urgency to use contraceptives as she had never become pregnant before, despite having multiple sex partners.

Ultimately, three girls did not use any modern contraceptives during sex. One girl reported using condoms but inconsistently because she felt that condoms reduced pleasure. She had heard of contraceptive pills from her friends but did not want to use them because she also heard that they might cause infertility.

Pregnancy. All pregnancies were unplanned, and three of the four girls were sent to live in shelter homes during their pregnancy. Girls described feeling sad, stressed, scared, worried, regretful and shocked when they learned they were pregnant. One girl reported suicidal ideation when she learned that she was pregnant. She had only had sex once. Two girls considered abortion, of whom one attempted abortion by taking an abortion pill but was unsuccessful.

Relationship outcomes. All girls remained unmarried after pregnancy. Two girls were still pregnant at the time of their interviews, of whom one was planning to raise their baby themselves, and one was planning to give her baby up for adoption. Two girls had already given birth – one was a single parent, while the other was still living in a shelter home.

Education. One girl completed secondary school while the other three left secondary school before completing. Only one girl expressed her intention to return to secondary school after delivery.

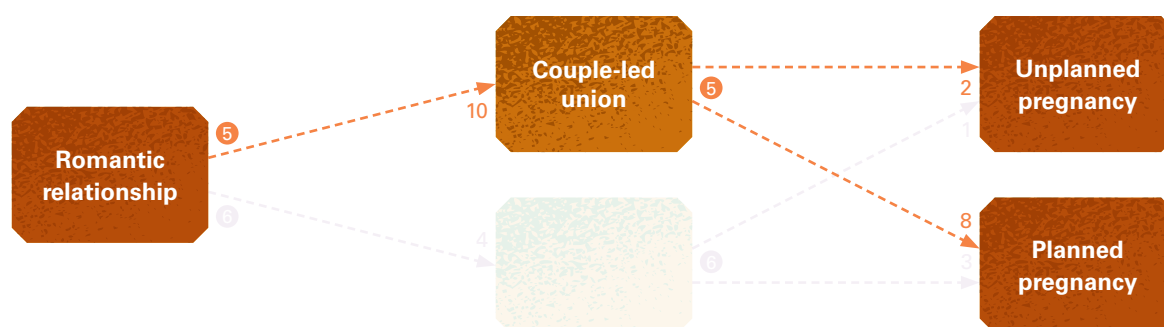
Within-union pregnancy pathways

About a third of the girls in this study followed within-union pathways to adolescent pregnancy, where pregnancy occurred following marriage or cohabitation.

5. Couple-led union leading to planned/unplanned but wanted pregnancy

The first within-union pregnancy pathway was through romantic relationships that led to couple-led union and pregnancy (see Figure 8). This pathway was observed in the narratives of 10 girls residing in rural areas in Pahang and Selangor. The girls were of indigenous and Malay ethnic backgrounds.

Figure 8. Malaysia pathway to adolescent pregnancy 5 – couple-led union leading to planned/unplanned but wanted pregnancy



Marriage/union. In this pathway, marriage (9) or cohabitation (1) was initiated by the couple, or when the boyfriend proposed to the girl, and she accepted. Five girls in this pathway were married before the age of 18 (age at marriage ranging from 15 to 17). Unions were motivated by love and the desire to legalize their relationship. For two girls, union was (to some degree) suggested by the girl's family because it was culturally acceptable and common in their community to marry young.

Sexual debut. Most girls experienced their sexual debut with the partner who got them pregnant, usually occurring within cohabitation or marriage. Only one girl had her first sexual experience with a prior boyfriend (she was forced). All girls described their first sex with the partner who got them pregnant as consensual (i.e. the girl mentioned that she wanted to have sex or agreed to her partner's request for sex) or planned or expected within union (i.e. the girl did not necessarily state whether she wanted to have sex but described having sex that was planned or expected following marriage).

Contraceptive knowledge, access and use.

All 10 girls in this pathway reported having limited awareness about sex, reproduction and pregnancy. Only half reported learning about these topics through classes at school, the rest either learned from friends or through "hands-on" experience once they were married. One girl reported that she learned about sex from her husband.

Almost all girls in this pathway did not use modern contraceptives before pregnancy because they planned or expected to get pregnant after marriage. Only one girl reported using condoms prior to pregnancy and stopping when she and her partner wanted to get pregnant. At the time of their interviews, three girls were using injections and two were using pills after the birth of their first or second child.

Pregnancy. Eight pregnancies were planned and two were not necessarily planned but wanted or expected after marriage. Girls described feeling happy and excited upon learning of their pregnancy. None reported considering abortion.

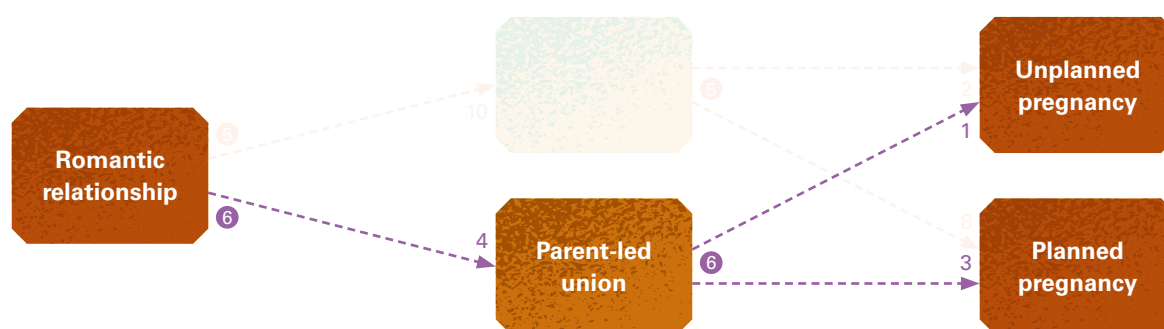
Relationship outcomes. At the time of their interviews, all girls were still in a union with the partner who got them pregnant. The couple that was living together planned to marry after the girl delivered her baby.

Education. Two girls completed secondary school, while four girls left school at primary level (Standards 3, 4 and 6) and another three left secondary school (at Forms 2 and 3) before completing. Reasons for stopping school early included financial constraints, loss of interest and inability to cope with school. One girl was eight months pregnant at the time of her interview but reported that she was still attending secondary school (Form 5) and planned to complete and take her exam after delivering her baby.

6. Parent-led marriage leading to planned/unplanned but wanted pregnancy

The final pathway to pregnancy was through romantic relationships that led to parent-led marriage and pregnancy (see Figure 9). This pathway was observed among four girls from rural communities in Pahang and all four were of indigenous ethnic background and married before age 18.

Figure 9. Malaysia pathway to adolescent pregnancy 6 – parent-led marriage leading to planned/unplanned but wanted pregnancy



Marriage/union. For three girls, marriage was arranged by the girl's family after the girl (ages 15, 15, and 16) was caught in a room with her boyfriend (boyfriends were 3, 3, and 6 years older than the girls). In this situation, an unmarried girl who was caught in a room with a man was seen as losing dignity or innocence, and according to customary practices, the girl was expected to marry to preserve the family's reputation. All three girls expressed that they did not mind because they loved their boyfriend and wanted to marry him.

In one case, marriage was arranged by the girl's and her boyfriend's families along with their village head, according to their cultural practices. The girl (age 17) had known her husband (age 20) for a year before they were arranged to be married.

Sexual debut. All girls had their sexual debut with the partner who got them pregnant, occurring within union for three girls, and before union for one girl. Girls described sex with their husbands as consensual or planned and expected within marriage and motivated by love.

Contraceptive knowledge, access and use.

All girls had limited or no knowledge about sex, reproduction, pregnancy and contraception before pregnancy, and usually learned more after their first birth. None of the girls used any modern contraception before pregnancy. At the time of their interviews, two girls were using injections and one was using pills. The fourth girl was still pregnant and did not report any intention to use contraceptives after birth.

Pregnancy. Three pregnancies were planned, while one pregnancy was unplanned but wanted. Abortion was never considered among the girls in this pathway. Girls and their partners wanted to start a family.

Education. All girls left school before completing – one girl left at primary level (after completing Standard 6) and the other three left at secondary level (at Forms 1, 2 and 3). Their reasons for leaving school included loss of interest and financial reasons (i.e. poverty, wanting to work).

Discussion

Factors contributing to adolescent pregnancy in Malaysia

Girls lack SRH information, including about contraception

Across the sample, many girls lacked knowledge about SRH topics (e.g. sex, reproduction, pregnancy and contraception) before pregnancy. This is consistent with prior research citing adolescents' lack of knowledge about SRH in Malaysia (Kanavathi, 2019). Sexuality education in Malaysia largely employs abstinence-based, risk-based messaging (Kanavathi, 2019), which limits young people's access to essential comprehensive SRH information (Khalaf *et al.*, 2014) and does not consider the reality that young people are having sex, and many are not waiting until marriage or union to do so.

In the study, most girls reported receiving some information about the sex, reproduction and pregnancy in science, health or religious classes at school, but levels of awareness and understanding varied. This variation could be partly due to the different levels of education that girls completed. For instance, a study among secondary school students in Malaysia found that upper-secondary students had more knowledge about SRH than lower-secondary students (Rahman *et al.*, 2011). In a few cases, the participants reported missing out on learning about SRH in school settings because they had left school early for other reasons. The variation in levels of awareness and understanding of SRH is likely also being influenced by prevailing misconceptions that sexuality education is only important for certain groups of adolescents (e.g. LGBTQIA+ persons, sexually active young people, and rape victims) as opposed to all young people (Kanavathi, 2019). Some girls in the study believed that the SRH information they received at school was not relevant to them at the time or they were simply "not interested" in the information. In other cases, participants reported that girls who were interested to learn about SRH were shy to ask questions because they were afraid of being stigmatized.

Other research has linked this to cultural and religious taboos surrounding sexuality in the country (Kanavathi, 2019).

Girls face barriers to SRH information, services, and supplies

Girls' lack of SRH knowledge was evident in some of the myths and misconceptions about contraception that they shared, which prevented them from accessing and using contraceptives. A few girls expressed fears about contraceptives "causing infertility," which they had usually heard from peers. Others did not think they would or could get pregnant or believed that withdrawal was effective for preventing pregnancy.

Among follow-up interview participants, a disparity was also observed in married and unmarried girls' perceived barriers to contraceptive access. For example, a married girl felt that she had no barriers to access, as her husband bought contraceptives when they needed or wanted to use them, but the situation would be much different for girls whose husbands do not support contraceptive use. On the other hand, an unmarried girl noted that it is difficult to get some contraceptives from government-run health facilities (choices were limited to pills or injections only), and another unmarried girl reported feeling shy to buy contraceptives at public places (e.g. pharmacies). In addition, another girl explained that girls usually feel shy to buy contraceptives over the counter because they are worried about what other people will think. In other cases, participants noted that another barrier to access was that some girls do not know how to use or where to get contraceptives, which can also be linked to their lack of SRH knowledge. These findings align with those of Othman *et al.*, (2019), that Malaysian adolescents are not comfortable accessing SRH services through primary healthcare facilities mainly because they feel embarrassed.

Girls' lack of SRH knowledge and barriers to accessing contraceptives help explain why most girls in the study did not use any modern method of contraception before their first pregnancy, even when they were sexually active and did not want to get pregnant. The findings are consistent



with those of other studies that have observed Malaysian adolescents' lack of knowledge on important aspects of SRH, including reproduction, pregnancy and contraception (Rahman *et al.*, 2011; Wong, 2012). However, as pointed out by a follow-up interview participant, some girls are aware of contraceptives but do not think about using them when it comes time to have sex. Similar observations were also noted in another study conducted in Malaysia (Kanavathi, 2019). The findings suggest that interventions aimed at preventing adolescent pregnancy will need to address girls' (and boys') knowledge gaps alongside barriers to contraceptive access and use at individual, relationship, community and societal levels.

Following unplanned pregnancy outside of union, seven girls in the study considered abortion. Some of these girls attempted to induce abortion through a range of approaches, some of which were based on myths and misinformation (e.g. eating pineapple, drinking soda), and some that could have caused the girl harm (e.g. throwing herself down a flight of stairs). In Malaysia, abortion is legal to save a woman's life and to preserve the physical and mental health of a woman (UNESCO *et al.*, 2013; Zainuddin, 2022), and one girl in the study sought abortion services from a clinic but was turned away. It will be important to improve timely access to sensitive and comprehensive health services care (including post-abortion care) and identify and address barriers that adolescent girls face in accessing legal abortion care.

Patriarchal norms limit girls' agency and decision-making power in relationships

The girls in the study had varied levels of agency and decision-making power at various points in their timelines (e.g. deciding whether and when to have sex, use contraceptives, and what to do following unplanned pregnancy outside of union). The findings highlight the persistence of patriarchal values that uphold male authority and dominance within intimate relationships (Lai *et al.*, 2018).

Though there were no reports of marital rape in the sample, during follow-up interviews, participants reported that girls and wives are not allowed to say "no" to their partners or husbands when they ask for sex. Beliefs such as this are reinforced by current legislation (Malaysian Penal Code Section 375), as marital rape is not currently considered a crime in Malaysia (Lai *et al.*, 2018). In addition, while most of the girls in the study had consensual sex in the context of romantic or casual sex relationships or union, a minority of girls (8) described experiences of forced sexual debut outside of union, some perpetrated by boyfriends, and a few by male relatives. Rape (statutory and non-statutory) and incest are punishable by law under the Malaysian Penal Code Section 375 (Abdulah and Shah Haneef, 2017). Yet only one of the girls who experienced forced sexual debut reported that her family filed a police report of the rape, indicating that there may be barriers to pursuing legal action following experiences of sexual violence that need to be explored further.

In terms of contraceptive decision-making, male partners and husbands also had more decision-making power. A few girls were able to access and use modern contraception prior to pregnancy, but during follow-up, girls noted that their partners and husbands were responsible for purchasing contraceptives and making decisions regarding contraceptive use. They also noted that there are instances when partners and husbands do not agree to use contraceptives.

Patriarchal norms were also evident in girls' accounts of decision-making following an unplanned pregnancy outside of marriage (pregnancy resolution). In the study, girls had varying levels of agency regarding whether to raise their baby on their own as a single parent, give their baby up for adoption, or pursue union and dual parenthood with the partner who got them pregnant. Under the Malaysian Child Act 2001, adolescent girls (aged 10 to 18) who engage in sex outside of marriage can be legally considered as "children beyond control," and their parents can submit a written request to the Court of Children for the girl to be admitted to institutional care because they can no longer "manage" the girl (Government of Malaysia, 2021). Many girls in the sample were admitted to shelter homes by their parents or families following pregnancy. In these settings, it was clear that girls often gave up decision-making control to their parents (usually led by the father) and had little or no real say in pregnancy resolution (i.e. adoption, single parenthood). In some cases, girls were also pressured or forced to end their relationship with the romantic partner who got them pregnant, even when the couple wanted to remain in the relationship. While shelter homes aim to provide protection and support for girls, research has found that girls experience poor social support and mental health outcomes while living in shelter homes (Saim *et al.*, 2013; Saim *et al.*, 2019). It will be important to identify and address areas for improvement within these institutional residential settings to ensure that girls are empowered to make their own decisions and able to achieve positive health and wellbeing outcomes during and after their stay. Related to this, it will be critical to shift patriarchal values underpinning existing policies and legislation that view adolescent girls' sexuality as something that needs to be "controlled" and "managed." Legal

and social policy frameworks need to balance protecting adolescents from harm with supporting and promoting adolescents' autonomy (Patton *et al.*, 2016).

Marriage practices to protect a girl and her family's reputation facilitate adolescent pregnancy

In most cases in this study, adolescent pregnancy gave way to child marriage and early union. Marriage to protect a girl and her family's reputation was sometimes deemed necessary by the girl's family following an unplanned pregnancy. However, for 14 girls, child marriage facilitated adolescent pregnancy. In a few cases, marriage was initiated after a girl was caught in a room with a man. Among girls in the study who entered unions, regardless of timing relative to pregnancy, the median age at marriage was lower among girls who entered parent or partner-led unions (15 years) compared to girls who entered couple-led unions (17 years). Also, most girls in the study did not enter unions following unplanned pregnancy outside union, some by their own choice. The findings suggest that when girls have a say in the decision to marry, they may choose to marry later (or choose not to marry) compared to if the decision was made for them.

During follow-up interviews, girls conveyed that parents, especially fathers, usually determine when it is suitable for a girl to get married. A few participants, however, felt that some girls have some control over who they marry, which was true for some girls in the sample. Some participants felt that girls should marry young if they have a boyfriend and are ready, whereas other girls did not agree and believed that such marriages are usually forced and could lead to more complicated consequences for girls. The findings show the persistence of harmful gender norms that view child marriage as a pre-emptive measure against "sinful" premarital sex and a "solution" to out-of-wedlock pregnancies (Awal and Samuri, 2018; Girls Not Brides, 2023; Kohno *et al.*, 2019; Lai *et al.*, 2018). The findings highlight the need to address the drivers of child marriage and adolescent pregnancy simultaneously, through complementary interventions.

Limitations

A key limitation of the study was that the sample included girls of Malay and Orang Asli ethnic backgrounds, and so the findings do not represent the experiences of Malaysian girls of other ethnic origins, such as Chinese or Indian.

Follow-up interview participants were all from Pahang. Participants from Kuala Lumpur and Selangor who were living in shelters were no longer living in the shelters at follow-up, and the rest were either busy or no longer willing to participate in the follow-up interviews. As such, it was not possible to clarify and validate the interpretation of findings, or gather recommendations from girls in Kuala Lumpur and Selangor. In addition, no data was collected on disability, and so the interpretations of findings do not account for girls' experiences of disability.

Adolescent girls' recommendations for programmes and policy

During follow-up interviews with 10 participants, they offered their recommendations on how best to help girls like them:

Teach girls about SRH and related topics

Participants expressed that girls need and want information about contraception, boundaries between men and women, abstinence, how pregnancy occurs, fertile period and prevention of pregnancy. When asked how they would like to receive this information, they said they preferred to learn from their partners, female family members, friends, schoolteachers or counsellors, social media and other online platforms. This indicates a need to employ an approach to comprehensive sexuality education (CSE) that spans socio-ecological levels.

Girls recognize the need to improve knowledge about SRH and contraceptives to improve girls' contraceptive use.

Create a supportive, enabling environment for girls to access SRH information, services and supplies

Some girls suggested that it would be good to sell contraceptives online (e.g. Shopee) to avoid embarrassment associated with buying contraceptives in person over the counter.

Aside from needing more SRH and contraceptive information, girls expressed that they also need the support and understanding of their partners, friendly healthcare staff, and easy access to contraceptives, such as through online shops.

Empower girls with guidance so they can have more say in their relationships

To help girls have more control over if and when to have sex and get pregnant, participants said that girls should learn or be taught how to say no if they do not want to or are not comfortable engaging in any sexual activity. They felt that girls should think thoroughly if they really want to engage in sexual intercourse and make efforts to learn from those who have experience. To achieve this, it would help if they were guided to make prior plans and reflect about pregnancy. They also noted that girls should be able to discuss with their partner or husband if they should or should not engage in sexual intercourse and subsequently, if and when they want to get pregnant and start a family. This indicates a need for assertiveness and life-skills training for girls, and also initiatives that help young people build healthy relationships and encourage communication between young couples.

Ensure that girls receive targeted support following experiences of sexual violence

Participants said that girls who experience rape should be guided and supported by police, doctors, hospital staff, counsellors and protection or shelter home staff on how best to handle their situation. Aside from this, they said that moral support from family members is important to girls, as is religious practice and spiritual guidance.

Provide parenting classes and financial and moral support

When deciding what to do following pregnancy, participants felt that girls need parenting classes and financial support, as well as moral support from family members and friends. Support from family members and their trusted circles is very important for the girls, so they will be able to discuss and share their worries and concerns and to keep them calm. In cases where girls give up their babies for adoption, some participants felt that adopted families should make an effort to maintain contact between the girl and their baby.

Implications of research and practice

The study found diverse pathways to adolescent pregnancy among girls in Malaysia, many of which do not necessarily involve marriage or cohabitation.

The findings highlight the need to ensure that girls have the resources to make informed decisions that affect their sexual and reproductive health before they become sexually active. This will entail assessing the content and quality of CSE currently being provided in schools, adjusting the curriculum as needed, and ensuring that adolescents also have access to CSE through non-formal, community-based programmes. It will likewise be imperative to address the legal and social barriers that girls face to contraceptive access and use. This requires revisiting legal and policy frameworks that constrain adolescents' access to essential SRH services, such as age limits and requirements for parental consent, and addressing social norms, myths and misconceptions that discourage contraceptive use.

Maternity and shelter homes facilitate decision-making around adoption or single parenthood following unplanned, outside-union pregnancy, particularly in cases where marriage, union or abortion are not desired by the girl's family.

The girls' agency and decision-making power in shelter home settings varied, with many girls having little or no real say in their pregnancy resolution (i.e. keep and raise the baby themselves or give the baby up for adoption) and relationship outcomes. Future research could look deeper into the decision-making processes and contexts of girls who are admitted to shelter homes to help develop adolescent-responsive institutional guidelines and models of care that prioritize girls' agency, health and wellbeing. Aside from this, it will be important to explore alternative ways to provide pregnant girls with the support they need during and after pregnancy.

Consistent with national data, in the study, some pregnancies still occurred in the context of union, most of which were couple-led. But some girls were pushed into union by parents to protect the girl and the family's reputation, or done in accordance with cultural practices of child marriage and early union to "preserve the girl's dignity." It would be beneficial to conduct further research that explores other pathways to adolescent pregnancy that may be salient in the experiences of girls from socio-cultural and ethnolinguistic backgrounds not included in this study (e.g. Chinese and Indian). In addition, future quantitative research on the prevalence of these pathways to adolescent pregnancy at a national level would help to tailor interventions, programmes and policies to the specific contexts and needs of adolescent girls.

Finally, given that some girls' pathways to pregnancy were characterized by experiences of forced sex, it will be important to implement CSE and gender-transformative programming (with girls and boys) that address harmful gender norms, communication, consent and violence. It will likewise be important to ensure that girls have access to comprehensive sexual and reproductive health care to make the best-informed decisions, and receive targeted support and clear legal guidance following experiences of sexual violence, alongside access to a child-friendly justice process.

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