

UNDERSTANDING PATHWAYS TO ADOLESCENT PREGNANCY IN SOUTHEAST ASIA

FINDINGS FROM

Cambodia



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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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for every child

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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 public health priority in Southeast Asia. In Cambodia, most adolescent pregnancies occur in the context of union (marriage or cohabitation), but about one in ten women who conceived before age 18 did so outside of union (Harvey et al. 2022; UNICEF and UNFPA, 2022). There is limited research on adolescent girls' pathways to adolescent pregnancy, especially when it occurs outside of union.

This study 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. 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.

This study was conducted in four countries, but this particular report discusses study implementation and findings only from Cambodia.

Using a participatory, qualitative approach, the study design placed adolescent perspectives at the forefront, using primary data collected with adolescent girls aged 16-20 years who experienced pregnancy or birth at age 18 or younger. A working group from the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), as well as two youth advisors from the study country, guided the study implementation. Data collection was conducted in two provinces – Kandal Province and Ratanakiri – and Phnom Penh, with study areas representing median (Kandal and Phnom Penh) and high (Ratanakiri) adolescent fertility and premarital conception.

During the first round of data collection, an in-depth, timeline interview approach was used. A framework analysis was applied during preliminary data analysis and developed candidate pathway typologies 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.

Through interviews with 80 girls, eight pathways to adolescent pregnancy were identified. These pathways were differentiated primarily by the timing of pregnancy relative to union – that is, within-union and outside union pregnancy pathways. Within-union pathways were more common and were differentiated further by who initiated union (couple-led or parent and/or partner-led) and pregnancy intention (unplanned, planned, partner-led). A single outside-union pathway to adolescent pregnancy was identified and was defined by the context of sex preceding pregnancy, pregnancy intention, and who initiated marriage following pregnancy (couple-led or parent and/or partner-led). Crosscutting factors contributing to girls' pathways to adolescent pregnancy included girls' lack of sexual and reproductive health (SRH) knowledge, barriers to contraceptive access and use, the influence of social norms over girls' agency and decision-making, and barriers to education that limit girls' life choices.

During 19 follow-up interviews, adolescent girls recommended that programmes and policies should prioritize teaching girls more about SRH (including contraception), helping girls to stay in school and find good jobs to prevent child marriage, and providing support to young parents.

Our study findings provide evidence that comprehensive sexuality education (CSE) for adolescents needs to be strengthened in school and made available to girls and boys through other programmes outside of school, especially in settings where early school leaving is common. Toward empowering girls to access and use contraceptives, girls need access to non-judgemental, adolescent-responsive health care and an enabling environment. Social and behaviour change (SBC) campaigns could be implemented using gender transformative approaches to help address harmful social norms that encourage girls to marry and begin childbearing early. It will likewise be important to supplement CSE-strengthening and SBC campaign with policy and advocacy around the need to transform harmful norms that support child marriage and early union, and challenge expectations around pregnancy immediately after

marriage (especially for adolescents), to create a more enabling environment for girls to make their own informed decisions about if and when to use contraceptives, get married, and begin childbearing. Finally, in line with the recommendations of the participants, the findings support the implementation of programmes that focus on keeping girls in school and developing their livelihood skills to prevent adolescent pregnancy, and the provision of parenting support to girls who are already pregnant, as well as their partners.

Future research on the prevalence of these pathways to adolescent pregnancy at the national level in Cambodia would be helpful for ensuring that interventions are appropriate to girls' specific needs and contexts. Future research could also look into developing a deeper understanding of unmarried and married girls' constructions of consent.

Abbreviations

APRO	Asia Pacific Regional Office
CSE	Comprehensive sexuality education
EAPRO	East Asia Pacific Regional Office
IEC	Information and education campaign
IRL	Indochina Research Limited
NGO	Non-governmental organization
SBC	Social and behaviour change
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, 2023, 2010).

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

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 initiated or requested sex and she engaged in sexual negotiation with him, and eventually agreed or was “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 started 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 includes cases where the girl described being “too drunk” to consent or was unconscious during sex.

Sexual violence

UN Women defined 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 is a major public health priority. Girls aged 10–19 years who become pregnant and their babies are at greater risk of adverse maternal and perinatal outcomes (Ganchimeg et al., 2014), compared to women aged 20–24 years. Pregnancy and childbirth-related complications are the second- and third-highest cause of death of girls aged 15–19 years in low- and lower-middle-income countries, respectively (Institute for Health Metrics and Evaluation, 2020). In Southeast Asia, maternal disorders are the third-leading cause of death among adolescent girls aged 10–24 years (IHME, 2020). Adolescent pregnancy is also associated with lower educational attainment and poverty, with substantial implications for girls' empowerment and gender equality.

While child marriage and early union is understood to be a driver of sexual debut and childbearing, new data suggests that this pattern is nuanced in many settings. Analysis of nationally representative data from Cambodia revealed that among women aged 20–24 who gave birth before age 18, three-fourths conceived in the context of union, while 9 per cent conceived before marriage (Harvey et al., 2022).

There is limited research to understand the drivers of 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.

Aims and objectives

This research project was implemented in Indonesia, Lao PDR, Cambodia, 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 **Cambodia only**.

The project was led by the Burnet Institute, in partnership with Indochina Research Limited (IRL) Cambodia, UNFPA Cambodia Country Office, UNICEF Cambodia Country Office, UNFPA Asia Pacific Regional Office (APRO), and UNICEF East Asia and the Pacific Regional Office (EAPRO).



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.

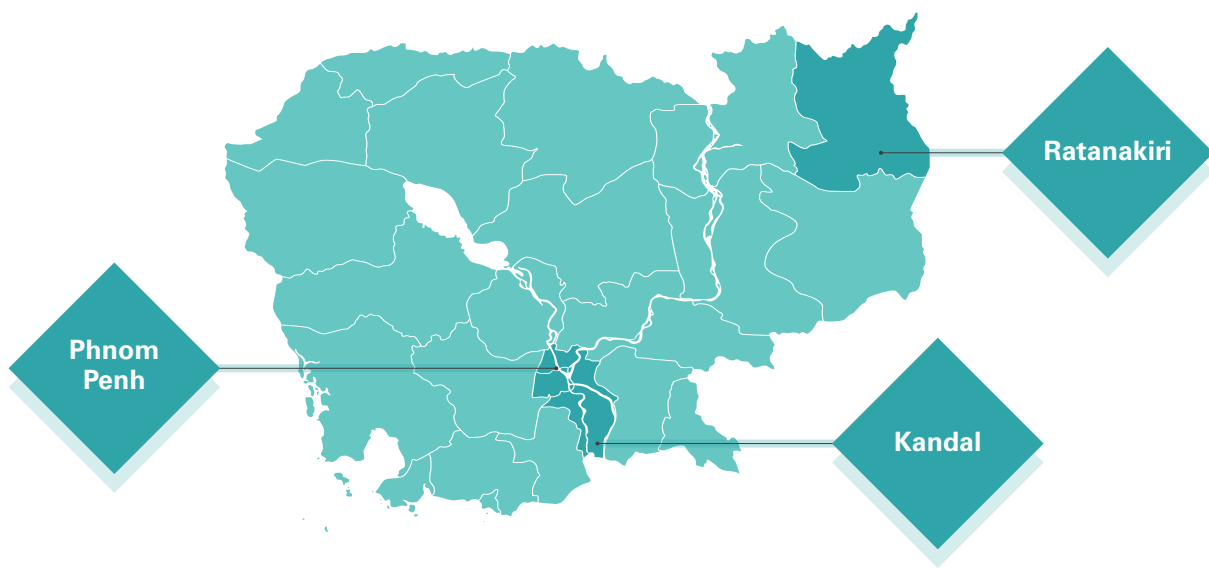
Setting and site selection

A working group was established, comprising representatives from UNFPA and UNICEF, as well as two youth advisors from the study country (in this case, Cambodian females aged 18-24). The working group reviewed the methodology and study materials, provided guidance on site

selection, and supported the interpretation and dissemination of study findings.

Two provinces in Cambodia were selected for the study to capture a setting of high adolescent fertility and premarital conception (Ratanakiri), and a setting of median adolescent fertility and premarital conception (Kandal, which contains the capital city Phnom Penh) based on the most recent data and analysis developed by UNFPA (see Figure 1). Additional considerations were feasibility and cost, and the inclusion of both urban and rural settings within each province.

Figure 1. Map of Cambodia showing Ratanakiri, Kandal, and Phnom Penh



Recruitment

Participants were sampled purposively, facilitated by partnering health care services and nongovernmental organizations (NGOs) providing support to pregnant adolescents. The young women recruited were:

16-20 years old

Aged 18 or younger
when they become pregnant
or gave birth

Married, in a union, in a
relationship, or unmarried
(i.e. never-married,
separated, divorced)

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

Data collection 1: In-depth timeline interviews

The study used a participatory method to understand the drivers and pathways to adolescent pregnancy from adolescent girls' perspective. Using a timeline interview approach, interviewers asked participants semi-structured questions to guide them to reflect on key life events and milestones in their journey to becoming pregnant. Interviewers participated in a five-day interviewer training, which covered the study objectives, key principles of research ethics, informed consent, personal privacy, protection of personal information, distress and mandatory reporting protocols, interview topics, visual timeline and in-depth interview approach, and conducting in-depth interviews in-person, online, or over the phone.

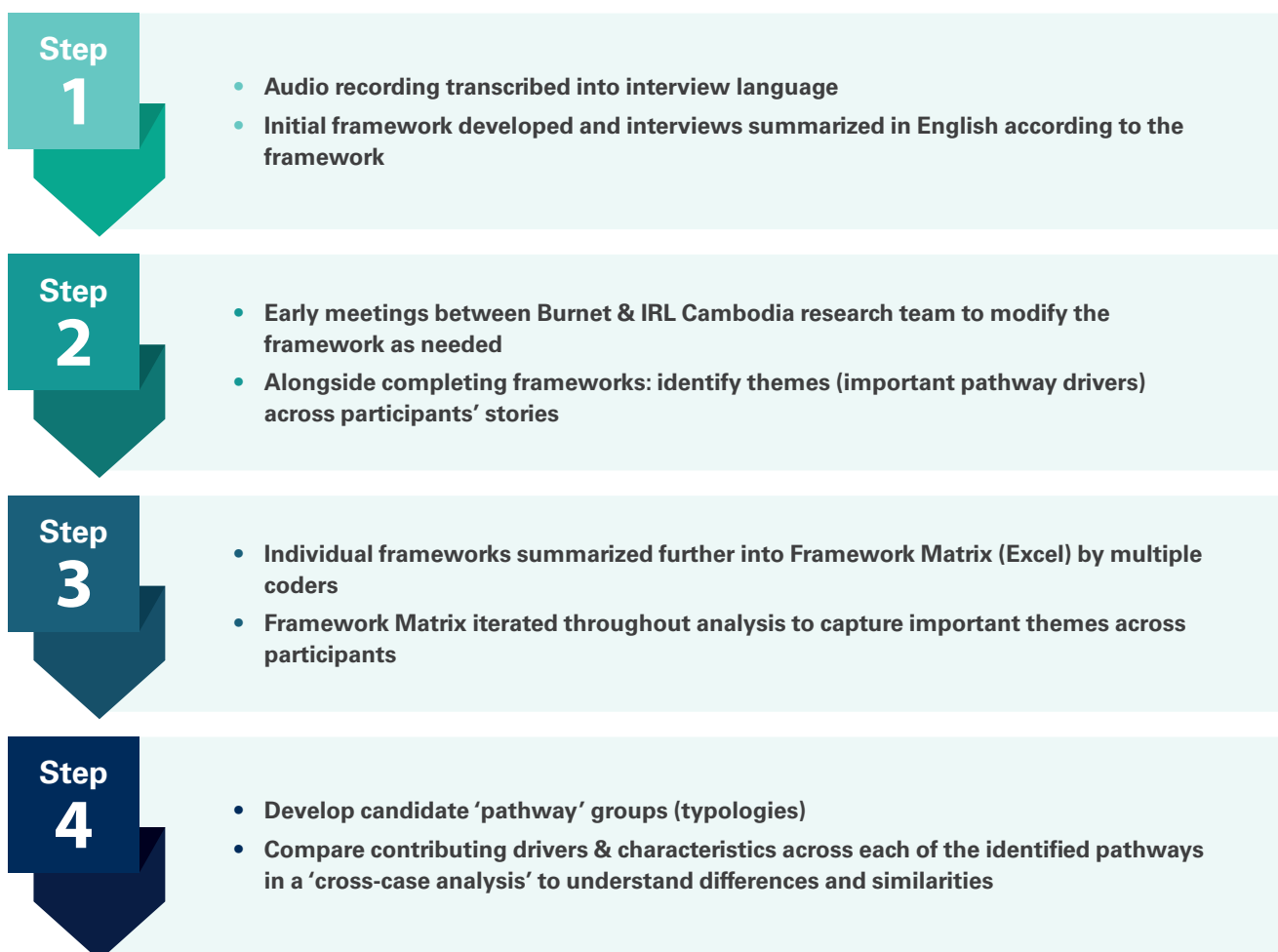
Due to COVID-19 restrictions, all interviews were conducted over the phone. Interviewers were

encouraged to draw visual timelines during the interviews to facilitate mapping out key life events in the girls' stories. The interviews were conducted in the Khmer language by trained interviewers who were native speakers. The topics covered during the interviews included: timing and feelings about pregnancy, relationship with the partner who got them pregnant, learning about sex and reproduction, sexual history, experiences with contraceptives, relationship with others (parents, family, community, health care providers) and community and school influences. Interviews were audio-recorded using a digital recorder with participants' consent.

Preliminary data analysis

The study used a blended inductive-deductive approach to preliminary data analysis. Specifically, a framework analysis was used to analyse qualitative data collected through individual interviews. The analysis steps are outlined in Figure 2.

Figure 2. Data analysis process (framework analysis)



Audio recordings were transcribed into English, supervised by the IRL Cambodia study team. During initial meetings between the IRL Cambodia and Burnet teams, an initial analysis framework was developed and modified to suit the local context, as analysis progressed. Key life events and contributing factors (important pathway drivers) to adolescent pregnancy described in the English interview transcripts were placed in analysis frameworks (one per participant, Word document). Regular Zoom meetings between the IRL Cambodia and Burnet teams were held to discuss the emerging themes from the analysis and develop the framework summary/matrix (Excel worksheet). The individual analysis frameworks were then summarized further by multiple coders into the framework summary/matrix. The matrix was iterated throughout the analysis to capture important themes across participants. Finally, the candidate pathways (typologies) were developed. The contributing drivers and characteristics across each of the identified pathways were compared in a cross-case analysis to understand differences and similarities in girls' stories.

Data collection 2: Follow-up phone interviews

Following preliminary analysis of the data gathered through the individual interviews, follow-up interviews were conducted with selected participants. These aimed to 1) validate and clarify the study findings and interpretations, and 2) gather participants' suggestions/recommendations for programmatic and policy action.

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) sexual and reproductive health (SRH) knowledge; 2) contraceptive access and use; 3) sex and pregnancy; and 4) marriage. During 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.

Follow-up interview participants were girls who a) participated in the in-depth timeline interviews, b) indicated their interest to be recontacted for the study's follow-up activities, c) had access to a mobile phone, and d) provided informed consent.

During the follow-up interviews, participants were sent the video clips and given time to watch them before the follow-up interview began. Interviewers then used a semi-structured interview guide to facilitate validation and clarification of findings, and gather participants' suggestions and recommendations regarding priority strategies to support adolescent girls relevant to each of the four topics. After the interview, interviewers completed a summary sheet where they documented participants' feedback on the study findings as well as their suggestions and 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 Cambodia. 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 from Cambodia. 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

80 in-depth timeline interviews were conducted over the phone between December 2021 and February 2022 with girls aged 16-27, of whom 19 participated in follow-up interviews. The median age of the participants was 19 years (see Table 1). One participant was found to be 27 years old after the interview had already commenced but experienced her first pregnancy at age 18; her data were retained in the data analysis and findings.

Table 1. Sociodemographic characteristics of the participants

Characteristics	No. of participants
Age at interview	
16	4
17	9
18	17
19	17
20	31
21	1
27*	1
Ethnic background	
Khmer	27
Kreung	18
Tompoun	7
Jaray	1
Other	1
No information/unclear	26
Province	
Ratanakiri	43
Kandal	20
Phnom Penh	17
Site (Residence)	
Rural	43
Peri-urban	20
Urban	17

Characteristics	No. of participants
Marital status at interview	
Living together but not formally married	5
Married	70
Separated/divorced	4
Unclear	1
Highest educational attainment	
No formal education	3
Some primary school	36
Some secondary education	38
High school graduate	1
Some higher education	2
Engagement in paid work	
No	57
Yes	22
No information	1
TOTAL	80

* One participant was found to be 27 years old after the interview had already commenced; her data were included in data analysis.

Participants were of Khmer, Kreung, Tompoun, and Jaray ethnic backgrounds. About half of the participants were from Ratanakiri (rural area), 20 were from Kandal (peri-urban area) and 17 were from Phnom Penh (urban area). Most of the girls were married at the time they were interviewed; only five were living with a partner but were not

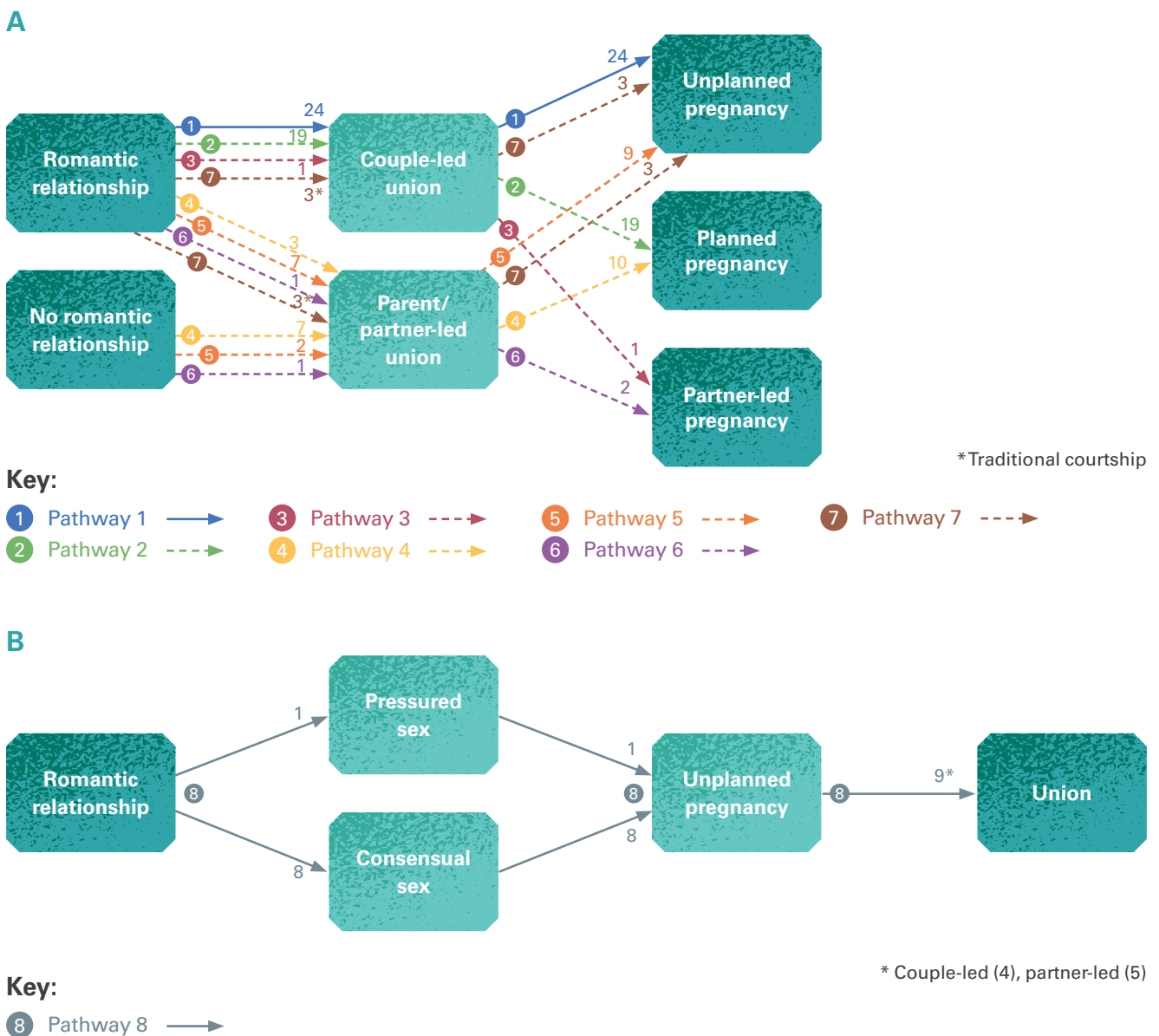
formally married, and four were previously in a union but were separated or divorced. About half of the participants had at least some secondary education, though 36 girls had only some primary education, while three girls had no formal education. At the time of interview, only about one-fourth of the participants were engaged in any paid work.

Findings

In Cambodia, eight pathways to adolescent pregnancy were identified, which are broadly mapped out in Figure 3. These pathways were differentiated primarily by the timing of the first pregnancy relative to union (i.e. marriage or cohabitation). Pathways to pregnancy within union were more common, though about one in ten girls followed pathways to pregnancy outside of union. Within-union pregnancy pathways

were further differentiated by who initiated the union, and pregnancy intention. There was only one pathway to pregnancy outside of union, but girls' experiences could be differentiated further by the nature of the sexual relationship preceding pregnancy (consensual or pressured sex) and pregnancy intention. Across pathways, contraceptive use/non-use was an important factor in girls' stories.

Figure 3. Pathways to adolescent pregnancy in Cambodia, [A] Within-union pregnancy pathways, [B] Outside-union pregnancy pathways



Note: Roman numerals correspond to distinct pathways; figures near arrowheads refer to frequencies.

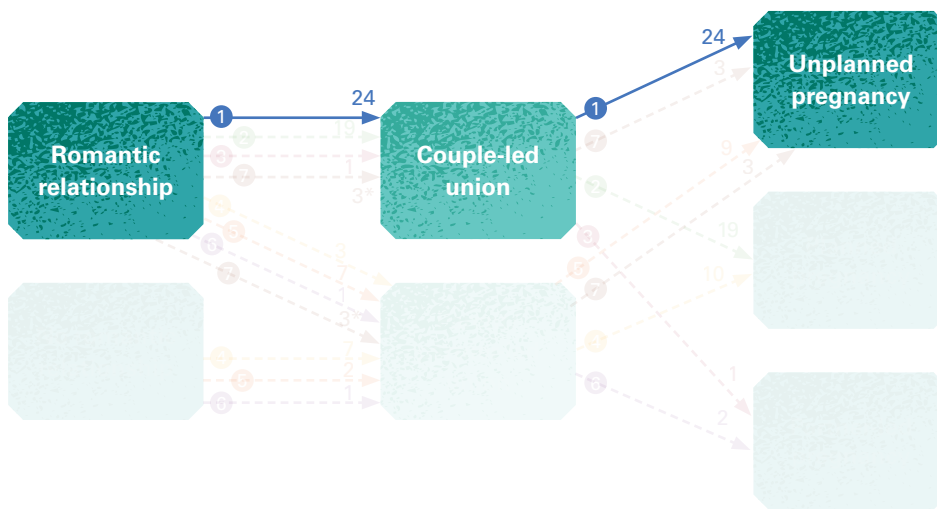
Within-union pregnancy pathways

1. Couple-led union leading to unplanned pregnancy

The most common pathway to adolescent pregnancy in the sample was through romantic

relationships that led to couple-led union (either marriage or cohabitation); 24 girls' narratives aligned with this pathway (see Figure 4). Following union, girls had unplanned pregnancies. This pathway was observed across all study areas, in rural (12 girls), urban (7 girls), and peri-urban (5 girls) communities. Girls belonged to Khmer, Kreung, and Tompoun ethnic backgrounds.

Figure 4. Cambodia pathway to adolescent pregnancy 1 – couple-led union leading to unplanned pregnancy



Marriage/union. Most girls in this pathway were in a relationship from a few months to two years before they got engaged to their partner. Girls' age gap with their partner ranged from 3 to 16 years. Most girls (18) had couple-led marriages, while the rest (6) entered couple-led cohabiting unions.

Sexual debut. Almost all girls had sex for the first time with their husband or partner who got them pregnant after union, but three girls reported having sex with the partner who got them pregnant before union.

Contraceptive knowledge, access, and use. Most girls only gained some awareness about contraception after marriage or first birth, usually

from female family members (mother, sister), friends, and health care professionals. As such, most girls did not use any modern contraceptives before their first pregnancy. One girl reported learning about contraception at school before she got married, but she did not use any modern contraceptives when she began living with her partner. Some girls expressed concerns about contraceptive pills making it difficult to conceive:

I do not want to use contraception because I am afraid that if I use contraception, then one day if I want the baby, I am afraid that I am not [able to] conceive.

(CA0202)

Five girls reported using pills after marriage to delay their first pregnancy, but four of them discontinued their chosen method for different reasons (e.g. experienced side effects, could no longer afford to buy pills, felt lazy to take pills daily). One girl described deciding to stop using contraceptive pills because of side effects:

I decided to stop because the pill bothers me. It makes me feel weak, dizzy and headache and I am skinny [losing weight]. (CA0415)

Pregnancy. All pregnancies were unplanned – some girls described feeling nervous/afraid when they learned that they were pregnant, and three felt unhappy, stressed, depressed, and ‘not ready.’ One girl was taking pills but missed a dose and got pregnant shortly after. She was saddened by the news as she was not ready to become pregnant at the time:

I am nervous and depressed because I am not ready yet. I am more stressful [stressed], I don’t have someone to discuss with. ... He [my husband] is depressed for me as well, he wants me to continue my study but I need to pause my study because I am pregnant. (CA0436)

Four girls had abortions, of which three were induced abortions and one was a medical abortion due to an ectopic pregnancy. Though pregnancies were unplanned, some girls in this pathway reported that their pregnancies were wanted; these girls reported feeling happy/excited about their pregnancy. For example, one girl recalled:

I was so excited. ... [But] I didn’t plan to have a baby yet. ... Because we didn’t have a house yet. ... He [my husband] didn’t say anything. He was also excited. (CA0331)

Another girl recalled feeling nervous when she learned she was pregnant, but described her parents’ excitement about her pregnancy:

Well, my parents are excited since they want [a] grandchild, they want me to immediately [start] having children after we were married. (CA0428)

Relationship outcomes. At the time of their interviews, almost all girls were still married or cohabitating with the partner who got them pregnant. Two girls were divorced due to the partner’s infidelity and because the couple fought a lot.

Education. Almost all girls left school before union, and the most common reason for leaving school was financial issues.

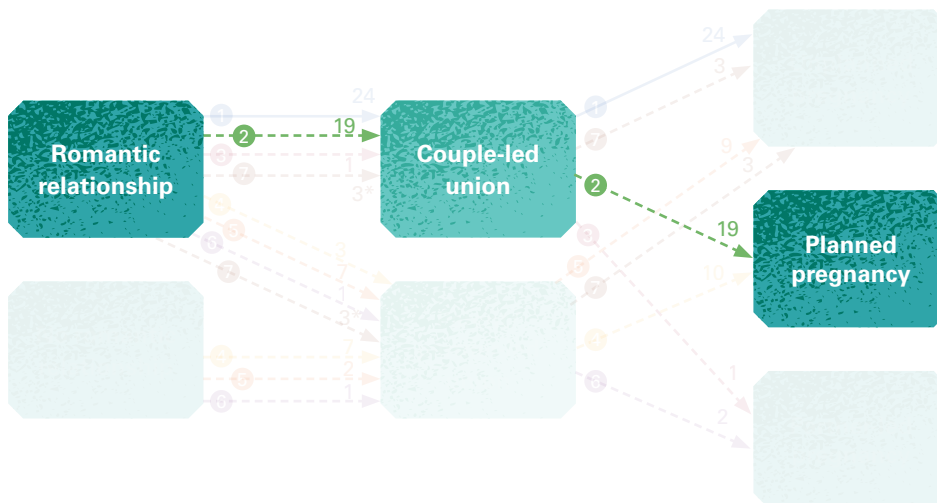


2. Couple-led union leading to planned pregnancy

In this pathway, girls' pathway to adolescent pregnancy was through a romantic relationship that led to a couple-led union (marriage), which was followed by a planned pregnancy within

marriage (Figure 5). Nineteen girls' stories aligned with this pathway. Like the first pathway, this pathway was observed across all study areas, in urban (5 girls), peri-urban (4 girls), and rural communities (10 girls). Girls were of Kreung, Tompoun, and Jaray ethnic backgrounds.

Figure 5. Cambodia pathway to adolescent pregnancy 2 – couple-led union leading to planned pregnancy



Marriage/union. Most girls in this pathway were in a relationship from a few months to a few years before entering a couple-led marriage and their age gap with their partners ranged from 0 to 8 years. One girl described offering food to ancestors before living together with her partner; they were married after a year of cohabitation.

Sexual debut. Almost all girls had sex for the first time with their husband or partner after they were married or began living together and became pregnant shortly afterwards. Two girls had sex for the first time after they were betrothed but before they were married. For most girls, there was an implication that sex with their husband or partner was wanted or planned/expected within union, but 11 girls did not mention whether they wanted to have sex at the time. One married girl talked about times when she had sex with her husband even though she did not want to:

Sometimes when he wants [sex] but I do not want, I tell him that I do not want, and he doesn't force me, but he would sleep with his back to me, he is also upset. ... He is not with me all the time, so I don't want him to be upset as well. (CA0302)

Contraceptive knowledge, access, and use.

Most girls in this pathway did not use modern contraceptives before pregnancy because they were planning to get pregnant. Only four girls used pills/injections after marriage to delay pregnancy; they stopped using contraceptive methods when they and their husbands decided that they wanted to have a baby. One girl described her decision to stop using injections because of side effects and her husband's request for her to stop so they could have children.

When we lived together, I used injection contraceptives. I got three injections and then I stopped taking injection as it had side effects. I had stopped injection for six months, and then I realized that I was pregnant. ... I stopped because of him [my husband] as well. [He said] I should not use contraception anymore since we are old. He wants to have children like other people, so I decided to stop the contraception. (CA0405)



Education. Most girls left school for other reasons before getting married, mainly due to financial reasons. Two girls left school because they had difficulty focusing in school and keeping up with lessons, one to take care of younger siblings, and one due to COVID-19 disruptions. Only three girls reported that they left school because they wanted to get married.

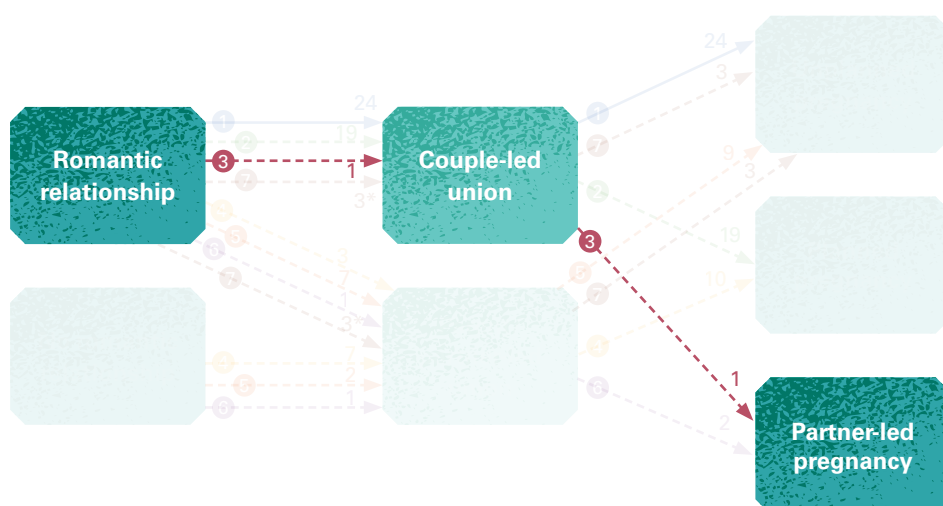
3. Couple-led union leading to partner-led pregnancy

As in the previous two pathways, one girl's pathway to pregnancy began through a couple-led union (see Figure 6). However, unique to this

pathway was that the girl had a partner-led pregnancy – she did not want to get pregnant, but her partner wanted a baby. The girl was from a rural community.

Marriage/union. Her husband was five years older than her, and they had known each other for two years before they got married. Their relationship developed mostly through talking on the phone. She was 15 years old at the time of marriage, which she described as a common age for girls to get married in her village. Despite objection from her partner's parents, she wanted to get married because her parents were getting old, and her family needed help with work:

Figure 6. Cambodia pathway to adolescent pregnancy 3 – couple-led union leading to partner-led pregnancy



I am happy to get married but for his side [parents], they do not want us to get married yet. They want me to keep on studying first, but I want to get married myself. Because I want to have people to help [with] working because my parents are old already. (CA0301)

Sexual debut. The girl experienced her sexual debut within marriage. The couple only spent time together in person once or twice before they were married and reported no physical intimacy until they were married.

Pregnancy. The girl expressed that she did not want to get pregnant yet because she did not feel ready and felt she was too young to have baby. She was not excited to learn she was pregnant but knew that her husband wanted to have a baby. She was also aware that her parents wanted grandchildren.

[I am] not really excited as I do not really want [the baby]. ... Because I am too young. (CA0301)

Contraceptive knowledge, access, and use.

The girl had some knowledge about sex and reproduction, and some awareness of contraceptives (e.g. pills, injections, intrauterine devices, implants) from school. However, she did not use any modern contraceptives before pregnancy even though she did not want to have baby. She decided to start using injections after the birth of her second child.

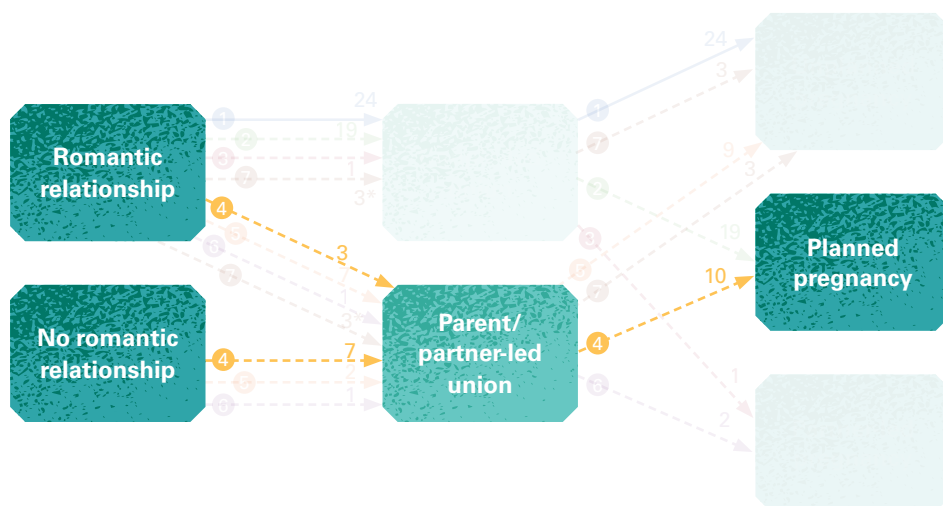
Relationship outcomes. The girl was still married and living with her husband at the time of interview.

Education. The girl left school at primary level (grade 7) a year before marriage because she needed to help her parents to earn a living.

4. Parent and/or partner-led marriage leading to planned pregnancy

For 10 girls, the pathway to adolescent pregnancy was through marriage typically led by the partner, partner’s family, or the girls’ own parents and was followed by planned pregnancy within marriage (see Figure 7). This pathway was observed across all study areas, in urban (3 girls), peri-urban (6 girls), and rural (1) communities, and girls were of Khmer and Kreung ethnic backgrounds.

Figure 7. Cambodia pathway to adolescent pregnancy 4 – arranged marriage leading to planned pregnancy



Marriage/union. Most of the girls had little or no real say in the decision to get married; marriage was decided by the couple's parents. Girls usually did not know their partner very well or for very long before they were engaged. Some girls only met their partner a few days before or on the day of their betrothal. However, most girls accepted the marriage proposal out of obedience to their parents, even when they did not expect to get married so young:

Well, even if am not happy or happy, I still need to marry him. I also follow my parents, I think that they will try to arrange a good person for me. It is just that I am young, I am married when I am 17 years old. ... I didn't think that I will get married when I am 17 like that. (CA0326)

to have sex with her husband a week after they were married, while two girls described being pressured by their husbands to have sex on their wedding night. One of these girls recalled not feeling ready to have sex and asking her husband for time. He refused, so she "agreed" to have sex. The other girl described being nervous on her wedding night, but she knew that if she did not agree to have sex with her husband, she would have to pay back the dowry:

At first, I don't know what it is, a honeymoon, and I cry when I see him coming to sleep at my house. ... I wonder what it is, I was nervous and my mom tries to comfort me and if I don't agree [to have sex] with him, then I have to pay back his dowry. So, then I agree. (CA0435)

One girl accepted the marriage proposal because she was threatened with a fine if she did not accept:

I was nervous, I was afraid, as I don't know that after I am married, [if] they would hurt me, or I can't go out as I used to when I was a virgin. I was afraid. And they said that if I don't accept him, they will fine me. ... I was nervous so I accept him. ... If I don't agree to marry him, they will take back the money and they will fine me. (CA0429)

Pregnancy. Girls in this pathway had planned or expected pregnancies within marriage. Some girls got pregnant soon after marriage, while others took some time (up to two or three years) after marriage before they conceived.

Contraceptive knowledge, access, and use.

Almost all had no or limited knowledge about contraception and did not use modern contraceptives prior to pregnancy. Only one girl used pills to delay pregnancy after marriage and stopped using her chosen method to get pregnant.

Relationship outcomes. Almost all girls in this pathway were still married at the time of interview. One girl divorced her husband early on in her pregnancy, citing that he was "not a good guy." The girl reported that he was jealous, used drugs, and hung out with gangsters, and she could not live with him.

Sexual debut. All girls had sex for the first time with their husband after marriage. Only three girls provided details on their first sexual experience with their husband. One girl reported agreeing

Education. All girls left school for other reasons before marriage, mainly due to financial issues.

5. Parent and/or partner-led marriage leading to unplanned pregnancy

As in the previous pathway, nine girls' pathway to adolescent pregnancy was through marriage initiated by the partner with the girl's parents or just the girl's parents (see Figure 8). Girls in this pathway then went on to have unplanned pregnancies. This pathway was observed in Kandal and Ratanakiri, in peri-urban (2 girls) and rural (7 girls) areas only, and girls were of Khmer and Kreung ethnic backgrounds.

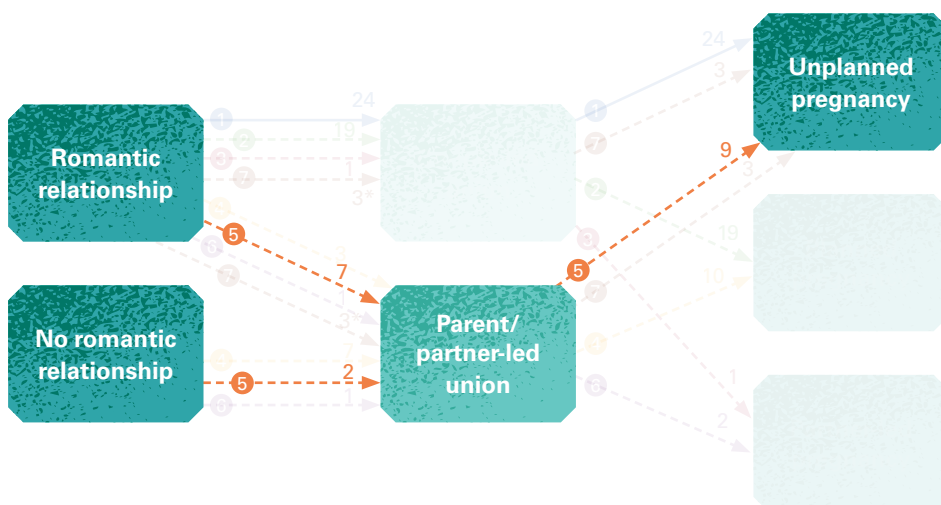
Marriage/union. Typical of all arranged (parent and/or partner-led) marriage pathways, most of the girls had little or no real say in the decision to get married. One girl refused her husband's proposal but was forced by her parents to accept it.

Sexual debut. Almost all girls had sex for the first time with their husband after marriage. Only five girls elaborated on the nature of their first sexual experience with their husband. Three girls reported having consensual sex, and one described having planned/expected sex on her wedding night. Another girl reported experiencing forced sex within union. She was forced to marry and recalled refusing to have sex with her husband after they were married. Her husband told her mother about her refusal, and the girl had sex with her husband only after her mother gave her money to convince her to agree. Nevertheless, the girl reported that her husband forced her to have sex by threatening her:

He asked to [be] betroth[ed to] me. ... I said no. ... He didn't say anything. ... [But we got married] because my parents force me to get married with him. (CA0421)

My mom gave me money to buy new clothes. ... so that I agree to have sex with him [my husband]. ... My husband told my mom. ... He told my mom that I refuse[d] have sex with him. ... [When we had sex,] he forces me. ... He said if I don't have sex with him, he will take my house. ... I feel scared.(CA0421)

Figure 8. Cambodia pathway to adolescent pregnancy 5 – arranged marriage leading to unplanned pregnancy



Contraceptive knowledge, access, and use.

Almost all girls in this pathway did not use any modern contraceptives before pregnancy. Three girls reported not wanting to use contraception because they had heard that it may harm the uterus or cause infertility. For example, one girl said:

As a virgin woman, I used to hear that I shouldn't take it [pills] as well, it's not good for my uterus. (CA0308)

Only one girl used injections to delay her first pregnancy, but she missed a dose and got pregnant shortly after. Another girl reported that her partner practiced withdrawal.

Pregnancy. Pregnancies were unplanned and three girls recalled feeling nervous or afraid when they learned that they were pregnant. One of these girls considered abortion because her husband did not want the pregnancy, but her parents dissuaded her, as they believed that abortion was "sinful." Four girls reported feeling excited on learning they were pregnant, even though they did not plan to get pregnant at the time.

Relationship outcomes. All girls were still married or living with their husband or partner at the time of the interview.

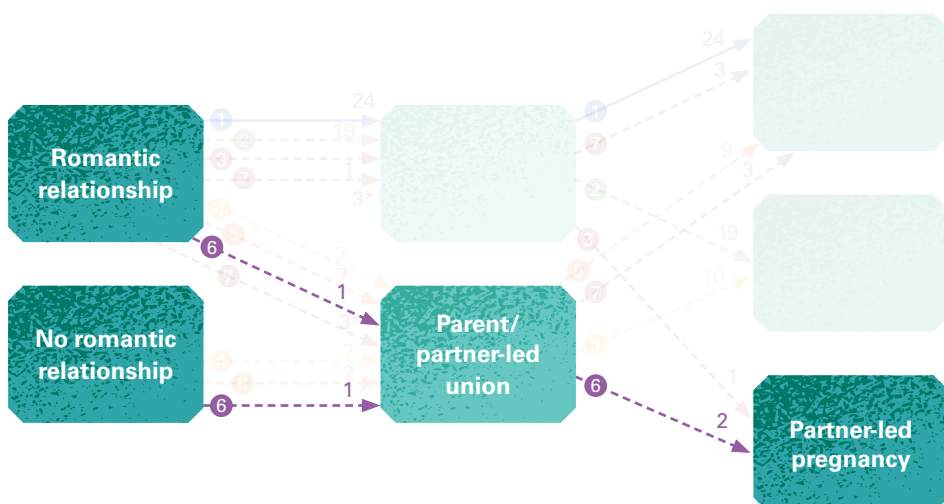
Education. Most girls left school for other reasons before marriage. Six left school due to financial issues and two due to COVID-19 disruptions. Only one girl left school to get married.

6. Parent and/or partner-led marriage leading to partner-led pregnancy

For two girls, the pathway to adolescent pregnancy was also through arranged marriage leading to partner-led pregnancy (see Figure 9). One girl was from a peri-urban area while the other was from a rural area. The girls belonged to the Khmer and Kreung ethnic backgrounds.

Marriage/union. In both cases, marriage was arranged by the partner and his family, and the girl's parents. One girl said she was happy to marry the man her parents had chosen, while the other girl did not seem to have much say in the decision to get married. She did not know the man who was to be her husband, but followed her parents' wishes:

Figure 9. Cambodia pathway to adolescent pregnancy 6 – arranged marriage leading to partner-led pregnancy



I heard the elders talk and asking me like [they were] asking for an egg. ... I want to laugh as I think it is a joke only, and then they ask me what I think, and I don't know what to think. I just tell them I will follow my parents because we never knew each other. ... My parents like him, so then we get married. ... I have talked to her [my mom], I do not want [a] husband yet. ... My mom said, ... 'If you don't marry him, who would marry you?' Because my father, when he is drunk, he is very violent and everyone in the village is afraid of him. [Mom said], 'It's good that he loves you now, otherwise, no one would.'

(CA0403)

The night after we got married, we didn't have sex. The following night, he asks me for sex, but I didn't agree because I am still angry with my mom [for] asking me to get married. ... He [my husband] is angry, he says that we are married because we want children and if we don't have sex, how can we have children? And he also tells his matchmaker. ... The matchmaker tells my older sister and he tells me that my husband is not my slave, he married me because he wants to build a family and children. If anything goes wrong, he can file a complaint against me. ... [I agreed to have sex with him] five months later. (CA0403)

Sexual debut. For both girls, their sexual debut was with their husband, after they were married. One girl described not wanting and refusing to have sex with her husband on their wedding night. This made her husband angry. The husband involved their matchmaker, who warned the girl that her husband can file a complaint against her if they are not able to build a family together:

Contraceptive knowledge, access and use. Both girls had limited or no knowledge about modern contraceptives before they got pregnant. One of the girls did not use any modern contraceptives before pregnancy. The other girl secretly used pills, but her husband found out about this and threatened to divorce her if she did not stop using them. Her family supported her husband's decision and advised her to stop taking the pills.



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Pregnancy. Distinct in both girls’ narratives was that they did not want or feel ready to have a baby, but it was clear that their husbands wanted a baby. One girl recalled feeling angry when she learned that she was pregnant:

I am angry, because I know that if I die or live, it’s because of him [my husband]. ... Because I have the baby when I am too young, so I have the baby with anger. [But] I am only angry for a short period of time, then it’s gone. ... I tell my older siblings, and I also cry as I am afraid. ... I am afraid of the delivery, ... as I am too young, I don’t know if God will take care of me. (CA0403)

Relationship outcomes. Both girls were still married and living with their husbands at the time of interview. One girl was pregnant during her interview and reported that her husband was not taking care of her.

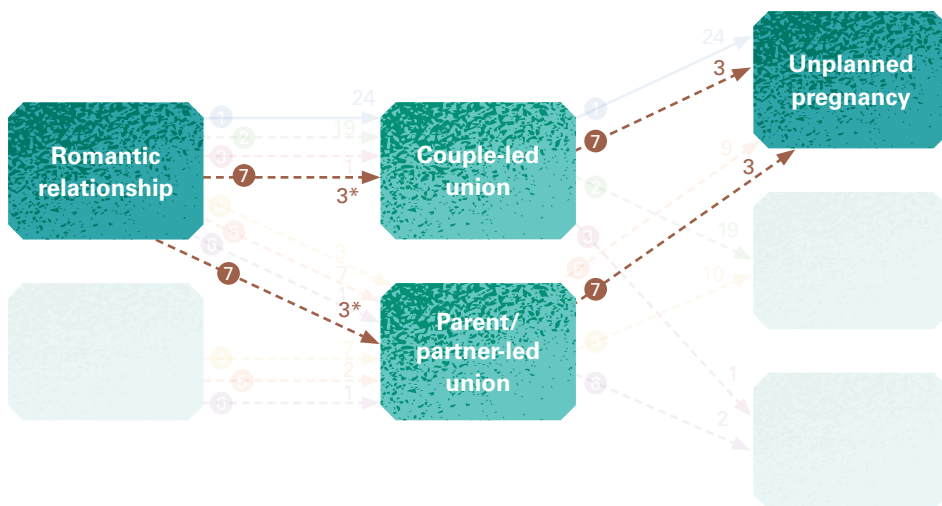
Education. Both girls stopped attending school (grade 7) before marriage due to financial issues.

7. Traditional courtship leading to union and unplanned pregnancy

Six girls’ pathway to adolescent pregnancy was through traditional courtship leading to union, meaning marriage or cohabitation. (see Figure 10). This pathway was observed only in rural areas and four of the girls belonged to the Kreung tribe.

Marriage/union. Traditional courtship sometimes entailed the girl sleeping in a “bride/virgin house” adjacent to her natal home, where a suitor could join her and attempt to convince her to accept him as her life partner.

Figure 10. Cambodia pathway to adolescent pregnancy 7 – traditional courtship leading to union and unplanned pregnancy



When he comes [over to my house] for the first time, we didn't sleep together. I am sleeping on the floor; he sleeps on the hammock. So, we don't sleep with each other, until we are taking each other seriously, then we sleep together. ... I am sleeping at the bride's house. ... When I discuss [my future] with him, I am afraid that I would bother my parents, so I build a small house in front of my [parents'] house, so it's convenient for us to sleep together as a virgin woman. ... I built that house for a virgin woman. ... when I am 15 years old. (CA0414)



Other girls in this pathway also described a cultural practice where the girl's family asks the boy if he is serious about the girl, and the boy's family asks the girl if she is serious about the boy:

[In] my tribe culture, he [my partner] doesn't betroth me. For my culture, the girl's side needs to ask the guy's side to see if he is serious with me, should we be husband and wife. ... We need to ask first, to see if he is serious or not. ... At first, the girl needs to ask, and then it is the guy's turn to ask, and then we check the date. (CA0410)

These courtship practices were followed by marriage or cohabitation. Some were partner- and parent-led, while some were couple-led. Marriage was formalized by offering food to ancestors according to tribal culture:

I decided to get married according to Kreung culture, as we are all poor. ... It's like a blessing and [then we] eat. ... Just kill the pig, we put [on] some make-up, ... and we drink jar wine. (CA0414)

Sexual debut. All girls had sex for the first time with their husband, after union. Two girls reported not wanting to have sex with their husbands on their wedding night and being "comforted" (convinced) to agree. One girl reported that her first sex with her husband was forced:

[We had sex] that night, after the offer to the ancestors. ... My husband started first. ... Even if I refuse, my husband still forces me. ... He said it's okay since we are married already. (CA0420)

Pregnancy. In this pathway, pregnancies were unplanned, though some were wanted. One girl recalled having mixed feelings about her pregnancy, because she had heard that some girls who get pregnant at a young age do not survive childbirth.

I felt happy and scared. ... Because some people said that when we were [are] too young while delivering the baby, some of them could bear [it], and some of them couldn't bear [it], so they have gone [died]. So, I felt hesitant, [whether] I wanted the baby or not. That's why I felt happy and scared. (CA0401)

Two girls wanted to have abortions, but their husbands did not let them do it. Most girls had to follow their husband's decision even when they did not agree.



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Contraceptive knowledge, access, and use.

Only two girls in this pathway used modern contraceptives before their first pregnancy (one used injections then changed to pills, the other used pills). Both discontinued their chosen method due to side effects such as headaches, dizziness, felt feverish, and got pregnant shortly thereafter.

After the wedding, my sister said, now I am married, do I want to have a baby now? And I said not yet, I am young. ... So, my sister asked me if I want to take a pill or injection. I told her I want an injection, but when I take an injection, it doesn't fit with me. I am feeling headache and dizzy and fever, so I take a pill instead. ... I have taken four tablets, but I am feeling the same as taking an injection. And my sister told me that, 'maybe it's because you are young, so let's stop taking pills and decide to be pregnant'. ... So, I decided to stop taking pills. ... Both injection and taking the pill bother me so I and my husband decided to stop. ... Three months later, I am pregnant.

(CA0414)

Relationship outcomes. At the time of their interview, all girls were still married and living with their husbands and described being satisfied with how their husband took care of them during pregnancy and after delivery.

Education. Four girls left school at primary level due to financial issues/the need to work, or because they wanted to get married (it seemed to be their choice). The other two girls had no formal education – one girl needed to help care for younger siblings, while the other didn't go to school because the school was far from her home.

Outside-union pregnancy pathway

8. Romantic relationship and sex leading to unplanned pregnancy and marriage

The final pathway to adolescent pregnancy was characterized by a romantic relationship that led to sex, followed by an unplanned pregnancy outside of union (see Figure 11). Nine girls' experiences of adolescent pregnancy aligned with this pathway, and our local research partners described these girls as the most difficult to find or reach because of cultural taboos around sex and pregnancy outside of union. Nevertheless, this pathway was observed across all study areas, in urban (2 girls), peri-urban (2 girls), and rural communities (5 girls). These girls were of Khmer, Kreung, and Tompoun ethnic backgrounds.

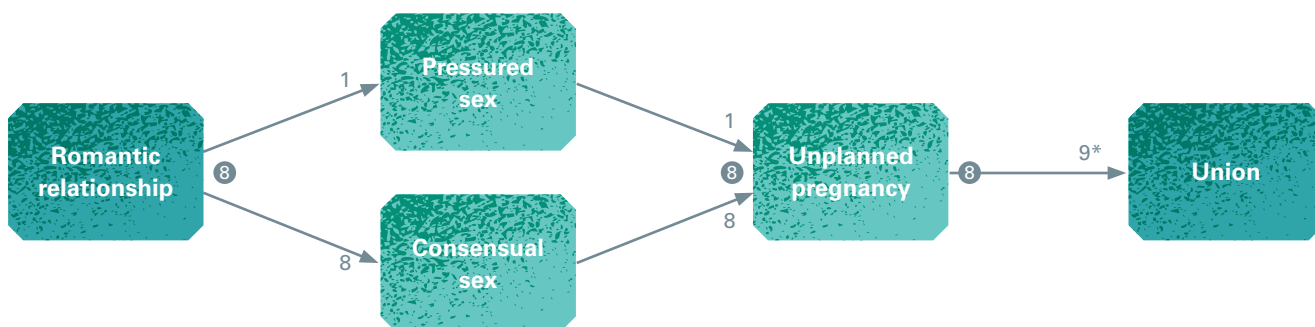
Sexual debut. Most girls in this pathway had known their partner or been in a relationship for at least a year before having sex for the first time. All girls had their sexual debut with the partner who got them pregnant. Almost all girls described sex as consensual, motivated by love:

I have become his girlfriend for about one year. He is from my village. ... We only went [out together] one time, to the province. ... On weekends, we go to the village with my friends, but we didn't go to the province, we only talk on the phone. ... [We had sex] because we love each other, we [have] trusted each other for one year already."

(CA0309)

One girl described agreeing to have sex with her boyfriend because he asked for sex and she felt sorry for him, while the other was pressured (her boyfriend made an angry face at her and she agreed). Three girls had only known their partner for a month to a few months before they had sex, but all of them had sex in the context of a romantic relationship. One girl was afraid to have sex because she was aware that she could get pregnant, but decided to have sex with her boyfriend after he reassured her:

Figure 11. Cambodia pathway to adolescent pregnancy 8 – romantic relationship leading to unplanned pregnancy and marriage



* Couple-led (4), partner-led (5)

I feel nervous [when we had sex for the first time]. ... I think too much, I'm afraid to have a baby. ... He swore to me. So, I decided to have sex with him. ... We just talked to each other. That's it. (CA0304)

I wanted to abort [the baby]. ... [I told my boyfriend] but he says that he doesn't have money. When I checked YouTube, they showed me that drinking lots of coffee will make me [have a] miscarriage, but it doesn't happen to me. (CA0406)

Contraceptive knowledge, access, and use. None of the girls used modern contraceptives before pregnancy because they lacked knowledge about contraception. Most girls in this pathway described learning about contraception after giving birth to their first child. Some girls had heard of contraceptives when they were younger, but were shy to ask other people for more information.

Pregnancy. All pregnancies were unplanned, but at least three of them were wanted. One girl described feeling excited on learning that she was pregnant, even though she and her partner had not planned to get pregnant yet:

I was so excited that I had nothing to say. ... [My partner] was excited because he also wanted a baby. ... At first, we didn't plan to have one yet because we wanted to earn more money but since we already had one, we kept it. (CA0330)

Three girls considered abortion, of whom one attempted to induce a miscarriage by drinking lots of coffee, but was unsuccessful:

Relationship outcomes. After learning that they were pregnant, most girls in this pathway went on to marry their partner because of the pregnancy. For some, the decision to marry was led by the couple, while for others, the decision was led by parents. Couple-led marriages were motivated by love and pregnancy. For five girls in this pathway, marriage was initiated by their parents following pregnancy, but in four cases, the couple was in love and agreed to the union. Only one girl expressed not having a choice in the decision to marry. One girl described her experience of a "rush" wedding after her and her partner's parents learned of her pregnancy.

I used to hangout a lot and I ending up having sex with him and it was also my first time. I was nervous. ... I did not dare to tell my mom [that I was pregnant] but for my husband, he told his parents, and then his parents come to talk to my parents and my parents know that I am now pregnant and then they arrange for our wedding. It's like, we are not planned, so things were really rushed. ... We got married immediately. (CA0320)

Education. Most girls in this pathway had left school for other reasons before they got pregnant. Three girls left school because they got pregnant.

Discussion

Crosscutting factors contributing to adolescent pregnancy in Cambodia

Girls lacked access to SRH information

Across pathways, many girls had little or no knowledge about SRH, including contraception, prior to pregnancy. Some girls only learned about contraceptives after they were married, indicating that unmarried girls face barriers to essential information and access to supplies. During follow-ups, girls clarified that the lack of SRH knowledge was due to a lack of information sources. Girls felt that their parents and elders viewed them as “too young” to know about this information, so they never discussed these topics with their daughters. The findings are indicative of the persistence of cultural taboos around SRH topics and are consistent with another study conducted in a rural setting in Cambodia, which observed that some married women believed that it was inappropriate for unmarried women to discuss contraception (Sreytouch, 2008).

During follow-up interview, girls reported that SRH education in school is limited or rarely discussed and both girls and boys are shy when these topics are brought up in school and that they “don’t dare to ask any questions.” One girl noted that some teachers are also shy to discuss these topics with their students. These findings indicate that SRH topics remain culturally sensitive, and because of this, girls continue to face barriers to essential information that could help them to make informed decisions about their health.

In addition, about half of the girls in this study left school during or just after completing primary school, indicating that many girls miss out on lessons related to sex, reproduction, and pregnancy that are provided during secondary



school. The findings lend support to strengthening SRH and comprehensive sexuality education (CSE) at primary and secondary school levels, as well as in non-formal, community-based settings (Kenny et al., 2019).

Girls faced barriers to contraceptive access and use

For girls who were not planning to get pregnant, lack of knowledge about pregnancy risk and contraception was one of the main barriers they faced to accessing and using contraceptives, both within and outside union. The findings are consistent with the latest quantitative data from the Cambodia Demographic and Health Survey, which found that adolescent girls aged 15-19 had the highest unmet need for family planning among all women of reproductive age (NIS, MoH, and ICF, 2022).

Others have found that Cambodian adolescent girls and young women (aged below 30) have low autonomy when it comes to accessing health care, which is associated with an increased risk of unintended pregnancy (Rizvi, Williams, and Hoban, 2019). In the study follow-up participants reported that health care providers ask a lot of questions if a girl is unmarried and wants to access contraceptive methods. This makes some girls feel reluctant to access contraceptives at health centres as they worry about their confidentiality, and also because some health care providers know the girls personally.

Among girls who were married or cohabiting, even where there was some awareness about modern contraceptives, another barrier to access and use was the girls' concerns about contraceptives "causing infertility" and "harming the uterus". These concerns were the result of myths about possible side effects. Follow-up participants confirmed that some girls are aware that modern contraceptives are available at health centres, but many do not access them because they have heard myths about side effects and are afraid of them. This was linked to personal, partner, and family expectations of childbearing soon after marriage, which (combined with their lack of knowledge about contraception) also deterred girls from attempting to access or use contraceptives even when they personally did not want or feel ready to become pregnant. This aligns with the findings of Rizvi et al., (2020) using data from Cambodia, that unmet need for contraception is higher when there is discordance between the wife's desire to space or limit births and her husband's desire for more children. The findings show that girls need access to non-judgemental, adolescent-responsive health care, as well as supportive relationships and enabling environments where they are empowered to make their own reproductive decisions.

Girls' agency and decision-making is influenced by social norms

The study found that girls had varying levels of agency and decision-making power in their relationships, especially regarding if and when to get married and get pregnant. This was affected by social norms and girls' obedience to their parents and elders. In Cambodia, the minimum legal age of marriage is below 18 years, and as such, one in five girls in Cambodia are married by the time they turn 18 years old (Girls Not Brides 2023). In the study, girls reported that child marriage and early union was common in their communities, particularly in settings where child marriage practices are embedded in tribal culture. Because of this, some girls agree to arranged marriages, or were married off without any real say in the decision, in accordance with cultural

practices and traditions. Most of the girls in this study then became pregnant within the context of child marriage and early union.

During follow-ups, some participants felt that girls should have more control over who and when to marry and that parents should not make this decision for them. They believe that forcing girls into marriage without love may result in unhappiness and lead to domestic violence. Yet, some participants also felt that girls should follow their parents because they are older and "know better."

These findings indicate that harmful norms and practices that support child marriage and early union, and traditional values that compel daughters to obey their parents' wishes, remain important drivers of adolescent pregnancy in Cambodia (Girls Not Brides, 2023). Social norm transformation will be necessary to curb adolescent pregnancies.

Barriers to education limit girls' life choices

Many girls had left school for other reasons before they entered a union or got pregnant, most often due to financial issues. This is consistent with quantitative data on Cambodian girls' lower and upper secondary completion rates, indicating that only two in five girls complete lower secondary school, and only one in five girls complete upper secondary school – both of which are far lower than the regional average for the East Asia and Pacific Region (UNICEF, 2021). It was within this context that girls in the study entered a union or got pregnant, indicating that for many girls, early school leaving due to poverty is a key contributing factor in girl's pathways to adolescent pregnancy as well as child marriage and early union. Girls recognized this relationship between education and pregnancy or union, as during follow-ups, participants noted that helping girls to get higher education and become financially independent or have a good job might help them to have more decision-making control over who and when to marry, and subsequently, if and when to begin childbearing.

Limitations

A key limitation of conducting interviews over the phone (in response to COVID-19 restrictions and exposure risk) was that interviewers were constrained in the level of rapport and trust that they were able to establish with each participant, particularly when it came to discussing their sexual history and details of those experiences. About half of the participants offered some detail about their first sexual experiences, but the other half (all from within-union pregnancy pathways) did not, with a few girls explicitly stating that they were not comfortable discussing sex. For this reason, consent to sex was not used as a decision point for differentiating pathways to adolescent pregnancy in Cambodia. However, it is important to note that eight girls in the study reported experiencing pressured sex and marital rape.

Adolescent girls' recommendations for programmes and policy

During follow-up interviews with 19 participants, girls provided their recommendations on how best to help girls like them:

Teach girls about SRH, including contraception

Follow-up interview participants recommended the implementation of outreach activities for girls, boys, and their parents/elders about SRH, covering topics such as sexually transmitted infections (STIs), HIV, sex, and reproduction. Girls would also like to learn more about where to access and how to use contraceptives. Aside from these, they believe that information and education campaigns (IECs) should discuss the consequences of child marriage and early union, and the benefits of delaying first pregnancy. Girls want to learn about these topics from their mothers, female elders, and health care

providers, and from their schoolteachers. They also conveyed that they would like for IEC resources to be available both in print and online.

In support of the girls' recommendations, this study's working group recommended that IEC materials should be developed using a holistic communication approach, which aims to simplify materials to make them easier for girls, boys and their parents and elders to understand. The IEC materials can be developed in English but should be translated to Khmer or ethnic languages before distributing in the community to ensure that young people understand. The IEC materials should also include links to and details about organizations that can provide further information and support.

Help girls to stay in school and find good jobs to prevent child marriage

Follow-up interview participants recognized that helping girls to stay in school and become financially independent/find good jobs may help to keep them from marrying at a young age.

Empower girls with life skills training to have more say in key life decisions

They felt that teaching girls how to assert themselves to their partners and families, and about their SRH rights could help girls to have more say in when to have sex and get pregnant. Assertiveness and life skills training could help girls to better express their views and preferences in their relationships, identify and develop their life skills, and become financially independent.

Provide support to young parents

For those who are already parents, participants suggested that it would be good for girls to learn how to raise children, and about young motherhood and a baby's health. They also suggested that it would be good for boys to be taught how to care for and support their wives or partners and babies.

Implications for research and practice

This study found that in Cambodia, pathways to adolescent pregnancy were facilitated mainly by child marriage and early union, but for a small subset of girls, pregnancy outside of union facilitated child marriage. While it was more common for unions to be couple-led, many girls were compelled to marry through arranged or parent-led marriages; adolescent pregnancy often occurred soon after marriage or cohabitation. Meanwhile, for a smaller group of girls, unplanned pregnancy was a direct result of contraceptive non-use, largely due to lack of knowledge about SRH. Future research on the prevalence of these pathways to adolescent pregnancy at the national level in Cambodia would be helpful for ensuring that interventions are appropriate to girls' specific needs and contexts.

Our findings provide evidence that CSE for adolescents needs to be strengthened in school and made available to girls and boys through other programmes outside of school, especially in settings where early school-leaving is common. Given that many girls stop studying after primary school, it is imperative that CSE is strengthened especially at the primary school level, to ensure that girls are equipped to make informed decisions about their SRH even if other circumstances preclude them from pursuing further education.

Toward empowering girls to access and use contraceptives, girls need access to non-judgemental, adolescent-responsive health care and an enabling environment. Social and

behaviour change (SBC) campaigns could be implemented using gender-transformative approaches to help address harmful social norms that encourage girls to marry and begin childbearing early. SBC campaigns should include modules and sessions with girls, girls' partners and families, teachers, health care workers and other key stakeholders and influencers in the lives of adolescents. In CSE-strengthening and SBC initiatives, it will be important to cover topics regarding healthy relationships (including how couples should have discussions regarding sex, contraceptive use, marriage and union, pregnancy) and how parents should approach discussions with their daughters on relationships and topics related to SRH. It will likewise be important to supplement these efforts with policy and advocacy around the need to transform harmful norms that support child marriage and early union, and challenge expectations around pregnancy immediately after marriage (particularly for adolescent girls), to create a more enabling environment for girls to make their own informed decisions about if and when to use contraceptives, get married, and begin childbearing. Future research could also look into developing a deeper understanding of unmarried and married girls' constructions of consent.

Finally, the study found that girls face barriers to education that are limiting their life options and contributing to their pathways to adolescent pregnancy and child marriage and early union. In line with the recommendations of the participants, the findings support the implementation of programmes that focus on keeping girls in school and developing their livelihood skills to prevent adolescent pregnancy, and the provision of parenting support to girls who are already pregnant, and their partners.

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