

Managing adolescent pregnancy: The unique roles and challenges of private general practitioners in Malaysia

Malek KA, Abdul-Razak S, Abu Hassan H, Othman S

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Authors:

Khasnur Abd Malek

(Corresponding author)
MFamMed, FRACGP, MBChB
Universiti Teknologi MARA
Malaysia
Email: Melkay03@gmail.com

Suraya Abdul-Razak

MFamMed, MBChB
Universiti Teknologi MARA, Selangor
Malaysia

Hasliza Abu Hassan

MMed Fam Med (UKM), MBBS
(Malaya)
National Defence University
Kuala Lumpur, Malaysia

Sajaratulnisah Othman

PHD, MFamMed, MBBS
University of Malaya, Kuala Lumpur
Malaysia

Abstract

Introduction: Managing adolescent pregnancy in the primary care setting is complex, as it requires doctors to navigate through a combination of medical, social, financial and legal needs.

Objective: This study explores the perspectives of private general practitioners on their roles and challenges in managing adolescent pregnancy in Malaysia.

Methods: Nineteen private general practitioners in Selangor and Kuala Lumpur participated in in-depth interviews in 2015. A topic guide was used for interview navigation. Participants were asked to discuss their experiences and approaches in managing pregnant adolescents. We used purposive sampling to recruit consenting private general practitioners who had experience in managing adolescent pregnancy. The verbatim transcripts of the audio-recorded interviews were analyzed using thematic analysis. Data reached saturation at the nineteenth in-depth interview.

Results: Two themes emerged. Under the theme ‘inadvertent advocator,’ participants described their tasks with regards to building trust, calming angry parents and delivering comprehensive counseling and care related to the sexual and reproductive health of adolescents, including requests for abortions. Theme two, ‘challenges of private general practitioners,’ refers mainly to personal and religious conflicts arising from a request for an abortion and deficiencies in support and multidisciplinary integration within their practice settings.

Conclusion: General practitioners practicing in the private sector identify themselves as active players in supporting pregnant adolescents but face many challenges arising from the personal, religious, professional and community levels. Addressing these challenges is important for optimal care delivery to pregnant adolescents in this community.

Introduction

Adolescent pregnancy is commonly unplanned and unwanted. It predisposes these adolescents to distinctive risks which require a unique element of care and deserve to be managed by skilled antenatal, childbirth and postnatal care personnel.¹ Adolescent pregnancy is complex, as it is often associated with late presentations to health facilities, lower attendance at prenatal classes, and high-risk pregnancies. Therefore, it is not uncommon for an unplanned adolescent pregnancy presentation to lead to a challenging consult.

These challenging adolescent consultations need to be tackled. General practitioners (GPs) may use variations on consultation skills to gain understanding of, and in

supporting, adolescents. One technique which can be utilized is placing a greater emphasis on communication, which can lead to shared decision-making processes. Such a result is evident in patient-centered care (PCC), which emphasizes the partnerships between patients and healthcare professionals and acknowledges patients’ preferences and values, which, in turn, promotes flexibility in the provision of health care (**Figure 1**). In primary care, PCC has resulted in significant benefits for patients; however, several challenges can limit the effectiveness, including time limitations and work pressures, both of which may make the doctor-centered approach seem more attractive. This qualitative study examined GPs’ experiences and challenges within consultations in which adolescents presented explicitly with either planned or unplanned pregnancies.

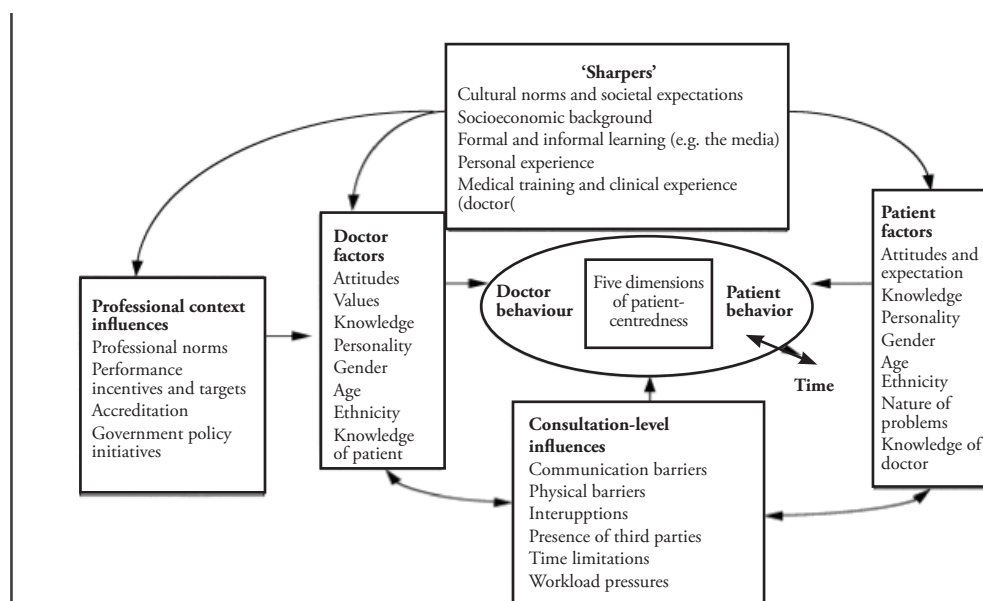


Figure 1: Factors influencing patient centeredness. Permission to reproduce the framework was received from Elsevier (license number 4492761078857).

Given adolescents' unique developmental status, as well as their physical and emotional needs, their health is best addressed through a multidisciplinary (MDT) approach utilized by teams of social workers, counselors, district nurses, primary care doctors, obstetricians, pediatricians and psychiatrists, among many.^{4,5}

Within the developed countries, GPs are part of the MDT team handling adolescent pregnancy. A bulletin from GPonline of the United Kingdom⁶ highlights the crucial role GPs play in linking pregnant adolescents presented to them to the relevant MDT team members. Equipping MDTs with knowledge, skills and guidance to manage adolescent pregnancy is important, as evidenced by the many comprehensive clinical guidelines produced within the United Kingdom and Australia.^{4,5}

Malaysia has both public and private primary care health providers. Since private GPs are independent health care providers, they are perceived of as offering a higher degree of confidentiality and privacy. Studies have shown that attending clinics that allow out-of-pocket payments overcomes concerns over confidentiality. This technique was perceived of as providing more confidentiality, as no insurance company is involved.⁷ Moreover, private GPs with urban practices have the additional advantage of being able to offer ease of access to patients.⁸ They outnumbered the public clinics by a ratio of 6:1.⁸ However, unlike the case of public-sector physicians, who are supported by guidelines and ease of access to MDT teams,⁸

little is known of private GPs' access to support systems. It is therefore timely to explore how private GPs perceived their roles and challenges in their encounters with adolescent pregnancies. Doing so will help health policy makers enhance comprehensive care for adolescents.

Methods

GPs in the private setting were purposively sampled via a snowballing technique. Each potential participant was asked if he or she had any experience managing cases related to pregnancies among individuals between the ages of 10 and 19 years.⁹ The first participant was identified by the researcher through an established private GPs network. Having established a rapport and their trustworthiness with the first individual, the researcher then went through the network one person at a time to identify other individuals who would be interested in participating in the study. This process continued until data became saturated at the nineteenth in-depth interview (IDI). The interviews were conducted at the participants' clinics towards the end of the clinic consultation period. The IDI format allowed the participants to express their experiences in detail and voice their views openly regarding adolescent pregnancy.¹⁰ The IDI started with participants answering some questions regarding demographics and their clinical practice, including years of general practice experience, type of practice (solo versus group practice) and the volume of adolescent cases in their practice.

The principal researcher and a trained research assistant conducted the interviews, which were guided by open-ended questions.¹¹ The topic guide included an exploration of a GP's experience in managing an unplanned adolescent pregnancy, the perceived health needs of adolescents and their role and challenges within the support system (**Table 1**). Interviews were conducted in English, with each interview lasting between 50 and 90 minutes. All IDIs were audio recorded with permission, transcribed verbatim and anonymized. A token of appreciation was offered at the completion of the interview. The completed transcripts were returned to participants to be checked.

The researcher and the other team members used a descriptive thematic approach to data analysis. They familiarized themselves with the data by systematically reading the transcripts and searching for emerging patterns. They coded phrases or short sequences of text. The occurrence patterns of these codes were identified, and the codes sharing similar meanings were further combined into categories. Themes were developed based on the broader concepts represented by categories with similar foci.¹²

Table 1. Questions used to guide interviews.

• Can you share your recent experiences in handling matters related to adolescent pregnancy?
• What do you think about it?
• How did you feel when you handled the matter?
• What are the common needs posed by the pregnant adolescent, parents or relatives in your clinic?
• What is your role in handling unplanned adolescent pregnancy?
• What support do you have in handling unplanned adolescent pregnancy?
• What resources do you have in handling unplanned adolescent pregnancy?
• What difficulties do you commonly face in handling unplanned adolescent pregnancy?

Ethical oversight

This study obtained ethical approval from the Universiti Teknologi MARA Malaysia (UiTM) Research Ethics Committee. Written consent was obtained from each participant prior to the interview sessions.

Results

The participants' demographic characteristics are summarized in **Table 2**. Eight female and eleven male private GPs participated in this study. Clinical experience with regards to general practice involvement ranged from two to 31 years (mean= 14.7 ±8.4 years). All except three participants ran solo practices. Managing adolescent pregnancy ranged from between 1% and 40% of their adolescent cases. More than three-quarters of the participants had been part of a government multidisciplinary team for the management of adolescent pregnancy when they were in the public sector.

Table 2. Demographic characteristics of the private general practitioners (N=19).

ID	Gender	Age (Years)	Ethnicity	Experience as a GP (Years)	Type of practice
001	F	58	Malay	19	Group
002	F	44	Malay	13	Solo
003	F	52	Malay	10	Solo
004	M	39	Chinese	6	Solo
005	M	34	Malay	2	Solo
006	M	65	Malay	28	Solo
007	F	37	Malay	9	Solo
008	M	68	Indian	31	Solo
009	M	54	Indian	25	Solo
010	F	51	Malay	19	Solo
011	M	48	Indian	20	Solo
012	M	49	Indian	18	Solo

ID	Gender	Age (Years)	Ethnicity	Experience as a GP (Years)	Type of practice
013	M	51	Malay	18	Group
014	M	47	Malay	18	Solo
015	M	67	Chinese	10	Solo
016	M	43	Indian	10	Group
017	F	43	Malay	7	Solo
018	F	56	Chinese	9	Solo
019	F	38	Malay	22	Solo

Two themes emerged from this study; the first was “an inadvertent advocator,” and the second was “challenges of general practitioners.”

An inadvertent advocator

Participants perceived their roles to consist of more than just taking care of the usual daily minor health issues. They saw the responsibility of managing adolescent pregnancy as something bigger involving the future life of their patients. Despite the limitations of a general practice setting, all the participants admitted that they pushed the limit to attend to the needs of these adolescents.

Bridge the tension between patients and parents

Unplanned adolescent pregnancy is a complicated matter. Beyond the confusion of the physical and mental changes due to pregnancy, both pregnant adolescents and their parents were in shock and at lost as to how to solve the issues surrounding the pregnancy. Emotions ran high in consultations, with expectations from parents that could sometimes be inappropriate, abrupt and dangerous for the patients. The tensions between the adolescents and their parents were heightened, especially when adolescent patients denied prior sexual encounters.

“...actually, she came with her mother. She was supposed to sit for her SPM. They wanted to abort the baby. So, the result, I told her, it was not possible. She was already 4 months, and she is a teenager. I told her, you better consult the O&G specialist to get their opinion and to find out the best option for you. So, I referred her to the hospital.” (Dr. 012).

“... they [referring to adolescents and their families] were sitting there. Emotionally in pain and confused, you know. Didn't know what to do.” (Dr. 018)

“You know, the girl denied that she ever had sex before. Most of the time, it is anguish. It was

terrible. It was a very emotional roller coaster, and I felt for the parents.” (Dr. 011)

The initial task of the participants was to calm everyone down so that appropriate actions could be discussed. The participants perceived the need to deal with the blaming issue, thus preventing the escalation of anger and redirecting the focus towards future management.

“I want the father and the mother to interact together, so we can curb the problem of blaming the adolescent. This thing [pregnancy] has already happened, so you have to move forward from there.” (Dr. 012)

Become “the trustful friend”

In another situation in which an adolescent appeared without their parents or guardian, participants highlighted the importance of establishing trust with the adolescents when pregnancy is first discovered. The trust allows disclosure of the pregnancy and matters that concern the adolescents. They became a ‘trustful friend’ to the adolescents to prevent the adolescents from shying away from them and their support.

“The first thing we need to do is to be their friend, ok. To be their friend so that they can trust us. We tell them that whatever their problem is, it is confidential. So, they may open up to us.” (Dr. 001)

Spend time exploring the insights of the pregnant adolescent

Participants also reported having a role in exploring the insights of the pregnant adolescents and providing possible options for going forward. The best interests of the adolescents were the aim, despite the extra demand added to their existing clinic loads. In contrast to the routine consultation time of 15 minutes, attempting to support the unplanned pregnancy of an adolescent largely takes up more than an hour of their consultation time.

“She (the adolescent mother) pleaded with me to help her...I even sat down with her for quite a long time, asking her [about her] concerns.” (Dr. 017)

“I will check with the parents, spend time with them, talking and discussing with them on what are the best ways. Then again, decision making and thinking takes a lot time.” (Dr. 018)

Participants reported that most patients and their parents resorted to the idea of terminating the pregnancy as an easy way out of the complicated situation. Considering the limitations of their practice settings, the participants provided referrals to reputable maternity or tertiary centers for terminations, as they were concerned about the possibility of adolescents resorting to backstreet abortion centers.

“For those who are pregnant, normally they wanted abortions. They come to the clinic, and they say they just wanted an abortion.” (Dr. 001)

“You see, what I worry about here is that there are multiple centers that do it (abortion), and they would do it properly, but, at the same time, there are centers where you are uncertain of their reputations and qualifications. I worry about what is going to happen to these girls, alright? You know, you can get infection and bleeding. So, I do tell them that if they want to go, try to find a maternity center. Cuz I am really against them going to these small backstreets” (Dr. 002).

Advocate the safest options for the patient

In certain circumstances, the termination of a pregnancy was not an appropriate option since the pregnancy was too advanced for a safe abortion. Participants perceived the importance of informing these adolescents of the harm involved in advanced-gestation abortions and provided other possible options.

“Her friend forced her to come to see the doctor because they did not know what to do. She was 8 months pregnant. She was shocked by the news because there was not enough time for her to prepare and all that.” (Dr. 017)

“At the time, she was about 6 months pregnant. I remember referring her to a place that provides care for unwed mothers. I think it was Raudhatul Sakinah.” (Dr. 003)

Adolescent access to continuous reproductive care at the point of contact was seen as an advantage. Participants were able to offer ease

of access to services related to intra-partum and follow up on reproductive care.

“I follow up and do everything, including the antenatal check-up. I do everything for them.” (Dr. 006)

“There were two or three adolescents who continued to obtain their reproductive care here with me.” (Dr. 010)

Challenges of General Practitioners

Managing adolescent pregnancies comes with many challenges for which participants voiced their need for guidance, support and integration into the multidisciplinary team.

Conflict with values

While the participants were aware on the legality of abortion, for some, supporting abortion contradicted their personal religious or moral values on the matter. These participants were more likely to counsel the adolescents and their families according to their personal values.

“I will ask the adolescent why she wants the abortion. If it is for health reasons, then that is ok but when it is not, I will not approve the abortion. My own religious belief is that you have already done one sin and then aborting the child is another sin. Two sins do not make one, right?” (Dr. 001)

“I ... practically do not encourage the termination of pregnancy ... because I think there will be lot more issues for the child (adolescent). They (adolescents)] will suffer later on. I will try to convince the parents to carry on with the pregnancy.” (Dr. 018)

These participants found themselves in a complicated position when the adolescents or their parents chose to abort pregnancies. Some participants were concerned about being accomplices if they provided direct referrals or resources for abortions.

“Abortion is illegal religiously. Sometimes, these teenagers will come to see me wanting to abort. So, if I see the heartbeat, I would say no. Heartbeat means life. You cannot remove or take away the fetus because life does not belong to you. God gave life, and it does not belong to you. I do not tell them where to abort or the abortion choices. I shouldn't. They shall have to find it themselves so that I am not guilty of the abortion.” (Dr. 006)

Others provided key advice in selecting a reputable maternity center so as to prevent adolescents from resorting to potentially unskilled practitioners.

“...it is a big concern (unregulated abortion centers), and if you don't want to tell them (about abortion centers), they will still go and hunt, alright. So, I do tell them that if they want to go [abort], try to find a maternity center. Cuz I am really against them going to these small backstreet kinds of clinics that do it ([abortion]), you know, quietly.” (Dr. 002)

Lack of guidance and support

Being in solo practice has been quoted as a challenge by the participants. The participants reported that care delivery for pregnant adolescents was somewhat limited by matters related to manpower, time and networking circles. Additionally, participants raised concerns over the lack of guidance they received, especially on the availability of standard procedures related to adolescent pregnancy. They were also unclear about where they stood in the network of agencies that dealt with the issues of adolescent pregnancy. These issues limited participants' capabilities in terms of extending their support to include matters related to the financial, emotional and psychological domains.

“Counseling, counseling and just discussing their options and what they can do about it and offering them a place to come to if they need further help. It is not easy you know, I must say. Because at that age there is also the money issue, the financial support, the emotional support, psychological support. Everything.” (Dr. 002)

“We need a counselor for counseling and support for the emotional wellbeing of the family. I cannot provide all these.” (Dr. 005)

“There is no proper black and white document or SOP [standard operating procedure] on what to do when you have this kind of problem. The relationship between NGO, government and all that is not clear. You see, if you have a communicable disease like dengue, you know what to do next. There is no guideline like this in this case.” (Dr. 007)

With limited resources within their own facilities, participants felt the dire need to access support from other networking agencies known to be supportive of pregnant adolescents. However, participants felt that it was challenging to access

these centers due to limited awareness of their availability.

“Adolescents need help. They need to know where to go, what to do and the kind of help they can get. I think the government did something. I think they did make a halfway home for pregnant adolescents, but I didn't know where the home was.” (Dr. 001)

“If the GPs can get the information and list of centers for us to refer pregnant adolescents to, then it would be easier on us. We really need to support them (adolescents).” (Dr. 014)

Therefore, participants saw tertiary centers as important links in the extension of care for pregnant adolescents, as evidenced by the many referrals made to tertiary centers for the continuation of support. However, two-way communications with tertiary centers remained a great challenge for the majority of the participants. In situations in which adolescents did not return for follow up, participants received no updates on them.

“I did not get the feedback. I don't know whether they (pregnant adolescents) get to see the person. She did not come back to me. I don't know what happened after that.” (Dr. 003)

Participants perceived that the care they furnished for adolescents' pregnancies could be expanded and enhanced further by including GPs in the private setting in the already established multidisciplinary networking teams as well providing them with direct access to counselor services.

“There need to be systems whereby when a referral from me is made to the tertiary center, I can simultaneously notify the counselor who would be anchoring the process, calling the family members and guiding them throughout every step of the process. Maybe this circle of networking could help.” (Dr. 016)

Discussion

Our interviews with nineteen GPs in private settings have helped us to better understand the unique roles and challenges of these GPs in their encounters with unplanned adolescent pregnancies. The participants tried to put forth a significant level of care for pregnant adolescents and their family members despite their limitations. Two key themes emerged in this study. Firstly, participants took up roles as inadvertent advocates to provide support

for adolescents and their family members. The second theme that emerged was the challenges faced in the delivery of care and support, which included dealing with conflicts in values and deficiencies in guidance from, and integration into, existing MDTs supporting pregnant adolescents.

Participants responded to adolescents presenting with unplanned pregnancies with great senses of responsibility. Within this study, participants identified their unique roles as inadvertent advocates. Their roles extended beyond the physical needs of their patients. They addressed and supported the heightened emotions, psychological distress and tension of the adolescents and their family members. Consistent with other studies, handling matters such as emotional turmoil^{13,14} and building trust with adolescents¹⁵ was common.¹⁶ These challenges are best addressed with effective communication skills, as consultations which address patients' perspectives and emotions with empathy¹⁷ have been shown to lead to increased physician-patient satisfaction^{18,19} and beneficial outcomes.³ Furthermore, participants' capabilities in terms of providing care at the point of contact and to offer follow up on ante natal as well as reproductive health care were seen as an advantage. Provision of reproductive health care has been proven to be effective in reducing repeat pregnancies.²⁰⁻²²

There is concern over handling requests for abortions, particularly among the participants who are against abortion personally. Objections to abortions are not uncommon, especially among those whose religion prohibits abortion.²³ Studies on doctors and abortion decision-making have shown, albeit in countries where abortion is legal, that some doctors do refuse to refer for or perform abortions.^{24,25} Other common reasons for opposing abortion are moral beliefs, the stigma associated with abortions^{24,26} as well as inadequate training, information and support.²⁷ It is imperative for private GPs to be aware of their values and recognize when to act on personal and professional stances. If a doctor's values are intertwined with adolescents' requests for abortions, then the adolescents should be referred to a health practitioner in the same discipline who does not share their conscientious objection.²³ However, such actions may be a challenge for the participants in our study context, as most of them work in a solo practice.

Referral for abortion or maintaining continuation of care can be challenging when participants find it hard to maintain communications

with tertiary centers, resulting in potential communication break-downs. Studies have highlighted the importance of communication between hospitals and primary care doctors, as evidenced by the strategies adopted for creating structured discharge letters.^{28,29} It is possible that the limited communications between the GPs and tertiary centers were due to the absence of a unified electronic system between hospitals and primary care providers within the local setting. However, there is a national development plan for interjurisdictional data sharing. Unfortunately, it remains a challenge to execute due to several reasons, such as operational costs.³⁰

The majority of the participants in this study highlighted the need for a guided management protocol with contact details for liaison services. An unplanned adolescent pregnancy is a vulnerable period for the adolescent and necessitates care from trained providers who are best supported by specific guidelines informing them of optimum care.³¹ Local comprehensive protocols related to adolescent reproductive health are well established³² and practiced in the local public primary care health clinics. Unlike their public sector counterparts, private GPs do not have these protocols readily available in their clinics, possibly because they are independent of the Ministry of Health and may not be automatically included in the distribution of guidelines published under the auspices of the ministry unless they have asked to be included. Therefore, sharing of available protocols, relevant national guides and training on sexual reproductive health through regular continuing medical education could potentially be the way forward in terms of addressing these challenges, which, when addressed successfully, can result in the improved quality of life and health outcomes for these adolescents.³¹

Given the results of this study, MDT may provide a platform through which private GPs can access immediate referral support. Having a clear notification pathway from GPs to MDT teams has been proposed by this study's participants as a way to improve their access to linkages and referrals and, most importantly, enhance their management of unplanned adolescent pregnancies. In particular, a strong link to an immediate counselor can potentially alleviate the burden carried by private GPs managing vulnerable cases of adolescent pregnancies. An MDT approach catering to pregnant adolescents' needs is essential for comprehensive, continuous and time-sensitive management of early pregnancy.^{31,33-35}

We would like to acknowledge the limitations and perspectives that were present in our study. One of the limitations was the absence of participants who had not managed adolescent pregnancies. Such participants may have presented the challenges of not managing adolescent pregnancies. Secondly, our focus was on private GPs and snowballing resulted in a narrow sample from two urban areas in Rawang and Gombak. When the private GPs in these areas were interviewed, they appeared to be dealing with more unplanned than planned pregnancies. Thus, the perspectives discussed here may not represent private GPs working in other areas of Malaysia or within the same area dealing with planned adolescent pregnancies. In addition, we did not attempt to examine differences in perspectives based on participants' characteristics such as gender, ethnicity or age. This is an important area for further exploration in future research.

In acknowledging our own values and perspectives, we hold that private GPs may face greater challenges in their encounters with adolescent pregnancies due to limited resources available in their settings. The findings described in this study reflect our multicultural perspectives and our biases as individuals, parents and primary care doctors within our defined community and society, perspectives and biases which we may or may not be conscious of. Finally, we acknowledged the difficulties in fully capturing the meanings of the interactions with the participants, meanings which may not be reflected in the written word.¹¹

Conclusion

In conclusion, the participants in our study acknowledged that their roles were important in the care of pregnant adolescents. They attempted to provide comprehensive care but lacked unique tools designed for teenage pregnancy. Challenges arose due to the limitations of their clinical settings, lack of manpower, inability to integrate into existing MDT teams and lack of access to guidelines. These findings may provide further input for policy makers to improve the resources, information and training provided to private GPs to ensure optimal care delivery for adolescents with unplanned pregnancies.

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How does this paper make a difference to general practice?

- This is the first study that explores in detail the issues related to the management of adolescent pregnancy in the private general practice setting in Malaysia.
- The findings provide an insight into the different ways private general practitioners manage adolescent pregnancy.
- This study highlights the need to support private general practitioners in addressing challenging issues such as pregnant adolescents requesting abortions.

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