

# Healthcare Professionals' Perspectives on The Provision of Sexual and Reproductive Health to Young People in Malaysia

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## ABSTRACT

**Objective:** In Malaysia, sexual health issues among young people encompassing premarital sex, the incidence of STI including HIV/AIDS, unintended pregnancy, unsafe abortion and the practice of baby abandonment. Little is known about the provision of sexual health care for young people since it has not been examined in-depth in a Malaysian context. This study aimed to explore the perspectives of healthcare professionals who deliver sexual health services provision to young people within primary healthcare settings which included schools as part of an outreach programme. **Methods:** This qualitative study used a self-developed topic guide for in-depth interview with twenty-four healthcare professionals of several government health clinics in Malaysia. The aim was to understand healthcare professionals' experiences of dealing with young people and their views on current sexual health services provision. The interview data were entered into Nvivo and analysed using thematic analysis. **Results:** The findings show that healthcare professionals regarded the use of the Adolescent Health Screening Form as a cornerstone for all initial interactions between and young people in health clinics. The findings also highlight the problem with an appointment system that includes lack of consultation times, privacy issues and the requirement of parental consent when dealing with unmarried young people. **Conclusion:** This study had recognized several facility-based obstacles that restricted sexual health services to young people in Malaysia. Their access to and the utilization of sexual health services are dependent on health care system improvement.

**Keywords:** Healthcare Professionals, Experiences, Perspectives, Sexual Health Services Provision, Young People, Malaysia

## INTRODUCTION

Malaysian is considered as a socially conservative society as evidenced by the statistics available for rates of premarital sex, while those for the numbers of abandoned babies are more difficult to determine. This situation shows that Malaysian society presents a complicated context for unmarried young people who are sexually active and who require sexual health information and

treatment.

In 1998, the Malaysian ministry of health (MOH) developed and tested the Adolescent Health Screening Form, Borang Saringan Status Kesihatan Remaja (BSSK/R/2008). It formally entered use in 2001 in all primary health clinics in Malaysia, including at schools, after a series of revisions by content experts based on the main areas such as nutrition, physical health, mental health and sexual health (1). According to the standard operating procedure produced by the MOH in 2012 regarding the use of the screening form at school, young people should undergo periodic screening on at least three occasions – in early (12 years old), middle (15 years old) and late adolescence (17 years old) – since young people typically face different challenges during their transition to adulthood.

In brief, the form consists of four sections that covers physical, mental, spiritual and social issues as a part of an adolescent's general health. Section

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A covers background information and Section B looks at the adolescent's health status, such as medical and surgical history and oral health. Section C covers eight elements of health risk assessment such as dietary intake, physical activity, sexual health, substance use, safety, spiritual, mental health and history of abuse. Section D reports the vital indicators of body mass index (BMI) and haemoglobin level. The sexual and reproductive health risk assessment includes seven questions that require 'Yes' or 'No' responses; for instance, problems related to genitalia for both boys and girls such as discharge, itchiness or painful urination. There are also specific questions for girls covering pregnancy, miscarriage, menstruation and breast changes, and questions regarding physical changes and pubertal status for boys, for instance, voice changes and enlargement of the testes and penis. Further questions asked regarding the reading or watching of pornographic material and masturbation and homosexuality. young people are required to respond to questions concerning their sexual relationships, number of partners, safe sex and contraception usage.

In 2012, the Malaysian MOH developed guidelines for managing adolescent sexual health issues in government primary health clinics. These guidelines contain a set of standard operating procedures covering the issues of unintended pregnancy, abortion, STIs and HIV, sexual violence and the provision of contraceptive services to young people irrespective of their marital status (2). Access to sexual health services is relatively unproblematic for young married couples because sexual activity is allowed within marriage in Malaysian society (3,4). The quality of the sexual health services that are available depends wholly on healthcare professionals' sensitivity with regard to universal access and uptake of the services by unmarried young people in particular (5). While there is growing interest in researching young people's sexual health issues in Malaysia, little attention has been paid to the views and experiences of healthcare professionals in providing sexual health information and services to unmarried young people in primary healthcare settings and the potential impact that such views may have on the delivery of services. Therefore, it is important that insight is gained, particularly into the views and experiences of healthcare professionals in providing sexual health services to unmarried young people in a primary healthcare setting.

## MATERIAL AND METHODS

### Study setting and recruitment:

This study was conducted with healthcare

professionals at four randomly selected primary health clinics in peninsular Malaysia. The primary health clinics provide a comprehensive range of services to approximately 15,000 to 20,000 people in larger towns and urban areas (6). The health clinics provide services such as maternal, prenatal, neonatal and child healthcare, school and adolescents healthcare, adult healthcare, geriatric healthcare and healthcare for people with disability (7). A total of twenty-four healthcare professionals who at least six months experience of providing sexual health information and care to young people were purposively sampled for the interviews. They were family medicine specialists, midwives, medical officers, public health nurses and school health nurses.

### Qualitative interviewing:

The researcher conducted in-depth qualitative interviewing with the healthcare professionals' in their workplace. The interviews were guided by a topic guide based on the objectives of the study. Moreover, the interview guide was developed following clarification of the ideas about the topic and referred to the literature review that focuses on healthcare professionals' perspectives, attitudes and experiences of sexual and reproductive health information and treatment to unmarried young people. Qualitative interviewing was selected as it provides a method for collecting rich and detailed information about how the healthcare professionals experience, understand and explain events with regard to sexual health provision in a healthcare context(8). Qualitative interview provides the interactive space and time required to enable the healthcare professionals' views and insight to emerge. It helped to elicit the healthcare professionals' responses and discourses that flowed from their multiple identities and social context. The healthcare professionals' responses echoed a shared discourse tied to one or more identities. Yet, 'as an emergent event, an interview conversation may elicit the participant's reappraisal of a taken-for-granted discourse and its social foundations'(9).

The qualitative interviews need to have a certain degree of structure, although they should be participant-directed (10). The researcher began each interview by asking the healthcare professionals a broad question aimed at identifying what they do and how they achieve the provision of sexual health. This contrasted with enquiring about what they are not doing and why based on the evidence-based practice. The researcher asked participants to describe the kind of support they provided to unmarried adolescents who required sexual health advice and/or treatment. This question allowed the participants to discuss their experiences in

providing sexual health support to young people. The researcher also prepared a set of follow-up questions or prompts in order to obtain optimal data from the participants. This facilitate a more focused exploration of the specific topics and to follow up on the specific issues that emerged during the interview. This approach permitted the thick description of the healthcare professionals' behaviours, beliefs and the context within the healthcare setting which in turn led to an in-depth understanding of the issues being studied (11).

#### **Data analysis:**

The thematic analysis was used as a guide for analysing the interview data and it was conducted simultaneously with the data collection (12). This was helpful in identifying the preliminary themes, thereby enabling unexpected issues to be included and explored in the subsequent interviews. The researcher promptly analyzed the data by a coding process after having completed the translating process. During the data analysis stage, the researcher was interpreting the participants' accounts and for constructing the meaning as wholly as possible based on the participants' perspectives. The process involves making sense of the raw data collected in textual forms such as interview transcripts, field notes, reflective diaries and memos by thoroughly scrutinizing and interpreting them (13). Code (HCP01, HCP02) were used when referring to the direct quotation from the interviews to avoid identification of participants.

#### **Ethical consideration:**

The approval for this study was granted by the University of Manchester Ethics Committee (UREC) and Medical Research Ethics Committee Malaysia (MREC). The researcher obtained the approval of the Director, Health Department for initial access to the healthcare professionals working in the primary healthcare system. Good rapport and sensitivity to the specific dynamics of each interaction are important which in this case would encourage the healthcare professionals to talk openly about their experiences and views regarding the provision of sexual health for young people in Malaysia. The researcher assured the participants of their right and opportunity to object to any questions posed during the interview (14). A good relationship with various healthcare professionals working in primary healthcare enhance the collection the collection of relevant and meaningful data from each individual participant (15). The researcher applied interpersonal and interviewing skills to encourage the participants to engage in the interview and to maintain an equitable power relationship. The researcher also accorded priority

to the participants in deciding the location of the interview, the most convenient time and whatever other elements were comfortable for them. The participants were at liberty to withdraw from the study even though they had provided signed consent.

#### **FINDINGS AND DISCUSSION**

The Adolescent Health Screening Form often triggered the healthcare professionals' interaction with young people regarding sexual health during their school health visits. Although the use of screening form triggers a response with regards young people health, but the content or the question asked framed the issues of sexual health as problematic. Thus, some of the healthcare professionals reacted by targeting schools for discussion about these 'problem'. For instance, one of the school health nurses explained that the Adolescent Health Screening Form was also used at school to determine the sexual health information that needed to be delivered to the schools under their clinic coverage.

*I distributed the screening form to the students at most of the schools under our clinic supervision ... so under the section of sexual health, if we found out many students reported they were ever involved in masturbation, premarital sex, gay, lesbian, we give a priority to that school for a health talk on specific problems related to sexual health. (HCP24, School health nurse)*

The narrative suggests that homosexuality, masturbation and premarital sexual activity are 'ill health problems' and was perceived as social issues that require a targeted response in terms of health education from the school health team. It indicates that, healthcare professionals targeted high-risk young people instead of general young people for health education based on the nature of sexual health questions in a self-reported Adolescent Health Screening Form. In this respect, young people at schools are expected to receive comprehensive sexual education from healthcare professionals to enable them understand their values, learn relationship skills which would help them to resist from becoming sexually active before they are ready, to prevent from unprotected sexual intercourse and to help them becoming responsible towards their sexual health(16).

The medical officer explained that an adolescent aged between 10 and 19 years who came to the outpatient department with a minor illness such as a mild fever would also be asked to complete the Adolescent Health Screening Form.

*young people who come here with a minor illness have to fill in the adolescent health screening form while waiting for their turn to see the doctor. In terms of their sexual health, sometimes we found out that young people reported that they ever had sexual intercourse either with a single partner or multiple partners or having a symptom like a vaginal discharge. For cases like this, I will give another appointment because the focus should be on the current health problem and explain to them why they need to come back. (HCP07, Medical Officer)*

She mentioned treating the young people' acute illness and then providing them with another appointment for a consultation regarding any sexual health issue that was detected from the health screening form. It should be noted that health screening conducted at health clinics is carried out on an ad hoc basis, particularly among late-stage young people and those who are working or not schooling who go to the clinic for minor treatments (17). According to the SOP, healthcare professionals have to decide whether to provide treatment, a referral or to schedule a further appointment, depending on the diagnosis and the seriousness of the problem. This indicates that the screening form is used for appointments or referrals, which is important for young people to access the health clinic.

### **The problem with follow-up appointments**

#### **Clinic timing**

One of the key issues for the young people who received follow up appointments at the nearest health clinic is inappropriate clinic timing. For instance, health clinic sites 2 and 3 had flexible times from 0900 to 1700 Monday to Friday, while health clinic site 1 had specific times three times per week (Monday, Thursday and Friday) from 1400 to 1700 which were inconvenient for those in certain employment and school sessions, thereby leading to more default treatments or follow-ups. The medical officers recognised the difficulties with this system, which included the delays in reviewing the forms:

*Actually, from the screening form, it is good if we can intervene immediately, but unfortunately, we cannot do for all students as it clashes with another routine like physical assessment and injection. We had to bring the form back to the clinic. Sometimes, we go through that form quite late. (HCP10, Medical Officer)*

*We use the form mostly in school, not in the clinic. If I am going to school, I will give advice immediately to them at the school. I also identify whoever needs to be referred for further assessment and inform their parents to bring them to the clinic. (HCP21, Medical Officer)*

Other participants highlighted a high defaulter rate due to the appointment system:

*young people admitted that they have a problem like insomnia, sleeping disturbance, drinking alcohol or delinquency from the screening form. So we asked them to come for further inquiry or psychoanalysis screening, they find it difficult to come, and default quite a lot. (HCP14, Assistant Medical Officer)*

*The problem with an appointment is some of them do not come to the clinic so that I will give another appointment. If they still do not come, I cannot do anything. We remind them a week, and even a day before the appointment date [...] Some of them tell us they are coming and they do not turn up. (HCP01, Medical Officer)*

The medical officer explained that young people show a lack of interest in coming to the clinic for consultation, and they do not attend follow-ups. She repeatedly remind young people about their appointments, as some of them do not comply with the appointment system. It was evident that the appointment system was a barrier to attendance, but the participants accepted the situation as typical for an appointment system. This situation is contributing to the delay in sexual health care seeking among young people, perhaps due to a perception of ignorance that they are healthy and/or by them not being convinced about the importance of continuing with their follow-ups.

Issues of clinic timings as a barrier to young people access to healthcare professionals have been widely reported in many articles.(5,18,19). In contrast to Brewin et al., in a qualitative study conducted among school nurses in the USA, found that sexual and reproductive advice was given informally to young people at any time of the day without an appointment schedule(20). The nurses commented about high young people uptakes with regards safer sex and contraception. This was convenient for the nurses in Brewin et al.'s study as they were based at a school; however, this is contrary to the school nurses in Malaysia, who are based at a health clinic.

#### **Long queues and lack of privacy in health clinic**

Another issue that emerged from the interviews with the healthcare professionals concerned long queues acknowledgement that there was often insufficient time for one-to-one consultations in the clinic.

One of the medical officers explained that dedicated STI-friendly clinics have a registration



counter that is separate from that of the general clinic's registration counter, to reduce the long waiting time. This encourages young people coming to the clinic to get support from healthcare professionals regarding their sexual health and ensures they have some privacy when attending the STI-friendly clinic. Yet, she also acknowledged the clinic's inconvenient operating hours for young people:

*As you can see, **many patients** are coming in daily, which lengthens the **patient waiting time**. So, we are trying to reduce our structural barrier. We need to give them an avenue to **come to the STI-friendly clinic**. It has their **own registration counter** as to provide them with an understanding that they can be brave enough to walk into a clinic to ask for assistance. Moreover, **8 to 5 pm is not convenient** for the student or certain types of occupation. (HCP11, Medical Officer)*

Another medical officer also expressed her concern that young people would be unlikely to attend for in-depth discussions, as the timing for consultation was short due to too many patients in the health clinic.

*In the clinic, the problem that we have is usually the time. We have **limited time** actually to explain all the things to young people. Even if they want to know more, it is tough for us to explain in detail. So, this is the problem in the health clinic; that is why we go to school. (HCP08, Medical Officer)*

It was clear that many healthcare professionals were perceived schools as more convenient places in which to provide sexual health information for groups of students. However, a common complaint concerned there being insufficient time to deliver sexual health information as the programme might clash with a routine school health visit.

*The time is **limited in the clinic** also time to go to **the school**. So far, after the training programme we had in December, I still haven't gone to school to give them information [...] providing sexual health talks at the school is the most appropriate, but we do have another programme as well running at the same time. We are going for **vaccination and medical examination**, we also have **HIV talk**, and now we have a **thalassemia programme**. So, I am not able to cover all schools for sexual health talks. I manage to give only **three or four sessions per year**. (HCP 21, Medical Officer)*

The medical officer revealed that she had still not been to a school to deliver the sexual health information at school. She reported that the school health team never had sufficient time because providing sexual health information was included

as an additional task alongside the regular tasks of physical examination and immunisation that they had to perform during a school visit. She explained about the limited number of sexual health information sessions that can be given per year, thus demonstrating the relatively low priority accorded to providing sexual health information at school under the school health programme.

### Parental consent issue

Several healthcare professionals expressed their understanding and concerns about parental participation in the decision-making regarding the young people's sexual health care and treatments that take place in the health clinics. For instance, Hakim appears to provide an explanation about the requirement for parental consent in order to prescribe any forms of contraception, counselling and testing to unmarried young people below the age of 18, which is based on the available SOP produced by the Malaysian MOH.

*If we come across a case like young people below 16 who are sexually active, regardless of the reason, it falls under statutory rape **where we should get consent from the parents or guardian** for management and treatment such as giving an oral contraceptive pills. A young person aged between 16 and 18 also needs parental consent, whereas for 18 and above we can provide contraceptives if they agree. (HCP14, Assistant Medical Officer)*

He appeared to understand how the parental consent requirement should be considered when dealing with unmarried young people in relation to their sexual health. According to the SOP for managing sexual health issues in a primary health clinic, medical officers and midwives have to refer unmarried young people below the age of 18 to family medicine specialists for further consultation in the clinic due to the parental consent requirement(21). Although medical officers and midwives have limited roles in managing sexual health issues for unmarried young people below 18, they reported having less experience in the referral of sexual health cases, perhaps due to underreporting, low uptake and the sensitivity of the topics.

One of the family medicine specialists who managed the only government-run STI-friendly clinic, explained that the clinic caters for sexually active people with or without symptoms, regardless of their age and marital status. She explained that the purpose of the STI-friendly clinic was to provide awareness about safer sex practices and STI prevention. She also explained

about the restrictions set by the Child Act 2001, whereby any testing or treatments require parental consent as young people are still considered to be children.

*However, when it comes to young people less than 18, we are sort of in the boundary. They usually come with friends; they do not come with their parents. So that is the major issue that we are facing in the clinic [...] I am afraid of the law as I cannot treat young people without the parents sitting there and so we have to talk in a way to convince them to bring their parents. (HCP13, Family Medicine Specialist)*

She reported that only a few young people attend with their parents and the remainder refuse to inform their parents because they might be afraid of the parents' negative reaction. This indicates that the requirement for parental consent prevents healthcare professionals from providing the appropriate type and quality of care in relation to young people's health. This also limits young people from having independent access to the health clinic.

She was concerned about the risk of diseases among sexually active young people and voiced her disappointment for not being able to provide any care or treatment without parental consent. She mentioned at least yearly follow-ups by only giving counselling about STI and HIV prevention without testing until they reach 18 years old. The time gaps between yearly follow-ups were too long and inappropriate to empower young people to lead a healthy lifestyle to prevent STI and HIV, particularly in the case of high-risk young people.

*I can go in two ways; first, I lose them totally if they do not involve their parent. Second, I can be diplomatic and try to keep them within care. So, we counsel them about STI if they are sexually active in a very unsafe method [...]. We want to test for STIs especially sex workers, as their risk profile is very high. Unfortunately, if they are below 18 years old, the law prevents us from doing any test without parental consent. Normally, they come here with a friend or NGO who is not a legal guardian and cannot make the decision. I will make sure they come back for the appointment every year basically to keep them coming until they reach 18. So once they are 18, then we can do whatever testing we want to do. (HCP13, Family Medicine Specialist)*

Although she commented on the difficulties associated with abiding by the law regarding parental consent, she actually agreed with the parents' right to provide a decision on behalf of their grown-up children. It is apparently socially acceptable within the Malaysian community for

parents to take a role in the making of health-related decisions for their children and young people below 18 years old (22). This means that, Malaysian young people are obligated to consult their parents on decision and treatment in terms of managing their sexual health, which in turn can be a barrier for the provider-young people's interaction. She also stated that parental consent is essential unless the parent is unwilling to get involved. In this case, healthcare professionals need to find a balance between their client's wishes and their responsibility to keep the adolescent safe from harm when engaging in unprotected sexual activity. She hoped that some flexibility would be accorded in order to overcome the conflict between parental consent and dealing with young people who are able to decide on their own.

*I am hoping that one day some leeway can be given to allow us to manage young sexually active young people with their permission, like the Gillick case in the UK. However, is that going to happen in Malaysia? Frankly, I do not think so. (HCP13, Family Medicine Specialist)*

The Gillick competence ensures that healthcare professionals can provide confidential medical treatment, advice and testing to young people under the age of 16 who have attained a sufficient understanding and intelligence to enable them to make the decision to receive a contraceptive prescription and advice without the involvement of a parent(23). In this way, young people who are sexually active will have the confidence to have early access to sexual health services to prevent unintended pregnancy and STIs. The specialist speculated that this initiative would be hard to apply in a conservative Malaysian setting, perhaps due to the fact that the adolescent is perceived as a child who lacks the maturity to make decisions and to understand the implications of such decisions. Such views need to be challenged by promoting empowerment to the parents, community and specifically to the young people with regard to their right to an sexual health education and access to services(24).

## CONCLUSION

The healthcare professionals reported that they rely on the use of national adolescent health screening forms to identify at-risk young people and to initiate interactions with young people who might not take up the services available to them in the health clinic. They also discussed the problems with follow-up appointments in a primary health clinic, comprising inappropriate clinic operating times, long queues and a lack of privacy, leading to insufficient time for consultation with young people. The requirement for parental consent for

young people below the age of 18 was also cited as an issue for healthcare professionals as they found it challenging to strike a balance between complying with the requirement and providing confidential sexual health services to young people. Hence, this study suggests that the policy and laws that require parental consent for accessing the services need to be reviewed and revised to ensure that specific services are available to unmarried young people in a safe environment that maintains confidentiality.

This study has revealed how cultural norms perpetuate a 'moral' approach in the provision of sexual health services to unmarried young people, and that most of the healthcare professionals involved have not been adequately trained to reflect upon the impact of such cultural norms on the health and wellbeing of young people. This limit both their confidence and competence related to the provision of sexual health information. These study findings appear to resonate with the initial understanding obtained from the literature, particularly regarding the organizational barriers in terms of the insufficient training for healthcare professionals in the area of comprehensive sexual health services provision to unmarried young people(25). It is recommended that, the healthcare professionals require opportunities for professional development in order to prepare them to work competently, sensitively and respectfully in the area of young people' sexual health needs, particularly with regard to safer sex and contraception and in order to avoid discriminating against unmarried sexually active young people. In doing so, they have the potential to act as a cultural change agent.

### Limitation of study

Being an 'insider' may be benefited for some researchers in terms of the familiarity of research settings (26) and easily building rapport with the participants (27,28). The researcher was an 'outsider' at the research sites but could be considered as 'insider' to the research participants due to having almost similar cultural and religious background with the Muslim healthcare professionals in this study. This means that having similar cultural and religious expectation informing about sexuality of unmarried adolescents posed a challenge to the research process during data collection, data analysis and writing up the article. To overcome this issue, the researcher shared most of the interview transcripts and reflexivity notes with team members who were not familiar with Malaysia context. This provides opportunity for the researcher to engage in critical

discussion with research team also reconsider the socially conservative views of premarital sex that oppressive to adolescent's sexual health rights.

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