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Influence of religion on healthcare professionals' beliefs toward teenage sexual practices in Malaysia

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Abstract

Background: Teenagers are influenced by their surroundings, and this may also include their sexual behavior or societal responses to this type of behavior. It is important to understand the complexity of religious mandates and sociocultural disapproval of premarital sex from the perspectives of healthcare professionals. **Methods:** This qualitative study aimed to explore the influence of religion on healthcare professional's beliefs toward providing sexual and reproductive health information and treatment. An interview topic guide was used in the in-depth interview of 32 healthcare professionals in several health clinics in Malaysia. The data were transcribed and entered into the NVivo 11 software. Thematic analysis was used to evaluate the data. **Results:** The findings show that some healthcare professionals positively incorporated Islamic beliefs into sexual health education session but excluded the contraception information. This study also highlights the strategies used by healthcare professionals (discourse on risk, being selective, maintaining their own honor) when providing sexual health services to teenagers. **Conclusion:** These findings revealed how religion perpetuates a “moral” approach in the provision of sexual health services that potentially affects teenagers' access to healthcare.

Keywords: sexual health, teenager, religion, healthcare professional

Introduction

Several studies have suggested that most major religions in the world, including Islam, Christianity, Hinduism, and Buddhism, discourage the practice of sex outside marriage, and personal interpretations of any faith vary from liberal to conservative in relation to the curtailing of this type of behavior.^{1,2} For instance, Muslims worldwide generally have similar basic beliefs on sexual relationships and contraception, although there are also different interpretations between Islamic scholars on this matter in line with local culture and traditions.³ Although Islam allows the teaching or provision of safer sex information to individuals as a health promotion strategy⁴ and attempt at preventing the transmission of HIV to other sexual partners,⁵ Muslim healthcare professionals may have different understandings and interpretations regarding what is good or bad for teenagers' sexual health, and this influences their approach to education and treatment at schools and health clinics.

Malaysia is a Muslim-majority country where sex is only considered lawful if it occurs within the context of marriage, indicating that entry into marriage is viewed as equating to consent to sex and exposure to

childbearing.³ Under Islamic (*Sharia*) law, the minimum legal age for marriage is 16 years for women and 18 years for men, although marriage is permitted below these ages with both parental consent and consent of a *Sharia judge*. Their judgment considers the presence of physical signs of puberty, such as menstruation in women. Regardless of religion, premarital sex, including same-sex sexual activity, is considered an immoral and sinful activity by the Malaysian society.⁶ A previous Malaysian study⁷ explored the views of professionals from various affiliations (public university, cultural center, government-based youth club, the Ministry of Health and the United Nations Population Fund Malaysia, the International Federation of Planned Parenthood, IPPF, Malaysia including nongovernment organizations) on the barriers of sex education to teenagers. It can be argued that these professionals provided insufficient information on their experiences of delivering sexual and reproductive health information to teenagers and limited insight into how their moral and religious beliefs may influence the provision of services provision. Thus, this study aimed to understand how Malaysian healthcare professionals' religious beliefs may influence the quality of sexual health information and treatment provided to teenagers.

Methods

Data collection process. A face-to-face interview of 32 healthcare professionals was conducted at their respective health clinics in Kuala Lumpur, Malaysia, between October 2015 and March 2016. An observation method may reflect concerns about confidentiality and privacy, which healthcare professionals need to maintain when dealing with teenagers with sexual issues. Thus, observation was not considered for this present study. Healthcare professionals consisting of school health nurses, nurses in charge of an adolescent health unit, medical officers, midwives, family medicine specialists, and teen educators from several health clinics were purposely sampled based on the inclusion criterion. The inclusion criterion was that the participants were qualified healthcare professionals with at least 6 months' experience of providing sexual and reproductive health information and treatment to teenagers in primary healthcare settings, including schools. The majority of participants were Muslim, and all were married with the exception of two unmarried participants. Three providers were Hindus, while one was a Christian. Only 3 men participated in this study. Participants' ages ranged from 20 to 60 years. They had experience of dealing with teenager health from one year up to 30 years.

All interviews were conducted in either English or Malay language based on the participants' preference, and each interview lasted for approximately 1 h to 90 min. The interviews were conducted at participants' workplaces at a mutually convenient time since they were held during working hours. The interviews were conducted in quiet and comfortable rooms at the respective clinics to prevent interruptions. Due to concerns about the conversations being overheard, the researcher also discussed with the participants the possibility of arranging a suitable alternative venue, such as another local health clinic or the researcher's office at the local university. However, none of the participants requested to be interviewed away from their workplace. The interviews were held in an informal way to create a natural feeling and make it comfortable for the participants to talk about their experiences.⁹ Individual semi-structured interviews were conducted, which allowed identifying nonverbal cues¹⁰, such as facial expressions and body language of the participants.^{11,12} This method also allows researchers to show their interest by nodding, maintaining eye contact, and smiling to encourage the participant to express their views and experiences.¹³ The researcher audio-recorded each interview with the participant's permission. The researcher personally transcribed the recordings in a private room using headphones to prevent the possibility of being overheard by others.

Data analysis. The researcher uploaded the English and Malay versions of the transcriptions, memos, and field

notes in Microsoft Word format into the NVivo 11 software to assist with the data management process and serve as an audit trail for the process of analysis. The use of the software for data management improves the rigor of the analysis.¹⁴ Different folders were created in the NVivo 11 software to separate the interview data into categories of participants. The researcher applied the steps of thematic analysis by previous study¹⁶ to gain an understanding of complex issues by identifying, analyzing, and reporting themes of sexual and reproductive health provision from the perspectives of healthcare professionals. The analysis was not a linear process but recursive throughout the six phases of thematic analysis: familiarizing data, generating initial codes, searching for themes and subthemes, reviewing, defining and naming the themes, and writing up.

Ethical consideration. Due to the small number of participants and requirement of "thick description," the possibility of the participant being identifiable is relatively high.^{17,18} Thus, the participant-related information that was recorded throughout the process of data collection and reporting of findings was maintained in the strictest confidence to ensure the participants could not be identified and would remain anonymous. Therefore, the participants' names never appeared on any document. The interview data (audio material and digital or paper transcriptions) were identified by a code number known only by the researcher (e.g., HCP01, HCP02). The interviews were audio-recorded using an encrypted tape recorder. For record keeping, all digital recordings, including personal information, were kept on a computer, protected with a password and accessible only by the researcher. The recordings, consent form, transcripts, field notes, and reflective diary and any printed copies of participant information were secured in locked storage in a designated location with no access to anyone except the researcher. The digital recordings and original data will be destroyed once the study is completed or no longer required after ten years.

Results

The results are presented and discussed in the following themes and subthemes:

Incorporating Islamic beliefs into sexual and reproductive health education sessions. Each religion serves as a belief system that guides its devout followers regarding sexual activity; as such, the influence of religion in individuals' lives cannot easily be denied.² HCP26 shared his thoughts regarding sexuality and Islamic perspectives by mentioning some popular Arabic verses from the Quran that relate to premarital sex:

"Amar ma'aruf, nahi munkar" (Enjoin good, forbid evil). We want to educate youngsters to enjoin what is right, forbidding what is wrong and believing in

Allah. We tell them “wala takrabul zina” (**do not go near adultery, fornication**), which means do not approach unlawful sexual intercourse; surely, it is an indecency and an evil way of fulfilling sexual urges...We refer to the “tarbiyahtul aulad fil Islam” book (Islamic education for children in Islam). It is mentioned in connection with sexuality. We had to convince people like parents or teachers that it is **not wrong to talk and discuss sexuality with the youngster**. We learn about “taharah” (purity and impurity), ritual bath after the end of menses, after childbirth and after sexual intercourse. It is all related to sexuality. We cannot deny sexuality education in Islam. (HCP26, teen educator)

The participant refers to a verse about moral education, suggesting that this forms a part of the role of healthcare professionals as guided by the notion that premarital sex is forbidden in Islam. The participant reflects on the concept of “prevention” from a second verse, whereby believers should distance themselves from any act that may lead to adultery or premarital sex. HCP26 suggests that it is important to discuss sex education with young individuals and that parents should be encouraged to do so. The discussion of sex education in the context of Islam was confined to information such as intimate hygiene, ritual cleanliness, and purity, and highlighting sexual abstinence outside marriage is the main approach. However, HCP26 did not mention the importance of knowledge and awareness of contraception as a way of preventing unwanted pregnancy, sexually transmitted infections (STIs), and HIV that can result from unprotected sexual activity. This indicates that strong religious beliefs may influence the types of information delivered to unmarried teenagers, which can lead to the view among healthcare professionals that comprehensive sexual and reproductive health education is immoral when it relates to teenager sexual practices.

HCP04 acknowledges the sexual health rights of teenagers, but she judged girls as lacking in shame for their sexual activity, commenting that some teenagers are involved in premarital sexual activity even though it goes against their Islamic beliefs.

*I cannot deny their (teenagers') **sexual health rights**...but deep inside they know that premarital sex is forbidden and is a great sin in Islam...they did not think about **religious transgression**. Nowadays, many teenagers are doing it consensually with their loved one without shame or fear of God. They come to us when they get pregnant (HCP04, midwife)*

HCP04 highlights a tension between her religious beliefs and professional duty and expresses awareness that there is a shift in the attitudes of teenagers away from the traditional toward the more liberal. Her approach seems inconsistent with the recommendation

of the Nursing Board of Malaysia's Code of Professional Conduct for Nurses (1998),¹⁹ which proposes respecting the client and ethically providing care without having a judgmental attitude. Respecting the client means that healthcare professionals prioritize their professional obligation and human rights as to protect teenagers from high-risk sexual behavior.

Some healthcare professionals incorporated Islamic teaching directly into their sexual and reproductive health sessions. HCP02 explained that questions about prayer form part of the assessment on the teenagers' health screening form, thus indicating that religion is a fundamental part of the interaction.

*We did ask about their spirituality or religious practice in the screening form. **Are they performing prayer?** All this can prevent them from doing this sinful activity. I will also emphasize about prayer and ask them to **think about their parents** if they wanted to have sex outside marriage, as this can prevent them from sexual activity. (HCP02, staff nurse)*

She felt obliged to advise teenagers to strengthen their prayer as this could prevent them from becoming involved in premarital sexual activity.

HCP17 explained that she advises teenager boys and girls to avoid socializing with each other since, in Islamic teaching, teenagers should avoid going to secluded locations together.

*I inculcate Islamic teaching in them, such as in friendships, don't go out together especially as a couple, they should bring someone else to accompany them whenever they go. I tell them nicely the consequence of not taking care of **the restriction in friendship**, especially with **the opposite gender**. (HCP17, school health nurse)*

She emphasized that girls should avoid mixing with boys since this might lead to physical contact, which may open up the chance for romantic intimacy or premarital sex and result in unwelcome “consequences.” Telling them “nicely” implies that she acts protectively by providing cultural and religious mores. There is a clear tension between their cultural, religious, and professional expectations, but it seems apparent that culture and religion dominated. The healthcare professionals perceived the concept of honor and reputation as being more important than their professional responsibilities, and this affected their interaction with unmarried teenagers. Hence, it is essential to raise awareness among healthcare professionals of religious stereotyping about sexual relationships and that religious views should not negatively affect the accuracy of the information given to young individuals.

Strategies used when providing sexual and reproductive health information. The healthcare professionals adopted several strategies when dealing with unmarried teenagers regarding sexual and reproductive health information and antenatal care for unmarried pregnant girls from the maternal and child health unit. It seems that some of healthcare professionals enter into discourse on risk, being selective about the information they give, trying to maintain young individuals' and their own honor and using scare tactics.

Discourse on risk. In the healthcare professionals' interactions with young unmarried girls, several of them reinforced punishment by God as a consequence of engaging in premarital sex, which they described as a sinful activity. HCP02 suggested that premarital sexual activity would result in an STI or unintended pregnancy, yet she did not discuss safe sexual activity with them.

*I tell them that this activity is sinful and they will **get something bad** from this like HIV or an STI. (HCP02, staff nurse)*

HCP04 also entered into a discourse on risk, stating that they can still contract serious diseases or become pregnant unintentionally, even though they know how to prevent it by practicing safer sex and using contraceptives.

*I believe many teenagers are involved in premarital sex and some of them know how to prevent pregnancy...I tell them "when you do not follow God's commandments, one day you will be **punished by God** by getting pregnant or getting HIV." (HCP04, midwife)*

In this way, HCP04 failed to be honest with teenagers by providing them information that deviates from the current scientific understanding of infection or conception. She appeared to contravene the ethical principles of medicine and nursing.

HCP13 cautioned teenagers to avoid premarital sex and warned them about getting the "same treatment" from their daughters in the future.

I told them: "You cannot do this (premarital sex), remember someday God will punish you by having your kids doing the same thing to you." (HCP13, school health nurse)

Being selective about sexual and reproductive health information and treatments. Several healthcare professionals withheld information regarding safer sex and contraception, as they believed that sharing such information would encourage sexual activity. HCP10 explained that the sexual and reproductive health information provided to teenagers at school and health

clinics did not include information about safer sex or contraception.

*When it comes to contraception, I would never say that to them...I am quite selective, mmm I am not giving them knowledge on safer sex and abortion...that is wrong [...] so **don't tell them about safe sex**...even about sex...I do not want to give them an idea of sexual activity...I would rather say about **sexual abstinence**, that's all. (HCP10, medical officer)*

This statement shows that she was flexible with regard to selecting certain information or "being selective," based predominantly on personal or religious preference rather than a professional expectation to equip the individual with accurate knowledge. The researcher asked HCP10 to explain why she decided to refrain from sharing information about safer sex and contraception with teenagers. She replied:

*Because **I am worried**.. they might say that I am introducing it to them about sex and pregnancy prevention...but I will answer in detail during the Q&A (question and answer) session...you know, that is **a common question from them**...I will explain and evaluate their understanding afterwards...I am afraid of **encouraging them to have sex**...I asked them to focus on school first.. the time for having sex will come in their **legal marriage** after school or college. (HCP10, medical officer)*

She explained that she only provided information on protection or prevention if students asked during a Q&A session. The excerpt shows that young individuals are more concerned about pregnancy than sexually transmitted diseases. However, HCP10 did not appear to worry if the students did not have the opportunity to ask during a session. In fact, she reminds the teenagers to focus on studying and avoiding a sexual relationship until they are married.

HCP16 had a slightly different approach, as she mentioned that information on safer sex and contraception is only provided to sexually active teenagers. She also expressed her worries over teenagers' unwillingness to declare their sexual activity. Thus, there are some contradictions in her ideas. This indicates that being selective with regard to sexually active teenagers to whom information is provided is ineffective in preventing STIs, unintended pregnancy, and baby abandonment.

To me, it is good to talk about safer sex, so they are aware of protecting themselves from pregnancy and sexually transmitted diseases. To give it to all pupils, in general, is not appropriate as we give them the idea that they can have sex. So, what we practice is

safer sex only for those who are sexually active. However, they will never confess that they are having sex. (HCP16, school health nurse)

Perhaps the reason that young individuals do not declare that they are involved in premarital sex is because they are afraid of being seen as promiscuous by the healthcare professionals. The healthcare professionals' collective perception that safer sex and contraception may encourage premarital sex influenced not only the information they were distributing but also their prescribing practice. HCP29 explained that she felt reluctant to prescribe contraceptives to unmarried sexually active teenagers despite a recommendation in the National Guideline for Managing Sexual and Reproductive Health in the Primary Health Clinic.

*I am aware this is unprofessional; I cannot be judgmental and not supposed to mix up with religion...however, as a Muslim, I am responsible for telling them that **premarital sex is forbidden, and contraception is wrong to prescribe to unmarried.** (HCP29, family medicine specialist)*

She was aware of her professional responsibility to not demonstrate prejudice in respect of the client's care, but her attitude appeared to be inconsistent with the Code of Medical Ethics published by the Malaysian Medical Association (2002). She rationalized that her decision not to prescribe contraception to unmarried teenage girls was influenced by her personal and religious beliefs surpassing the professional ethical code. From the abovementioned excerpts, healthcare professionals' experiences only refer to the provision of contraception specifically to girls. It is worthwhile considering the role of boys, since they should also be involved in the decision-making to prevent pregnancy and STIs.

Maintaining their own honor: the healthcare professionals experience of delivering sexual and reproductive health information. Given that many of the respondents were young Muslim women themselves, their responses highlighted how they tried to protect their own "respectable" image when delivering sexual and reproductive health education to young individuals. The healthcare professionals' discomfort in delivering sexual and reproductive health information to teenagers was often rooted in the notion of appropriate behavior for individuals, especially for young women and men. Some of them were embarrassed about providing sexual and reproductive health education to a mixed-gender group of students and concerned about others' perception of them. In the absence of medical officers, school health nurses are responsible for delivering sexual and reproductive health education to teenagers during a school visit. HCP02 is unmarried and expressed shame at providing sexual and reproductive health information to teenagers, particularly boys. Her embarrassment and

worry about being judged is best captured in the following excerpt:

*I separate the boys and girls when I'm giving a sexual health talk. I feel awkward and **uncomfortable talking about sex in front of males.** I was in a female school and being in nursing school is also all female...I think this makes it difficult for me to speak openly with them [...] I'll explain what is sex in the simplest way, not too direct. I always think about what they will think and say about me...**I am still single, but I know about sexual relationships and pregnancy prevention.** (HCP02, staff nurse)*

HCP02 explained her discomfort here and how she attempted to deliver the information in a simple and indirect way to avoid being seen as knowledgeable about sexual health since this conflicted with her image as a respectable single Muslim woman.

Feeling embarrassed about talking about sexual and reproductive health to men also affected married women. HCP10 described her concern regarding the presence of a male teacher during her talk. Eventually, aware of her reticence, the teacher encouraged her to explain in more detail about sexual relationships, but she still excluded information about safer sex and contraception.

*I give talks about the secondary sex characteristics, the signs of sexual development, menstrual cycle, and so on...when a male teacher is present during my slot, I feel it is **hard to explain about sex** and to connect with social problems...**I am afraid that the teacher is uncomfortable with my content...but the teacher noticed my situation, and he supported me by saying, "You just tell them, don't worry, they should know"....So I got a positive response from the teacher.** (HCP10, medical officer)*

It was evident that HCP10 made the assumption that her own honor and reputation were in jeopardy by providing sexual and reproductive health information to teenagers, particularly about safe sex and contraception. The healthcare professionals felt that family honor and their own individual honor were of prime importance, which led to embarrassment and limited information sharing during talks about sexual relationships as they assumed that individuals surrounding them would judge them. A reluctance to acknowledge such discomfort, alongside feelings of embarrassment or fear of being judged, means that some healthcare professionals are prioritizing their own self-image over the real difficulties faced by young individuals in dealing with their sexual health issues. This situation might give an impression to students that sexual issues cannot be discussed in a straightforward manner or that it is not possible to talk frankly about them.

HCP08 expressed her own concern about the depth of sexual and reproductive health information and uncertainty as to whether or not to include information about safe sexual activity as she was worried about parents' reaction. This indicates that the decision is made based on the assumption of how she thinks a parent would respond rather than her personal experiences delivering sexual and reproductive health information in the presence of the teenager's parents

*...sometimes I do not know how much information I should provide...I cannot tell them too much because the **parents will get curious** when they know that we are educating about sexual health...**they might think that their children were not supposed to know** about sex and contraception. (HCP08, medical officer)*

HCP07 discussed the resistance to sex education from the community in the local low-cost housing area, despite a recognized need for input.

*We also organized a health camp in a community, particularly in PPR (Program Perumahan Rakyat or low-cost housing) flats. We did provide health talks but not about sexual health, even though many cases of unintended pregnancy reportedly came from this area...the **local community won't accept it**, they will say all these actions would encourage youngsters to have sex. (HCP07, medical officer)*

She explained that the community response was negative, thereby discouraging the dissemination of sexual health information. This indicates that delivering sexual and reproductive health education is challenging within the healthcare system, at schools, and in the community. The finding indicates a lack of awareness about the benefit of sexual and reproductive health education to prevent STIs, unintended pregnancy, and baby abandonment by healthcare professionals. This is explained by the strong belief held by both the community and many healthcare professionals that sex education encourages further sexual activity. The data indicate that cultural and religious beliefs tend to override professional ethics for some healthcare professionals. Healthcare professionals shying away from providing sexual and reproductive health information means they are failing to provide care and support for teenagers from healthcare clinics relating to their sexual health needs. A qualitative synthesis conducted in the United Kingdom indicated that teenagers appreciate healthcare professionals visiting schools to deliver sex education as opposed to it being delivered by teachers.²⁰ Young individuals reported that they felt comfortable and less embarrassed as they perceived healthcare professionals to be experts and outsiders due to their separation from the school²⁰.

Discussion

Muslim healthcare professionals, who made up the majority of the participants in this study, chose to advocate sexual abstinence prior to marriage as the first line of prevention for unintended pregnancy and sexual diseases. Some healthcare professionals rationalized that their approach was aligned with Islamic beliefs by stating a principle from the Quran about avoiding premarital sex, such as "*wala takrabul zina*" (*do not go near adultery, fornication*), meaning do not approach unlawful sexual intercourse. The healthcare professionals in this study perceived unmarried adolescents who are sexually active or unintentionally pregnant to be immoral or as transgressing from social and religious norms. For instance, some healthcare professionals expressed that sexually active adolescents lacked values and were ignorant. The personal and religious beliefs shown to be held by one participant prevented her from providing contraceptive services to unmarried adolescents; instead, she advised adolescents to abstain from sex until marriage. She made it clear that "*as a Muslim, I am responsible for telling them that premarital sex is forbidden, and contraception is wrong to prescribe to unmarried.*" This indicates how devout Muslim healthcare professionals may provide health information based on their own interpretation of Islamic principles, as if being a Muslim hindered them from adhering to human rights and providing good care for their clients.

The findings of this study support the review article²⁰ on Islamic culture and religious beliefs in relation to sexual and reproductive health, which suggested that devout Muslims' own experience of sexual and reproductive health matters is limited and leads to the provision of weak evidence-based practice to their clients. In contrast, some Iranian Muslim male clergy acknowledged that although there was no religious prohibition on the provision of sex education to adolescents. They felt it was necessary to protect them from negative sexual health outcomes such as unintended pregnancy and sexual diseases.²¹ This indicates how these providers were finding a balance between their professional obligations and applying the principle of human rights to ensure adolescents maintained optimum health.

The use of "scare tactics" in sex education is a long-standing strategy adopted by some educators in public health interventions aimed at discouraging adolescents from engaging in premarital sex.^{22,23} In this approach, health educators instill fear to adolescents who are engaged in high-risk sexual behavior to make them think about the worst-case scenario, such as becoming unintentionally pregnant and/or contracting a sexually transmitted disease. Although this type of health promotion strategy may positively alter some individuals' attitudes to sexual behavior and improve their sexual health outcomes,²⁴ other evidences show

that the use of scare tactics by educators that rely on fear and shame of sex can lead to induction of greater risk-taking behavior among adolescents.^{25,26}

The finding of this study regarding healthcare professionals' use of "scare tactics" during sex education sessions at school is thus similar to that found in previous studies.^{25,26} Most healthcare professionals described a variety of negative consequences related to engaging in premarital sex or being sexually active. For instance, they warned adolescent boys and girls of the risk of "getting something bad" as a "punishment by God," referring to the risk of contracting STIs, including HIV/AIDS, and negative consequences that would ensue for their individual and family honor. The nature of advice focused solely on sexual abstinence is likely to underestimate that adolescents, in particular girls,²⁷ are also at risk of coerced, forced sex and becoming pregnant or contracting an STI and/or HIV infection. This study highlights that the strategy of using scare tactics is not necessarily effective in terms of preventing unintended pregnancy or sexual diseases among sexually active adolescents.

The findings are limited to the specific local context of primary health clinics located in urban areas. Thus, the findings of this study may not apply to the situation in other health clinics. Caution must be applied since the findings of this study may not necessarily be transferable to other primary healthcare professionals working in primary healthcare clinics across Malaysia.

Conclusion

The study findings add to the understanding of the influence of culture and religion and the resulting tension between guidelines and beliefs in delivering comprehensive sexual and reproductive health. The findings suggest that healthcare professionals should be aware of comprehensive sexual and reproductive health education as their professional responsibility and the need for them to manage their own conflicts with regard to fulfilling their role.

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Conflict of Interest Statement

The authors declare that they have no conflict of interest.

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