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The strategies used by the school health team during the delivery of sexual health information to unmarried adolescents in Malaysia

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Abstract

Background: Adolescents' sexual health is vital to overall health and well-being to achieve sustainable development goals. Yet, research on the strategies used by Malaysian school health teams regarding their experiences of providing sexual health information to adolescents is sparse.

Objective: This study was conducted to explore the experiences of school health teams in Malaysia who provide unmarried adolescents with sexual health information either during school health visits or at health clinics, with a particular interest in the strategies they use to educate these young people.

Methods: This qualitative study used semi-structured interview data from twenty participants from four multidisciplinary school health teams. The participants included staff nurses, medical officers, and family medicine specialists. The transcripts were analysed for common themes.

Results: Four main themes were identified: discourse on risk, being selective, using scare tactics and maintaining own honour. The findings indicate that the interactions between school health teams and unmarried adolescents were not always 'adolescent friendly'. The school health teams tended to use discourses of 'risk' or scare tactics to encourage abstinence in the adolescents they advised. Staff were also selective about the information they gave, prioritising notions of 'maintaining honour' over 'safer sex' messages.

Conclusion: This study revealed how school health teams perceived sexual health education to be about moral issues and social attitudes. Influenced by both culture and religion, the sexual health services provided were underpinned by a 'moral' approach and promoted abstinence. However, most of the nurses in this study held the belief that sexual health knowledge acts as an encouragement for sexual activity. Thus, as part of school health teams, nurses need to embrace evidence that improved sexual health education may delay sexual initiation and prevent unintended pregnancy and HIV/STDs.

Keywords

school health team; nurses; sexual and reproductive health; information; unmarried adolescents; scare tactics; Malaysia

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Background

School health teams (SHT) in Malaysia are working under the Ministry of Health (MOH) and play a role that complements the Ministry of Education regarding sexual health education through the provision of an outreach programme in schools. The school and adolescent health teams in government primary health clinics fall under maternal and child health services and the outpatient department. These two units are responsible for the delivery of sexual health information and treatment to adolescents aged 10 to 19. **Table 1** shows sexual health information is commonly delivered to groups based on age which also coincides with the immunisation programmes.

The SHT will conduct health screening using a self-administered adolescent health screening form. Three sections cover the adolescent's background information and health status, with the final section requiring 'yes' or 'no' responses to seven questions related to sexual health. These questions focus on health issues for females, such as vaginal discharge, itchiness or painful urination, pregnancy, miscarriage, menstrual period, and breast changes. For males, the questions focus on physical changes and pubertal status, as well as a number of questions focus on the reading or watching of pornographic material, masturbation, sexuality

and homosexuality. Students are also asked about their sexual activity, sexual intercourse, number of partners and contraception usage. An appointment letter to the adolescents' parents will be issued by the doctor for further consultation at the health clinic. The maternal and child health clinic also provides antenatal, postnatal and child care to pregnant women, including adolescents, regardless of marital status.

It is acknowledged that sexual health education provided in schools does reach children and young people where school attendance is high (Shackleton et al., 2016). In Malaysia, the MOH has committed to increasing adolescents' knowledge of sexual health to reduce the incidence of unintended pregnancies and sexual diseases (Lim, 2010). Since early 2013, SHT has provided sexual health education within the school health programme to primary and secondary school pupils (Canan & Jozkowski, 2017; Talib et al., 2012). This complements the sexual health programme delivered by school teachers across a range of subjects (Hamid & Fallon, 2020). During their school visits, SHT encourages adolescents to attend health clinics or adolescent health units for consultation or treatment related to their general health, which includes sexual health issues like unprotected sexual activity, STIs/HIV and sexual violence. In addition, adolescents could access the outpatient clinic for minor illnesses or emergency and accident cases. Furthermore, pregnant adolescents may access an antenatal care unit for maternity booking purposes, enabling them to deliver their child to a government maternity hospital.

Literature related to this topic highlights that strategies used by SHT may include the 'scare tactics' approach in sexual education to discourage adolescents from the engagement in premarital sex and to think about the worst-case scenario, such as becoming unintentionally pregnant or contracting a sexually transmitted disease in order to encourage abstinence (Hazariah et al., 2021). Although this approach may alter individuals' attitudes and improve their sexual health outcomes (Olsson, 2015), other evidence shows scare tactics approach or the invoking of fear or shame of sex can lead to greater risk-taking behaviour among adolescents (Lederer, 2017; Wilson et al., 2012). Thus, it is possible that adults provide misleading information about sexual relationships. In this way, adolescents perceive that as exaggerated, aiming to control their sexual behaviour. Unfortunately, specific studies on the strategies used in the primary healthcare setting and schools in Malaysia are scarce, and the role of SHT and their contribution to sexual health provision is less explored. Therefore, exploring this topic is an essential step towards understanding the factors influencing the effectiveness of the programme.

Table 1 Sexual health information and immunisation based on age

Grade/Age	Immunisation	Sexual health information
Standard 6 (12 years old) primary school	BCG, DT, MMR	Early adolescent phase/growth and development/ puberty
Form 3 (15 years old) secondary school	HPV (for girls)	HIV – boys and girls

BCG (Bacillus Calmette-Guerin), DT (Diphtheria and Tetanus), MMR (Measles, mumps, rubella), HPV (Human Papillomavirus)

Methods

Study Design

This is a generic qualitative study aimed at identifying and describing the strategies used by the SHT when dealing with young people's sexual health matters. This methodological approach focuses on describing what and how participants' experiences are, and this simply seeks to understand a process or the perspective of the people involved (Bellamy et al., 2016).

Participants

Twenty school health team members from four health clinics in the capital of Malaysia were interviewed individually (see **Table 2**). Participants had at least six months of experience working in primary health clinics and were part of a school health team who provided sexual health information to adolescents. The school health team was recruited based on the inclusion criteria. The majority of participants were Muslim, two Hindus, and female ages ranged from 20 to 50 years. They were briefed on the aim, data collection process and their rights to withdraw at any time from the study.

Data Collection

The data was collected between November 2016 and March 2017 using semi-structured in-depth interviews conducted in either Malay or English at the participants' workplace. The interview took about 40 to 90 minutes and was audio-recorded and transcribed verbatim. In addition, the researcher recorded information on the environment in the fieldnote.

Data Analysis

The analysis of interview transcripts used six steps thematic analysis (Aronson, 1995; Braun & Clarke, 2006) to identify the participant's experiences during interactions with adolescents. Transcriptions, memos and field notes were uploaded into Nvivo12 software to serve as an audit trial. Data familiarisation was done by reading line by line to generate initial data. The researcher highlighted the similarities based on the perspectives of the SHT across the interview data set (Marks & Yardley, 2004). Then, the analytical process of reducing the data by searching for themes and subthemes.

This step captures a meaningful pattern or recurrent experiences within the data set (DeSantis & Ugarriza, 2000). Themes are abstract and difficult to identify due to the participants' indirect description (Ormston et al., 2014). The next steps were to review, define and rename the formulated tentative themes to ensure they represent the text's meaning. Lastly, a discussion to verify the themes with interesting and meaningful quotations for analytical writing was done among the research team.

Rigour

Multiple data sources or triangulation, prolonged engagement and reflexivity to clarify researcher bias were used to achieve rigour throughout the research process (Creswell & Miller, 2000; Patton, 1999). Interviews were conducted with SHT's various designations and from four different clinics. In this way, personal experiences and views could be verified by others (Shenton, 2004).

Ethical Considerations

This study was approved by the University of Manchester Research Ethics Committee, Medical Research Ethics Committee Malaysia (NMRR-15-129-25990) on 5 October 2015 and the respective primary health clinics. This article is derived from the PhD thesis of the first author (Hamid, 2018). Informed consent and contact details of the researcher were given to participants during the first meeting. They were brief on the objective of the study and the interview process. They were given at least 24 hours to decide on their participation, and an interview session was arranged based on their agreement.

Table 2 Participants' characteristics

Participant	Designation	Age range	Sex	Marital status	Race	Religion	Years of working with adolescent
SHT 01	Medical officer	35 - 40	F	Single	Indian	Hindu	3
SHT 02	Staff Nurse	20 - 25	F	Single	Malay	Muslim	3
SHT 03	Head Nurse	45 - 50	F	Married	Malay	Muslim	15
SHT 04	Midwife	35 - 40	F	Married	Malay	Muslim	14
SHT 05	Staff Nurse	20 - 25	F	Married	Malay	Muslim	4
SHT 06	Staff Nurse	30 - 35	F	Married	Malay	Muslim	5
SHT 07	Medical officer	30 - 35	F	Married	Indian	Hindu	6
SHT 08	Medical officer	30 - 35	F	Married	Malay	Muslim	2
SHT 09	Head Nurse	45 - 50	F	Married	Malay	Muslim	12
SHT 10	Medical officer	30 - 35	F	Married	Malay	Muslim	5
SHT 11	Staff Nurse	30 - 35	F	Married	Malay	Muslim	7
SHT 12	Staff Nurse	25 - 30	F	Married	Malay	Muslim	5
SHT 13	Staff Nurse	25 - 30	F	Married	Malay	Muslim	3
SHT 14	Specialist	30 - 35	F	Married	Malay	Muslim	10
SHT 15	Midwife	30 - 36	F	Married	Malay	Muslim	1
SHT 16	Staff Nurse	25 - 30	F	Married	Malay	Muslim	4
SHT 17	Staff Nurse	25 - 30	F	Married	Malay	Muslim	4
SHT 18	Staff Nurse	20 - 25	F	Married	Malay	Muslim	2
SHT 19	Midwife	35 - 40	F	Married	Malay	Muslim	6
SHT 20	Midwife	35 - 40	F	Married	Malay	Muslim	8

Results

Approaches to Sexual a Reproductive Health Education

During their interactions with the adolescents, the participants discussed their approaches to information giving, including using discourses of risk, being selective with the information they provided and using scare tactics. The final finding gives some insight into how some of the participants, particularly the young Muslim women, were challenged by this aspect of their professional role as it clashed with the maintenance of their own perceptions of maintaining honour (**Table 3**).

Table 3 Themes on the strategies used by SHT

Themes	Subthemes
Discourse on risk	Punishment by God Getting sexual infection
Being selective	Withheld information on safe sex, contraception and abortion
Scare tactics	Running away from home Discussing premarital sex Informing about HIV and STDs Abortion/Termination of pregnancy Controlling movement outside of home
Maintaining own honour	Respectable image

Theme 1: Discourse of risk

The analysis revealed that the SHT approach to discussing premarital sex all centred on risk, which included a high possibility of getting infectious diseases, religious transgressions, unintended pregnancy, angry parents and others' reaction of disobedience. This is illustrated in the quotation below, where a staff nurse explains the sexual health information she gave to a group of adolescents at school:

> *I told them 'not to have sex before getting married because **if they were unfortunate,** they would **get infected with sexually transmitted diseases**, may get **pregnant out of wedlock** or be **caught by the religious department**. How would their parents feel at that time? How would they feel towards their friends, teachers, and neighbours if things happened like that?' (SHT13, Staff nurse)*

This participant lists a number of potential risks, including interference by the religious department' which points to the likelihood of punishment by society in the name of religion. However, some participants take this message further, alluding to retribution carried out not by the community but by God. The quotations below highlight how premarital sex was perceived as sinful by a number of participants, who then reinforced to the adolescents that God would punish them if they engaged in this activity, for example, by contracting an STI or becoming unintentionally pregnant.

> *I tell them that this activity is sinful and they will **get something bad** from this, like HIV or an STI. (SHT02, Staff Nurse)*

> *I believe many adolescents 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'. (SHT04, Midwife)*

> *I told the student, 'from my experience, the youngest HIV-positive is 13 years old, mmm, just like your age, right?' Try to imagine if you were having (un)protected sex starting from a young age when you think **you would get HIV?** I want them to be cautious and don't ever try it. (SHT12, Staff nurse)*

*I told them: 'You cannot do this (premarital sex); remember, someday God will punish you by having your **kids do the same thing to you.'** (SHT13, Staff nurse)*

The finding highlights that instead of discussing safe sexual activity with the adolescents who came to them for advice, the participants in this study invoked notions of risk, particularly the risk of retribution from God through disease or pregnancy or through some form of punishment that would be visited upon the adolescent in their future adult life. Clearly, such an approach deviates from current public health approaches to adolescents' sexual health.

Theme 2: Being selective about the sexual health information given

Withholding information about contraception and safer sex was also a strategy used by several participants who believed such information would encourage sexual activity which was perceived to be appropriate only within the confines of marriage, for example:

*I would never give information on contraception to them…, I **don't tell them about safe sex and abortion.** I would rather say about **sexual abstinence**, that's all… 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** (SHT10, Medical officer)*

The quotation below highlights how sexual health information given to 'general' adolescents (presumed to be sexually inactive) at health clinics and schools purposefully did not include information about safer sex or contraception, which was reserved for those who identified themselves as sexually active. But the comment 'they will never confess' illustrates the contradictions of this approach since this is an admission that staff are unaware of who is sexually active and who isn't, which means that the advice given using this approach is not necessarily reaching the intended audience.

*To me, it is good to talk about safer sex so they are aware of protecting themselves from pregnancy and sexually transmitted diseases. But it is not appropriate to give that information to general adolescents. So, what we practise is **safer sex only for those who are sexually active.** However, they will never confess that they are having sex. (SHT16, Staff nurse)*

Furthermore, their decision to select certain information appeared to be based on personal preference rather than a professional expectation of providing adolescents with accurate knowledge. One participant explained their reluctance to give contraceptives to unmarried sexually active adolescents despite recommendations by the National Guideline for Managing Sexual and Reproductive Health in the Primary Health Clinic (Ministry of Health Malaysia, 2015).

*I am aware this is unprofessional; I cannot be judgemental and am 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.** (SHT 14, Family Medicine Specialist)*

This highlights how the participants' personal beliefs surpassed the professional ethical code in the context of sexual health, sometimes to the detriment of young people.

Theme 3: Use of 'scare tactics' to promote abstinence

Some of the participants described how they used scare tactics as an approach to sex education. For example, a description of 'frightening' words or images during their interactions with adolescents and openly discussing the threatening undertones of their information implies that they believe this is an acceptable approach to sex education.

*I will say, 'Don't you feel afraid of venereal diseases?' I will show them pictures that I retrieved from the Internet. 'Don't you love your life? Don't you want to have your own family?'…. we have to **threaten them,** 'If you are infected with this disease, **you could die (of it),** you know.' (SHT09, Head Nurse)*

*So I highlight the effects of drug abuse and being promiscuous ... I show them scary **pictures and videos of Syphilis and AIDS** so that they will think twice about whether to get involved in premarital sex and drugs. I explain to them how the viruses are transmitted, the signs and symptoms of HIV infection… I tell them you're still young (12 years old) and just entering your teen phase; you have another 6–8 years to explore your teenage age; it's wonderful if you're able to **control yourself** … and not be involved in an **unhealthy** activity like sex. It is only **a trap that ruins your entire life**. I always said, 'please think twice if you want to do something risky in your life ... **remember your parents** ... sure they expect you to become a good person. It is like motivation (smile). I hope they avoid sex. (SHT17, Staff nurse)*

Abstinence is clearly the only acceptable option presented to the adolescents in this scenario as they are advised to exercise self-control rather than being told about contraceptive options, and attempts are made to invoke feelings of guilt and shame as they are reminded of their family honour. The underlying message is clearly about delaying sexual activity, and adolescence is put forward only as a 'wonderful' time if they are able to avoid sexual activity, which will ultimately 'ruin their entire life'. The 'delay' and abstinence messages are supported by exaggerated risks of shame, a blighted existence, disease and death. One participant described the implementation of the 'no apologies' abstinence programme (Dobson & Ringrose, 2016) as part of their approach, giving some insight into why the promotion of safer sex was avoided:

*The **'No apologies'** programme is **not promoting safe** sex because if we encourage safe sex, we send the message saying students can have sex but with a condom. We show them one of the modules with a **condom, and the failure rate** is still there. STDs can be transmitted even if you wear a condom. In fact, we show them the diagram; even using a condom, they still can get infected because **there's skin contact**. That is why they can **still get an STD even though they are wearing a condom.** So, we tell them this is the logic behind why we don't promote safe sex. We want them to abstain from sexual activity until they get married. (SHT10 medical officer)*

In highlighting the condom failure rate and providing inaccurate information regarding condom use, the adolescents in this scenario are being manipulated into accepting the notion that sexual activity within marriage could avoid HIV/STDs.

Other scare tactics were used to promote abstinence when discussing the termination of pregnancy. For example, in the quotation below, the doctor clearly expressed that their intention was to scare the girls with the unnecessarily detailed description and viewing of footage of the abortion procedure.

*… I showed a video of how the **curettage is inserted through the vagina to scrape the foetus out of the womb** … so that they know*

the process. This would scare them off ... they look at it and imagine that something is going inside their vagina; at least that process will be on their mind; I ***don't see anything wrong with that.*** *(SHT07, Medical Officer)*

Abortion is allowed in Malaysia under certain criteria and often at an early stage of pregnancy (Abdullah, 2009). Nonetheless, this participant attempted to undermine the availability of this option to those who might need it in the future by presenting it in the most frightening way they could. This participant disregarded any of the potential emotional distress this might cause to a young person requiring termination of pregnancy in the future, believing instead that presenting this option in the most frightening way possible would be a successful approach to ensuring abstinence.

It was clear from the narrative presented by another participant that unmarried girls who do become pregnant are in need of more and, indeed, more accurate sexual health information, particularly related to the termination of pregnancy. This doctor described antenatal check-ups among unmarried adolescents as always delayed near delivery, which in itself is a cause for concern. However, this meant that the doctor was left with little option but to counsel them to continue with the pregnancy since the time for performing safe, legal abortion had passed.

*… **abortions** in the government hospital are **allowed with certain conditions**. Many pregnant adolescents are **not eligible for abortion** as both the mum and baby are healthy. They come to us too late.. and obviously, it is impossible to do, either in a government or private hospital. I have **never heard of any abortion done** so far, although it is less them 120 days. Unmarried pregnant girls will carry on with the pregnancy. (SHT08, Medical Officer)*

This highlights the potential consequences of neglecting to provide accurate and non – judgemental to young people around the topic of abortion. The focus on the risk of unsafe abortion and instilling a frightening and painful abortion procedure serves to discourage pregnant young people from seeking help, leaving them only to continue with the unintended pregnancy. This indicates that participants were less concerned about the psychological impact that unmarried pregnant girls may face**.**

In addition, the participant seems to use sexual health education to promote abstinence by controlling the movements of girls outside of the home, as the following quotation illustrates:

We try ***to scare them not to go to a friend's house****. 'If you go to your friend's house, then the brother or uncle can rape you.' It sounds trivial, but* ***we do not know how to tell them.*** *Just … erm, however, it happens! This is a normal story in SCAN (Suspected Child Abuse and Neglect) meetings. So we tell them 'please don't run away'. (SHT05, Staff nurse)*

Here, with no knowledge of the reality of the relationships they are referring to, the staff nurse presents the male relatives of a friend as sexually predatory. They also highlight a lack of skills related to communicating about sex with young people. The impact on the girls is that they instil unwanted sexual attention or violence if they are outside the home and unaccompanied. This shows how deeply ingrained the promotion of premarital sexual abstinence is in this society and may give some insight into why the SHT use such scare tactics in their approach to sexual health information.

Theme 4: Maintaining Honour

Further insight into the challenges posed by sexual health information in this study was given by the participants, who were young Muslim women. These participants often expressed that they were embarrassed about providing sexual health information to a mixed-gender group of students. They also expressed concern about others' perceptions of them. The following quotation illustrates how one participant tried to protect their own image when delivering sexual health information to young people:

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 sex is 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.*** *(SHT02, Staff Nurse)*

This staff nurse is concerned about seeing others as knowledgeable about sexual health, which contradicts the respectable image of a single Muslim woman. A female doctor described feeling uncomfortable towards the male teacher during her talk even though she did not include information about safer sex and contraception.

I give talks about the secondary sex characteristics, the signs of sexual development, the 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' (SHT10, Medical Officer)*

This doctor perceived her reputation to be in jeopardy due to providing information regarding safer sex and contraception to adolescents. Feelings of discomfort, embarrassment and a fear of being judged show how self-image is prioritized by some providers of sexual health information over the reality faced by adolescents in dealing with their sexual health issues.

The participants were also concerned about parents' reactions. This influenced the type and depth of information given to adolescents by individuals, as the following quotation illustrates:

… 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 them about sexual health ...* ***they might think that*** *their children are* ***not supposed to know*** *about sex and contraception. (SHT08, Medical Officer)*

Additionally, such resistance influenced the provision of sexual health innovations at a broader level, as another participant explained:

We also organised a health camp in a community, particularly in 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. (SHT07, Medical Officer)*

This shows that despite a need for sexual health input, perceived community resistance also discouraged the dissemination of sexual health information in places where it may have had a positive outcome, highlighting further challenges faced by those delivering sexual health education.

Discussion

The finding of this study revealed that many of the participants involved in sexual health education believed that providing accurate information, particularly around the topic of safer sex, would encourage premarital sexual activity. Influenced by cultural and religious beliefs that outweighed their professional ethics, some participants avoided providing evidence-based sexual health information, instead using scare tactics to promote abstinence. This indicates that they are unable to provide appropriate support for adolescents' sexual health needs from health clinics (Pound et al., 2017; Pound et al., 2016).

The influence of cultural or religious beliefs could be the utmost barrier to delivering sexual health information to adolescents in Malaysia (Hazariah et al., 2021). The SHT in this study demonstrated little awareness that the emphasis on religious and cultural restrictions would deprive the adolescents who sought the advice of their right to effective sex education. There was also little insight into the potential impact this approach might have on the unintended pregnancy rates in Malaysia (Hazariah et al., 2021). Using 'scare tactics' with the aim of instilling fear is not only ineffective in reducing unintended pregnancy cases (Lederer, 2017) or baby dumping but by being complicit in depriving adolescents of essential knowledge, the services designed to help adolescents may be putting them in a detrimental position, rendering them unable to make evidence-based decisions relating to their own bodies. Furthermore, the low acceptability of premarital sex demonstrated by these participants may impact low follow-up attendance, exposing pregnant girls to medical risk. This situation violates the rights of girls to non-judgemental sexual health services as stated in the National Adolescent Health Policy Plan of Action 2006–2020 (Ministry of Health Malaysia, 2015). The adolescents may default appointments due to unfavourable experiences with providers, which contradicts the recommendation for adolescent-friendly services. The staff should portray respect and concern (Raworth, 2007; Tylee et al., 2007).

The strategies for delivering sexual health information described by these participants are against the codes of conduct that require evidence-based and non-judgemental care. The strong personal, cultural and religious beliefs among staff hindered adolescent-friendly services such as equitability, acceptability and accessibility. Interestingly, none of the participants mentioned any negative consequences or criticism for staff who did not follow the guidelines or disregarded professional ethics or health policy. This study highlights that sexual health information to unmarried adolescents prioritizes the promotion of sexual abstinence before marriage rather than ensuring young people's sexual health, which is in line with Wannarit (2022). The findings highlight that most of the participants tended to describe negative consequences of high-risk behaviour, such as engaging in premarital sexual activity. The 'scare tactics' approach during sex education sessions with adolescents is similar to studies by Wilson et al. (2012) and Lederer (2017).

Santelli et al. (2017) emphasized that sexual health advice focuses on sexual abstinence but fails to acknowledge that some adolescents may be a high tendency to coerce forced sex, become pregnant and contract an STI/HIV infection. Thus, the strategy of using scare tactics towards sexually active adolescents may be ineffective in preventing unintended pregnancy or sexual diseases (Kocsis, 2017). This study revealed that SHT excluded information on contraception and safer sex at schools. Some of them emphasised the failure rate of contraception, aiming to discourage young people from abstaining from sexual activity. Adolescents should be informed that STIs and pregnancies are preventable and treatable with early medical intervention (Wood & Rk, 2011). Lederer (2017) reported the impact of exposing adolescents to STI images that they expressed as disgust, prompting stigma. Thus, the SHT is expected to deliver unbiased information to ensure that contraception is accessible and acceptable to adolescents.

Threatening messages on abortion procedures dissuade adolescents from entering a premarital sexual relationship. Using fear-provoking videos on abortion procedures may result in opting for unsafe abortions or secretly continuing the pregnancy. These findings suggest scare tactics approach in sex education is a disadvantage to adolescents' access to health clinics. This study recommends professional development for SHT is needed focusing on competency and respecting adolescents' sexual health needs. The SHT should be recruited among those interested and passionate about a human rights agenda in relation to preventing unintended teenage pregnancy in Malaysia. This study implies that sexual health education should address the sociocultural and gender norms that impact negatively, especially girls. Adolescents need to be empowered to question the rigid gender or social norms that require health services (World Health, 2020).

Moreover, adolescents should seek to challenge the social norms that suppress their knowledge and access to health services rather than reinforce gender stereotypes and inequalities (World Health, 2020). The importance of education is highlighted in the literature as an important factor in empowering individuals with regard to their sexual health and practical skills. The skills include interpersonal communication, decision-making abilities, critical thinking and the ability to negotiate when faced with unwanted sexual activity (Mori et al., 2017; Temin & Levine, 2009).

Conclusion

Malaysia has an issue with unintended pregnancy and baby dumping among unmarried adolescents. This study revealed that the current approach to sexual health education resulted in limited or deliberately improper prescribing practices, and this led to a failure to empower Malaysian adolescents about their sexual health and well-being. The SHT personal beliefs present a barrier to sexual healthcare provision, discouraging them from including information about prevention and thus leading to greater sexual risk among adolescents in Malaysia. Those who deliver sexual health information need to scrutinise the impact of their approach not only on adolescents' sexual health but on their mental health. Delays by young unmarried

pregnant women in seeking healthcare led to delays in detecting and treating complications in their pregnancy. These women prefer avoiding shame over their own or their unborn child's health by hiding their pregnancy. This study has a small sample, and the finding may not be generalizable to the sexual education approach in Malaysia as a whole. Nevertheless, it provides insight into the experiences and is the starting point for further studies on this topic.

Declaration of Conflicting Interest

The authors declare there is no conflict of interest.

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Authors' Contributions

All authors contributed equally to the study concept, design, definition of intellectual content, literature search, data acquisition, data analysis, and manuscript preparation. SHAH also contributed to manuscript editing, and DF reviewed the manuscript. All authors were accountable in each stage of the study and approved the final version of the article to be published.

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Data Availability

Research data is kept at the corresponding author's university and will be released upon request if related.

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