

# An exploration of sexual and reproductive health (SRH) services provided by private clinics in Peninsular Malaysia

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## Background

The World Health Organisation (WHO) estimates that 1/3 of all pregnancies globally end in stillbirths, miscarriages, and induced abortions.<sup>1</sup> Sexual and reproductive health (SRH) services, provided with a rights-based perspective, are an integral part of providing comprehensive and essential healthcare. As a result of the Covid-19 pandemic, an estimated 47 million unintended pregnancies are expected to occur globally as due to limited access to family planning and contraceptives over a 6 month period.<sup>2</sup> In Malaysia, a lack of access to modern contraceptives as a result of the pandemic is expected to cause up to 15 million unintended pregnancies if disruptions continue for a 12 month period.<sup>3</sup>

Earlier this year, the clause on abortion was removed from the Malaysian Medical Council Code of Medical Ethics (as abortion provision for medical reasons are covered in the exception clause of the Penal Code Section 312 and non compliance are covered in the sections 312 to 315). This could potentially encourage more doctors to be open about making safe abortion services accessible to patients.

In 2012, the Ministry of Health (MoH) of Malaysia developed the 'Guidelines on Managing Adolescents Sexual and Reproductive Health Issues in Health Clinics',<sup>4</sup> as a guide to providing SRH services for adolescents. Although health guidelines for adolescents have since been developed, government clinics have yet to develop a guideline for the comprehensive sexual and reproductive healthcare of unmarried persons. Additionally, youths may not be made aware of services available to them at government clinics or have access, and thus continue to experience unmet needs with regard to sexual and reproductive health, including resources on comprehensive sexuality education (CSE), access to Sexually Transmitted Infections (STIs) testing, contraception, and services pertaining to unplanned pregnancy.<sup>5</sup>

In a landmark case in 2014, a 24 year old Nepalese migrant worker and Malaysian doctor were sentenced to jail and later acquitted for undergoing and performing an abortion procedure, respectively.<sup>6</sup> This was the first arrest made in Malaysia in relation to the law surrounding abortion, which attracted the attention of international human rights as well as local non-governmental organisations and activists. While the doctor who provided the abortion was acting well within the ambit of the law, which provides that abortions are allowed to be carried out by a medical practitioner who believes that continuing the pregnancy would pose more risk to the pregnant person than if the pregnancy was terminated, the imprisonment experienced by the Nepali migrant worker as well as threat of legal repercussions on the doctor proved unnecessarily traumatic and highly stressful in this case.

<sup>1</sup> WHO, 2011.

<sup>2</sup> According to data released by the UN Population Fund (UNFPA) and partners, 28 April 2020.

<sup>3</sup> It is estimated that between 13 million and 51 million women, who otherwise would have used modern contraceptives, will be unable to continue in the Covid pandemic due to disruptions. This may result in 325,000 unplanned pregnancies for disruptions of three months' lockdown. It can also be up to a staggering 15 million unintended pregnancies if disruptions occur up to 12 months.

<sup>4</sup> FRHAM, n.d.

<sup>5</sup> FRHAM, n.d.

<sup>6</sup> Archer, 2018.

## Keywords

Sexual health, reproductive health, sexual rights, reproductive rights, contraceptives, birth control, unplanned pregnancy, safe abortion, Sexually Transmitted Infections (STIs), women's rights.

## Definitions

**Pregnant persons** - This study acknowledges that pregnancy is experienced by all genders, including but not limited to transgender men, non-binary individuals, and other gender nonconforming individuals.

**Non-judgemental** - Having a discernment of one's own attitudes towards people based on cultural, religious, ethical or moral principles allowing healthcare practitioners to provide services without discrimination to patients.

**Barriers of access** - Barriers may include financial costs (cost of services and logistics), structural (availability of and accessibility to clinics), social barriers (lack of community support and stigma), and cognitive barriers (relating to attitudes of service providers).

**Service providers** - Doctors providing sexual and reproductive health (SRH) services.

**RRAAM network** - The Reproductive Rights Advocacy Alliance Malaysia (RRAAM) consists of individuals and organisations, including researchers, activists, lawyers, social workers, service providers and partner NGOS.

**SRH** - Sexual and reproductive health.

**SRHR** - Sexual and reproductive health and rights.

**IUD (Intrauterine Contraceptive Device)** - A small, often T-shaped birth control device that is inserted into the uterus to prevent pregnancy.

**Implanon** - A hormone-releasing birth control implant, used subdermally by individuals with uteruses to prevent pregnancy.

**Depo-Provera** - A contraceptive method, usually medically administered every three months, typically to suppress ovulation.

**MA** - Medical abortion is achieved through a combination of 2 pills, mifepristone, which blocks growth of placenta and misoprostol causing uterine contractions to expel the products of conception. Misoprostol alone may be used to abort the pregnancy but at a lower success rate.

**SA** - Surgical abortion is achieved through the D&C or Aspiration (VA) method

**D&C** - Dilation & Curettage is the process of using a sharp metal instrument to scrape out the pregnancy. It is now considered outmoded, having been replaced by manual vacuum aspiration (MVA), which uses a plastic cannula to suck out the pregnancy. It is considered much safer for patients than D&C.

**LARC** - Long-Acting Reversible Contraception. Methods include Implanon

## Introduction

The objectives of this study are to:

- a) evaluate the gaps in the provision of sexual and reproductive health care, and how private healthcare services are fulfilling this gap within Peninsular Malaysia,
- b) assess accessibility for persons seeking non-judgemental services at private clinics in Malaysia by exploring existing barriers of access, and
- c) gain further insight into the levels of stigma experienced within sexual and reproductive health (SRH) services.

## Methodology: Qualitative Research and Sampling Methods

### *Study Design and Setting*

Qualitative in-depth interviews were conducted at 18 clinics in Penang, Kedah, Kelantan, Pahang, Johor, Melaka, Negeri Sembilan, Perak and Selangor, between January 2020 and October 2020. The interviews conducted were based on a questionnaire on sexual and reproductive health services offered at the clinic.

*Number of clinics attached to a private hospital: 4  
Number of general practitioner (GP) clinics: 7  
Women's health and maternity specialist centres: 7*

The clinics were chosen based on the SRH services offered, including testing for Sexually Transmitted Infections (STIs), contraceptive services and safe abortion. The scope of the interview also included inquiries into the provision of services to vulnerable communities, such as the LGBTQ+ community, as well as observations from clinic staff for signs of sexual assault and domestic violence.

The research aimed to interview one medical doctor and one member of staff per clinic to provide a more thorough understanding of the patients seeking SRH services from the private sector, from the different perspectives of medical practitioners, nursing staff and clinical assistants. However, this was not always achieved due to staff unavailability.

*Number of doctors interviewed: 17  
Number of nurses interviewed: 4*

It should be noted that whilst the research aimed to include staff such as nurses in the interviews, in most clinics surveyed, nurses did not wish to participate in the interview and actively deferred to the doctor in charge to provide responses. Only in 3 clinics were the researchers permitted to interview both a doctor and nurse. The doctor and nurse were interviewed individually in separate rooms in such cases. In 1 clinic, only the nurse was interviewed. The responses given by the participating head nurse, therefore, represent the data provided by the clinic.

### ***Purposive Sampling Method***

All participating clinics provided SRH and safe abortion services at the time of the ongoing research. When asked, 3 out of 11 clinics suggested by RRAAM contacts as prospective research participants, refused to participate in this research. One clinic denied that they provided abortion services and did not allow the researchers to speak with the doctor when the clinic was visited in person. The two other clinics did not want to participate in the research, and did not disclose their reasons.

*Clinics that refused to participate: 2 clinics attached to private hospitals, 1 women's maternity clinic.*

### ***Cold Calling Method***

Additional clinics that provide sexual health and reproductive health (SRH) services were identified via the cold calling method. This method consists of two parts: a) identifying the clinics through the internet and b) cold calling the clinics identified.

- a) Internet sources were used to identify private clinics that provide sexual and reproductive health services, including abortion services within the geographical areas covered. Keywords used included, but were not limited to: "klinik gugur", "klinik gugur kandungan", "klinik pakar wanita", "pil gugur", "women's clinic" and "abortion clinic."
- b) The researchers then followed up by cold calling listed clinics to inquire about services or any known information regarding the availability of sexual and reproductive health (SRH) services in the state. Nonetheless, successfully engaging with clinics posed a challenge using this method. Most clinics denied the provision of services (stating 'no' over the phone) with some clinics hanging up after hearing the words 'abortion' or 'pengguguran' mentioned. This gave some indication as to the stigma surrounding abortion services, amongst private clinics in Malaysia. For example, one clinic when asked about their provision of SRH services, was initially receptive and had inquired about the size of the pregnancy over the phone, with further instructions to the researcher to make an appointment to see the doctor for the abortion procedure. However, at the clinic when the researchers introduced themselves, the nurse denied providing abortion services or giving out such information over the phone.

Example of a conversation with a staff nurse at a private clinic:

*Researcher: "Hello. I would like to ask if you provide abortion services at this clinic?"*

*Example 1 Nurse: "Abortion? No we don't provide."*

*Example 2 Nurse: "No."*

*Researcher: "Do you have any information about any clinics in this area that provide abortion?"*

One clinic participant was identified and included in this research through this method. The nurse confirmed over the phone that they provided abortions and recommended making an appointment to speak with the doctor.

### ***Snowballing Method***

This method allowed the researchers to identifying one new SRH service provider in a state which, prior to the research visit, no safe abortion service providers had been identified. The researchers walked into private clinics and hospitals in the main town areas of each state to inquire about the availability of abortion services. Where none were available, the researchers would then ask for local referrals or leads to other clinics which might provide the services instead. Clinics were chosen through information provided through a telephone inquiry, or by virtue of being the closest in distance to known service providers. 6 clinics were identified using this method:

*Lead from private hospital: 1 clinic  
Lead from 2 family planning associations: 2 clinics  
Lead from the RRAAM network: 3 clinics*

### ***Other Sources of Information***

This research study also involved partners who are medical doctors but chose to not participate in the interviews due to logistical constraints and safety concerns during the Covid-19 pandemic. These doctors are members of RRAAM who provided feedback on this study's findings.

The researchers also obtained information regarding service providers from various reproductive health associations (RHA). The researchers contacted reproductive health associations in 6 states informally by cold calling numbers listed on their websites and one state via email. After providing details relating to the identity of the researcher and the nature of the research being conducted, 4 out of 7 clinic staff who responded to the phone calls stated over the phone that they did not have information on clinics providing safe abortions and could not provide this information to the researchers. For example, during one phone call, when asked about what the procedure would be if a woman was seeking access to safe abortion services, the clinic staff proceeded to inform the researcher that they would provide counselling to continue the pregnancy. This method was partially effective due to its informal nature. Using a formal written request to all RHA branches in each state, in addition to cold calling the organisations, may have yielded different results. The additional method of communication through formal written requests might have introduced increased accessibility to the information required for this research.

### ***Research Limitations with Government Clinics***

Despite Covid-19 constraints, researchers also had the opportunity to visit a Klinik Nur Sejahtera (under Lembaga Penduduk dan Pembangunan Keluarga Negara) outside of restricted movement periods. This visit was not initially planned as the scope of research pertains to private clinics. However, the visit was carried out to gain informal insight into SRH services provided by government clinics, pertaining to family planning and contraceptives. The researchers had a sit down, informal conversation with two staff members, including one clinic manager.

The researchers also contacted the Ministry of Health (MoH) for permission to conduct interviews with government clinics providing SRH services. Efforts to conduct the latter were unsuccessful, due to Covid-19 safety concerns expressed by the MoH. Such access would have provided the researchers an opportunity to compare the manner in which sexual health and reproductive health services were provided, both in private and government clinics.

## Research Findings

### 1. Service Providers

This study identified 18 clinics providing SRH services, including safe abortion. 14 of the clinics were served by male doctors, with only 3 female doctors out of 17 interviewed. All nurses interviewed in this research identified as female. In general, the doctors had more years of medical working experience compared to the nurses, although some of the head nurses who participated in the interview had worked at the clinics since its establishments. Out of 3 clinics where both a doctor and nurse were interviewed, the research found 2 clinics where information provided by both doctor and nurse were similar. In the third clinic, the nurse did not disclose any information regarding the cost of services and deferred instead to information provided by the doctor.

**The mean number of years in women's health services experienced by the doctors interviewed is 29 years**, with the minimum years of experience being 6 years and the maximum being 49 years. **Eight out of 17 interviewed doctors had more than 30 years of medical experience each.** All doctors except two did not disclose their age. However, the two doctors revealed that they were more than 70 years old.

Routine collection of basic information, comprising the patient's background, was performed by the clinic, including details such as age, religion, marital status and nationality of the patient. Such information was normally taken by nurses when patients first came in requesting services. In 1 clinic, where both doctor and nurse were interviewed, the doctor disclosed that the marital status of the patient is taken at the counter by the nurse, whereas the nurse said that it is the doctor who asks the patient about her marital status. Most doctors who were asked maintained that the collection of such information was routine procedure at the clinics and would not affect the services provided. However, two of the doctors interviewed went on to reveal that a patient's marital status would affect the services made available to them. For example, the doctors preferred to recommend birth control pills rather than a LARC method to unmarried women.

The research also found out that 2 clinics which used to provide safe abortion services were no longer providing abortions during the period in which the interviews were conducted. The researchers found out that these clinics had been taken over by younger doctors who, chose not to continue to provide abortion services. All of the doctors who participated in this interview informed the researchers that patients facing unplanned pregnancies are informed of their choices before making the decision to terminate, as well as provided contraceptive counselling to decrease the chances of further unwanted pregnancies. **Four doctors informed the researchers that they would consider discussing the continuation of the pregnancy with the pregnant person as a part of their options.**

**Discussion**

The reluctance on the part of younger doctors (to perform abortions in particular), could be attributed to:

- a) moral questions surrounding abortion,
- b) the personal beliefs of doctors, which affect patients,
- c) the need for in-depth discussions and explorations of sexual and reproductive health (including provision of contraception and safe abortion procedures) within medical syllabuses, as well as,
- d) needed government strategies to provide wider access to a variety of sexual health and reproductive health services, as a key element of creating access to women-centred healthcare.

**2. Access to Contraceptives**

Doctors in this research were not able to provide concrete numbers when asked about contraceptive uptake among patients who visit for other SRH related services. While most doctors reported generally low contraceptive uptake levels among their patients, some noted increases among certain demographics of patients or uptake levels of a certain contraceptive method. **Many doctors maintain that contraceptive uptake remains low among women who seek abortions for multiple unwanted pregnancies.** According to one doctor, only 1 in 20 patients who seek abortion services, opt for post-procedure IUD insertion. One doctor revealed that 8 out of 10 of his patients take up contraceptives. One doctor observed **better contraceptive uptake among Chinese women, whilst 2 doctors observed a general reluctance among Malay women, both married and unmarried.**

Nine doctors said they would **recommend LARC methods such as IUD** as it is effective, and more cost-efficient. Seven doctors revealed that the **Oral Contraceptive Pill (OCP) remains the most popular method of contraception among their patients.**<sup>7</sup> Three doctors revealed that the Depo Provera injection was found to be particularly popular among foreign workers, especially for shift workers. In such cases, the Depo shot was preferred to the OCP as it was seen as convenient with an injection administered every 3 months.

<sup>7</sup> A 2014 survey by LPPKN found that out of 52.2% of women who were using a family planning method, the most popular method was the birth control pill (13.2%).

One doctor associated contraceptive use with women’s level of education.<sup>8</sup> He shared that contraceptives are often used by “young and educated” persons, further disclosing that “women with higher levels of education would be more open to using a method such as IUD.” He also associated living in urban areas as being a factor for unmarried couples actively seeking SRH services, as opposed to the rural population. He further disclosed that child marriage (at 15-16 years old) was rampant in conservative states, explaining that his “only opportunity to provide family planning to them is when they come in for abortion.”

<sup>8</sup> Strong links between women’s education levels and its influence on contraceptive use was found through studies in several countries including Kenya (Shapiro, D., Tambashe, BO., 1994), Serbia (Radulovic et al., 2006), Tanzania (Ayoub S., 2004), India (Moursund and Kravdal, 2003) and Uganda (Buyinza and Hisali, 2014).

One common difficulty encountered by a number of doctors in recommending the use of IUDs, was due to the male partner feeling discomfort at the thought of encountering the IUD string during sexual intercourse.

Nine clinics in this research did not provide the emergency contraceptive pill (morning after pill). The doctors explained that it can be purchased at pharmacies.<sup>9</sup> In the other 9 clinics that do provide it, doctors disclose that requests were rare, occasionally up to 3 in a month. The prices range between RM8-RM100.

<sup>9</sup> Purchase of emergency contraception provides savings to women, who otherwise would have to pay for a doctor’s consultation at a clinic.

One doctor disclosed that she only provides contraceptives to married women. All other doctors in this interview actively advocate for contraceptive use among patients, both married and unmarried.

According to one doctor who did not take part in this research, **doctors who encourage the use of contraception after an abortion, in fact earn less than peers who perform repeated abortions without providing contraceptive counselling.**

Doctors revealed that the rhythm method had to be practised with caution due to high failure rates, which suggesting that they had patients who still practised this method. Doctors and nurses did not comment on patients using the withdrawal method. According to doctors, even when birth control is used correctly, contraceptive failure continues to occur leading to unplanned pregnancy.

A nurse from a participating clinic revealed that she had seen a woman come in to the clinic for an abortion on 8 separate occasions. She further stressed that Malay women are reluctant to take up contraceptives due to lack of support from their spouse.

Seventeen clinics expressed the need to stress the importance of contraceptive use, especially with women who faced an unwanted pregnancy. This research found 5 doctors providing surgical abortions who preferred to recommend that IUD insertion take place at the same time a safe abortion is performed, as IUD insertion is an easy procedure and not time-consuming.

### **Discussion**

Observations regarding the influence of patients' ethnicity on contraceptive choice was consistent with prior research conducted by other researchers.<sup>10</sup> The lack of contraceptive uptake was observed despite patients being provided contraceptive counselling, before and after an abortion procedure. For the long-term, it is worth noting that the the costs of contraception were more affordable than that of an abortion for patients. Yet, **other barriers continued to exist to prevent contraceptive uptake, in spite of the greater financial costs associated with undergoing abortions.**

<sup>10</sup> Najafi-Sharjabad, 2014.

Spousal control was found to be a huge barrier for female patients seeking to prevent pregnancy, as doctors reveal that many women choose not to take up contraceptives without their male partner's approval. Major reasons cited by doctors for lack of contraceptive uptake include:

- a) lack of spousal consent from husbands (despite the female patient's desire to prevent or delay future pregnancy), and
- b) misconceptions about contraceptive side effects, despite information provided on the various birth control choices available.

The authors of this study made an impromptu visit to a Klinik Nur Sejahtera (a branch of LPPKN services) during this research to find out more about their contraceptive practises in comparison to private clinics. The impromptu conversation with staff revealed that contraceptives and family planning were only made available to married couples. The staff further disclosed that although there



were initiatives to provide counselling and increase awareness on contraceptives among youth, services were limited to married persons. Condoms were not provided to adolescents as part of the initiatives to prevent pregnancy or transmission of Sexually Transmitted Infections (STIs).

### **3. Abortion Services Provided**

The research found that 17 doctors participating in this research agree that medical abortion (MA), rather than surgical abortion (SA), remains the most preferred solution for women to address an unwanted pregnancy. Nine doctors revealed that they provided MA to patients. 9 doctors did not provide MA and believe that it is not available in Malaysia. Three doctors stated that following the withdrawal of the misoprostol license a few years ago, both authentic and counterfeit medication to induce abortions are increasingly accessed through black market sources, such as on social media sites online.

Three doctors who were approached but chose not to participate in this research revealed that they used to provide both medical and surgical abortions. Two doctors revealed that they stopped providing any abortions when misoprostol was deregistered for use whereas one doctor revealed that he would still provide abortions in the event of an unwanted pregnancy due to sexual assault. Two doctors in a single state revealed a significant drop in requests for terminations due to availability of MA pills online, especially as stigma was more prevalent due to the majority conservative values in the state.

All the doctors who do not provide MA maintain that it is not available in Malaysia, but acknowledged the prevalence of online sales. Some doctors also revealed that most patients tend to ask for medical abortion pills as their preferred method due to misinformation, as patients are not aware that MA is not allowed in Malaysia. Eleven clinics encountered through the interview only provide terminations of pregnancy in the first trimester, up to 12 weeks gestation, despite that abortion in Malaysia is permissible up to quickening (around 22 weeks gestation). Only 7 clinics provide second trimester abortions.

More than half of the doctors in this research revealed that they have provided abortions based on the length of the pregnancy and the pregnant person's reason for wanting a termination. They also highlighted the importance of providing counselling and support to the patient to continue the pregnancy as an option. The researchers often noted at the beginning of the interviews that doctors were reluctant to speak openly with the researchers. However, as the interview progressed, the doctors became less apprehensive and revealed more information, such as anecdotes on patients.

**In cases of unwanted pregnancy, abortion services remain very much in demand, despite high levels of stigma. This is why doctors choose to provide abortions despite being highly stigmatised.**

All doctors (including doctors who did not provide abortions) were open to receiving information from the researchers regarding the availability of services, and open to referring patients to clinics in other states if necessary. Doctors who only provide abortion services in the first trimester agreed that they would refer their patients to other doctors, given that they knew of clinics providing second trimester abortions.

One doctor referred to his experience in performing abortions as "traumatic" and always recommends continuing a viable pregnancy. This doctor disclosed that he now chooses to provide abortion for pregnancies that are less than 7 weeks along, but only if he assesses the pregnancy to pose a serious health risk to the pregnant person.

Another doctor at a private hospital revealed that in order to terminate a pregnancy before 9 weeks, he would require another doctor in the building to sign an agreement that the procedure was necessary in accordance to the hospital's policy.

A doctor in another private hospital disclosed that he would normally perform an abortion at less than 6 weeks gestation (due to reasons of emotional or psychological stress on the patient) without questions. Once a heartbeat is observed at 7 weeks, he would proceed to discuss with the pregnant person her reasons for requiring an abortion. If a medical reason is present, i.e. a special needs child, then he will perform the abortion. If he does not feel comfortable with the reasoning of the pregnant person, he will then choose to counsel her to continue the pregnancy or refer her to a colleague for the procedure.

Three doctors, in contrast, stated that safe abortion as a medical procedure is an aspect of essential healthcare for women, and that it must be upheld and provided as part of the right to healthcare.

### **Discussion**

The authors would like to raise the possibility that many women are not aware of their options when it comes to assessing their sexual and reproductive health and rights (SRHR), and may often depend on the doctor to provide them with information. Hence, limiting information on the various medical choices available has proven problematic for patients in cases when doctors impose personal principles, judgments and assumptions. Barriers to access, in the case of MA, have been compounded further due to the deregistration of misoprostol in Malaysia and the stigma attached to the use of medical abortion pills.

Reasons disclosed by women, to the doctors, for seeking safe abortion services include: rape, premarital sex, failure of contraceptive method, a pregnancy following a traumatic C-section and the lack of family planning.<sup>11</sup> Although this research has observed women's reasons for requiring an abortion, the exception clause of the Penal Code Section 312 allows a medical practitioner to terminate an unwanted pregnancy if it has potential to cause mental or physical harm to the expectant person. Any attempts to formulate acceptable forms of mental or physical harm go against the intention of the exception clause.

<sup>11</sup> This information is found to be similar to that obtained from women on the RRAAM hotline.

4. **Cost of Services Provided in Private Clinics**<sup>12</sup>

4.1 **Sexually Transmitted Infections (STI) Tests**

Cost of Sexually Transmitted Infections (STIs) testing vary depending on the charges of the laboratory to which the test is sent, as well as the type of infection that is being tested for. As shown in the table, the range of costs for STI tests to be between RM50 (VDRL and gonorrhoea group test) and RM600 for a full blood test. A number of doctors also revealed that "not many" people did STI tests but did not elaborate further. Some doctors did acknowledge that this was due to stigma. The questionnaire did not further inquire into STI testing.

<sup>12</sup> Costs listed were based on costs quoted by the clinic. Costs vary at other clinics based on feedback from doctors who were not included in this interview.

Service	Min Cost (RM)	Max Cost (RM)	Median Cost (Average cost of middle-range option available, RM)
Sexually Transmitted Infections Test(s)	50 <sup>13</sup>	600	100
Oral Contraceptive Pill (OCP)	9	60	30
Depo Provera (3 months)	40	300	60
Implanon	500	950	680
Intrauterine Contraceptive Device (IUD)	150	800	200
Emergency Contraceptive Pill (ECP)	8	100	20
Urine Pregnancy Test	10	60	17.50
Prenatal Follow-up	20	280	80
Medical Abortion (MA)	300	550	N/A
1st Trimester Surgical Abortion (SA)	350	2000	850
2nd Trimester Surgical Abortion (SA)	1300	9000	3000

Table 1. cost of services provided in private clinics

In general, the research found that doctors believed that **their clinics did not provide judgement of any kind towards sexual behaviour**. They generally agreed that **stigmatisation could potentially serve as a barrier of access to STI testing for patients**.

4.2 **Surgical Abortions (SA)**

The surgical abortion (SA) costs in the first trimester as revealed by 18 clinics range between RM350 - RM2000. In the second trimester, doctors revealed a range of costs between RM1300 - RM9000.

Three clinics disclosed that they only provide abortions up to 8 weeks. One doctor at a women's maternity clinic revealed that he provides abortions at a discounted rate for women if they had delivered a child previously. He normally charges patients between RM1400 - RM1500 for an abortion, but if they had a previous delivery, then the charges would be reduced to between RM900 - RM1300. Another doctor revealed that he charges "around RM1000" for an abortion up to 8 weeks. The other doctor charges between RM600 - RM1500 up to 8 weeks.

One doctor who revealed that he provides abortions to minors disclosed that he charges up to RM 2500 for first trimester abortions and up to RM5000 for second trimester. He receives more requests for medical abortions (MA), and performs up to 20 abortions in a month. The same doctor informed the researchers that he would provide discounts depending on socio-economic factors. He further

<sup>13</sup> A doctor commenting on this research, who was not interviewed, offers HIV rapid tests for RM5. Despite affordability, patients were reluctant to test for HIV due to fear of a positive result and possible self-stigma.

informed that he would charge a higher amount to women who he felt could afford to pay more, depending on their reason for wanting a termination but would provide discounts for young persons.

Some service providers who do not have the facilities in their own clinics disclosed that they use the operating theatre at a nearby private hospital. One doctor at a private hospital disclosed that this will affect the cost of services i.e. his charges would be RM600, and hospital charges would be an additional RM600. Other factors that could affect the cost of services include use of a general anaesthesia.

Two doctors, one at a private hospital and the other at a clinic, in this study revealed that they prefer to use a combination of sedation and analgesic before a D&C procedure rather than having a general anaesthetist as it would "cost half as much".

One doctor informed that the clinic would advise the keeping the pregnancy when receiving patients seeking second trimester abortions. A number of doctors disclosed that they would discuss with the patient to continue the pregnancy as an option before agreeing to provide an abortion in the first trimester. Doctors also revealed that they would provide referrals to other clinics for second trimester terminations if they knew of service providers. They also disclosed that they would speak with the pregnant person to provide them with information on their options.

### **4.3 Medical Abortion (MA)**

One doctor revealed that he provides MA at RM500. He stated that he would charge the patient an additional RM200 for a surgical evacuation if the patient experiences an incomplete abortion with the MA method. The nurse at this clinic revealed that they saw up to 50 patients a day during the Movement Control Order (MCO) period, and that the doctor could receive up to 6 requests for terminations daily.

Doctors maintain that MA administered under doctor supervision is effective in the first trimester. One doctor who provides MA up to 9 weeks acknowledged a 5% failure rate of the method.

Another doctor revealed that he provides MA at RM300. According to him, he performs 15 MA procedures in a month. This doctor further disclosed that he remains discreet and attributed this to the clinic's need to avoid issues with authorities due to the stigma surrounding abortion service providers.

#### 4.4 Contraceptives

Modern contraceptive methods such as the IUD, Depo Provera shot, Implanon and OCP were offered in most clinics. Sixteen clinics offer the IUD, 14 clinics offer the OCP, 13 clinics offer the Depo injection and 11 clinics offer Implanon. In terms of cost, Implanon was thought to be the most expensive form of contraceptive offered, followed by the IUD and Depo Provera. One doctor disclosed that he did not provide Implanon because it was “too expensive.” When highlighting contraceptive choice of patients, doctors generally acknowledged that they recommend the IUD. The hormonal patch was found to be the least popular among patients, and doctors revealed not providing them in the clinic due to low uptake.

When asked about how often patients seek contraceptive services, many responded with “rare”, “seldom” and “not many.” **One doctor who does not provide IUDs, Implanon or pregnancy tests revealed that he refers patients seeking IUDs to LPPKN clinics.**

The cost of contraceptives was not highlighted by doctors as an obstruction to women who visit for SRH services at private clinics. Doctors stressed on disinterest and stigma as causing poor attitudes towards contraceptives, thus obstructing many women and girls from using a form of contraceptive to avoid unplanned pregnancy. Doctors also attributed lack of CSE as a cause of issues associated with unplanned pregnancy.

#### Discussion

In Malaysia, STIs have been rising continually and there is an increase in positive diagnoses of chlamydia, genital warts, and herpes. This increase can be attributed to a greater awareness of the problem, more reliable diagnostic techniques, and an increase in the number of health clinics carrying out the tests. The highest increase in STIs has been among the 16 - 24 years age group, suggesting there is a greater need to make contraceptive services and STI treatments accessible to young persons.<sup>14</sup> This can be addressed by actively encouraging contraceptive awareness among youth and making SRH services accessible to everyone.

<sup>14</sup> MyHealth, 2019.

The costs of safe abortion services which remain unregulated in private clinics are a barrier of access to safe services for many. Safe abortion services remain accessible only to persons who have the financial means to afford it, or have the resources to raise funds for their procedure.<sup>15</sup> Some doctors reveal that women have had to continue their pregnancy because they are unable to afford the procedure. Some doctors revealed that they do offer considerable discounts for persons at risk.

<sup>15</sup> A study of women in Kenya found “induced abortion reports were highly associated with high economic status”.

Some doctors disclosed that safe abortion services are an element of essential healthcare for women, and thus they seek to make it as accessible to women in need as much as possible. Doctors disclosed during the research that whilst they sometimes provide safe abortion services free of charge or at discounted rates (when women experience financial constraints), some charge female patients higher fees when they believe that this can be afforded by the woman or when women seek multiple abortions at the same clinic (as a deterrent to future unplanned pregnancies).

Doctors also highlight that they recommend contraceptive use to women facing multiple unwanted pregnancies as a more cost-efficient alternative to abortion,

but it often goes unheeded. Doctors in this research have linked contraceptive use to education levels. Having limited expendable financial resources could serve as a deterrent to women seeking to avoid unplanned pregnancy.

### 5. *Services to the LGBTQ Community/Individuals*

Eight doctors revealed that they do not discriminate and would provide services to anyone in need when asked about services provided to LGBTQ individuals. One doctor revealed that he provides services to “female homosexuals only” and stated that he has not had any transgender patients. He further disclosed that he seldom receives LGBTQ patients. Two doctors stated/revealed that they have not received any LGBTQ-identifying patients. Three doctors revealed that there has been a significant decrease over the past years from LGBTQ-identifying patients, and now they “hardly see any.” **Three doctors stated that they do not provide services to LGBTQ-identifying patients.** In one clinic where both a doctor and nurse participated in the research, the doctor stated that they do provide services to LGBTQ-identifying persons whereas the staff nurse stated (after confirming with other staff in reception) that they do not provide services to “*pondan*” (a transgender slur, usually meant to identify transgender).

### *Discussion*

Most doctors observed that the transgender community specifically do not seek services at their clinics. They surmised that this could be due to patients fearing further stigmatisation and judgement while accessing medical services, and the possible lack of awareness about the availability of services within the community.

There was observable stigma towards gender non-conforming persons due to the prevailing archaic social constructs. This could potentially cause queer identifying persons to avoid seeking SRH care in fear of judgement.

### 6. *Racial Biases*

The research also found that there is a degree of influence of racial bias on practises by some doctors. For example, when asked about contraceptive uptake levels, one doctor disclosed that “Malay people are reluctant to take up contraceptives.” Two nurses who chose not to take part in the interviews also disclosed a general reluctance among Malay women to take up contraceptives. One nurse disclosed that Malay women would rather use abortion as a form of contraceptive rather than using a birth control method.

One doctor disclosed that “abuse is not recognised in Malay culture.” He further opined that in relationships, Malay women tend to tolerate and accept negative behaviour, even when it includes a form of violence from one’s spouse. He surmised that this might be the reason why women from the Malay community are less likely to report incidents of domestic abuse to the police.

Another doctor revealed that “Indian people have a low tolerance for pain.” The doctor gave the example that an Indian woman “will flinch even before I pinch her.” He further disclosed that the amount of painkillers he provides to women before a procedure is based on her race and his assessment of her pain threshold levels. Another doctor, who does not provide abortion services to minors, revealed that he suggests keeping the pregnancy and considering adoption, “especially to Indians as it is a culturally sensitive issue.”

### **7. Observations by Clinics for Signs of Violence**

Seven out of 18 clinics interviewed disclosed that either the doctor or a staff nurse observes for signs of sexual assault or domestic violence in patients. Nine clinics did not observe for signs of abuse or assault while 2 clinics practised referring victims of sexual violence to the government hospital. Signs that were observed include visibly shaking hands, scars and bruises as well as body language with a partner. **Some doctors choose to see the patient alone during the initial consultation to ensure that the patient has the privacy to speak freely. This is carried out to minimise the psychological coercion that might otherwise occur with an abusive partner present.** Doctors who have had experiences with abusive couples reveal that when victims are encouraged to lodge a report, most choose not to take any action.

One doctor disclosed that he had seen situations of violence unfold in his clinic between couples. He further acknowledged that he has observed “mental abuse of the husband by the wife” and provided the example of a situation where the wife has threatened to leave the relationship if the husband did not agree with her choices. He disclosed that he “provides advice” to patients in such situations.

For patients experiencing pregnancy as a result of sexual assault, 3 doctors preferred to refer patients facing an unwanted pregnancy to the government hospital for the safe abortion procedure, and also for ease of reporting to the police. Seven doctors revealed that they do provide services for women and girls facing an unwanted pregnancy as a result of sexual violence due to empathy, both for their social realities, and the trauma caused by the process of lodging a police report. One doctor, who disclosed providing abortions to minors with parental or guardian consent, believed that the concept of familial abuse is not recognised in traditional family structures and relationships.

### **Discussion**

The research noted that victims of sexual violence are more vulnerable to limitations when seeking access to sexual and reproductive health care, such as STI testing and contraceptives. Some barriers of access include an abusive partner, a family with conservative attitudes towards SRH, lack of financial resources for STI tests and contraceptive to prevent pregnancy, as well as stigma towards victims of sexual violence.

### **8. Awareness on Legality of Abortion**

Some of the participating doctors believed that abortion is illegal. They disclose that abortion is illegal, with the exception of instances where the mental or physical health of the pregnant persons is at risk of harm. However, these doctors would perform the procedure if it was deemed necessary to preserve the health of the patient. Despite the legality of abortion services, this fact is not known to or embraced by many healthcare personnel. Three doctors who revealed that they do provide abortions chose not to participate in this research, but did not disclose their reasons. Two doctors revealed apprehension in relation to revealing that they provide abortions, due to the fear of repeated visits from authorities. According to one doctor, many doctors do not know that safe abortion is permissible and are therefore, less open about providing the service due to fear of prosecution. The research found that all doctors agreed that preserving the health of a pregnant person was an accepted reason in terminating an unwanted pregnancy.

### Discussion

A survey conducted by Reproductive Rights Advocacy Alliance Malaysia (RRAAM) conducted in 2007, which polled 120 doctors and nurses, found that only 57% of respondents were familiar with abortion law. This misunderstanding of the law, combined with a fear of prosecution by government authorities, has caused many medical service providers to be reluctant to reveal that they perform abortions. Such misunderstanding may explain the absence of younger doctors who are willing to perform safe abortions under the law. This could be highly detrimental to the future of SRH services. As the number of known safe abortion service providers dwindle, people are turning to unverified sources of information and fake doctors to purchase medical abortion pills. Medical abortion pills consumed wrongly can have severe adverse effects on the person. Currently in Malaysia, lack of strategy to address safe abortion services as part of essential healthcare provision is exposing women to risk of serious harm. If this trend continues, there would be severe consequences to women's health and safety in the future.

Cultural and religious dogmas, and the personal beliefs of the medical doctor, in assessing the damage to the patient's physical or mental health, can serve as a further barrier of access for a woman seeking an abortion, in addition to contraceptive services to prevent pregnancy. Again, such barriers are compounded by fear of persecution by the authorities for providing safe abortions in particular, as well as societal stigma surrounding medical doctors who provide the service and persons who seek such services.

### 9. Barriers of Access

Geographic location of clinics was not found to be a limiting factor in this study, as most doctors reported they received patients from all over Malaysia.<sup>16</sup> Some doctors also highlighted that patients prefer to travel a longer distance, to seek the services of a doctor, provided that the referral was provided by a trusted source.<sup>17</sup> Travelling across state lines to seek abortion services was also seen as a protective measure to avoid risk of having their family or community members discover the unplanned pregnancy or abortion. Other reasons for women crossing state lines include the unavailability of late-term abortion services within the state and rejections by doctors in the state<sup>18</sup>, who refuse to perform an abortion based on stringent criteria beyond their interpretation of the law.

Sixteen clinics in this research revealed that they required some **form of consent**, **either written or verbal, from the patient** before performing an abortion. Three doctors revealed that they do not ask for written consent from the patient and would proceed with the abortion after receiving verbal consent. Seven doctors revealed that **they require consent from both the pregnant person and their partner/ or spouse in order to perform an abortion**. One doctor revealed that he would not provide an abortion without consent from the partner; he applied this criteria to unmarried couples as well as married couples.

All doctors who provided **terminations for minors under 18 years of age, required a parent or partner to provide consent** as well. Doctors disclose that they would provide terminations to minors who came with their partner without parental consent. Several doctors disclosed that they have **turned away adult patients seeking abortion services without their partner's written consent**. Although most doctors maintain that safe abortion is a woman's right and choice, some doctors

<sup>16</sup> The data provided by doctors in this research encompasses women with the financial ability to access doctors providing SRH services, even with additional transport costs.

<sup>17</sup> This contrasted with other research conducted by RRAAM, which discovered that many women seeking TOPs were unable to do so due to costs of travel.

<sup>18</sup> A staff at a reproductive health association informed the researchers that she provides referrals to neighbouring states as there were no known service providers within the state.



maintain that safe abortion is a woman's right and choice, some doctors revealed that partners have a tendency to cause a scene at the clinic if they find out their partner has had an abortion without their knowledge.

When asked, doctors revealed that they do not openly acknowledge their provision of safe abortion services, even among fellow medical practitioners. Doctors agreed that **there exists stigma around abortion, even among doctors**. Many doctors are not open about providing abortions as they are fearful of the law. Four doctors revealed that they continue to provide abortions because it is an essential service and without access to safe abortion, an unwanted pregnancy can have adverse effects on the pregnant person. All the doctors in this research agreed that abortion is a safe medical procedure and allowed in Malaysia.

### **10. Gender Norms**

The research found that gender norms affect access to SRH care. A main cause of low contraceptive use in women, especially married women, was found to be lack of spousal consent. One nurse disclosed that married patients, especially Muslim female patients, disclosed that the IUD was not suitable for them because their husbands found the attached string uncomfortable during sexual intercourse, even with the risks of pregnancy. One nurse revealed that when suggesting a contraceptive method to women, they often responded by saying "*tak apa lah kak, suami saya tak suka*" (it's ok, my husband does not approve). Doctors and nurses have also disclosed that women are reluctant to take up contraceptives for fear of side-effects: such as permanent infertility, weight gain and other hormonal changes.

### **Discussion**

Heteronormative gender roles can be seen to play out when women are asked to make contraceptive choices. According to doctors and nurses, women reveal that sexual and reproductive health decisions required discussion and absolute consent from their partners, which was a major factor influencing low follow-up compliance. This pattern was also observed among women who sought multiple abortions. Lack of contraceptive knowledge in men could often result in them denying their partners the right to use a contraceptive method. This reveals that family planning knowledge must be provided to both married and unmarried men and women. As a result of patriarchal family systems, women's sexual and reproductive health is governed by parents or spouses. They could be denied the right to contraceptives, and have to resort to abortion to address unwanted pregnancy because of the lack of family planning knowledge. Persons could also be forced to carry on with an unwanted pregnancy in many situations because abortion services are stigmatised and women are chastised for obtaining a safe abortion. Such systems and norms deny women their right to bodily autonomy and the right to choose if and when to have children.

The researchers would also like to highlight that the power dynamics between a medical service provider and a woman seeking to address an unwanted pregnancy is significant in affecting women's choices. Women facing unwanted pregnancy are stigmatised and vulnerable, unmarried and have been subject to judgement, are involved with an unsupportive partner, face financial constraints, or support large families. These women rely on doctors to provide them with a solution in a time-sensitive manner, whether to prevent pregnancy or to seek conducive

solutions to unwanted pregnancy. When denied safe and affordable SRH services by doctors, women are denied their right to healthcare.

A greater awareness on the part of the medical provider, of their degree of influence on female patients, is important to communicate to women their reproductive health options effectively and in a supportive manner. This degree of influence may also extend to encouraging the male partner to understand the physical and psychological challenges posed to women who experience unplanned pregnancy.

## Discussion of Strengths, Limitations, Bias and Challenges

### *Strengths*

- a) Despite limited resources and travel restrictions imposed by the Covid-19 pandemic, the researchers of this study were able to access all Peninsular Malaysia states to gain insight into SRH services provided at private clinics.
- b) All of the interviews conducted in the 18 clinics were conducted in-person, between Covid-19 restricted movement periods. In-person interviews provided a better assessment of the clinics, and allowed researchers to build trust on the part of doctors and clinic staff. Providing accountability in person allowed doctors and clinics staff to clarify the scope of the research in person, and to feel more comfortable about sharing their experiences of providing sexual and reproductive health services, which still invite local stigma. In-person visits also allowed the researchers the opportunity to understand clinic operations upfront, and to view and assess clinic facilities, such as the operating theatre and recovery room.
- c) Travel to the various states enabled the researchers to seek out clinics that would have otherwise remained anonymous. Despite having scheduled appointments, not all doctors ended up participating in the interview. For clinics that were non-responsive over the phone, showing up at the clinic allowed for better communication with the staff, to gain permission to speak with the doctor in charge. In some states where information on services were not available online, in-person visits to local reproductive health associations allowed the research to be informed on the options available for women seeking access to SRH services.

### *Limitations*

It should be stressed that the findings of this research do not aim to provide an exhaustive review of all service providers in Malaysia. The researchers acknowledge the existence of other private clinics providing similar sexual health and reproductive health services in Malaysia.

- a) Where researchers were able to identify potential clinic participants in various states, including some of those clinics in this research was not possible due to the Covid-19 pandemic. For example, 3 clinics were closed during the duration of a visit to one particular state by the researchers. Travel restrictions caused by the pandemic also meant that researchers were limited in their time spent per state.
- b) Gaining knowledge of other existing clinics proved difficult, as researchers were limited to online searches, and referrals from other clinics in-state or NGO partners. Again, such limitations were compounded upon by the

pandemic, as researchers were unable to travel to more towns per state, for the purposes of locating potential clinics and hospitals that were willing to participate in the research.

- c) Researchers were prevented from visiting East Malaysia due to Covid-19 travel restrictions. **Including findings from Sabah and Sarawak would have provided a better understanding of the different micro-challenges faced in both Peninsular and East Malaysia.**
- d) Although this research focuses upon the provision of SRH in private clinics in Malaysia, access to government clinics would have allowed the study the opportunity to learn from government best practices of providing women-friendly services. Comparing SRH services provided in women-friendly health clinics, both in the private and government sector, would have also provided a more comprehensive view of the resources available to the public and of possible collaborations available to private and government clinics within a wider framework in future.
- e) None of the clinics that participated in this survey had disclosed keeping records of patients. Therefore, all quantitative data provided by doctors and nurses were based on average estimations based on memory recall.

### **Biases**

Several factors introduced a bias in this study when identifying clinics:

- a) The stigmatisation of SRH services created multiple hurdles when seeking information both through the telephone and in-person. As a result of this, the researchers were not able to obtain information that could represent a larger number of service providers in the country, thus limiting the scope of the study to the clinics that were willing to participate. Some clinics did not want to be included in the research.
- b) The female gender of both researchers impacted the process of obtaining information. For example, when asking about the provision of safe abortion services at both a private clinic and a private hospital, the researchers were asked to register as patients in order to see the doctor. In this situation, the staff assumed that one of the researchers was pregnant and seeking a termination. In order to maximise chances of being able to speak with the doctor, the researchers complied with the staff's requests. The researchers always disclosed their roles as researchers when speaking with the clinic staff and doctor.

### **Challenges**

This research observed that the development of the Covid-19 pandemic environment provided additional challenges that affected access to healthcare for women. During the interviews, all doctors in this study reported a drop of 50% or more in the number of visits by patients to the clinic during the periods of restricted movement imposed by the government.<sup>19</sup> Fear of contracting the virus and travel restrictions resulted in the inability of many women to seek various sexual and reproductive health services in a timely manner. This resulted in unplanned pregnancy or delayed access to safe abortion services, which would result in increased costs of procedure, or couples having to carry the pregnancy to term.

<sup>19</sup> At the same time, the RRAAM hotline had experienced a 48% increase in the number of callers to the hotline, seeking information on unwanted pregnancy and abortion services

## Conclusion

As the analysis and examples in this research paper have demonstrated, significant improvements need to be made in order to improve the quality of and access to SRH services in private clinics. The research also found through interviews with experienced doctors and partners of the study that there exists significant barriers of access to SRH services for women both in the public and private health sector. Stigma remains widely prevalent in private clinics and serves as a factor that obstructs women's access to safe and non-judgemental services. SRH services, especially contraceptives and abortions, remain accessible to women who can afford services at private clinics. Access is severely limited to women who face financial barriers and are denied services at government clinics. Women are not guaranteed to receive non-judgemental service both in private and government clinics.

## Recommendations

### *For The Wider Public*

1. To advocate for non-judgmental and safe SRH services for all.
2. To advocate for the provision of scientific and fact-based information to persons requiring SRH services in government and private clinics.
3. To advocate for the need to carry out technical seminars on sexuality, contraception, abortion, reproductive rights and gender equality within a SRH medical framework for government and private service providers.
4. To encourage the provision of SRH services as a right and promote greater bodily autonomy by practising non-judgement and supporting health rights for all.

### *For Policymakers and Government*

1. To recognise that access to SRH services by all members of the public is essential to their healthcare, and that the denial of care impacts adversely on access to sexual and reproductive health and rights (SRHR).
2. To develop a framework of sexual and reproductive health (SRH) service provision to provide SRH training from a rights-based perspective, to both private and government sector medical service provider
3. To regulate costs of SRH services, including tests for Sexually Transmitted Infections (STIs), the full range of contraceptive methods and safe abortions to increase accessibility through affordability.
4. To register mifepristone and misoprostol in Malaysia. MA pills should be made accessible to all doctors to perform early terminations (9 weeks and below).
5. To enact policies that standardise the provision of, and regulate charges for, early surgical terminations (12 weeks and under) using Vacuum Aspiration, under light sedation and local anaesthesia.
6. To stress clearly on the intention of Section 312 of the Penal Code to reduce ambiguity, in the public and among service providers, on the legality of safe abortion.

7. To create opportunities for greater public - private sector collaborations for SRH care.
8. To provide information on STI prevention and treatment, contraception and safe abortion upon request.
9. To support and expand upon efforts by state family planning associations to increase awareness on and access to SRH services.
10. To increase advocacy efforts with the public to acknowledge the need for destigmatised access to STI testing, contraceptive use and safe abortion services.

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