# "If You Don't Try, You Wouldn't Know Right?" Exploring Adolescent Sexuality, Sexual Risk-Taking Behaviour and HIV Risk

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## INTRODUCTION

In this paper, the authors make problematic adolescent sexuality in the context of a growing HIV epidemic. The objectives of this paper are; 1). to explore qualitatively adolescent attitudes, subjective norms and practices regarding sexuality and risk-taking behaviour, 2). to develop a clearly defined research problem for future applied research in HIV prevention among adolescent groups and 3). to explain the discrepancies between knowledge on HIV prevention and sexual practices with some suggestion for adopting a comprehensive HIV prevention strategy.

Why is the study on sexuality important? There is not a moment in a day where our sexuality does not impinge on us. Often, the consequences felt are innocuous, for example, through the way people perceive us; as assertive or capable, harmless flirting, complements, aesthetics and biological rhythm, however, there are times when sexuality can lead to risk. More so during the adolescence period where new experiences and freedom can mean exploring unchartered territories. Sexual risk here refers to HIV/AIDS specifically (although the risk to other health related issues such as STDs are just as important). Statistic on HIV/AIDS globally shows a worrying trend that those infected tend to fall within the age bracket of young adult.

**Keyword:** Adolescence, Sexuality, Sexual Risk-Taking, Prevention Strategies.

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## AN ARGUMENT FOR BROADENING THE SCOPE OF TARGETTED GROUPS

The focus in addressing the rising figure of HIV infection in Malaysia have for a long time been among high risk groups identified to include Intravenous Drug Users (IDU) and commercial sex workers (mostly, among the lower segments of the industry). The approach was two-pronged; government took a rigid and unforgiving stance through strict enforcement and non-governmental organizations (NGO) such as the PT foundation and Ikhlas, conducted outreach programs that included distributing free condoms, providing counselling and educational services and creating networks of support groups for sex workers and drug addicts. A recent statement made by Dr. Hans Tieru, the WHO representative to Malaysia, however reflects the limitation in this approach. According to Dr. Tieru Malaysia is on the threshold of a HIV epidemic (NST, 2005b).

Because of the rising figures, the failure of previous practices and approaches need to be readdressed. This point is not loss on the government as it is now considering implementing what it terms as drastic measures.

To her credit, Datin Paduka Marina Mahathir, the president of the Malaysian AIDS Council has for over a decade been passionately advocating for more liberal measures in combating the rising number of newly infected HIV cases in Malaysia and the results are beginning to show. Recently the Ministry of Health (MoH) announced that it is considering harm reduction methods such as distributing free condoms, introducing the needle exchange programme and providing alternative drug treatment services to curb the spread of HIV among Intravenous Drug Users (IDU) (NST, 2005, Star, 2005b, 2005c). This move towards harm reduction has a partner in Datuk Zaman Khan the previous Director General of Prisons (Star, 2005a). A few weeks ago it was announced that the Ministry of Education (MoE) was going to introduce sex education in school; a move the MoE has resisted for several years due to the conservative belief that teaching about sexuality means condoning pre-marital sex. These are positive signs, firstly that the government recognises HIV/AIDS as a social problem and is taking steps to address this issue through the role of different ministries and secondly, the measures are addressing substantive issues. Nevertheless resistance from conservative faction remains as a stumbling block. Many people continue to feel that measures such as those advocated in the harm reduction programmes condone and may promote promiscuity and drug abuse. They see effective intervention of HIV/AIDS infection through moral enforcement, the more extreme view being to segregate the sick from the rest of society.

Marina and others have pointed out that the Malaysian experience with HIV/AIDS is not unique. Other countries around the world are also faced with this problem and have been successful in keeping the figures low or as in Thailand and Ghana, in bringing drastic reduction to the numbers of newly infected. It is interesting to note that last year Australia saw an increase in HIV infection by 600 people. That same figure was reported for the state of Kelantan alone. In Malaysia during the same period, there were over 6000 reported cases of newly infected. Marina reminds us that HIV should not be addressed as a moral issue rather we should approach the problem scientifically.

Statistics tell us that 20 people in Malaysia are being infected by the HIV virus daily. The challenge is to bring down this figure. For IDU, Dr. Adeeba Kamarulzaman, the

convenor for the Malaysian Harm Reduction Working Group, states that "(drug users) were more likely to change their HIV-risk behaviour if there was a supportive environment where health and social injustice were addressed and they had equal access to appropriate healthcare, prevention and treatment services." (Star, 2005c). The new approach proposed by the MoH appears to reflect this belief.

The MoH position to address drug users directly is commendable, however, the problem HIV raises is a holistic one and requires cooperation between different ministries and NGOs. Nevertheless, the Minister of Health has also made another step forward by recognizing that the challenge in reducing the number of newly infected HIV cases extends to include sexual related activities such as through unprotected sex. Perhaps as a gesture to placate the conservatives, the minister stresses that focus of harm reduction will be among injecting drug users (NST, 2005b). This move, consistent with earlier approaches, empowers high risk groups which are marginalised but due to the nature of HIV, stigma and discrimination which causes it to be shrouded in secrecy, what this also means is that the responsibility in curbing the spread of HIV rests largely with them. Without extending consistently information and services through public programs, the move may dis-empower the general public by the persistence of ignorance and stigma. Currently, there is no concerted effort to address adolescents, young adults, professionals and the mainstream public in general to the risk of HIV/AIDS. The sex dimension of HIV refers to the clients and their spouses, the perception of safe sex in middle class commercial sex industry and sexually active young adults exposed to an ever changing environment on courtship norms, commercial sex, pornography and drugs. These dimensions continue to be ignored in formulating HIV prevention approaches.

In addressing the risk of HIV/AIDS to young people, better intervention approaches can be achieved only through a frank discussion about individual experiences in experimentation with sex, drugs, and abortions, as well as trying to understand the general social atmosphere that permeates through much of the adolescent world, with its views and attitudes on the boundaries of acceptable behaviour in courtship norms, nightlife, accessibility to commercial sex and sexually explicit materials, premarital sexual relationships and the availability of a variety of recreational drugs as well as what these means to them.

## KEY CONCEPTS

There are three main concepts central to this research. These concepts are adolescence, gender and sexuality. A fourth concept, Power, elucidate the interrelation between gender, sexuality and HIV risk (Gupta, 2000). While gender and sexuality are two different concepts these are concepts that are acutely expressed during the adolescence period as this is often characterized by experimentation and the continued search for their own expressions and identities.

Adolescence is often described as a period of transition from childhood to adulthood. It begins usually by the onset of puberty and ends when a person is given responsibility over adult activities. The duration of adolescence varies. In traditional societies this may be marked by marriage or having gone through a ritual that marks the rites of passage. In contemporary times, this period may be extended as in societies where a high degree of

technical skills and intellectual maturity has to be acquired before an individual can assume adult status. Other factors may also lengthen the period of adolescence such as delayed marriages, increased participation of women in education and the employment sector and improved healthcare services (Zulkifli, 1986). John Dacey and Maureen Kenny, two adolescence development psychologists explain that this period is often accompanied by increases in sexual arousal, interest and behaviour. The increase in interest in sexuality results from both biological and social factors. They explain that hormonal changes stimulate sexual interests and motivation which contributes towards changes in physical appearance and attractiveness to members of the opposite sex. Changes in physical appearances and attractiveness indirectly affect sexual behaviour as young adolescents suddenly find themselves becoming the object of sexual attention. However, while biological factors assert influences on sexuality, social factors "...including expectations and controls that limit opportunities for sexual behaviour also have an influence on the way in which sexual interest is expressed. The timing and incidence of sexual expression is largely determined by socio-cultural norms in the community, family and peer group." (Dacey, John and Maureen Kenny, 1997:2).

Sexuality is a word that has many connotations. Popular meaning of the word includes "... (i) quality of being sexual or having a sex, (ii) recognition of or a preoccupation with what is sexual, (iii) possession of sexual powers, capacity for sexual feelings and (iv) sexual orientation or preferences". (Oxford, 1993) As a concept, sexuality has a much more complex connotation. Broadly, it deals with the social construction of a biological drive.

Gupta (2000) elaborates that an individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes. However, sexuality is a concept that covers more than sexual behaviour encompassing both a multidimensional and dynamic frame. What influences one's sexuality across cultures is a combination of explicit and implicit rules that includes socio-cultural, gender, age, economic status and ethnicity. These are regulated norms and behaviour imposed by society. Sexuality consists of several components which include practices, partner, pleasure/pressure/pain and procreation. The first two components refer to how one has sex and with whom, while pleasure/pain/pressure and procreation refer to the underlying motives. A fifth component power is a binding force underlying any sexual interaction, heterosexual or homosexual which determines how all the components of sexuality are expressed and experienced. Gender is defined as a culture-specific construct. A gender role refers to a pattern of behaviour that result partly from biological make up and partly from the socio-cultural construct of the society.

## CONTEXTUALIZING SEXUALITY AND HIV RISK

HIV is a growing problem globally and has many medical, social, economic and moral implications. In 2002, there were 42 million people living with HIV/AIDS globally. The figures indicate that men outnumbered women by double, at 38.6 million, while infected women number at 19.2 million (UNAID, 2002). HIV/AIDS is a disease that inflicts all age groups, especially the young and productive in the community (15-49 years of age). The disease is transmitted mainly through sexual intercourse (mostly heterosexual and in some countries the prevalence is through homosexual intercourse) and Intravenous

Drug Use. Those infected by the HIV virus are immediately affected by the disease; the costs of medicine and healthcare services, the stigma and discrimination, the real threat of being abandoned by their families and shun from their friends and colleagues as well as the deterioration of health, however there is a broader spectrum of victims encompassing non-infected people, including children[1], spouses, family members, friends and society. Stigmatization of the disease has almost meant that information about it often touches on taboo or socially avoided topics such as sex.

HIV/AIDS is also a growing problem domestically. There are at present over 60,000 people infected with HIV/AIDS in Malaysia and the data register an annual increase by about 10% (refer to table 1). The Minister of Health, Datuk Dr. Chua Soi Lek believes that if left unchecked, the number of infected cases in ten years will be around 300,000 (Star, 2005b). According to the statistics over 70% of infections are due to Intravenous Drug Use (IDU). Nevertheless a study done among drug rehabilitation centres in 1998 showed that of the 77.6% who admitted to being sexually active only 18.7% used condoms (Star, 2005b). In Malaysia, the second most common source of infection is through sexual intercourse.

**Table 1: HIV/AIDS cases Reported in Malaysia between 1986 to September 2004.**

| YEAR | HIV Infection * | AIDS | AIDS Death |
|---|---|---|---|
| 1986 | 3 | 1 | 1 |
| 1987 | 2 | 0 | 0 |
| 1988 | 9 | 2 | 2 |
| 1989 | 200 | 2 | 1 |
| 1990 | 778 | 18 | 10 |
| 1991 | 1,794 | 60 | 19 |
| 1992 | 2,512 | 73 | 46 |
| 1993 | 2,507 | 71 | 55 |
| 1994 | 3,393 | 105 | 80 |
| 1995 | 4,198 | 233 | 165 |
| 1996 | 4,597 | 347 | 271 |
| 1997 | 3,924 | 568 | 473 |
| 1998 | 4,624 | 875 | 689 |
| 1999 | 4,692 | 1,200 | 874 |
| 2000 | 5,107 | 1,168 | 882 |
| 2001 | 5,938 | 1,302 | 975 |
| 2002 | 6,978 | 1,193 | 881 |
| 2003 | 6,756 | 1,076 | 700 |
| 2004 (Sept) | 3,474 | 661 | 535 |
| **TOTAL** | 61,486 | 8,955 | 6,665 |

** Includes AIDS cases and AIDS death never previously notified as HIV*
Prepared by the Ministry of Health

[1] *The NST in an article titled HIV ALERT! reports that there are 15,000 children made orphaned by HIV/AIDS.*

While it has been commented that the existing data may be bias towards IDU through inclusion by compulsory testing among prison and drug rehabilitation centre inmates, they do register some worrying trends, firstly that it affects largely a relatively young age group; the majority infected are between the age of 20 and 39 years, about 1/3 are between the age of 13 and 29 years, secondly, that there is a rising figure among women (for a break down of people infected with HIV/AIDS by age refer to table 2). In addition the data is unclear on the socio-economic background of the risk groups making a study on adolescence and risk-taking behaviour especially important to understand the risk these groups have to HIV/AIDS infection (refer to table 3).

**Table 2: Statistics on HIV/AIDS in Malaysia by Gender, Age and Method of Transmission**

| Factor | Classification | HIV | AIDS |
|---|---|---|---|
| Sex/Gender | | Infection | Cases |
| | Male | 54,231 | 7,594 |
| | Female | 3,781 | 700 |
| | Total | 58,012 | 8,294 |
| Age group | < 2 yrs | 131 | 35 |
| | 2-12 yrs | 333 | 99 |
| | 13-19 yrs | 902 | 190 |
| | 20-29 yrs | 21,295 | 1,727 |
| | 30-39 yrs | 24,793 | 3,723 |
| | 40-49 yrs | 8,281 | 1,882 |
| | > 50 yrs | 1,596 | 609 |
| | No data | 680 | 29 |
| | Total | 58,011 | 8,294 |
| Transmission based on risk factor | IDU | 43,8917 | 5,027 |
| | Needle prick | 0 | 0 |
| | Blood receiver | 28 | 17 |
| | Organ receiver | 3 | 3 |
| | Homo/bisexual | 593 | 170 |
| | Heterosexual | 7,498 | 2,140 |
| | Mother to child | 399 | 102 |
| | No information | 5,600 | 835 |
| | Total | 58,012 | 8,294 |

Sources: AIDS/STI Unit, Ministry of health Malaysia
Prepared by: Resource Centre Malaysian AIDS Council

**Table 3: HIV Cases by Employment**

| Types of employment | Frequency |
|---|---|
| Unemployed | 9, 062 |
| Factory worker | 4, 190 |

Source: Utusan Malaysia.

## RESEARCH IN ADOLESCENT SEXUALITY IN MALAYSIA

Research into adolescent sexuality is at its nascent in Malaysia. Much of the existing body of literature was carried out quantitatively and generally has been largely descriptive; quantifying among other things the percentages among adolescents who have engaged in sex, the age they first had sex, types of sexual practices, attitudes towards sexuality, sources of information on sex as well as including gender informed theoretical perspectives. There is still much work that needs to be done especially since there appears to be hardly any local work that addresses these issues substantively.

A quick and by no means exhaustive search on the topic of adolescent sexuality in Malaysia shows a dearth of material. Most of the research work in this area at University Malaya for example was concentrated in the Health Education Research and Development Unit (HERDU), Faculty of Medicine. Among Non-Governmental Organizations interested in this subject area, such as the Federation of Family Planning Association Malaysia (FFPAM), commissioned research work remain relatively low. Listed are among the significant research carried out locally on adolescent sexuality. In 1986 Siti Zulkifli published a paper titled *Adolescent Sexuality: Any in Malaysia*, in the Singapore Journal of Obstetrics and Gynaecology, followed by another publication in 1995 by Siti Zulkifli, K. Yusuf and Wong Yuet Low, titled *Sexual Activities of Malaysian Adolescent* published in the Medical Journal Malaysia, and a third publication in 2002 by Siti Zulkifli and Wong Yuet Low titled *Knowledge, Attitudes and Beliefs related to HIV/AIDS among Adolescents in Malaysia.* A study was also commissioned by the National Population and Family Development Board, titled *National Study on Reproductive Health and Sexuality of Adolescent in Malaysia.* A more recent research commissioned by the FFPAM in December, 2003 titled *Adolescent Boys' Health: HIV/AIDS, substance use and reproductive and sexual health* was conducted by Low Wah Yun, Ng Chirk jenn and Kamal S. Fadzil.

The findings suggest more work needs to be done in this area (Zulkifli, 1986). Data presented suggest males were engaged in sex earlier than females. Females generally felt more confused over masturbation than males and the level of general knowledge about HIV/AIDS among adolescents was high (Zulkifli, Low WY, Yusof K., 1995). The data also indicates that while generally a small percentage admitted to having engaged in sexual intercourse, most did not use condoms and they did not consider themselves to be at risk (Zulkifli, Wong YL, 2002). Research also showed that sexual behaviour was predicated upon several factors including gender, employment and sexual perception (Zulkifli, Low WY, 2000). These studies advocate sex education as a method of reducing sexual risk-taking behaviour and to prolong the onset of sexual experimentation (Zulkifli,

Wong YL, 2002, Zulkifli, Low WY, 2000, Zulkifli, Low WY, Yusof K., 1995).

Data presented shows that there is much gap in what we know and not many research publication have attempted to answer these shortcomings. For example who were adolescent males engaging sex with? Why were males having sex earlier, and what factors contributed to females engaging in sex later? Why were the majority of respondents not using condoms as a means of contraception? What does sexual risk-taking behaviour mean to young people? Do they consider their actions as risk-taking? Why engage in sexual intercourse, what does it mean to them? Do male respondents generally take more risk than female respondents? Is there a link between knowledge, gender and sexual risk-taking behaviour? Can education be an effective intervention instrument in promoting safe sex? How do gender, employment and sexual perceptions influence sexual behaviour?

There is a need to make a paradigmatic shift in addressing sexuality and HIV, especially if we make adolescent sexuality the research problem. We need to change from approaching the issue as 'top-down', i.e. thinking for adolescents and knowing what is best for them to learning about their needs and attitudes from a 'bottom-up' perspective and to understand the changing dynamics in adolescence sexual values, attitudes and experiences.

## METHOD

The study carried out in 2002 was a qualitative based research and had applied several research methods, including conducting a focus group discussion, in-depth interviews and general observation. The main approach to research however, was the in-depth interview method. A female research assistant close to the age of the respondents was selected to conduct the interviews with the female respondents[2]. A total of 16 respondents were interviewed, six males and ten females. The respondents selected for the research were among students in private institutions of higher learning because it was felt that they have ready access to information on HIV/AIDS through available sources. Other studies also show that it is during this time, in their late teens that most young people gain access to freedom and are able to explore their own sexuality.

Initially an FGD was conducted to test the structured and semi-structured questionnaire for the in depth interview. The FGD was also useful in helping the researchers and research assistants formulate ways to conduct the interviews. Subsequently, 16 in-depth interviews were carried out (please refer to table 3). The research themes included family relationships, attitude and perceptions towards sexuality, sexual behaviour, attitude towards use of contraceptives, knowledge of safesex and HIV/AIDS as well as attitude towards violence in relationships. Respondents were given a structured questionnaire to answer and afterwards were interviewed based on a semi-structured questionnaire. The interviews were carried out at places where the respondents felt comfortable and would last on the average about 2 hours. Transcripts from the

[2] *The researchers would like to acknowledge the significant contribution of Khoo Ying Hooi, the research assistant for her invaluable work.*

interviews were produced and analysed based on the themes. Analysis of the data was carried out using SPSS, NuDist Qualitative Survey Software and by two researches independently. The results were discussed in a built-up towards understanding the research findings.

This paper narrows the focus from the research work[3] looking specifically at the sexuality and sexual risk-taking behaviour of two selected narratives.

## BACKGROUND

The respondents interviewed in this research were between the age of 18 and 22 years. All have experienced sexual intercourse. The respondents are currently studying in a tertiary level education programme or have access to information. Having access to computers either at home, where they study or work meant they are not only exposed to local sources of information on a variety of topics but also have access to a broad source of information. Topics deemed taboo for adolescence, such as on sexually transmitted diseases, HIV/AIDS, alternative sexual orientations, etc. are not unfamiliar or out of bounds.

Technology and privacy facilitate for an alternative means of experiencing one's sexuality. It also allows for sharing private matters confidentially with anonymous acquaintances acquired in cyber space. The internet also functions as a storehouse of information where young people can go to learn about the unknown and share these facts with their circles of friends.

Most of the respondents are still residing with their parents, however, this can be described as a transient phase in which they are either planning to go abroad to study or are highly mobile; commuting between domiciles (i.e. home and friend's home). Most have what can be described as good relationships with their families (only two admitted to having problems at home). They all agree that talking about sex with family members, especially with parents is taboo. One respondent puts it as a form of protection, not wanting to make her parents worry. Most simply find it difficult and embarrassing. They feel the same way about talking to teachers about sex. There appears to be a barrier in the vertical relationships when dealing with sexual matters. However, the same barrier does not exists in horizontal relationships. For example, they have no problems confiding in friends or even seeking advice on sexually related matters from friends. Both male and female respondents depend on their friends for information, advice and affirmation of their actions.

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[3] *The research titled A Study of Adolescent Knowledge, Attitude and Practices Towards Sexuality and HIV.AIDS Risk was funded by the Vote F fund. The findings were first presented at the 2nd Qualitative Conference organised by the Faculty of Education, UM in a paper titled Using Qualitative Study to Explore Issues in Adolescent Sexuality and HIV/AIDS Awareness. This paper However focused on the role qualitative research can play in addressing HIV/AIDS. This discussion was further elaborated with the focus on presenting the research findings in a paper titled Bridging the Gap between Adolescent Sexuality and HIV Risk: The urban Malaysian perspective. The paper was Submitted in 2004 to the Asia Pacific Journal of Family Medicine and is currently under review.*

**Table 3: Background of Participating Private College Students**

| Variable | | Frequency (n=16) | | Mean (range) |
|---|---|---|---|---|
| | | N | % | |
| Age | | | | 19.8 (18-22) |
| Sex | Male | 6 | 37.5 | |
| | Female | 10 | 62.5 | |
| Working (Part-time) | | 5 | 31.3 | |
| Age of first sex | Male | | | 15.8 (15-17) |
| | Female | | | 17.2 (12-20) |
| Tried drugs (e.g. ecstasy, marijuana, heroin) | Male | 3 | 50% | |
| | Female | 6 | 60% | |

## EXPLORING SEXUALITY: ATTITUDE, SUBJECTIVE NORMS AND PRACTICES

This paper focuses on the discussions about sexual attitudes, subjective norms and practices with two respondents. Interviews with the respondents were engaging. The respondents participated actively in contributing their views and ideas as well as narrating their experiences openly and honestly. The topics explored includes asking them when they first had sex, how they felt afterwards, what motivated them to engage in sex, how they defined sex, their sexual practices, how they selected their partners, whether they practiced safe sex, the number of sexual partners they had, their opinions on commercial sex; on sex workers as well as customers and their knowledge on the mode of transmission for HIV. Here the respondents will be referred to as Respondent A, referring to the male respondent aged 21 years, Respondent B, referring to the female respondent aged 21 years and a third, Respondent C, a 21 years old female respondent whose experience with abortion is included in Appendix A.

### First sexual experience

Both the respondents spoke at great length about their views on sex as well as their sexual practices. Respondent A first had sex at the age of 15, while Respondent B waited until she was of legal age before engaging in a sexual relationship. Both their first experience were described as weird, funny, uncomfortable and slow. They also explained that initially they engaged in sexual intercourse because they were curious. As respondent B puts it "I feel it is something everybody has to explore. I mean if you don't try, you never know right?"

Respondent A describes his first sexual experience as something that happened because they were curious and they had the privacy. Before they had engaged in sexual intercourse, Respondent A would visit the girl at her house or she would come to his house for non-penetrative sexual activities such as kissing, grouping, etc. He admits that from his early teens, he was already exposed to pornography as well as masturbation.

He feels it was because he had experience the sensation of orgasm and he was visually stimulated and curious that he was motivated to experience sexual intercourse.

"I was exposed to a lot of porno and curiosity builds up. It just comes naturally (like masturbation). It is curiosity and after you start masturbating you already know the pleasure of it when you reach climax... I was fifteen; it was very funny, basically before we had sex we already did a lot of making out. She would come to my place I would go over to her place and...we start touching each other, kissing...no penetration yet. And after that when we actually went deeper all the way, the process was very funny at first you won't be able to get it in and then both will feel weird." (Respondent A)

Respondent B had her first sexual experience at 18. She describes her experience, " When I turn 18... in secondary school, I sort of told myself I am going to wait until it is legal because I don't want to get into trouble. When I was in college that time so we were like why don't we just do it? He had never done it. I don't remember everything about it but all I remember was that it was funny. We don't know what we were doing. We used a condom. When the guy the first time does it, I mean he doesn't know how to control himself. I mean we don't really think of STD, just pregnancy." He first sexual partner was 2 years older than her.

Why engage in pre-marital sexual intercourse

Sex was a natural progression as they had the privacy and were both very curious. For her, the time had to be right. Sex is not something she feels lightly about. It must be based on love and emotional commitment. For Respondent A, sex fulfils a biological urge as well as a means to strengthen the bonds in a relationship and as an expression of love.

For him sex in a relationship is "...a deeper way of showing your love... with my girlfriend I won't call it sex. I would call it making love. It is a strong feeling". However, he also sees sex as a means to satisfy an urge "But when you know some chick walk up to me and say hi in a club and we start talking and all we have a one night stand, that is just to fulfil a desire, to unload that time. Something a normal guy would want...just to fulfil a need" (Respondent A)

For the female respondent, sex is "something that has to be fulfilled like hunger or thirst". However she adds, "There is no sex without love. "...I don't think you should just sleep around without any feelings because for me that is almost the same as prostitutes already. ..You are willing to commit and sacrifice to do something for the person that you love. It is also for sexual gratification".

Sexual relationships

Both the respondents have had more than one sexual partner. For Respondent A, he had his first sexual experience at 15 and cannot quite remember how many sexual partners he has had but feels it is not more than 15. He is heterosexual asserting the fact that he has never experienced any homosexual experience. Respondent B waited till she turned

18 before engaging in sexual intercourse. Since then she has been in 5 sexual relationships. Her current relationship lasted two years and has not yet been consummated through conventional sexual intercourse.

Definition of safe-sex and safe sex practices

According to Respondent A, safe sex is defined as "...not getting a girl pregnant, not getting any disease. And if you are doing with someone you are not supposed to be doing with, make sure no one knows." The female respondent places preventing STDs in the first order followed by preventing pregnancy. In practice however, the male respondent almost never uses the condom and the female respondent only used to insist a boyfriend with a liberal past to wear a condom, but did not make it clear if she insisted on it all of the time. In her other relationships, because she believed as she is a virgin she did not feel a need for using a condom. For the male respondent, the main method of avoiding pregnancy involves relying on knowledge of the menstrual cycle. About this method, he says he learnt about it "... in form three.... My teacher taught us the safe way....so do not need to use condom" .He explains than in almost all his sexual encounters he relies on this method, but if at that time she is ovulating, he will go out to buy condoms, "I don't carry condoms and the girl's don't carry condoms, but if the timing is right you can do it fine. Just go on. But when the timing is wrong the girl will tell you ah it is not safe. And if she still wants it, I'll go to 7-11 laa".

Sexual practices

Sexual intercourse can be seen as a means of relieving stress, for pleasure, for giving pleasure or as an expression of love. Generally, intercourse involves foreplay, oral sex and vaginal intercourse. The frequency of sexual intercourse depends on the nature of relationship. Currently Respondent B has not had any penetrative sex with her boyfriend whom she has been seeing for close to two years because he is in the United States. For Respondent A, he says that it depends on the relationship, the current relationship he is in is based on a different level of understanding and while they are sexually active, they may only engage in it twice a week.

Respondent B however, due to the long distance between herself and her partner, now engages in internet sex. She describes this experience as "...a bit stupid but first of all you get the sex pressure, you can use your imagination and pleasure yourself so it is kind of like a masturbation but in a better way. I mean you are having... you are masturbating but you are thinking of your partner. And he does it and I do it also."

There is no appropriate number to the length of time that they have to know their partners before engaging in sex. Both admit they have had on-night stands. A one-night stand is when a person has sex with a partner who he or she is not emotionally involved with and usually last for one moment. Usually, in a one night stand the sexual relation does not extend beyond that one sexual encounter. For Respondent B, she had one such experience and she describes why she had sex with the person, "this guy was attracted to me, so we spent a lot of time talking and stuff...after that he made the first move and I got turned on. I really got flattered when the guy makes the first move. I sort of like him but

not really love so I feel I cannot perform sexually...although there is desire but not really. So I just did it one day and like I said I was very flattered...you cannot believe that kind of guy will like you." Respondent A has had about five such experiences. He explains how he engages in a one-night stand"...after form five when I had the freedom to go out clubbing. Basically for one night stand you have to go to clubs...I will still chose the person. She has to look clean. I have to at least know her in a way, like through friends. But it is mutually understood there and then done. Don't mention it anymore." For him, he does it because "... (It) is just to fulfil a desire, to unload that time. Something a normal guy would want...just to fulfil a need."

Attitude towards sex

For Respondent A, sex is no longer a taboo subject for people his age. Many of his friends both male and female talk to each other about sex. He feels that a lot of them are sexually active. Both the respondents feel that young people in their early teens are well exposed to sexuality and therefore sex education should start at an early age, preferably at about 12 years old. They both agree that schools and parents should do more to educate their children about their sexuality. They feel that apart from the science course in form three, they learn a lot about sexuality from watching pornography, magazines, and internet and from their peers.

Both the respondents feel that one should only engage in sexual relationships when a person is ready for the responsibility. Respondent B was adviced by her mother that when she when off to the US to study that she should protect herself and not get pregnant. If she did, she was on her own. However, the respondent feels that she is at an age whereby she can make her own decisions and can access medical services if required. She feels that for girls who are in their early to mid teens, the problem may be worse. She queries on how they would they take care of themselves if they got pregnant or were infected with an STD?

For Respondent B, pre-marital sex is both something she desires but something she feels guilty over. According to her, sex is a gift from God to procreate. Pleasure from sex is sinful. For her, sex, especially pre-marital sex is contentious. Although she does engage in sexual activities, her faith do raise doubts making her feel guilty.

"...sometimes I really hate having sex. I don't like it. I think it is disgusting. Once in a while I will think it is gross, but sometimes it will be right. It is very desirable that I really want it. Then when the time I think it is gross I will tell myself okay, that is the point when you do it, and it is just for having kids only. I don't want to do all sucking and stuff like that. Actually all these are things that God gave for us to have kids. So that is why I think people who do sex for pleasure ...is not very right, I am not very religious but once in a while I feel guilty. I mean God give us this...not for lust because lust is a sin. Lust is considered a sin and does it because of lust and not because of love or any other reason then it is sort of a sin". (Respondent B)

Nevertheless, she enjoys sex and feels she may want to explore other alternatives to vaginal intercourse. As she puts it "(Anal sex)...it is a part of sex as well." For Respondent

A, what started out as being curious, has developed into something more positive. He enjoys sex but feels that it has to be with someone you love, because when it is then you are making love. That expression of love and commitment through sex is supported by his views on gratification for himself as well as his partners. For the female respondent, gratification usually means making sure the partner is satisfied first. She still feels she has not really reached orgasm.

The idea that sex satisfies a male urge is not new and neither is it limited within the boundary of an emotional exchange or relationship, to put it in another way as a gift. From both their narratives, it appears to be that there exists a thriving industry in sex catered to a largely male clientele[4]. For example, they both make reference to several types of commercial sex activities such as prostitutions, strippers and Guest Relations Officers who may provide sexual services with a little inducement. In Respondent A narrative of his experience in a brothel, the organization appears well managed and patronized.

Knowledge on HIV transmission

The respondents appear to know sufficiently enough on how HIV is transmitted. Responding to a question on whether he could be at risk to HIV infection, Respondent A answered he doesn't feel he is at risk because "he doesn't go fucking around. I mean I stick to one person." Asked on how he should avoid from becoming infected, he replied "...don't do those stupid stuff...like go around fucking someone you don't know. Don't take drugs...and if you are, if you know that you are infected don't spread it to your wife...don't take drugs and basically stay faithful to your partner."

Respondent B feels the same as well. When asked who are at risk of becoming infected by HIV/AIDS, she replied "...people who share multiple partners. People who have HIV can spread the HIV, the mother who spread to the child through the blood system". When asked on how to avoid becoming infected, Respondent B's answer was, "...don't share needles and drugs. Use condoms at least if the guy doesn't want to use the condom then the girl must use the cup thing. It has to be something that stops the liquid from going into someone ...just practice safe sex." Asked if she felt she was at risk, she explains, "...usually before I start with a new partner I will usually think of going for the doctor to check whether I have contracted anything,...probably I will check when I do my full body check up".

Summarizing their views on HIV transmission, both the respondents were able to identify exchanging body fluids as the means of HIV transmission. Nevertheless, their portrayal of people who were at risk were people they could not identify with. For example, Respondent B said the risk were among people who shared multiple partners. Respondent A's view was that people who were indiscriminate about who they slept with were at risk.

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[4] *Respondents were asked about what they thought of men and women patronizing brothels. Their responds were generally, it was wrong but understandable for males to visit brothels but it was not acceptable for a woman to do the same. If she wanted sex, it was agreed, there was always going to be willing male partners. However, it was understandable, and in fact some of the female respondents empathized with these women, for a woman who felt she had no option but to work as a prostitute to make ends meet.*

## DISCUSSION OF THE RESEARCH FINDINGS

### Views on sex

Why do young people engage in sexual intercourse? Why do they continue to have sex? Sex marks the onset of a period of transition for childhood to adulthood. Watching pornography and learning from watching adults, sex is perceived as the final barrier that divides children from adults. What begins as a curiosity, from having experienced orgasm from masturbation and watching pornography (incidentally often involves getting it from the adults, either stealing it from the parents room, or being shown illicit material by an adult) added with peer pressure, leads an adolescent to that first sexual encounter. However the sexual experience does not end there. They continue to engage in sex and over time the meaning and ways one engages in sex changes. In both the respondents started as physical, exciting, funny and uncomfortable which later became a way of expressing long term commitment with a partner. In short, sex facilitates the process of maturity.

### The role of Gender and power in adolescent sexual risk-taking behaviour

The Gender and Power theory focuses on the idea that there is a distinct gender script that rigidly informs gender roles; women in this framework are often excluded or marginalised from decision making, access to services and information and power. However, in this research, although there are these frames through which behaviour, practices and perceptions are gendered, for example, in how gender roles are reproduced and societal demands that a woman remains a virgin until marriage, the reality is that alternatives do exist which enables women more choices in how to lead their lives while maintaining the public appearance of the good woman (e.g. if a woman found out she was pregnant she had the option of a discreet abortion[5]).

Women who we interviewed were not under surveillance by their families or spouses nor were they marginalised. In Appendix A, the narrative of an abortion tells us of how a young woman made up her mind to have an abortion because she was not ready to settle down. She felt she had a lot of things to do before she was ready to settle down such as to further her study and make a living. Her partner came from a stable background and was more than willing to marry her. He wanted to keep the baby, but in the end she prevailed and he paid for a professional medical service. She describes the pain as being both physical and emotional. In her words, "I just had an abortion and I killed another human being". But being in the situation she found herself having no choice and having to deal with the emotional trauma alone.

Since abortion is generally illegal in Malaysia, the respondent did not have access to pre and post-session counselling nor could she confide in people she was close to like her parents or even close friends for reassurance. While many of the respondents

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[5] *Abortion is illegal in Malaysia unless the life of the mother is threatened by the pregnancy or the child was conceived as a result of rape. However, as mentioned in Appendix A, there are clinics thatprovide abortion services for a high fee. Because it is expensive, abortions by trained medical staffs are not a widely available option for everyone.*

felt that abortion is an alternative if they are not prepared for the responsibility, the implications often is it becomes the burden of the expectant mother. But having a child would mean the woman would have to give up part of her freedom. She would have to obey a much stricter code of behaviour that regulates her movement, appearance, the company she keeps with and most importantly her ambition. Hence, abortion becomes a viable alternative if a woman is not ready for these changes and feels she has much to develop herself before settling down. It should be noted that although attitudes towards premarital sex is changing and becoming more liberal, women continue to carry the weight of responsibility for example in ensuring she does not become pregnant. In this context where the respondents do not use condoms and instead rely on the menstrual cycle to avoid pregnancy, the views expressed is that since it is her body she should know when she is "safe" and when she is ovulating. Interestingly, the methods of contraceptive use depends on the women.

In this research, both the male and female respondents do ascribe to different sets of gender roles. However, in the context of the topic on sexual risk-taking behaviour the impact of applying the gender and power theory appears less relevant (this does not however exclude the significance of the gendering roles and the differential impact it has on the lives of adolescents, i.e. in decision making, their choices, etc.). Young, educated, middle class women have the power to negotiate the use of contraceptives. The answer to why they continue to underutilize condom use in preventing pregnancies as well as in taking care of their reproductive health is best explained in understanding the nature of group roles, functions and dynamics.

Perceptions of partners

Why do our respondents feel that their behaviour does not put them at risk especially when it contradicts their views on sexual risk? To what extend does how they construct their partners influence the use of condoms? Both the respondents have had multiple sexual partners. However, they only demand the use of condoms in very few of these sexual engagements.

Related to the decision on whether or not to use condoms is the social meaning of concepts such as "clean", "trust" and "relationship", constructed as expressions for group support, affiliation and intimacy. Sexual liaisons are clearly defined; what you do and with whom. For example, if your sexual partner be it a one night stand or longer term relationship comes from within the group of peers; i.e. among friends, extending to acquaintances of friends and social circles, the sexual conduct is based on a set of rules that informs behaviour among insiders. This is expressed in words like "clean" or "I don't just fuck around ...I don't go picking-up just anyone, I will pick-up someone I know or someone a friend knows". The respondents do not use condom even if it is a temporary sexual encounter with a peer because it would challenge the perceived social bond. On the other hand, if the partner is confirmed an outsider; i.e. he or she admits to being promiscuous an identifiable risk, or the partner is a sex worker, then the respondents will use a condom. The lack of condom use was not expressed in terms of personal gratification or motivations. Looking back at the narratives, the adolescent period not only marks a biological change, but also a social one. This is a time when young people

respondents it is because of trusts such as when respondent A describes why he did not use condoms with a one-night stand partner "that the person looks clean". This form of trust comes from a web of interconnected identifiers that form levels of associations and relationships. Hence, they do not perceive a risk because the sexual activity takes place in the context of established boundaries of relationships. In more stable relationships, this is expressed as trust towards a person. In temporary unions, this trust is expressed not towards the individual but rather towards the group.

Risk towards HIV/AIDS is apparent when we contextualize the conceptual framework young people apply in negotiating sexual relationships within the context of a growing epidemic. Young people become at risk to HIV infection through how they engage with their peers, their attitude towards the relationships as well as the behaviour which is influenced by these attitudes and perceptions. It is our recommendation that for intervention strategies to be successful it has to address the group level as the operational unit.

## REFERENCES


1. Dacey, John and Maureen Kenny. 1997. Adolescent Development, Brown and Benchmark:Chicago.

2. Low WY, Ng Chirk Jenn, Kamal S. Fadzil. 2003. Adolescent boy's health: knowledge: HIV/AIDS, substance use, reproductive and sexual health. Report for FFPAM. (unpublished)

3. Ministry of Health. 2004. Statistics on Reported HIV/AIDS cases in Malaysia between 1986 to September, 2004.

4. Malaysia AIDS Council. 2004. Demographic data on HIV/AIDS cases in Malaysia.

5. National Population and Family Development Board. 1994. The National Study on Reproductive Health of Adolescents in Malaysia.

6. Ng Chirk Jenn, Kamal S. Fadzil. Bridging the gap between adolescent sexuality and HIV risk: the urban Malaysian perspective. Currently under review for publication by the Asia Pacific Journal of Family Medicine.

7. Ng Chirk Jenn, Kamal S. Fadzil. Using Qualitative Study to Explore Issues in Adolescence Sexuality and HIV/AIDS Awareness. Paper was presented at the 2nd Qualitative Research Conference held in October 28, 2003. (unpublished)

8. Ortner, Sherry and Harriet Whitehead. 1981. Sexual Meanings: The cultural construction of gender and sexuality. Cambridge University Press: Cambridge.

9. Rao Gupta. 2000. Gender, Sexuality and HIV/AIDS: The what, why and how. Plenary Address, XIIIth International AIDS conference, Durban, South Africa.

10. Sherr L. AIDS and adolescents. In Rosenthal D. Expanding the context: Australia adolescents' behaviour and beliefs about HIV/AIDS and other STDs. Amsterdam: Harwood Academic Publisher, 1997:91-106.

11. Sunday Star. Crimebuster on a new mission. 12th June, 2005a.

12. Sunday Star. Reducing the harm sensitively. 12th June, 2005b.

13. Sunday Star. Educating the public on benefits of programme. 12th June, 2005c.

14. The New Strait Times. Bold steps to curb hIV, 4th June, 2005a.

15. The New Strait Times. HIV Alert: WHO warns Malaysia on the threshold of an epidemic, 14th June, 2005b.

16. Utusan Malaysia. HIV di tahap darurat- PM. 17th June, 2005.

17. Worchel S., Joel C. George R.G, James M.O. 2000. Social Psychology, Wadsworth:California.

18. Zulkifli SN. Adolescent sexuality: Any in Malaysia? Singapore Journal of Obstetrician and Genecology 1986; 17:99-102.

19. Zulkifli SN, Low WY, Yusof K. Sexual activities of Malaysian adolescents. Medical Journal Malaysia 1995; 50:4-10.

20. Zulkifli SN, Low WY. Sexual practices in Malaysia: Determinants of sexual intercourse among ummaried youths. Journal of Adolescent Health 2000; 29: 276-280

21. Zulkifli SN, Wong YL. Knowledge, attitudes and beliefs related to HIV/AIDS among adolescent in Malaysia. Medical Journal Malaysia 2002; 3-23.

**Appendix A:**

**A narrative of an abortion:**

"Well it did once so it was really screwed up. Really, really screwed up! But probably because after a while it is normal to human beings when you think that it won't happen to you it will never happen to you. You think that it won't happen to you. It will never happen to you. You think that it won't happen to you ever so you slowly neglect... neglect.... neglect... and boom, it hits you! Oh shit, verry, very screwed up..."

"I missed one period (a year before the interwiew) so I started getting worried. At first I thought it is maybe (caused by) my diet because at that time (I) was anorexia so it could be my diet but then I went to buy the pack, the pregnancy test yeah and tried it and it is positive.

Then I told my boyfriend at the time so he wanted to keep but after I explained to him "we know it is not the right time, come on.." so we went to see a doctor, he wanted something that is safe so we ended up spending thousand over dollars on the abortion. I was five weeks pregnant.

It really did hurt inside as you won't realize it until it happens. After the whole surgery and everything, you khow... it just hit right on your face. Oh shit! I had an abortion and I just killed a human being you khow. So it is like people don't realize (the hurt), as we don't show it"