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Development of a Sexually Transmitted Disease Client-friendly Unit at a Primary Care Clinic in Malaysia: Lessons Learnt

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Abstract: Management of sexually transmitted diseases and human immunodeficiency virus is challenging due to the social stigma attached. We describe the development of a client-friendly sexually transmitted disease service in a primary care clinic in Malaysia with a special focus on key populations. Challenges and key lessons learnt from its development and implementation are discussed.

Key populations (KPs) include persons who inject drugs, female sex workers, transgender (TG) people and men who have sex with men. The KPs are at a higher than average risk of exposure to and transmission of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) in most developing countries. In Malaysia, injecting drugs used to be the driving force behind the country’s HIV epidemic but this has been overtaken by sexual transmissions which now account for 80% of new infections. Malaysia is a country with 61.3% of the population practicing Islam. Hence, STDs are challenging to manage due to persecution of the KPs and strong socioreligious stigma. The judgmental attitude toward people with STDs has led them to shy away from seeking help, which could contribute to the proliferation of the disease. Although KPs have the highest risk of contracting and transmitting STDs, they have the least access to health prevention, care, and treatment.

All primary care clinics in Malaysia provide STD services as part of the provision of comprehensive care. However, in most clinics, people with STDs are seen along with the general population. In addition, heavy clinic workload, overcrowding, and shortage of staff in primary care clinics have resulted in doctors carrying out consultations with several patients in the same consultation room. This has raised issues of confidentiality and privacy. Hence, clients might not disclose their reasons for attending to the triaging nurse or doctor. This could deter vulnerable populations from seeking help, causing delay in diagnosis and disease management, and leading to poor quality of care and follow up. Recognizing this critical gap, an STD intervention program, the Anggerik (Malay term for Orchid) program, was initiated specifically to improve STD management and reduce its risk among the KPs in the community. We describe the development and implementation of this program, highlighting challenges and key lessons learnt.

STD UNIT DEVELOPMENT AND IMPLEMENTATION

The Anggerik program was initiated in a primary care clinic in September 2014. Its development involved a 6-stage process (Fig. 1). We identified evidence-based effective intervention strategies for STDs and formed a core intervention team in the clinic. Then, we brainstormed with nongovernmental and community-based organizations to identify ways of optimizing service delivery to the KPs. As a result, 4 main objectives for this new STD unit were identified: to create an enabling environment to reduce stigma, to recruit and empower the KPs, to create awareness regarding prevention and management of STDs, and to establish early diagnosis of HIV. Caseworkers employed by the Non-Governmental Organizations were trained to assist KPs to access care and support. They were oriented to the clinic work processes, rules, and regulations before starting work.

The next stage involved training and sensitizing health care providers (HCP). The core team received a 2-week attachment at a specialized genitourinary medicine clinic and an HIV clinic at a tertiary hospital. All personnel in the clinic underwent a one-day training workshop in which we used a modified sexual orientation, gender identity and expression framework with the help of caseworkers as facilitators. Role plays and group discussions were conducted about KPs, gender dysphoria, sexual orientation, gender identity and expression, knowledge and impact of HIV and STDs, disease burden, terminologies, homophobia, transphobia, stigma, and discrimination. Health care providers interacted with KP members who shared their experiences in facing stigma and discrimination during visits to health facilities.

Next was development of the care pathway. A client could be referred for consultation via 1 of 3 routes: self-referred, referred and accompanied by the caseworkers, or referred by other doctors in the clinic. The consultation room was named Anggerik (Orchid) to enhance patient confidentiality. Anggerik was also used as a code word for clients at registration to avoid disclosure of the purpose of the consultation in public. Instructions were given to all staff to address TG clients by their preferred gender and name at all points of contact in the clinic. Our aim was to make the Anggerik room a 1-stop management unit. The room was equipped with a consultation table with a flip chart for STD education, a box of condoms for clients to take, an examination couch, a phlebotomy
workers and clients was very positive and encouraging. Feedback from case-
work and snowballed to clients’ partners and networks even without the
non-KP (18%). The news of this program spread via social media
accompanied by caseworkers. Clients included men who have sex
70% of the new attendances were self-referred, whereas 30% were
from its inception in September 2014 until December 2017. About
clinic received 2382 new clients and a total of 9597 consultations

treatment and prevention at primary care level in Malaysia. The
gram were determined: number of attendees from the KPs, number
of KPs screened, incidence of HIV, and number of HIV serocon-
vention sessions were conducted to address the issues.
Self-stigma was common among the KPs. Some were extremely sensitive to the attitudes and behaviors of HCPs and misconstrued their intentions. For instance, an HCP who was re-
served would be viewed as a person who stigmatized them.21,22
Key populations needed to be handled with tact, and regular counseling sessions were held with them to explain about self-
 stigma and ways to handle it. Some disgruntled clients used social media to name and shame HCPs. This stressed and demotivated HCPs. Regular debriefing and counseling sessions were held with HCPs to provide support. They were further educated on strategies
to develop rapport with clients. Clients were also educated on the
appropriate ways to lodge formal complaints to avoid liability.
Some caseworkers lacked knowledge of medical ethics and professional boundaries. They would promise sickness certificates to clients without consulting doctors, coerce the KPs’ attendance, and had unprofessional relationships with their clients. To address
this, a standard operating protocol was developed and imple-
mented for all caseworkers. Some clients misused the fast track service offered by the Anggerik room and used this service for complaints other than STDs. In such instances, they were politely rerouted and educated.
Although stigma and discrimination were the main obsta-
cles to accessing STD services,5–7 constraints in manpower, lab-
atory services, and medications were ongoing challenges. The
frequent turnover of staff in the clinic limited the expansion of the
STD services to its full potential. More resources are needed for
sustainability of the program. Nevertheless, compared with a
week-long waiting time before the Anggerik program, the on-site
laboratory service was now able to provide a presumptive diagno-
sis of gonorrhea (Gram stain) within several hours. This was due
to the awareness given to laboratory personnel during the training.
Prior to the Anggerik program, repeated applications to the Na-
tional Drug Committee to list azithromycin in the national primary
care drug formulary were futile, for cost constraint and fear of an-
tibiotic misuse. However, data from the Anggerik unit successfully convinced policymaker to list azithromycin in the primary care drug formulary recently.

The introduction of the Anggerik program has rejuvenated
STD management in Malaysia. Following an increased number of
STD notifications from the program, the HIV division of the
Ministry of Health Malaysia has initiated and replicated this STD
program in 22 primary care clinics covering all states in Malaysia.
This nondiscriminatory program has been recognized by the af-
fected community to be accessible. The lessons we learned could
be applied in other countries, in particular countries that are resource-
constrained or have a Muslim-predominant population where cul-
ture and religious boundaries impede STD management.

CHALLENGES AND LESSONS LEARNT

The Anggerik STD unit is now the largest center for STD
treatment and prevention at primary care level in Malaysia. The
clinic received 2382 new clients and a total of 9597 consultations
from its inception in September 2014 until December 2017. About
70% of the new attendances were self-referred, whereas 30% were
accompanied by caseworkers. Clients included men who have sex
with men (72%), TGs (5%), female sex workers (5%), and the
non-KP (18%). The news of this program spread via social media
and snowballed to clients’ partners and networks even without the
aid of Non-Governmental Organizations. Feedback from cas-
workers and clients was very positive and encouraging.

The implementation of the Anggerik program was chal-
enging. Initially, there was resistance among the clinic staff to run-
ing this clinic due to ignorance about STDs and the needs of KPs,
and due to the associated stigma. There were homophobic senti-
ments, due to conflicting personal values, cultural, and religious
beliefs. These sentiments were more prevalent among doctors than
other HCPs. During the implementation of the program, 2 doctors
specifically requested to be transferred. Overall, clients appeared
to be more satisfied with services from paramedics than from doc-
tors. Ideally, this unit should be run by open-minded HCPs with an
interest in STD prevention. However, in a resource-constrained
practice, this may not be feasible. Repeated training and sensiti-
ization sessions were conducted to address the issues.

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