STAKEHOLDERS' ASSESSMENT OF THE NEED FOR SEXUAL HEALTH EDUCATION AMONG ADOLESCENTS IN SAUDI ARABIA: AN EXPLORATORY STUDY

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ABSTRACT

Sex education has been shown to improve the sexual health outcomes of adolescents, yet many countries still lack the provision of formal sex education programmes. In Saudi Arabia, although having a large adolescent population, no formal sexual education programme exists in the country. Some information is provided within the national curricula, mainly through the subjects of Science and Islamic Jurisprudence.

The aim of this thesis is to assess the need for sex education for adolescents in Saudi Arabia, and possible provision for such a programme, in addition to the obstacles and facilitators for implementation from the perspective of stakeholders.

A qualitative approach was applied using in-depth semi-structured interviews with 28 stakeholders from four different stakeholder groups: policy-making agencies and officials; social and healthcare providers; teachers and other school staff; and religious scholars.

The findings of this research revealed a unanimous agreement on the need for sex education. Opinions varied regarding adopting a science-based approach vs a religion based one. Both approaches were drawn on as non-conflicting sources to guide a feasible, appropriate programme in the country. Opinions varied on the required areas to cover including harm reduction strategies. Various public health terminology were conceptualized differently than their international definitions. Harm was perceived as not limited to physical harm but encompassed spiritual and social harms as well. Ambiguity was not only adopted during expressing opinions but also suggested as a strategy for packaging otherwise sensitive information which differs than international guidelines that recommend clear messaging tactics in these programmes.

The need for sex education was not presented as a preventative measure exclusively against physical disease, rather it was needed to ensure happy marital relationships and to preserve the family unit. Obstacles and facilitators for implementation were mostly related to the local Saudi context, specifically the structural factors related to the

education and public health infrastructure, as well as the fast pace social and political changes occurring in the country.

Findings form this thesis can be of use to policymakers in Saudi Arabia as well as officials at the MoE and MoH, not just for the formulation for sex education in the country but also for identifying obstacles for implementation. Findings can also be of use in neighbouring countries with similar political systems. Results can also help international organizations to formulating sex education guidelines that are culturally sensitive to Muslim communities around the world.

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For Teta, Tété, and Nana, the feminists of the family; each in her own way.

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CM	Child Maltreatment
CSA	Child Sexual Abuse
CSE	Comprehensive Sexual Education
GDP	Gross Domestic Product
EBM	Evidence Based Medicine
EMENA	Extended MENA Region
GCC	Gulf Council Countries
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IUD	Intrauterine Device
IVF	In-Vitro Fertilization
KSU	King Saud University
LSHTM	London School of Hygiene and Tropical Medicine
MENA	Middle East and Northern Africa
MoE	Ministry of Education
MoH	Ministry of Health
MPH	Masters of Public Health
NAP	National AIDS Programme in Saudi Arabia
NCD	Non-communicable Diseases
NGO	Non-Governmental Organization
NHS	The National Health Services in the United Kingdom
NFSP	National Family Safety Programme in Saudi Arabia
OCP	Oral Contraceptive Pills
PI	Primary Investigator
PLWHA	People living with HIV/AIDS

PRB	Population Reference Bureau
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UK	United Kingdom
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States of America
WHO	World Health Organization

CHAPTER ONE- INTRODUCTION AND BACKGROUND

CHAPTER OVERVIEW

In this chapter I begin by explaining how this thesis originated. I then provide a background to Saudi Arabia and its governmental, educational and healthcare systems and its culture, specifically focusing on features related to sexual health. I also include definitions of essential terms related to adolescence, sexual health and sex education.

1.1. ORIGIN OF THE THESIS

Deciding to go into medicine is the clichéd dream of many Middle Eastern children, or parents for that matter. I was proudly one of those children and so were my parents. I was naively going into this field believing I could heal patients with simple, easy to follow instructions. However, I quickly realized that health is not the equivalent of absence of disease, rather it encapsulates a multifaceted set of needs including social, economic, physical, mental and even political wellbeing. My clinical frustrations began to develop and were mostly related to the unmet needs of the disadvantaged. Daily clinics were at times tedious when certain cases could have been prevented had patients been empowered and equipped with the right resources (including proper education). Applying metaphoric and physical bandages to my patients' problems rather than addressing how 'the system' was failing us all became vexing. With newly admitted patients, I found myself spending hours taking medical histories which my colleagues continuously ridiculed. I was intrigued by the 'social history' that usually revealed a complex set of issues that directly impact the medical problem that very few seemed to pay attention to. When looking after women specifically, I found that not only were they lacking knowledge, but also a safe space to describe their complaints without it being dismissed as *'women's talk'*.

During my early clinical experience, I found myself consoling women whose husbands took on second and third wives and holding women's hands during childbirth while trying to explain to them the stages of labour they were so oblivious to. I also observed clinics where physicians urged families to keep their daughters in school and tried to convince them of the importance of education for girls. When I went into paediatrics, I faced more obstacles related to adolescents' health and their social needs. There were times, where it was difficult to provide a confidential, safe space for them to open up and voice their concerns. Rules and regulations about their autonomy continues to be blurred and social expectations further complicate their clinical age. Many times, I had to admit adolescents to adult wards where they lay awkwardly in the same room as dying elderly patients which made me recognize how the medical system continues to fail this population. In addition, the general stereotype of this age group being 'problematic' and 'attention-seeking' constrained medical professionals' outlook on adolescents.

Few of the cases that stayed with me to this day were of young adolescents hesitantly trying to vocalise their concerns regarding their sexual maturation or report sexual assault. Senior physicians at times had to ask around on how to manage the latter cases as there were no clear guidelines on how to report or what resources exists to help victims of sexual abuse. This lack of sexual health awareness, from both the patient and healthcare perspectives was beyond frustrating and was the main driver of my interest in the fields of adolescent and young women's health.

Gaining an MPH from Boston University with a focus on maternal and child health allowed me to appreciate the role of public health interventions and further expanded my knowledge in research principles and social and behavioural theories. It was then that I decided to switch gears from a clinical profession to a more research based one in the hopes of influencing women's and adolescents' health policies in Saudi Arabia. The lack of interest in adolescent health in the country provided an opportunity to explore this 'virgin' ground. Hence, I applied for a PhD at London School of Hygiene and Tropical Medicine (LSHTM).

I originally planned on conducting an intervention study to measure the effects of sex education on sexual health related knowledge, attitudes and practices among adolescents. On meeting my supervisors and reviewing the literature, it became clear that there was little research conducted in the Saudi context, which highlighted the prematurity of the original proposal. Preliminary research was needed in order to assess the need for sex education in the first place and explore the viewpoints of stakeholders who may have a role in decision making, or implementing. Immersing myself in qualitative methodology, an uncharted territory to me, was daunting. I needed to expand my disciplinary base since I lacked experience in qualitative approaches. Although my clinical experience provided me with interviewing skills, it was not enough. Hence I registered in several courses within and outside of LSHTM (**Appendix 1**) to learn more about conducting qualitative studies. My supervisors have also been a tremendous help in guiding me throughout this journey with their expertise in this field.

1.2. COUNTRY CONTEXT

The Kingdom of Saudi Arabia is an Arab, Islamic country, constituting the majority of the Arabian Peninsula. The Kingdom is an absolute monarchy and rules by Islamic law or *Sharia'.* The 'Basic Law of Saudi Arabia' is a constitution-like charter which identifies its source as the *Quran*[*] and *Sunnah*[†]. The King has full authority over the three branches of the government; legislative, executive, and judicial, and has power over final court of appeal and acting as an official source of pardon. He is also the prime minister over the council of ministers and head of the *Shura* council (Consultative Council)[‡]. The Council of Senior Scholars (Council of Senior Ulama) is the country's highest religious body and

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[*] Islamic Holy Book
[†] Prophet Mohammed's sayings and traditions.
[‡] The consultative council is an advisory body to review laws and regulation and provide suggestions related to the annual reports presented by the ministries.

acts as an advising body to the King, providing *fatwas*[§] (Council of Ministers of Saudi Arabia 1992). The King appoints all members of these chambers via royal orders.

The latest census estimates the population at 34 million, of which two-thirds are Saudi nationals (Saudi Census 2019). Life expectancy is estimated as 74.2 years and the crude birth rate is 22/1000 (Saudi General Authority for Statistics 2016).The economy of Saudi Arabia, which heavily depends on oil revenues, is among the top 20 in the world with a GDP of $23,411 per capita (The World Bank 2019). The newly appointed Crown Prince Mohammed Bin Salman announced 'Saudi Vision 2030' which was launched in 2016. This plan aims to reduce the country's dependency on oil by diversifying its economic resources and developing public service sectors including health, education, recreation and tourism infrastructure (Saudi Vision 2030 2016).

1.2.1. EDUCATION

In Saudi Arabia, school education is free to all children, nationals and foreigners. Public universities allow the enrolment of Saudi and Arab Gulf nationals. Private schools and universities allow the enrolment of students of all nationalities. The school system is divided into three levels; primary (6 years), intermediate (3 years) and secondary (3 years) and is segregated by gender, which also applies to the majority of public universities. The national school curriculum includes mathematics, science, Arabic literature, English and Islamic studies and is overseen by the Ministry of Education (MoE) (Ministry of Education of Saudi Arabia, Official Website, accessed 2019).

Educational rates have overall risen in the Middle East and North Africa (MENA)[**] region over the past two decades, especially among girls and the gender gap in primary school

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[§] Religious legal opinion
[**]The MENA region includes: Iraq, Iran, Jordan, Lebanon, Syria, Palestine (West Bank and Gaza), Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates, Yemen, Algeria, Egypt, Libya, Morocco, and Tunisia.

enrolment has almost disappeared in most of the region (Dejong et al. 2007). In Saudi Arabia, the gender gap has also decreased in all levels of education from primary school to university. In fact, in 2017, 53% of the graduates from higher education were women. Yet, men continue to make up the majority of overseas scholarship programme students (GaStat 2016). Although women's education has increased over the past years, it was initially met with opposition from some communities and families in Saudi Arabia. The girls' national curricula used to be a less comprehensive version of that of boys' and was under the supervision of the 'General Authority for the Education of Girls', rather than MoE. However, in 2002, the Authority merged with the MoE, and the girls' curricula became almost identical to that of boys. Yet, female students still receive exclusive topics like home economics and tailoring that are not offered their male counterparts (Ministry of Education of Saudi Arabia, Official Website, accessed 2019).

1.2.2. HEALTHCARE

Free healthcare is available to all Saudi nationals according to Article 31 of the Basic Law of Governance (Council of Ministers 1992). With regard to legal non-Saudi residents, those working within the governmental sector receive free provision at public hospitals while those working within the private sector receive healthcare at private healthcare centres through mandatory employer covered insurance plans. However, all residents receive emergency care regardless of nationality. Exceptions for free public healthcare also occur for particular foreign groups including non-Saudi children of Saudi women and non-Saudi dependents of Saudi nationals.

The Ministry of Health (MoH) controls about 60% of hospitals and is entrusted with the provision of primary, secondary and tertiary healthcare services for the population. Twenty percent of health services are financed by the Ministry of Defence and Aviation, the Ministry of Interior and the Saudi Arabian National Guard and delivered through designated hospitals to specific armed forces and security personnel and their families. The private sector accounts for the remaining 20%. All private hospitals and health

centres are monitored by the MoH (Al Asmri et al. 2019). Primary healthcare centres are located in most cities of the country and are open to all residents of the assigned district. The MoH is currently attempting to expand its public health efforts by increasing awareness through a series of campaigns concerned mainly with non-communicable diseases (NCD) such as Diabetes Mellitus, Hypertension and Breast Cancer. Yet, although the new focus on primary healthcare and public health, the vast majority of the healthcare budget is spent on treatment rather than prevention (El Bcheraoui et al. 2013).

Plans to privatise the healthcare system have been announced as a part of 'Saudi Vision 2030'. The aim is to increase the privately controlled share of healthcare from 20% to 30% and increase competition (Khaliq 2012).

1.2.3. CONCEPTS OF ADOLESCENCE

The transitional period from childhood to adulthood encompasses multiple physical, behavioural and psychological changes alongside shifting social expectations (Alderman et al. 2003). In the past, the transition to adulthood was seen as relatively abrupt (Sawyer et al. 2018). More recently, however, adolescence has been recognized as a distinct phase of life (Alderman et al. 2003; AlBuhairan et al. 2012) with its own unique set of health needs (UNFPA 2013). Investing in adolescent health has been found to yield health and economic benefits (The Lancet 2016). Hence, international organizations have been encouraging addressing the needs of adolescents through promoting research, data collection and youth involvement in formulating and delivering adolescent health programmes (WHO 2017a). Since adolescence is highlighted by sexual maturation, sexual and reproductive health and sex education can be seen as essential aspects of adolescent health (WHO 2019).

Concepts of 'adolescence', 'youth', and 'adulthood' vary with cultural context. In some cultures, adolescence is even believed to sometimes extend beyond the teenage years to encompass a unique phase of 'emerging adulthood' that can extend to the early

thirties (Arnett 2000). Definitions and age limits to each phase can differ according to international organization. For example, according to the WHO, childhood includes those between the ages of 0-18, while adolescents are those between the ages of 10 and 19 (WHO 2019). Youth encompasses people between the ages of 15 and 24, and young people are those between the ages of 10 and 24 (WHO 2019). The American Academy of Paediatrics identified the upper age limit for paediatric care as 21. Yet, it further classified the age groups to: infancy (0-2), childhood (2-12), adolescence (11-21) (Hardin et al. 2017). It further classifies adolescence to early (11-14 years), middle (15-17 years) and late (18-21) (Hardin et al. 2017).

In Islamic teaching, puberty marks the beginning تكليف *takleef,* or becoming responsible for religious duties. The age of discretion or *takleef* is denoted by the appearance of puberty signs like menstruation or reaching the age of 15; whichever is reached first. At this age, the individual has to face the consequences for his or her actions in both in the penal system and in the 'afterlife'. Additionally, this is the age where gender segregation is enforced in conservative societies. In many Islamic courts, judges can use their discretion in each case; some adolescents may be tried as adults while others as children depending on the crime, the circumstances and the individual judge (Otto 2010).

Within Saudi Arabia, although 18 is the age of majority, yet age of license, differs according to different legal rights. For example, boys are required to apply for national ID cards at the age of 15 and girls at the age of 18. However, they cannot travel without the permission of their guardian until they reach the age of 21, which is the legal age for applying for one's own passport independent of their guardian.

For girls, male guardianship laws prevented them to travel even after reaching the age of 21 without the permission of their male guardians. However, as of August 1st, 2019, women also have the right to travel freely as soon as they reach the age of 21. Driving licenses can be obtained at 18, for both men and women, as of 2018 (Saudi Arabian Ministry of Defence and Aviation. accessed 2019; Saudi Arabia Ministry of Interior. accessed 2019; Chulov 2018). The age of 15 is sometimes used as the legal age or سن الرشد in the judicial system in Saudi Arabia.

Because of the variation, there is much confusion surrounding the boundaries of adolescence. This can make formulating legislation more complicated as illustrated in the ongoing debate within the public and among religious scholars and policymakers in Saudi Arabia, on the legal age for marriage. The commonly accepted belief among many religious scholars was that a girl is fit for marriage as soon as she starts menstruating. However, recent efforts by the consultative assembly have suggested setting a minimum age limit for marriage for both sexes at 15 and laying down specific restrictive regulations for aged between 15 and 18. However, the legislation has not yet been announced or implemented. Although child marriages are a hot topic of discussion in the media, the average age of first marriage in 2017 was 25.3 for men and 20.4 for women (GaStat 2017).

There has been a slow but progressive acknowledgment of the requirement to address the needs of adolescents, especially within the health sector (AlBuhairan 2015). Many hospitals in the country are starting to recognize the importance of including adolescent health as a distinct specialty within its paediatrics departments (Alderman, Rieder, and Cohen 2003). Recently, the MoH officially raised the paediatrics' age limit from 12 to 14 in all healthcare sectors (Okaz 2015).

Another marker of increasing recognition of the needs of adolescents was the establishment, in 2014, of a national based adolescent surveillance survey –*Jeeluna* or 'Our Generation', which aims to collect data on health behaviours and health status (AlBuhairan et al. 2015). However, sexual health indicators are not currently included in this survey.

In this thesis, I use the WHO definitions of adolescence (10-19 years), youth as (15-24 years) and young people as (10-24 years).

1.2.4. SEX RELATED SOCIAL NORMS AND TRADITIONS IN SAUDI ARABIA

Marriage in Saudi Arabia follows Islamic law. Although Islam discourages racial discrimination, tribal customs can sometimes clash with such teachings and can limit the individual's decision in choosing their spouse. This can have multiple effects on the society from both a social and health perspectives. Some families insist on limiting the marriage of their family members to certain families, tribes, classes or religious sects. Hence, consanguineous marriages are prevalent, especially among those with consanguineous parents (Warsy et al. 2014). Women require their father's approval, or that of their male guardian[††], to get married. Polygamy is allowed only for men and they can marry up to four women at a time. In addition, Muslim women can only marry Muslim men, while Muslim men can marry women from the Jewish and Christian faiths. Furthermore, since Saudi law follows a local interpretation of Islam, variations in opinions among scholars and judges may occur. *Kafaáh,* or compatibility/equivalence between spouses, is viewed as a doctrine in the Muslim law of marriage where it is mostly described as the need to have religious compatibility between husband and wife. Yet, some scholars define it as financial and/or social compatibility. Several stories surfaced in Saudi Arabia that sparked a public debate regarding the forced separation of spouses after some family members, usually the brothers of the wife, filed complaints about the incompatibility of the lineage or religious sect. Some judges have ruled for the separation but after appeal, some cases were reversed and couples were allowed to remarry (Alhayat Newspaper 2016).

The age of marriage is on the rise as with the rest of the MENA region. According to the 2011 statistics, almost a third of Saudi women aged 30 and above have never been married. This has been described as a national 'problem' (Batrawi 2015). News outlets have reported these numbers as 'catastrophic' and 'scary' and demanded solutions from policy makers. Interestingly, the General Authority for Statistics published a *clarification*

[††] Usually the closest male next of kin.

about the rates of spinsterhood in Saudi Arabia to differentiate between those who were never married (above the age of 15) and those who could formally be referred to as spinsters (Alhumeidan 2016). According to the Authority, spinsterhood 'refers statistically to woman who was past the usual or legal age for marrying'; this age was calculated as 32 as of 2016. The Authority mentioned that this statement had to be issued as a result of the false frenzy the media was promoting about spinsterhood when the real numbers point to a prevalence of 10% of women above 32 who have never been married (Alhumeidan 2016). The *Shura* Council have stated that the rise of 'individual freedom', 'openness' and unemployment (especially among men) are possible reasons for the delay in marriage among the Saudi community, alongside the rise of 'elective spinsterhood', where women chose not to marry. The council formed a special committee to identify factors and solutions to the delay and abandonment of marriage in order to prevent spinsterhood and divorce within youth (Albalawi 2019).

Gender roles are still strongly traditional. A woman's primary role is believed to be procreation, and caring for children and the household. Men and women are not allowed to cohabitate or have sexual relationships outside the context of marriage. Advice from imams to lower the dowry or *Mahr*[‡‡] have been a focus of Friday Prayer sermons. In fact, the Grand Mofti of Saudi Arabia called the increased costs of marriage a 'crisis' and described it as a great sorrow of this time that poses great obstacles for the youth to get married. He used one of the Prophet's quotes to focus on the importance of facilitating marriage for young men; '*When someone with whose religion and character you are satisfied asks your daughter in marriage, accede to his request, if you do not do so there will be temptation in the earth and extensive corruption*'.[§§]

Local laws restrict the marriage of Saudi nationals to non-Saudis individuals to specific circumstances like a woman reaching the age of 25 and never marrying. All nuptials

[‡‡] Mahr is a financial right for Muslim women paid by the husband to the bride herself and not her family.

[§§] Sunan al-Tirmidhî (1084)

however, need to be approved by the government. Laws give limited rights to Saudi women's children born to non-Saudi men since these children cannot obtain the Saudi citizenship from their mothers. However, talks of nationalising gifted individuals born in Saudi Arabia or belonging to *displaced tribes*[***] القبائل النازحة or non-Saudi children of Saudi women have been circulating on media outlets recently.

Traditional marriages are for the most case not forced but courtship between the couple is usually restricted and almost always chaperoned. Sexual interaction is not allowed until after the official religious marital ceremony occurs. In fact, *zinah* or adultery, which includes both premarital and extramarital sex, is illegal and punishable by law. Premarital sex, according to Islamic teachings, has the penalty of receiving 100 lashes, while the penalty for extramarital sex is *rajm* or stoning until death. However, in order to prove the act of adultery individuals accused of adultery need to admit to the act of adultery in front of a judge or in case a non-married woman becomes pregnant or four men should testify in court that they physically viewed the act of vaginal penetration (Bello 2011). Sexual acts that do not include vaginal penetration are not classified as adultery. They are still forbidden and can receive punishments but do not amount to that of adultery and the judges have the right to choose a punishment they see fit. 'Sodomy', however, is punished by death, although not specified in the Quran. If someone accuses another individual of adultery without bringing forward enough witnesses, the accuser would be flogged 80 times for slander, which usually makes proof of adultery almost impossible. There is no statistical data on how often these penalties take place in Saudi Arabia.

Divorce is allowed but is within the man's power where a husband can automatically divorce his wife without requiring the intersection of a judge. If the wife seeks divorce, she can ask her husband to divorce her. In case of his refusal, she would have to file a

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[***] Displaced tribes, sometimes referred to as 'stateless bedoins' or 'bidoon' are unregistered indigenous tribes living in Saudi Arabia.

case within the court and provide the judge with a legitimate reason for the divorce. The power then lies in the hands of the judge to allow a divorce. However, a different type of divorce called خلع *khul'* is within the woman's power but still requires the judge's approval and requires the woman to give back her dowry in case of proceeding. Yet, divorce can sometimes be difficult to obtain in the case the husband refuses to appear in court. Divorce rates have also been gaining public attention. In 2018 there was one case of divorce for three new marriages, which was described as a national problem since it is steadily increasing *(Alriyadh Newspaper 2019)*. Research shows conflicting information on the percentage of increase in divorce rates in the country with some studies claiming divorce rates increasing from 25% in the 1990s to 60% in 2010 (Saleh and Luppicini 2017). However, the latest census in 2018, shows a crude divorce rate of 38% in 2018 (GaStat 2018).

Men are required to take care of the financial needs of their wives and children are obligated to pay alimony for their children in case of separation. Women on the other hand are not required to contribute financially into their households, under any circumstance (Islamweb 2011). Although dual income households are rarely found in the MENA region (Moghadam 2013), this may be underreported and changing. Yet, with divorce laws that hinder women's financial compensations after separation, it would not be surprising that women feel wary of contributing to the financial needs of the household. Interestingly, public debates have been taking place on social media on defining feminism and gender equality within a Saudi context. Several arguments highlighted how Western ideologies of equality in secular, civil settings may be difficult to apply in traditional, Islamic settings like Saudi Arabia. Recently however, the Saudi government has announced major amendments to several laws that have drastically pushed women's rights towards equality. As of August, 2019, Saudi women are allowed to apply and renew their passports, register their marriage, divorce, and children without the need of their 'male guardian' (Graham-Harrison 2019), which may facilitate divorce attainment if husbands refuse to show in court. This moves the country closer towards viewing men and women as equal citizens in the eyes of the law. It is still early

to see how these laws have impacted Saudi society on the ground, however it has lifted many of the responsibilities, and power off of men. These changes may have an effect on the sexual behaviour of young people in addition to shaping new social and traditional gender norms, especially with the current lax gender segregation laws. Yet, social stigma towards divorced women still exists.

1.2.5. SEX EDUCATION AND SEXUAL HEALTH

Defining sexual health, reproductive health, sex education and sexual rights has been a work in progress. The WHO has provided definitions for all these terms, which are provided in **Boxes 1, 2, 3 and 4** respectively**.** Although the WHO has emphasized the critical role of access to knowledge on positive sexual health outcomes, sexual health education is still a controversial topic around the world (WHO 2010). In Europe, sex education programmes have evolved over the years to encompass new emerging topics **[See Box 5].** Other countries, however, are still debating how to formulate programs to address the sexual needs of adolescents while remaining sensitive to cultural and/or religious values. In the United States, there are on-going debates on which type of sex education programme to implement in schools; comprehensive or abstinence only programmes. **[See Box 6]**. In the MENA region, sex-related topics are considered taboo and are rarely addressed. Some of the main aspects of the WHO definition of sexual health education may not be applicable to the local cultures within the region (Dejong et al. 2007).

The ability to reach a good state of sexual health depends heavily on access to information about sexual matters (WHO 2017b). In fact, sex education has been shown to be effective in improving sexual health outcomes (WHO 2010; Macdowall et al. 2006).

Sexual Health: A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Box 1: Definition of Sexual Health (WHO 2017)

Reproductive Health: *A state of complete physical, mental and social well-being in all matters related to reproduction, including sexual health. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so.* The definition also included: family planning information and services, safe pregnancy and delivery services, post abortion care, abortion where it is not against the law, prevention and treatment of STIs including HIV, treatment of reproductive tract infections, information and counselling on sexuality, reproductive health, and responsible parenthood. The programme also appealed for the elimination of "harmful" practices like female genital mutilation.

Box 2: Definition of Reproductive Health (WHO 2017)

Comprehensive Sexuality Education (CSE): CSE is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.

Box 3: Definition of Comprehensive Sexual Education (WHO 2017)

Sexual Rights: *Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons to be free of coercion, discrimination and violence to the highest attainable standard of sexual health, including access to sexual and reproductive health care services, seek, receive and impart information related to sexuality, sexuality education, respect for bodily integrity, chose their partner, decide to be sexually active or not, consensual sexual relations, consensual marriage, decide whether or not and when to have children and pursue a satisfying, safe and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others.*

Box 4: Definition of Sexual Rights (WHO 2017)

Sexuality Education in Europe

- 1960-70s: Prevention of unintended pregnancy.
- 1980s: Prevention of HIV
- 1990s: Awareness about sexual abuse
- 2000s: Prevention of sexism, homophobia, and online bullying
- Current: Analysis of gender norms and reflections on gender inequality

Box 5: Sexuality Education in Europe over the Years (Wellings and Parker 2006)

Abstinence-Only Sexuality Education programs vs. Comprehensive Sexuality Education Programs in the United States: Views on Sexuality Education in the United States separate into those favouring Abstinence Only Sexual Education or Comprehensive Sexual Education (CSE). Arguments in the literature have been inconclusive about the effect of comprehensive sexual education, when compared to abstinence-only programs. While CSE has been shown to delay the first vaginal intercourse, there was no significant difference in STI diagnosis when compared to abstinence-only programs. However, adolescents who received CSE were less likely to engage in vaginal intercourse and less likely to become pregnant when compared with those who have not received any formal education. It is important to note that CSE was not associated with increased sexual activity among adolescents, which is the main parental concern.

Box 6: Abstinence-Only Sexuality Education programmes vs. Comprehensive Sex Education Programmes in the U.S. (Underhill et al. 2007a; 2007b)

SEX EDUCATION IN SAUDI ARABIA

In Saudi Arabia, there is no dedicated, distinct sex education programme within the national school curricula. Yet, some material related to sexual matters is presented through Biology and Islamic Jurisprudence. Topics including information on female puberty and menstruation are also covered in Home Economics, which is exclusively taught to girls and mainly focuses on the proper Islamic hygienic rules regarding menstruation. Sexual intercourse is presented in the 10th grade Islamic jurisprudence text book as a spousal right when practiced within marriage but a deviant behaviour and a great sin, when practiced outside of marriage (Saudi MoE 2019). The books also mention that premarital and extramarital sex are the main reason for the spread of sexually transmitted infections (STIs) and immorality without providing any information on protective measures other than abstaining from illegal sexual relationships (Saudi MoE 2019).

The books provide a technical definition of what constitutes adultery and specify it explicitly as penile vaginal penetration between a man and a woman who are not married. There is no mention of other sexual practices apart from anal sex that is mentioned when discussing 'the sin' of sodomy. Oral sex, masturbation and non-penetrative intercourse are not addressed (Saudi Arabia MoE 2019). In addition, no information is presented on the importance of communication between partners or spouses, even from a religious perspective. The texts do not include information about sexual rights, neither do they cover issues related to reproductive health, such as contraception. Given the little information on sexual matters taught in schools in Saudi Arabia, it is speculated that knowledge levels among adolescents regarding sexual health are low.

Contraception is permissible religiously for the purpose of spacing children within marriage and is widely used in Saudi Arabia (Sheeha 2010; Abdel-Fattah et al. 2007). Yet, with the decreasing fertility rates (2.53 in 2016 vs 4.75 in 1996), it can be assumed that contraception is used to limit childbearing as well in the country (World Bank 2017). Religious scholars allow the use of contraceptive methods if they do not pose a threat to the woman's health; if it is a temporary method and if it is approved by both spouses. Oral contraceptive pills (OCPs) are available free of charge, through public hospitals. They are also available through private pharmacies, over the counter, without a prescription, to everyone, irrespective of marital status. In Vitro Fertilization is permissible in Islam between married couple, although sperm and egg donation are prohibited. IVF services are available in Saudi Arabia and are mostly provided in the private sector due to long waiting lists in public hospitals (Almaslami 2018).

As for abortion, most Islamic schools of thought agree on the forbiddance of inducing an abortion after 120 days of conception when it is believed that the 'soul develops' and hence it would be considered murder to abort the foetus at this stage. The only exclusions to this rule are proof that continuing the pregnancy puts the mother's health in danger and/or in the case of foetal demise. Rape and incest are also legitimate reasons to allow abortion. Some Islamic schools of thought allow abortion before 40 days of conception for any reason and others allow it before 120 days of conception in case of foetal deformity (Hessini 2007). In Saudi Arabia, according to the 'Health Practitioners' Law', article 22 (which cites Decision no. 140 from the Council of Senior Scholars), pregnancies prior to 40 days with a clear harm on the mother's life can be terminated after the assessment of a trustworthy medical committee (Health Practitioners Law, accessed 2019). Abortions are not allowed in cases of personal preference or due to fear of poverty or inability of parents to raise the child. In pregnancies that exceed 120 days of conception no abortion is allowed unless a committee of at least 3 specialized doctors,

and the head of hospital, determine that the continuation of this pregnancy may kill the mother and that all measures to save the foetus have been exhausted.

Approval of the husband or male guardian (in case of the absence of the husband) is needed after informing them of the health consequences of this procedure ("'The Health Practitioners Law" 2005). Insisting on the husbands' approval may limit women's autonomy over their bodies and their decision-making capacity over their health. Although new legislations have been introduced to allow women to undergo surgeries without the need to prove their husbands' approval, procedures that are 'related to fertility' are exempted and it is not clear if abortions are within these exempted procedures. It is important to mention that these laws apply to married women with the exception of rape and incest crimes where single women would be able to benefit from gaining access to legal abortions in hospitals in Saudi Arabia.

1.2.6. RECENT PUBLIC HEALTH INITIATIVES RELATED TO SEXUAL HEALTH

The mandatory premarital screening programme or *Healthy Marriage Programme* was introduced in 2004 to screen for hemoglobinopathies; sickle cell anaemia and thalassemia, which are prevalent in Saudi Arabia, especially with the acceptance of consanguineous marriages (Alswaidi and O'Brien 2009). Couples, identified by screening to be carriers, are then offered counselling session but their right to marry, irrespective of status, is ensured. Evaluation of the program showed a 60% decrease of at-risk marriages between 2004 and 2009 (Memish and Saeedi 2011). In 2008, mandatory screening for HIV, Hepatitis B and C was introduced to the program via a royal decree in spite of evidence of low HIV prevalence and no proven cost-effectiveness. Yet, research showed that demanding HIV testing may have social impact especially in conservative communities who may not voluntary test for HIV due to the stigma surrounding it (Alswaidi and O'Brien 2009). HIV treatment is free of charge to all Saudi citizens, yet migrant workers found to be HIV positive are deported out of the country. The National AIDS Program (NAP) was founded in 1994 under the unit of Deputy of Public Health at

the MoH. It raises awareness on HIV and AIDS and has been advocating for the rights of people living with HIV (PLWHIV). The MoH website provides information on HIV and AIDS and promotes prevention strategies that include avoiding sex outside of marriage as well as 'avoiding homosexuality' (Saudi MoH "Infectious Diseases - HIV/AIDS" 2019).

Syphilis is the only STI that is regularly screened for during pregnancy but is done routinely as part of wider pregnancy tests, and often patients are not informed of what specific infections they are being screened for. There are no clear national guidelines for cervical screening in the country. Cervical cancer is the 3rd most common cancer among Saudi women and is usually diagnosed at advanced stages due to the lack of national guidelines (Al-Badawi et al. 2011). When conducted, cervical screening is usually applicable to those who are or have previously been married and is not mandated through guidelines, which excludes single women under the assumption that they have not engaged in sexual activity (Alzahrani 201; Almazrou 2019; Jradi and Bawazir 2019). Two vaccines that protect against the most common strains of Human Papilloma Virus (HPV) are available in the country but only on request. In contrast, in the UK the NHS provides free Gardasil vaccine[†††] to girls between the ages of 12 up to their 25th birthday and has recently expanded to include boys (NHS 2015).

Another example of public health efforts in Saudi Arabia is the work of the National Family Safety Program (NFSP), a public organization classified as an NGO. It was founded in 2005 by a royal decree and is mainly concerned with child abuse and neglect, including sexual abuse and harassment. The NFSP has mounted several national campaigns to address issues such as bullying, and abuse against women and children (National Family Safety Program-Saudi Arabia 2014). The Programme faced criticism due to its limited jurisdictions. Further, abused girls are usually taken into protective shelters and are only

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[†††] Gardasil protects against HPV 6 and 11 which cause genital warts and HPV 16 and 18 that are the most common causes of cervical cancer.

released with their male guardians' approval and onto their custody. Male guardians are in many cases the perpetrators of (Aldosari 2017). Recent announcements in allowing women to live independently in the country may permit women to leave these shelters without needing to go back to their perpetrators' homes. Yet, it is unclear if this legislation has been applied. 'The Law of Protection from Abuse' was announced via a Royal Decree 2013 by King Abdullah bin Abdulaziz, and for the first time included a definition for the term 'abuse', which included sexual abuse (Saudi Council of Ministers 2013). However, the definition was general and excluded marital rape and sexual harassment. Furthermore, the mechanism for reporting abuse was vague with no clear reporting pathway to a specific authority. In May 2018, a new 'anti-harassment law' was released defining the crime of harassment as any physical, verbal or implicit behaviour or innuendo of sexual nature by one individual against another targeting the individual's body, honour (reputation), or embarrassing him/her by any way including modern technology. The law applies to both genders and goes into details of the type of penalties that includes an upper limit of 5 year imprisonment and financial penalties of up to SR300,000 which is equivalent to $80,000 (Dbais 2018). This law was passed in congruence with the announcement of several new reforms related to women's rights including lifting the ban on women driving, which was announced on September 2017 and activated in July 2018. In 2019, laws against discrimination were also announced, including discrimination based on race, religion and gender although no mention of sexual orientation was made (Saudi Press Agency SPA 2019).

Few educational initiatives have been introduced in the school system to promote critical thinking or prevent drug use, smoking and following extreme religious ideologies. The MoE even recently announced plans to include physical education (sports) in girls' schools, which was previously viewed as inappropriate for female students (Paul 2017). Yet, sex education initiatives are still lacking. A programme under the name of *Nabeeh* has been initiated in 2018 to raise awareness among children about sexual abuse and

violence. However, it seems to be small scaled and limited to one area in Saudi Arabia (Saudi Press Agency 2018).

The WHO, has identified five main domains for developing a framework for sexual health programmes which include laws, policies and human rights, education, economics, health services and society and culture (WHO 2016.). The last domain is of significant importance since research has asserted that programmes that contradict cultural teachings may face opposition and understanding the cultural context is vital for any public health policy-making (Napier et al. 2017). In Saudi Arabia, before any sex education programme can be formulated or adapted, a vital preliminary step is required, which is to explore the views of different stakeholders that are directly involved with adolescent health and education in Saudi Arabia, on the provision of a formal sex education programme for adolescents in the country. An additional critical step is to acknowledge the religious beliefs and cultural traditions of the Saudi society especially in relation to sensitive topics related to sexuality and gender roles. The new 'Saudi Vision 2030' focuses on promoting a healthier population and understanding the specific needs of adolescents in Saudi Arabia. This may be an opportune time for an enquiry into the perceived sexual health educational needs of young people in the country ("Saudi Vision 2030" 2016).

CHAPTER TWO- LITERATURE REVIEW

2.1. LIMITATION OF SEX-RELATED RESEARCH IN MENA REGION

The difficulty of conducting research around sexual health in the MENA region has been well documented. Most of the research that has been carried out cites social, cultural and religious conservative views on sexuality as the main limiting factor for collecting this type of data (Dejong et al. 2007; El-Kak 2013; Memish et al. 2015; Population Council 2017). This is often highlighted by the classification of sexual activity outside of the context of marriage as 'immoral' in the large part of the MENA region (Dejong et al. 2007; El-Kak 2013). Other research focuses on reasons like traditional gender roles that generally dictate the societal views and expectations of men and women; the former expected to be authoritative and the latter submissive (Dejong et al. 2007; K. Ali 2015; Mensch et al. 2003). Although gender disparities are an international phenomenon, the gender gap is far more apparent within the MENA region (AlBuhairan et al. 2015). Furthermore, topics related to sexuality are usually closely linked with family honour and reputation, especially for women (Shirpak et al. 2007; Dejong et al. 2007).

A commonly held belief among the public is that unmarried youth are adhering to the cultural and religious values and abstaining from sexual activity. However, available data from the MENA region reveals an increase in STI prevalence, which makes the need for research surrounding the controversial topics of sexual health and sexuality, highly important (Dejong et al. 2007; Memish et al. 2015; El-Kak 2013; Population Council 2017; Badahdah 2010).

Most of the studies in the MENA region have been quantitative in nature. As far as can be assessed, there are no published qualitative studies exploring sexual knowledge, attitudes and beliefs among adolescents within the Saudi community. Most of the surveys have used easily accessible but often highly selected populations with the

possibility of bias. Several surveys in Saudi Arabia (Raheel et al. 2013; Al-Shaikh et al. 2014; ALMalki 2014; Badahdah 2010), and elsewhere in the region, including a survey in Lebanon (Barbour and Salameh 2009) have collected data from university students with the potential for bias towards more affluent and better educated young people. Studies among high school/secondary school students in Saudi Arabia have been less common (Alquaiz et al. 2012; 2013)though this population has been studied in other countries in the region, like Lebanon and Iran (Mohanna et al. 2017; Javadnoori et al. 2012). It is noteworthy that Saudi studies usually investigate either men or women, which may be due to the nature of gender-segregated schools (AlQuaiz et al. 2013; 2013; Raheel et al. 2013; Al-Shaikh et al. 2014; ALMalki 2014). Another limitation is that men but not women are often included in studies inquiring about pre-marital sexual practices. This is especially true in Saudi Arabia which further perpetuates the gender differences in Middle Eastern societies, where premarital sexual activity is more tolerated in men than in women (Raheel et al. 2013).

A few general population studies on sexual health have been carried out, notably in Lebanon, Yemen (Kahhaleh, El Nakib, and Jurjus 2009; Al-Iryani et al. 2009) and among Yemeni at-risk young people (Al-Serouri et al. 2010). Most of these surveys have been conducted in highly populated, urban cities. In Saudi Arabia, surveys have been conducted mainly in Riyadh, which is the capital and most densely populated city in the country (Raheel et al. 2013; Al-Shaikh et al. 2014; Badahdah 2010; Alquaiz et al. 2012; 2013). In other countries, large cities have also been chosen as the main area of focus like Tehran, Iran (Javadnoori et al. 2012), Aden, Yemen, (Al-Serouri et al. 2010; Al-Iryani et al. 2009), and Beirut, Lebanon (Wagner et al. 2012). We therefore know far less about sexual health-related knowledge, attitudes and practices of people living in rural areas of the MENA region.

In relation to the topics investigated, the focus has largely been on clinical and biomedical issues. In Saudi Arabia, research assessing sexual health knowledge and attitudes mainly focus on topics related to STIs, especially HIV, and touch upon knowledge of safe sex

practices, mainly related to condoms' preventive role in HIV transmission (Raheel et al. 2013; Al-Shaikh et al. 2014; ALMalki 2014; Badahdah 2010). However, condom use has not been assessed in studies conducted among girls (Alquaiz, et al. 2012; 2013). Neighbouring Arab countries; Lebanon, (Barbour and Salameh 2009; Kahhaleh et al. 2009) Egypt, (Al-Iryani et al. 2009), Yemen (Badahdah and Sayem 2010; Al-Serouri et al. 2010)and Palestine (UNICEF 2011) have conducted research assessing knowledge surrounding STIs. Interestingly, in the Egyptian survey, researchers only asked ever-married participants about contraception use and pregnancy history (Al-Iryani et al. 2009).

Few studies have explored the prevalence of sexual activity and practices among adolescents in the MENA region. Most have not clearly defined what constitutes 'sexual activity' and have failed to inquire about 'alternative' forms of sexual activities that may not be socially, culturally or religiously acceptable. Research on same sex practices, especially among men, are limited and surveys that do inquire about them usually formulate the questions indirectly (Roudi-Fahimi and El Faki 2011).

It may have been necessary for researchers to intentionally keep the definition of 'sexual activity' broad to gain ethical approval or social acceptance for their studies. Research conducted in the United States has shown that interpretations as to what constitutes sexual activity differ, especially among adolescents (Bersamin et al. 2007; Uecker et al. 2008). Abstinence and virginity can be defined according to religious beliefs, personal morality and/or cultural norms (Bersamin et al. 2007; Uecker et al. 2008). Hence, asking clear, explicit questions may be necessary to properly assess practices. The limited scientific data related to sexual health in the MENA region, coupled with the complexity of the Arabic discourse on those matters highlights a gap in research related to this area and a possible opportunity to better explore it.

Although published research exploring the sexual health needs of young people in the MENA region, including Saudi Arabia, is scarce, research in Western countries focusing

on Muslim and Arab immigrants and their offspring may provide some insights (Ahmed 2014; Adamczyk and Hayes 2012; Shirpak et al.2007; Smerecnik et al. 2010). However, there are obvious difficulties in extrapolating from the findings because of the issue of acculturation. The results of such studies transfer poorly to young people living within the MENA region since the Western studies highlight the effect of migration on beliefs and attitudes related to sexuality and the tensions faced by adolescents living in other countries than their parents' home country (Adamczyk and Hayes 2012; Smerecnik et al. 2010).

There is increasing attention being paid to sexual trends in countries with predominantly Muslim populations. Several reasons are given for this, which include demographic changes influencing the sexual lifestyles of young people; globalisation and exposure to new sexual norms through the Internet and social media; and changing trends in sexual health status (El-Kak 2013; Dejong et al. 2007; DeJong et al. 2005; DeJong and Battistin 2015).

2.2. DEMOGRAPHIC TRENDS

The literature highlights changes to the demographic landscape in the MENA region including the growing population of young people, the increasing age at marriage, the emergence of novel forms of marriage and relationships among young people, and rising divorce rates. Young people make up the majority of the population in the MENA region; one in five people in the region are between the ages of 15-24 (Dejong et al. 2007). Most of the studies emphasize this point as a rationale for the increasing interest in conducting research within this age group in the MENA region (Dejong et al. 2007; El-Kak 2013) as well as Saudi Arabia where almost 15% of the population is between 15-24 years of age. (Raheel et al. 2013; AlBuhairan 2015).

The literature also points to the emergence of novel types of marriage and relationship trends among young people in the MENA region as another reason to explore sexual practices and attitudes among young people. These are usually described as secretive in nature and not culturally accepted. Research mentions the different types of marriages in different countries. In Egypt for example, *urfi* marriage, which is not formally registered, is usually practiced by university students in order to legitimize the sexual relationship between the couple, and is usually documented on a piece of paper with the presence of two witnesses who may be friends of the couple (El-Kak 2013). In Saudi Arabia, a form of marriage called *misyar* has been legalized by many religious scholars including the Grand Mufti. This type of marriage requires women to give up their rights to financial support and housing. Where marriages are not legally recognized, women will have difficulty in accessing reproductive health services, which are generally for married women (El-Kak 2013; Dejong et al. 2007). Because of their clandestine nature, it is difficult to estimate the prevalence of these relationships and the sexual practices occurring within them and, more importantly, it would be difficult to reach couples, engaging in these alternative marriages with appropriate interventions. Further, since these relationships are classified as 'legitimate' since they are categorized as marriage, they may provide a false sense of protection especially with public health and religious messages promoting avoiding 'illegitimate' relationships to prevent STIs.

Although child marriage still exists in the MENA region, a noticeable shift in the age of marriage has been documented. More women are delaying marriage and pursuing education and a career (Dejong et al. 2007). In addition, women are spending longer in education and higher proportions of their time in work outside the home. It is hypothesized that young people have a longer time period in which they are single and possibly exploring sexual activity (Dejong et al. 2007).

2.3. GLOBALISATION AND THE INTERNET

Globalization is another factor identified by researchers as accounting for the growing attention to young people's sex education in the MENA region (AlBuhairan 2015; El-Kak 2013; Dejong et al. 2007). The introduction of social media outlets and the availability of smartphones has facilitated exposure to other cultures and communication between the sexes. In addition, the Western media have introduced young people to sexual norms that differ drastically from those in the MENA region (Dejong et al. 2007). Open access has also allowed exposure to different Islamic websites. Access to Islamic websites have allowed Muslims around the world to explore opinions from different Islamic schools of thought and different Islamic sects, which may provide people with alternative opinions and regulations to those in their local culture, which may extend to sex-related regulations (Abdullah 2007). It has also allowed access to alternative ideologies, beliefs and practices and may have influenced many of political and social movements in the MENA region, including the rise of the Arab Spring (Khondker 2011). In addition, the use of social media has allowed girls and women to express their views and identities while still being veiled from the public and interact more freely with the opposite sex (Al Lily 2011).

2.4. CHANGING TRENDS IN SEXUAL HEALTH STATUS

Evidence of the growing prevalence of STIs is often cited as an indication of the need for sex education in the MENA region (El-Kak 2013). The avoidance of STIs is a more common plank of arguments for effective sex education in the Islamic context than is the need for more positive sexual experiences. However, increasing divorce rates have intensified concern for the reasons for marital disharmony. These have been shown to include ignorance in relation to sexual activity and sexual function (El-Meliegy et al. 2013). Vaginal penetration phobia (VPP) is said to be a distressing issue worldwide, but the

problem may be heightened among Arab women, because of cultural taboos about bleeding, and also the strong emphasis placed on avoidance of intercourse before marriage. A study looking at vaginismus [‡‡‡] found several associated risk factors for this condition including violent vaginal penetration and negative attitudes towards sex, but the most commonly reported risk factor was insufficient knowledge about sex (Muammar et al. 2015). Research into the sexual problems of men has also highlighted the importance of education to prepare them for sexual relationships (El-Meliegy et al. 2013). In fear of not performing well sexually, men may also be influenced by expectations gathered from pornographic films. Sexual dysfunction and anxiety interfere with sexual relations and may lead to unconsummated marriage, (Badran et al. 2006) infertility, (Abolfotouh et al. 2013) and divorce. Since insufficient knowledge of sexual intercourse is a major contributor to sexual problems, sex education is increasingly seen as important in their prevention and treatment (Muammar et al. 2015).

2.4.1. SEXUALLY TRANSMITTED INFECTIONS RATES

Although the MENA countries have the lowest rate of people living with HIV globally, the number of new cases in the region rose by 31% between 2001 and 2014 making it one of the fastest growing HIV epidemic regions in the world (Gökengin et al. 2016). In addition, the MENA region has the lowest rates of treatment coverage (Gökengin et al. 2016).

Data on the prevalence of HIV and other STI cases in Saudi Arabia are rarely published and not readily accessible. However, the most recent published study examining HIV case reports between 2000 and 2009 estimated the rate of HIV at 1.5 cases per 100,000

[‡‡‡] Vaginismus: recurrent or persistent involuntary tightening of muscles around the vagina whenever penetration is attempted. (NHS)

for Saudi nationals and 13.2 per 100,000 for foreign residents in Saudi Arabia (Mazroa et al. 2012). The MoH reported 4323 cases of Hepatitis B in 2014, with the majority of cases (3002) in men aged 15-44 ("Ministry of Health, Kingdom of Saudi Arabia."2016.). Since sexual relationships outside the context of marriage are forbidden religiously and penalized by law, the general assumption is that people abstain from sexual relationships until marriage. Many people therefore believe that cases of STIs are limited to foreign visitors and workers and are not a domestic problem. Several studies however have shown increased rates of STIs generally, and reported an increase in the contribution of Saudi nationals to the number of cases of HIV in the country (Filemban et al. 2015; Memish 2015). The main HIV transmission route has progressively changed from being a result of contaminated blood transfusions to heterosexual sex over the years (Al-Mozaini et al. 2014).

A recent study among patients attending obstetrics and gynaecology, dermatology, urology and infectious disease clinics found that 6.2% of people had an STI, most commonly gonorrhoea (2.7%) and least commonly HIV (0.005%) (Filemban et al. 2015). A study looking at the prevalence of Herpes Simplex Virus Type 1 and type 2 showed a high prevalence for HSV-1 (88.8%) and a low one for HSV-2 (1.26%) (Memish 2015). Interestingly, many of the papers in Saudi Arabia that report STI rates and sexual risk behaviour differentiate between the rates among Saudi nationals and non-Saudi residents. A common observation made by researches is that 'risky' behaviours are the product of the influx of foreigners, especially migrant workers into Saudi Arabia (Memish et al. 2015; Filemban et al. 2015; Madani 2006). Screening programmes seem to be lacking in the country. In fact, one study conducted in Riyadh, highlighted how partners of female patients infected with STIs were not screened (Fageeh 2013).

2.4.2. UNPLANNED PREGNANCIES AND UNSAFE ABORTIONS

Studies from different cities in Saudi Arabia between 2010 and 2018 revealed high usage of contraception (Alhusain et al. 2018; Sheeha 2010; Khraif et al. 2017; Al-Mass et al. 2018; Mubashar et al. 2016). The most common form used was OCPs, followed by intrauterine devices (IUD). Condoms were the least used method of contraception. In addition, knowledge on adverse effects, proper usage and other forms of contraception was low in all of the studies. Higher education and older age were associated with higher use of OCPs and better knowledge (Alhusain et al. 2018; Sheeha 2010; Khraif et al. 2017; Al-Mass et al. 2018; Mubashar et al. 2016). Although limiting birth permanently through sterilization is not permissible according to religious scholars, unless it is medically indication, many women use contraception to not only space births but to also limit them (Mubashar et al. 2016). Discussions about possible population control regulations may raise a religious debate about the permissibility of limiting birth in the future.

Data on unsafe abortions is limited, and very little is known on abortion rates among unmarried women in Saudi Arabia. One study showed that out of 678 women in an obstetrics and gynaecology clinic, 7.4% used misoprostol as an abortifacient, which was higher than in other countries. The study revealed poor knowledge about the medication and reported friends and colleagues as the main source of information about this drug (Alsibiani 2014).

Estimates for the Western Asia and the North Africa region suggest that an estimated 153 and 164 abortions per 1,000 women aged 15-44 occurred between 2010-2014 respectively (Sedgh et al. 2016). Since most studies from countries that do not permit abortions for single women would not report them, these figures may represent abortions among married women only.

2.4.2. SEXUAL ABUSE

Links of child sexual abuse (CSA)[§§§] to poor mental health outcomes in adulthood have been reported (Fergusson, McLeod and Horwood, 2013). Yet, research assessing CSA is limited in the Arab world as well as in Saudi Arabia (Almuneef 2019). A meta-analysis reported a prevalence of 15%-21% of CSA in Saudi Arabia (Alsehaimi 2016). Further, analysis of the National Family Safety Registry from 2011-2016 showed that 14% of cases of child maltreatment (CM) were cases of CSA (National Family Safety Program, 2016). Further, a survey conducted among secondary school pupils aged 15-18 found that 13% reported experiencing sexual abuse (Al-Eissa et al. 2016). Another study conducted in Riyadh aimed to assess consequences of CSA found surveyed adults (above 18 years) and found that 20.8% of respondents experienced contact CSA (Almuneef 2019). Males were more likely to have experienced abuse and approximately 10% of all reported CSA was penetrative sexual abuse (Almuneef 2019). The study suggests that underreporting is highly possible due to the taboo nature of sexual abuse within the Arab world. Cultural factors associated with sexual violence may play a role in the tendency not to report, especially with the high rates of stigmatization and victim blaming (Caskey, Lindau, and Alexander 2009; Dartnall and Jewkes 2013)

A study conducted among female school pupils averaging 15 years of age, found that 10% of girls reporting being exposed to sexual violence. The study also reported that those with sexual violence exposure were more likely to have parents that are 'less supportive in sexual education' (Alquaiz et al. 2012).

As for intimate partner violence, most studies in Saudi Arabia still use the term 'domestic violence' and usually limit their participants to 'ever married women', which may neglect a large proportion of women who may be experiencing violence from other male

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[§§§] Include contact abuse and non-contact abuse (Almuneef 2019).

relatives (Barnawi 2015; Abo-Elfetoh and Abd El-Mawgod 2015). A survey conducted in Northern Saudi Arabia found that 80% of 'wives' experienced violence from their husbands (Abo-Elfetoh and Abd El-Mawgod 2015). In Jeddah, Saudi Arabia, the prevalence was between 34% and 44.5% (Fageeh 2014; Eldoseri 2017) while in Riyadh 20% of participants reported domestic violence in the past year (Barnawi 2015). In the Western province intimate partner violence was reported at 12% (Alzahrani 2016). Younger women were more likely to report domestic violence and one study reported significant association between childhood violence and domestic violence (Eldoseri 2017). All of these studies assert that underreporting is expected and recommend raising awareness and education on all forms of violence.

2.5. SEXUAL BEHAVIOURS AND ATTITUDES IN THE MENA REGION

Studies looking at sexual behaviours among adolescents in Saudi Arabia have usually restricted the sample to male students (Raheel et al. 2013; Alsubaie 2019). In 2013, cross-sectional study in Riyadh, Saudi Arabia found that a third of male university students reported engaging in premarital sexual activity (Raheel et al. 2013). A recent study in 2019, conducted in Riyadh, surveyed male high school students (Alsubaie 2019). Although this sample was younger in age, a higher percentage of students -38% - reported having experienced sexual contact outside of marriage, and more than two-thirds believed their friends engaged in premarital sexual activity, though these studies fail to define what constitutes sexual activity. The study also reported that more than half of the students said they masturbated daily. Further, 72% of the sample indicated that they believed men engage in sex before marriage. The study also reported on students' views towards the need for sex education in school and found the vast majority supportive of such programmes and believed in their effectiveness in reducing risk (Alsubaie 2019).

Studies in other neighbouring, Muslim-majority countries such as Iran (Mohammadi et al. 2006) and Tunisia (Dejong et al. 2007) have shown similar results and limitations. The study in Iran showed that almost a third of males aged 15-18 reported having 'sexual contact' at least once (Mohammadi et al. 2006). A survey in Tunisia, conducted among unmarried out-of-school youth aged 15-24, revealed that the vast majority of the men and one in four women, believed that their unmarried friends were having pre-marital sex (Dejong et al. 2007). Only one in 10 Tunisian women below the age of 20 had engaged in some sexual activity (Dejong et al. 2007). In Lebanon, a survey among 1,400 unmarried students in public and private universities suggested that half of men had had 'sexual relationship with vaginal penetration' while less than 20% of women had done so. The authors explained the gender difference with reference to sampling error but also to the social norms of Lebanese society which, like other Arab societies, encourages sexual practices among men but prohibits them for women (Barbour and Salameh 2009). This may also result in reporting bias, as women may fear the effect on their honour and reputation when disclosing such sensitive information.

Most of the studies have failed to inquire about safer sex practices (Dejong et al. 2007; Raheel et al. 2013; Awaluddin et al. 2015; Ahmad et al. 2014). Some have examined the association between sexual activity and other risk behaviours, like drug and alcohol use. Within the survey of young educated men in Riyadh, the authors reported an association between premarital sexual activity and use of illegal drugs, travelling alone, and viewing 'pornographic material' (Raheel et al. 2013). The type of pornographic material was not specified or defined in the paper. A Malaysian survey reported viewing pornography, masturbation and low religiosity as factors associated with sexual activity (Awaluddin et al. 2015). A study in Lebanon looked at the association between alcohol and/or drug consumption and sexual debut among university students. The results showed that 10% of participants confessed to consuming alcohol or drugs at sexual debut, which was more common among males and those identifying as less religious. Further, those consuming

alcohol or drugs during their first oral and or vaginal sexual experience were more likely to do so with an unfamiliar partner (Ghandour, Mouhanna, Yasmine and Elkak, 2014).

With the growing prevalence of HIV in the region, researchers have increasingly been interested in investigating attitudes towards people living with HIV/AIDS (PLWHA). A number of studies have reported negative attitudes towards PLWHA (Badahdah 2010; Barbour and Salameh 2009; Al-Iryani et al. 2009; UNICEF 2011; Badahdah and Foote 2010). In a study among young people in several Arab countries including Yemen, Qatar, Kuwait and Jordan, more than 60% of respondents believed that having a relative with HIV would tarnish their reputation, more than 67% believed that women living with HIV should be sterilized and around 67% believed that in the case of pregnancy they should get an abortion (Badahdah 2010). In Saudi Arabia, almost three quarters of students surveyed believed that PLWHA should be isolated from society and 70% would not want to marry into a family with a member suffering from HIV or AIDS (Badahdah 2010). Sixty-five percent did not feel comfortable being touched by someone with HIV, 59% believed that people with HIV should be fired from their jobs, and 39% said they would end their relationship with a friend if they found out that they contracted HIV. Half of the participants believed that people with HIV should be 'ashamed' of themselves while 68% said it was shameful for people to be diagnosed with HIV in Saudi Arabia. More than half of the participants believed that PLWHA were personally responsible for their infection and three quarters believed it to be a punishment from God (Badahdah 2010). The study also found that religiosity did not affect attitudes, rather, knowledge did. Students who were better informed about HIV had more positive attitudes towards PLWHA (Badahdah 2010). However, more recent studies have demonstrated society's move towards tolerance. A study published in 2018 found that 22% of participants claimed they would ask for a divorce if their spouse had an STI which is lower than previous reported numbers (El-Tholoth et al. 2018; Fageeh 2014).

The current turmoil within the region after the Arab Spring uprisings and its associated instability in many countries including Syria and Yemen that have been suffering from

ongoing wars and displacements has had a tremendous effect on the health and wellbeing of young people. Several studies have looked at the sexual exploitations of displaced youth and women and the profound effect it had on their health that go beyond the scope of this thesis but nonetheless should be mentioned (Dejong et al. 2017; Taleb 2015; Albuhairan 2016).

2.5.1. EXISTING LEVELS OF KNOWLEDGE OF SEXUAL HEALTH MATTERS

Research shows low levels of sexual health knowledge and awareness among young people in the MENA region (Dejong et al. 2007; AlQuaiz et al. 2013; Population Council 2017). A qualitative study conducted among students in Iran showed that many girls expressed shame and awkwardness when going through puberty (Javadnoori et al. 2012). Similarly, two thirds of young women surveyed in Egypt, said that they reacted with shock or fear upon experiencing their first menstrual cycle (Population Council 2017).

Studies in the MENA region show high awareness of HIV/AIDS, but knowledge regarding routes of transmission is reportedly poor. Even where studies have shown higher knowledge of transmission, (Population Council 2017; UNICEF 2011) they have shown high prevalence of beliefs in myths around HIV transmission. Studies in Saudi Arabia have shown high prevalence of myths around HIV, including the belief that HIV is exclusively transmitted through men having sex with men (Raheel et al. 2013; Badahdah 2010). Similarly, studies Saudi Arabia have shown poor knowledge of the aetiology of cervical cancer and the role played by HPV, and low awareness and uptake of the HPV vaccine, even among health care providers (Sait 2009; Al-Darwish et al. 2014; Al-Shaikh et al. 2014; Jradi and Bawazir 2019). Support for vaccination to girls was also low (Jradi and Bawazir 2019). Other misconceptions surrounding STIs have been shown to be common

in Saudi Arabia. A study in 2017 revealed that almost half believed that genital pruritus is transmitted by masturbation (Balbeesi and Mohizea 2017).

Knowledge of safer sex practices has been assessed mostly with reference to condom use. In a Palestinian survey, more than half of 15-19 year olds surveyed did not know of the protective role of condoms in HIV prevention (UNICEF 2011). A survey in Lebanon assessing knowledge and practices regarding contraception among university students found that half of the sexually active men knew how to put on a condom and knew to check for the expiration date before use but less than a third knew when a condom should be taken off (Barbour and Salameh 2009). In Saudi Arabia, several studies revealed that young men are unaware of the protective role of condoms in HIV transmission (Raheel et al. 2013; Badahdah 2010).

2.5.2. SOURCES AND QUALITY OF SEXUAL HEALTH INFORMATION MATTERS

When identifying sources of information more recent literature points to the increasing dependence on the Internet to access sexual health information. Yet, other sources were mainly peers as well as television, books and family.

In Egypt, a survey reported gender differences in reported sources of sexual health education. Half of the male participants reported peers as the main source of sex education while more than two thirds of female participants identified a family member; other than their parents; as the main source (UNICEF 2011). Schools, religious leaders and the Internet featured less commonly among sources (Population Council 2017). Other surveys conducted in Egypt among female university students found that the Internet was the main source of information, yet when asking specifically about menstruation, participants said they sought their mother's advice (El Gelany and Moussa 2013). Surveys in Lebanon have shown that peers were the main source of contraception information among university students (Barbour and Salameh 2009) and that only a third receive information about HIV from schools (Mohanna et al. 2017). In Palestine, almost

90% of 15-19 year olds stated television as their main source of information regarding HIV (UNICEF 2011).

In Saudi Arabia, there is evidence that only 11% of male high schools students in Riyadh discuss sexual health matters with their family (Alsubaie 2019). As for female students whilst 42% discuss such matters with friends, 17.3% with domestic helpers and only 15.8% discussed them with their mothers (Alquaiz et al. 2012). However, a more recent study in Saudi Arabia of men and women aged 18-25 found that the main source of education was the Internet (71.7%) (El-Tholoth et al. 2018).

2.5.3. RELIGIOUS EFFECTS ON SEXUAL BEHAVIOURS

Most religions including Judaism, Christianity, and Islam have specific strictures relating to sexuality and reproduction, and a clear distinction between what constitutes acceptable and unacceptable sexual practices, gender roles and family planning techniques (Tomkins et al. 2015). Yet, interpretations of religious texts and teachings may vary among and within each religion. In Islam grey areas between what is permissible or, as called in Islam, *halal* and what is prohibited or *haram* can vary widely between Muslim sects and local communities and affect sexual behaviours (Adamczyk and Hayes 2012).

Research has shown that, regardless of denomination, religion has the potential to confer both protection and vulnerability on individuals. Religious belief has been shown for example, to buffer young people from sexual risk behaviours (Muhammad et al. 2016; Ameri et al. 2016; Dalmida et al. 2018; Gandour et al. 2014). Several studies found an association between adolescents' religiosity and delayed first sexual intercourse, sometimes to after marriage (Adamczyk and Hayes 2012; Holder et al. 2000; (Shirazi and Morowatisharifabad 2009). A cross-sectional study using data from the Demographic and Health Survey found that Muslims and Hindus are less likely to report pre-marital sexual relationships compared to other religions, including Christianity, Buddhism and Judaism, specifically among women (Adamczyk and Hayes 2012). Yet, research also

identifies cultural norms and traditions as influencing sexual practices, especially for women (Dejong et al. 2007). Abstaining from sex until marriage is a common regulation among Western religions and while some studies have found that more religious adolescents abstain from all forms of sexual acts, others have shown avoidance only of penetrative sex (Uecker et al. 2008; Bersamin et al. 2007). Further, religious beliefs continue to influence many of the sex education programmes even in secular countries. In the U.S. tension over adopting abstinence-until marriage messages vs providing comprehensive sex education prompted research to assess the effect of such programmes on delaying sex among adolescents. In the first decade of the 20th century, systematic reviews were published showing that abstinence-only programs did not stop teenagers from engaging in sexual activity and did not even delay the onset of sexual activity (Maynard et al. 2007, Underhill et al. 2007). Further, critics of abstinence-only programmes deemed them un-ethical since they provided inaccurate information (Mynard et al. 2007). Research also shows that what further complicates the efficacy of abstinence-only messages is how the blurriness of what adolescents consider 'abstinence', especially when construed with religious definitions. Terms like 'technical virgins' have been reported in studies in the U.S. where young people report being virgins as long as they have not engaged in vaginal penetrative sex. This was common among so called 'virginity pledgers' [****]as a means to adhere to their religious convictions of abstaining from sex until marriage (Martino et al. 2008; Uecker et al. 2008). However, sometimes engaging in non-penetrative sex was to prevent pregnancy rather than to preserve virginity (Ueker et al. 2008).

In the Extended MENA (EMENA) region[††††], avoiding vaginal penetrative sex has been reported due to religious, cultural and legal restrictions; mostly to preserve virginity and

[****] Virginity pledge programme was founded by the Southern Baptist Church in 1993 in the U.S. (Martino 2008)

[††††] In addition to the MENA countries, the EMENA region includes Turkey, Afghanistan and Pakistan.

the intactness of the hymen (ELkak 2013). The literature on sexual practices within Muslim-majority countries has highlighted the link between female honour and virginity. Several studies looked at attitudes towards hymen reconstruction surgeries, honour killings and virginity testing (Eisner and Ghuneim 2013; Kaivanara 2016; Wild et al. 2015) and found that even women who chose to break away from cultural sexual norms in abstaining from sex until marriage opted to undergo hymen reconstruction surgeries out of fear that virginity can be physically detected (Kaivanara 2016). Many of these practices were linked to predominant patriarchal views on sexuality within the MENA region where many societies express intolerance to women being sexually active prior to or outside the context of marriage (Dejong et al. 2007).

The control of women sexuality is further evident with the practice of female genital mutilation (FGM). FGM is not exclusive to Muslim communities and is not popular in the majority of MENA countries, including Saudi Arabia (Rouzi, 2013). Although, this practice has been linked to ancient social traditions rather than religious teachings, some Islamic scholars continue to condone it (Rouzi 2013).

2.5.5. STAKEHOLDERS' VIEWS, KNOWLEDGE AND ATTITUDES

Studies have explored the views of different stakeholders regarding health knowledge and practices in the MENA region, especially in relation to young people (Alquaiz, Almuneef, and Minhas 2012; AlQuaiz, Kazi, and Al Muneef 2013; Javadnoori et al. 2012). Although limited data exists on the views of teachers on discussing sexual health topics, studies among students in Saudi Arabia (Alquaiz et al. 2012), Lebanon (Barbour and Salameh 2009), Egypt (Population Council 2017), Palestine (UNICEF 2011) and Iran (Javadnoori et al. 2012) have suggested mainly negative attitudes on the part of teachers. 80% of adolescents in the Lebanon never spoke to their teachers about sexual and reproductive health (Mohanna et al. 2017). In Iran, female students expressed a

preference for learning about sexual health issues in schools but complained of negative attitudes, inaccurate information, hasty delivery and unease on the part of teachers. Furthermore, many described the use of 'scare tactics' to warn them off specific behaviours like masturbation. They also held the view that information should be introduced to them earlier than immediately before marriage, especially regarding puberty and menstruation (Javadnoori et al. 2012).

Research has also looked at the role of Imams and mosques in health promotion, mostly in Western countries (King et al. 2017; Mustafa et al. 2017; Vu et al. 2018). Sexual health issues, however, are still a sensitive subject to address. In Egypt, a report published by the Population Reference Bureau (PRB) examined the readiness of Imams to raise awareness of HIV/AIDS (Dejong et al. 2007; Population Reference Bureau PRB 2010) and found although levels of knowledge were high when compared to the general male population in Egypt, misconceptions were common. The report emphasized the importance of including Imams in HIV/AIDS awareness but stressed the need for formal training (Population Reference Bureau PRB 2010). Research on the preparedness of Imams to participate in in raising awareness of other sexual health issues is lacking. In Egypt, a study examining the role of school nurses in sex education found that perceived barriers included personal beliefs, shyness and awkwardness in providing information to male students, lack of training, confidence and knowledge and parental resistance due to fear of Western influences (Farrag and Hayter 2014)..

A study of healthcare providers in Saudi Arabia, found that although the majority reported caring for adolescent patients, less than half of them received formal training in adolescent health and little more than half had 'adequate knowledge' about adolescents' specific healthcare needs (Albuhairan and Olsson 2014).

Several studies in the MENA region have looked at the views of parents on sex education. In Oman, parents were found to be supportive of shared responsibility between parents and teachers in delivering sex education covering sex abuse prevention and

reproduction (Zaabi et al. 2019). Yet the study revealed that parents preferred sex education to conform to Islamic teachings and emphasise the need to abstain from sex until marriage. Parents did not see the need to address topics related to safe sex practices and contraception (Zaabi et al. 2019). A study in Iran which explored parents' experiences in what the authors described as 'children sexual training' (Sharifi et al. 2016) found that parents saw the main role of sex education as preventing sexual abuse. Parents in this study also believed they lacked the necessary skills to be able to deliver sexual health information to their children (Sharifi et al. 2016).

CHAPTER THREE— AIMS AND METHODOLOGY

CHAPTER OVERVIEW

In this chapter I describe the methodology adopted in the thesis, a critical reflection on my positionality, and the obstacles encountered within the data collection and analysis phases. The three papers making up the thesis contain methodology sections specific to the approach taken in each.

3.1. AIMS AND OBJECTIVES

The aim of this research was to explore stakeholders' views on the need for, and factors inhibiting and enhancing provision of, sex education among adolescents in Saudi Arabia. The objectives of the PhD were to:

1. Explore the views of key stakeholders in Saudi Arabia on the need for sex education among young people and on barriers and facilitators to provision.

2. To disseminate relevant material from the study to national and international agencies, tailoring the style of output to the target audience **(Appendix 1).**

3.2. METHODOLOGY

3.2.1. TEXTUAL REVIEW

Before embarking on this project, I decided to review texts related to sexual health matters in the official Saudi national curricula in the intermediate and secondary school

levels. I began with identifying curricula that contained topics related to sexual health which were Science, Islamic Jurisprudence and Home Economics. The latter is only available to female students. Since the scope of my research is related to adolescents I focused on the academic years from grades 5-12 where students' ages range from 10-18. All textbooks were retrieved online. When I first began reviewing the books, the most recent available version of these textbooks was from 2013.

I identified all texts relating to sexual health topics including human development, the reproductive system, fertilization, conception, pregnancy, childbirth, puberty, menstruation, sexual maturation, STIs, HIV, marriage, adultery, homosexuality, and divorce.

I paid specific attention to how topics were 'framed', the language used and sequence of ordering. During the interviewing process, I was able to provide those participants who were not aware of the current curricula with copies of the texts. In addition, familiarity with this material on my part enabled me to ask specific questions of MoE officials and school staff on how these topics were delivered within the classroom and the types of questions raised by students. Since my research spanned four years, I needed to familiarize myself with consecutive versions of the textbooks to identify any changes. I was able to retrieve copies of the 2016, as well as the 2019 versions and found noticeable differences which I report on in **Chapter Four**.

Some of the examples of the texts from the Islamic Jurisprudence books are available in **Appendix 2.**

3.2.2. FIRST FIELD VISIT AND SCOPING EXERCISE:

During my first eight months in London, I focused on finalising my research proposal. It was, however, difficult to gain the local perspective while being away from Saudi Arabia. Many of the online resources were either not updated or unavailable in English. In

addition, the former Deputy Crown Prince Mohammed Bin Salman (now Crown Prince) announced the introduction of 'Saudi Vision 2030', which included drastic changes economically, socially and politically. Being in London hindered observing these changes in real time and I was not able to assess the public's reaction to the plans.

I decided to visit Riyadh during Ramadan; July 2016 to conduct a scoping exercise. The first aim of this exercise was to assess the feasibility of the chosen methods through testing the draft of the topic guide. Secondly, I wanted to seek the help of key informants to identify potential participants and build a network that could help me identify and recruit participants for the data collection phase. In addition, the scoping exercise helped in identifying possible obstacles and enabled me to 'get a feel' of what was going on in the country in this transitional period.

I initially reached out to several potential stakeholders via email. Those who replied and agreed to meet for a brief informal interview were either senior staff I had worked with as a junior doctor during my medical training, or co-workers of my acquaintances and friends within the healthcare field. Having personal contact played a major role in securing people's agreement to meet. I interviewed several people working within different specialties.

Because my visit fell during the last two weeks of Ramadan and Eid, many people were on annual leave, and those who were working, were working fewer hours (Ramadan working hours shift from 8 to 6). I did, however, gain much needed feedback and insight.

During the initial phases of the formulating my proposal I had thought of gaining the perspective of adolescents through focus group discussions and surveys. A senior colleague advised against the former. According to her, gaining approval from the MoE is difficult since focus groups require time and students would have to be pulled out of classrooms for that. In addition, it is difficult to keep students after school hours, especially female students. Schools themselves could refuse to allow access to

researchers. Further, due to the sensitive nature of the topic, gaining parental approval would be a further obstacle.

This was echoed by a social worker I met with; in her experience people tend to disengage in group discussions especially pertaining to taboo topics. Worry of tarnishing one's reputation or bringing shame to one's family or tribe would hinder individuals from being open in group settings.

The scoping exercise was useful in identifying some of the anticipated obstacles I would face during formal data collection. Most of the people I met immediately introduced me to other colleagues within the same setting, who in turn would allow me to set up quick, unofficial interviews with them. The fast pace at which I met key informants helped me appreciate how people in Saudi Arabia set appointments and how flexible I needed to be in planning spontaneous interviews. I had also set up two mock interviews with friends and colleagues who commented on how animated my facial expressions can be when listening to their answers. I had to practice listening and controlling my reactions, to avoid leading my participants' answers. The scoping exercise proved beneficial in preparing me for the data collection.

Details of the scoping exercise are available in **Appendix 3.**

3.2.3. THEORETICAL FRAMEWORK

My original proposal contained a quantitative element to try and measure sexual health related knowledge, practices and attitudes among adolescents. However, while reviewing the literature, it became clear how little sexual health research has been conducted within the Saudi context. As discussed in the literature review, most of the research regarding sex education and sexual health in Saudi Arabia focuses on quantitative reporting of infection prevalence, and measurements of knowledge,

attitudes and practices. Although most of these studies recommend raising awareness of sex education, they rarely explore how to implement that as a health policy.

During discussions with my supervisors, I realised that preliminary research was needed in order to attempt to understand the Saudi context and the way sexual health and sex education are contextualized in the country. Therefore, qualitative methodology was chosen to facilitate this process.

However, choosing a theoretical framework proved difficult. Not only did I want to tackle my topic from a health policy analysis angle but I also needed to frame the cultural discourse related to sex education in Saudi Araba, since it does not only impact social norms but the policymaking process as well. Several bodies of theory guided the conceptualization of this thesis including sexuality theories and health policy theories.

SEXUALITY THEORIES

Theories of sexuality generally differ on which epistemological traditions they draw from. These can be summarised very broadly as espousing:

- Essentialism, which proposes that sexual expressions are innate, instinctual, and determined chiefly by biological forces (Wellings et al 2012: 6-7).

- Social constructionism, which views sexual behaviours as 'plastic and malleable, amenable to modification and shaped extensively by cultural norms and socialisation, often mediated by language as a way of organizing experience and sharing concepts' (Wellings et al 2012: 7-9).

As a broad generalisation, essentialists view sex through a biological lens, which is reflected by their choice of terminology. Freud, for example, described sex as a 'drive' (Freud 1949). Havelock Ellis described it as an 'impulse', suggesting sex is an uncontrollable, natural 'energy' that should be released, and otherwise may cause neurotic psychological effects. This 'energy' is repeatedly viewed as more prominent in

men than in women. Freud categorized sexual behaviours into normal and abnormal (Freud 1949). He also applies terms like 'aberrations', 'deviations' and 'perversions' to describe those sexual behaviours deemed unconventional (Wellings et al 2012: 7)

Social constructionists, on the other hand, highlight the differences between and within different cultures with regards to sexuality, sexual expression and behaviours. One of the most influential social constructionist theorists in the field of sexuality is Michel Foucault who emphasizes that not only does sexual conduct change over time but so too does the way in which it is conceptualized and spoken about, or what he calls sexual 'discourse' (Foucault 1978). Foucault formulated his 'repressive hypothesis' in order to understand why discussions on sex were believed to be repressed among Westerners in the 17th and 18th centuries. He links repression to the rise of the bourgeoisies in Europe during those centuries, who unlike the aristocrats, became rich through work and industriousness and hence focused on promoting work ethics. Sex for pleasure was viewed as unproductive, and wasteful, and as a result, should be repressed. Repressing sex was not just in the form of limiting it to procreative relationships within the instruction of marriage, but also repressing its discussion, publicly. Sex became a private matter in practice and discussion (Foucault 1978). Foucault was also known for his theories regarding power and its intricate and inseparable relation to knowledge; seeing knowledge as an exercise of power while power is a function of knowledge. When linking this theory back to the repressive theory, Foucault assumes since the bourgeoisie were in power, they controlled knowledge and in turn the sexual discourse at that time (Foucault 1978). Modern sexual discourse is hence viewed by Foucault as a political movement to rebel against the bourgeoisies and move towards shifting the power dynamics within society (Foucault 1978).

The power of religion is also discussed in Foucault's work. He claims the influence of the Church on Europe had seeped into the 18th and 19th century secular culture and into the way scientists spoke about sex and sexual conduct. This may resonate within societies in which Christianity was common, and in ex-colonies of these countries. It also can be

evident in many of the sex-related legislations in modern secular Western countries, where the laws seem to be heavily influenced by Christian values. As for the 'other countries', Foucault differentiates between the sexuality of Western civilization which he describes as scientia sexualis, while he characterized 'Eastern' civilization's sexuality as ars erotica, prioritizing pleasure. This categorization can be viewed as arbitrary if all Eastern civilizations were clumped together. It also may not apply to modern Eastern civilizations. Edwards Said puts forward the theory of Orientalism and describes the classification of the 'Orient' as a product of the Imperial domination and hence uses Foucault's theory of power to criticize Foucault's own views over the Middle East (Said 1978).

APPLYING SEXUAL THEORY IN AN ARAB AND ISLAMIC CONTEXT

The classification of Middle Eastern sexuality as ars erotica may be linked to medieval Arabic and Islamic literature which was regularly categorised as pornographic by Western researchers. The abundancy of erotic description may clash with some of the predominant Christian views on legitimate sexual relationships which are usually procreative and limited to the institution of marriage which is heterosexual, monogamous and only broken after death. However, Islam's view on legitimate sexual relationships can go beyond marriage and extend to 'the institution of concubine' (Abu-Lughod 1998). Marriage can also be polygamous and divorce is permissible, allowing individuals to have multiple legitimate sexual partners throughout their lifetime. Sex for pleasure is also permissible and encouraged and contraception is permitted. Hence, many of the authors of the medieval erotic literature included information on abortifacients and contraceptive measures form their time within their writing (Musallam 1983). Researchers argue that this type of literature is 'as much medical as erotic', refuting Foucault's classification (Musallam 1983: 90). The literature also contained descriptions of homosexuality, sometimes as a form of contraception or as

preference of 'boys' (Musallam 1983). Homosexuality was not perceived as an orientation or an identity. Rather, 'sodomy' was a described form of sexual pleasure (El-Rouayheb 2005; Massad 2007).

Yet, the generally agreed upon interpretation for the Quranic story of Sodom and Gomorrah is that they were deserving of God's punishment for engaging in Sodomy, since it was described as فاحشة or *fahisha*[‡‡‡‡], which is the same description used in the Quran to describe adultery. Although it seems that society during that time was more tolerant of these practices, historians link this tolerance to the expansion of the Islamic civilizations and the effect of other cultures, specifically the Persians. Others believe that since the Medieval Islamic era was known to be a time of prosperity, scientific advance and wealth, materialism and indulgent behaviour became popular, especially among those in power who may have played a part in controlling the sexual discourse during that time (Massad 2007).

In modern times, medieval Islamic literature containing erotic passages has been censored, destroyed or banned in some Arab countries, including Saudi Arabia. Sexual discourse seems to have gone through its own repressive phase in the modern Middle East. This change may be linked to the extensive geo-political and geo-economic changes that gave rise to new identity in the Arab and Muslim worlds. Colonial powers' scientific output and religious beliefs affected the social norms as well as legislation in the region. Many of the countries affected by colonialism to this day may have remnant legislation from European laws like the anti-debauchery law in Egypt (National Legislative Bodies/National Authorities 1961). The rise of modern Islamic movements like the Muslim Brotherhood in Egypt and the Sahwa movement in Saudi Arabia in addition to the Islamic Revolution in Iran may be viewed as having an aim to regain power of the sexual discourse within the region by moving away from more liberal sexual behaviours

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[‡‡‡‡] Abomination or atrocity.

practiced by Western countries during colonial time. Much like the Bourgeois did in Europe.

Yet, many of the terminology, descriptions and language surrounding sex in the Arab world is influenced by Western perspective. For example, modern Islamic scholars regularly use the word فطرة or *fitra*, which can be translated to 'natural disposition' to describe sexual urges and sex in general. However, when it comes to homosexuality it becomes 'against natural disposition' and is hence referred to as الشذوذ الجنسي or sexual aberration, and homosexuals as aberrant. This reflects an essentialists approach in describing sexual behaviours. Homosexuality was previously exclusively referred to as liwat لواط (from Lot) which is equivalent to Sodomy (from Sodom) in earlier centuries (pre-Fruedian times) (Massad 2007; Dalacoura 2014).

Hence, like the essentialists, Muslim scholars link sexuality to biological factors. Arguments for polygamy, which is allowed in Islam, are usually linked to 'scientific facts' claiming man's expansive sexual urges that cannot be met by one woman. Other scholars used arguments about women's decreasing sexual urges with age to promote polygamy as a natural solution. Linking science to religion is not exclusive to Muslims. In the UK anti-abortion groups claimed links between abortions and breast cancer (Vasagar 2012). In Saudi Arabia, to provide religious legitimacy to the ban on women driving, a religious scholar claimed that women have half a brain of a man and it shrinks further to a quarter when driving. Another scholar announced his hypothesis of the effect of women driving on ovaries. He linked the low birth rates of the Western world to women driving cars there, completely ignoring that all countries in the world, including the rest of the Middle East allow women to drive. Although his claims were publicly ridiculed, making scientific assumptions to support religious stances or local legislation related to women's sexuality is a common practice. Like Freudian stances on female hysteria, many Islamic scholars claim women's' emotional 'nature' makes them more susceptible to neurotic actions and hence should be monitored by their male guardians.

Familiarizing myself with different social theories further highlighted the tension I faced within this thesis. Sex education may fit within the social constructionist discourse since through education, sexual conduct can be seen as learned and modifiable. However, the current dominant view amongst Islamic scholars is that sexual behaviour is fixed and innate. Discontinuities between my chosen perspective for the thesis and the cultural context in which I had been brought up forced me to re-examine my cultural position and the 'taken for granted' assumptions and dispositions.

HEALTH POLICY THEORIES

How does a health policy come to life? What factors are important in policy formation, adoption, implementation and acceptance? Policy scholars have developed several frameworks in order to help answer these questions drawing on concepts from several disciplines including political and social science.

In 1993, Sabatier and Jenkins-Smith developed the Stages-Heuristic Framework (Policy Cycle) **(Figure 1).** This framework consists of a simplistic flow of stages and assumes policy formulation occurs in a smooth, systematic manner **(Figure 2)** (Buse, Mays, and Walt 2012: 9). This framework has been widely criticized for being unrealistic since policy is rarely formed in a linear, step-wise manner. The policy process was described as 'extraordinarily messy' by Kingdon who posited that policy change occurs in specific 'windows of opportunity' that are random and rare (Kingdon 2010). In order for these windows to open, three different streams have to collide: the policy, political and problem streams. The problem stream includes the issues that society is facing, the political stream comprises the political transitions of the country and its societal pressure, and the policy stream consists of the proposed policy alternatives to address the problem(s) (Kingdon 2010). This theory better represents the messiness of the policy process and the complexity of change, but is not a practical framework for analysis.

Other researchers have focused on the role of evidence in policy making. Recently evidence-based medicine (EBM) has been a 'hot topic' in clinical practice with many practitioners being urged to use evidence to guide their clinical decisions. In public health, however, basing decisions on evidence may be more complicated. Several models express the effect of evidence on policy change, including linear, enlightenment and strategic models (Glasby 2011). The linear model assumes change happens when evidence becomes available. The enlightenment model suggests evidence has a cumulative and complex effect on policy change, while the strategic model argues that evidence is used to support predetermined positions. These models are considered descriptive and may not help in analysing policy change, yet they highlight the different ways evidence may be used and illustrate how inconsistent and unpredictable the policy process is.

Walt and Gilson developed a more structured framework, the policy triangle, that takes into account additional variables and facilitates mapping them out for analysis (figure 3) (Buse, Mays, and Walt 2012). According to this framework, context, content, process and actors all interact to shape policy formulation (Walt et al. 2008). Other theories have focused on the importance of understanding the dimensions of power among different actors or agencies. Actors exert different forces on a policy in order to either move it forward or halt it completely from reaching the agenda in the first place. These dimensions can be categorized differently. According to Lukes, the three dimensions of power include the first or overt dimension which deals with declared political preferences, the second or covert dimension that focuses on the power of "non-decision making", and the third dimension on the struggle between political preferences and real interests (Lukes 2004). The effect of the different dimensions of power on policymaking is another layer that further complicates the policymaking process.

Most of the literature dedicated to analysing health policy has classically focused on high-income, Western countries that usually have democratic political systems. Their application to countries in the MENA region is not without challenges For example,

within the policy triangle framework, actors are categorized into the state, the market, and civil society. Many countries in the MENA region lack civil society. In addition, the so-called 'market' may not play a significant role in policy change, especially if the market is owned by 'the state'. Furthermore, evidence may sometimes have no role in shaping policy, and may not even exist. At other times policies are introduced when there are clearly contradicting evidence, which was the case in Saudi Arabia when HIV testing became a mandatory part of the premarital screening programme despite having been proven not to be cost-effective (Alswaidi and O'Brien 2009).

I chose to use the Walt and Gilson Framework guiding framework during my analysis and interpretation phase. Although this framework is simplistic and allows incorporation of elements unique to a specific setting, I still faced struggles using it in a Saudi context. Religion for example seemed to seep into every angle of the framework and at times it seems I was trying hard to fit my data onto the framework. Hence, I decided to focus one each angle separately, as evidenced in my papers.

| Problem Identification | → | Agenda Setting |

Figure 1: Stages-Heuristic (1993)

- Evaluation
- Policy Formulation
- Policy Adoption
- Implementation

CONTEXT

ACTORS

CONTENT

PROCESS
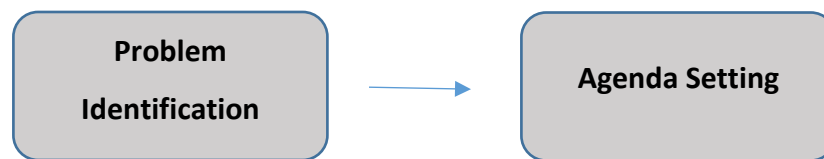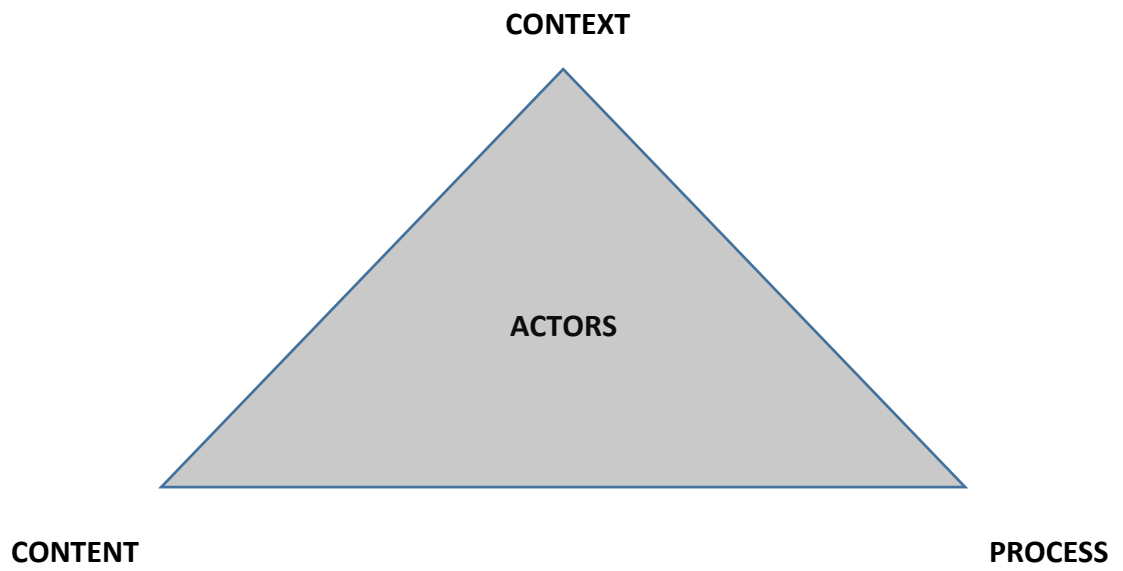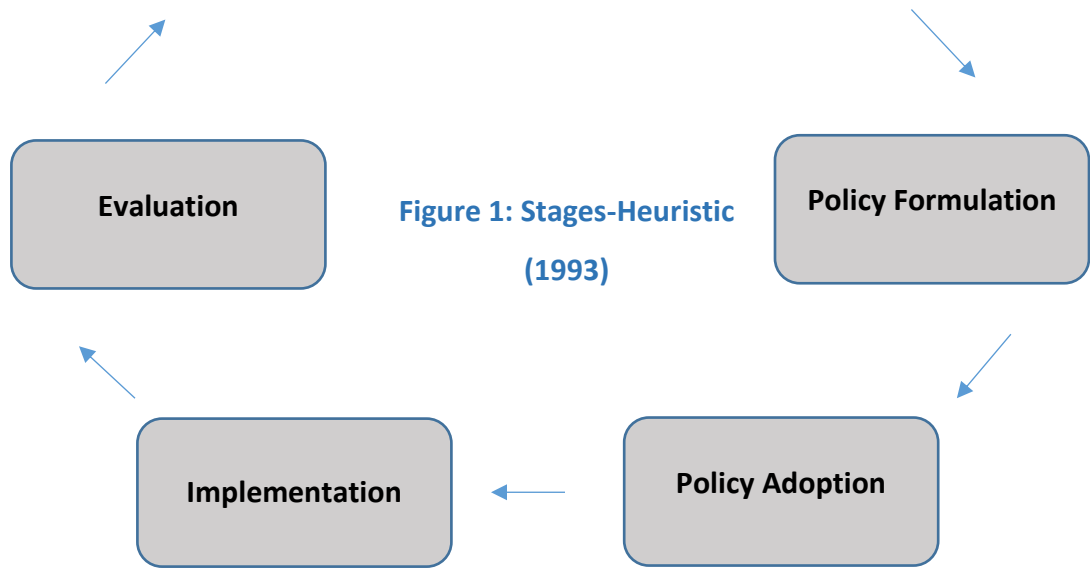
Figure 2: Walt and Gilson Policy Framework (Walt and Gilson 1994)

3.2.4. Rationale for choosing in-depth interviews

To explore the views of stakeholders, I chose a qualitative approach using in-depth interviews with open ended questions, which allowed me to probe the sensitive topic of sexual health and education in Saudi Arabia and allow participants to lead the interview and provide opinions beyond the limits of questions. Qualitative design allowed for rich exploration of my participants' narratives (Denzin and Lincoln 2005).

Due to the sensitivity of the topic, interviewing stakeholders one-on-one was preferred over focus groups to reduce discomfort in disclosing views that may oppose generally accepted norms and allow representation of marginal opinions which may not be disclosed in group settings (Green and Thorogood 2013; Morgan 1996).

3.2.5. Sampling strategy

A stakeholder is defined as an individual or group with a substantive interest in an issue, including those with some role in making a decision or executing it (Buse, Mays, and Walt 2012: 191). The term can be treated as synonymous with that of 'actor' which are at the centre of the Walt and Gilson policy framework. Selecting stakeholders to participate in this project was based on their professional relationship to the field of adolescent health and/or education. After conducting a literature review and upon returning from my first field trip, my supervisors and I had a brainstorming session to identify possible stakeholders. Although initially we identified adolescents as the primary and most important stakeholder group, it proved extremely difficult to interview adolescents about sex-related topics. In addition, due to the political nature of the country with the power of policymaking being restrained to the central government with a top-down implementation approach, we decided to focus on those stakeholders who can directly or indirectly influence policy formulation or implementation related to adolescent health and education in Saudi Arabia.

Potential stakeholders were categorized into four distinct groups **(Table 1).**

TABLE 1. STAKEHOLDERS' CHARACTERISTICS

Profession	Gender	Mode	Language
Policy Making Agencies			
MoH Official	Male	Face-to-face	English
MoH Official	Female	Phone	Arabic
MoE Official	Female	Phone	Arabic
MoE Official	Male	Face-to-face	Arabic
MoE Official	Male	Face-to-face	Arabic
MoE Official	Male	Phone	Arabic
MoE Official	Female	Face-to-face	Arabic
Social and Healthcare providers			
Gynaecologist	Female	Face-to-face	English
Psychologist	Female	Face-to-face	English
Paediatrics Consultant	Female	Face-to-face	English
Official at a national health promoting programme	Female	Face-to-face	Arabic
Family Medicine Consultant	Female	Face-to-face	Arabic
Health Educator	Male	Phone	Arabic
Official at a national health promoting programme	Female	Face-to-face	English
Social Worker	Female	Face-to-face	Arabic
Gynaecologist	Female	Face-to-face	English
Paediatric Consultant	Female	Face-to-face	English
School Setting Educators and Staff- Intermediate and Secondary School Levels			
Science teacher, Girls' Public School	Female	Face-to-face	Arabic
School Counsellor, Girls' Public School	Female	Face-to-face	Arabic
Religion teacher, Boys' Public School	Male	Phone	Arabic
Principal, Girls' Public School	Female	Face-to-face	Arabic
Science teacher, Girls' Private School	Female	Face-to-face	Arabic
Religion teacher, Girls' Private School	Female	Face-to-face	Arabic
Science teacher, Boys' Private School	Male	Face-to-face	Arabic
Religion teacher, Boys' Private School	Male	Face-to-face	Arabic
Science teacher, Boys' Public School	Male	Phone	Arabic
Religious Scholars			
Religious Scholar	Male	Phone	Arabic
Islamic Studies University Researcher	Female	Phone	Arabic

3.2.6. RATIONALE FOR CHOOSING STAKEHOLDERS:

Policymaking agencies

I chose to recruit officials from the MoE since curricula are formulated and implemented by the MoE. Assessing these officials' opinions is vital for any future programme implementation. They are also responsible for formulating extra-curricular programmes at schools. I also recruited officials from the MoH since this ministry is responsible for public health issues in the country in addition to overlooking, approving and implementing health awareness campaigns and educational programmes. In addition, schools' health was recently transferred from the MoE to the MoH's responsibility. Most of the health and education policies in Saudi Arabia result from direct recommendations by the two ministries to Alshura Council and the Ministries' Council. It is important to highlight that the so-called policy making agencies are more policy shapers and recommenders. Nevertheless, their role within the policy making process should not be undermined.

Social and healthcare providers

I recruited those working within adolescent health including paediatricians, family physicians, and gynaecologists, in addition to clinicians working in HIV clinics. These stakeholders are highly respected within the community and their opinions help shape many of the health practices within the Saudi society. They also directly interact with adolescents and can evaluate their healthcare needs and concerns. Most of the healthcare research is produced by or in collaboration with physicians, hence their understanding of the prevalence of sexual health related issues is valuable. Their opinions also influence many of the MoH's recommendations since they provide them with much of the research and practical evidence.

School teachers and staff

This group can be viewed as an implementing agency since teachers directly deliver educational programmes to adolescents within the school system. Their close interaction with this age group on a regular basis gives them a clear understanding of the adolescents' needs, beliefs, concerns, and practices.

Islamic scholars

Since Saudi Arabia rules by Islamic Law, legislations and policies need be in line with Islamic teachings; specifically, Saudi approved Islamic regulations. In addition, since they are highly respected by the public, they can directly influence the public's acceptability of any proposed programme.

Several studies have included similar groups when assessing views on adolescents' sexual health needs and education (Musiimenta 2013; Kristo, Cuk, and Krzelj 2016; Pound et al. 2016).

3.2.7. RECRUITMENT

I began by contacting key informants interviewed in the scoping exercise to request that they recommend possible participants. I also used my personal and professional networks to recruit potential stakeholders. I quickly learned that in order to increase the chances of participation, I needed to emphasize my professional role of being a physician and teaching staff at KSU. In addition, in many cases, mentioning the name of the common acquaintance who provided me with the contact information of the potential participant ensured participants' reply to my initial recruitment message.

I chose participants based on their professional involvement in activity related to adolescent health, adolescent education, sexual and reproductive health and religious studies. I also chose those with influence in formulating policy and/or implementation

in the country or with a role in delivering sexual health education. A total of 28 participants were interviewed who were categorized into the four distinct groups: policy-makers (n=7); social and healthcare providers (n=10); teachers and other school staff (n=9); and religious scholars (n=2).

Participants came from different social backgrounds and included Saudi and non-Saudi participants. Several of the stakeholders, especially clinicians, received their higher education in North America, Europe and Australia. Several participants had experience working in higher governmental chambers while others had exclusively worked as service providers in teaching or healthcare.

The study was conducted in Riyadh, the capital city of Saudi Arabia, which is also the largest and most populated city in the country. Data collection took place between May and June, 2017 over 10 weeks. The research was limited to Riyadh for several reasons. First, it is a city I am familiar with Riyadh and find easy to navigate. Second, my professional position within KSU provides me with many connections with several hospitals and universities in Riyadh and can facilitate access into these places. Third, Riyadh acts as the headquarters of the country's central government bodies and houses the main universities and hospitals. Hence, stakeholders working within these institutions can be seen as decision makers or in close proximity of those shaping policies which provides a glimpse into the policy-making process in the country.

3.2.8. DATA COLLECTION- CONTENT

On return from the first fieldwork trip, my supervisors and I reviewed the first draft of the topic guide and reformulated it based on the data from the scoping exercise and the reviewed literature **(Appendix 4)**. Although the guide included written questions, they were merely suggestions on how to formulate the verbal questions, especially when the interview setting was tense. Questions were asked in an open-ended format and carefully planned to be non-leading and non-judgmental. I did not follow a specific order

when asking the questions and tried to let stakeholders lead the conversation to ensure spontaneity. I informed all participants that I would be taking notes throughout the interviews to aid further exploration of topics. Interviews were conducted in the language of preference of the participant; Arabic, English or a combination of both, which is common within medical professional settings. Participants were given the choice for preferred mode of interview; either face-to-face at the venue of their choice or via phone. The majority of face-to-face interviews took place at participants' workplace while one was at a café and another at the participant's home. Interviews lasted, on average, 45 minutes and were recorded with the participants' consent. They were provided with verbal explanations of the aim of the study in addition to information sheets available in both Arabic and English **(Appendix 5 and 6).** Consent forms were also provided in both Arabic and English and freedom to stop the interview at any stage was emphasized at the beginning of each interview **(Appendix 7 and 8)**. Some participants asked for the recording to stop to disclose personal stories or demanded some parts of the interview be 'taken out'. These requests were accommodated and were not included within the data analysis. For phone interviews, consent forms and information sheets were sent and signed via email in addition to confirming consent verbally at the beginning of the interviewing session which was recorded. I also took field notes recorded either on my notebook or as voice notes on my phone before and after interviews. I typed out the written and voice notes to make use of them during the analysis process. Documenting my feelings and some of the circumstances surrounding the interview provided context during the analysis phase (Phillippi and Lauderdale 2018).

3.2.9. Data management

Password protected audio files of recorded interviews were saved on the LSHTM server. Interviews were anonymised and given unique identification code. I formed a chart with participants' names and numbers, also saved on the LSHTM server with no one but

myself having access to it. Although I had originally assumed transcribing my own interviews would serve to keep me close to my data, in effect I found doing so prevented me from listening to the interview in a continuous and aware manner. Through my funding from the Saudi Arabian Cultural Bureau in the UK, I was able to hire a transcriber with whom arrangements were made to protect confidentiality **(Appendix 9 and 10)**. Files were encrypted and password protected and were only shared by myself and the transcriber. All shared files were destroyed after completion of transcribing. Transcription was done verbatim. Many of the interviews conducted in English had many grammatical mistakes which were not corrected or changed to preserve the authenticity of the tone and expressions used by participants, especially since, at many times, English phrases used by participants seemed to be direct, literal translations of local Arabic idioms and expressions.

Although I did not transcribe the interviews myself, I edited all of them, which required extensive corrections and repetitive replays and allowed me to familiarize myself with the data. In fact, during my meetings, I could recall, and identify all interviews by their coded numbers. I also removed all names of participants, their affiliated organizations, and mentioned names of individuals from all transcripts. Furthermore, any comments specified by participants to be off the record were removed from the edited transcripts and not analysed. Participants, on the transcripts, were only identified as either 'male' or 'female' at the beginning of each of their answers.

I chose to keep my transcripts in their original language. Cultural nuances and expressions can be lost in translations, especially with the repetitive use of common prayers and invocation that can be used to praise or deplore specific issues, based on the wording, tone and infliction. Seven of the interviews were conducted in English, but even with these interviews, brief Arabic anecdotes and phrases would exist. I did however translate an additional four interviews to allow the non-Arabic co-investigators/supervisors to take part in the analysis process. I was able to explain some of the phrases, their meanings, and uses. In addition, sometimes, within the English

transcripts, participants were literally translating Arabic proverbs and saying them in English which can be difficult to comprehend or may seem out of place. I provided context to the transcripts and provided my co-investigators with details about the setting of the interviews.

3.2.10. DATA ANALYSIS

I applied a framework analysis approach developed by the National Centre for Social Research for use in analysis of qualitative data related to policy research (Smith and Firth 2011). Framework analysis provides a systematic approach that enables structured outputs of summarized data to be produced (Gale et al. 2013). It comprises several stages; transcription, familiarization, coding, developing an working analytic framework, applying the framework, charting the data and lastly interpreting the data (Gale et al. 2013).

I initially used the Walt and Gilson framework as a guiding framework to organize the data. Deductive analysis was initially applied using codes derived from the main aspects of the policy triangle. Later, my supervisors and I carefully read the transcripts, line by line and labelling the initial codes mentioned above. We began by first analysing the 11 English transcripts independently and I carried on with the remainder of 17 Arabic transcripts. Discrepancies were then discussed and resolved. I then charted the data into Excel sheets. After the primary coding phase, we noticed the emergence of other secondary themes. At this stage, an inductive approach was adopted and we used open coding, that is, according to what was said rather than what was asked. Having different co-investigators with different disciplinary and cultural backgrounds provided varied perspectives and ensured that one viewpoint did not dominate (Gale et al. 2013). The secondary codes were used to formulate an analytical framework that was applied to all transcripts. Subsequent Excel sheets were formed to chart the data. During the analysis process, I would revisit to the audio files to reassess the tone used. Although in

framework analysis, the content of the interview is the primary interest rather than conventions of dialogue; nevertheless, understanding why a specific idiom can significantly impact the analysis. Listening to audio files also provided me with context and reminded me of my feelings and impressions during the interviews.

Although initially, I had planned on utilizing N-Vivo, a qualitative data analysis computer software package, which I received training on using, it was unfortunately incompatible with Arabic due to its right to left reading nature. Hence, I chose to code manually and on Microsoft word and chart the data on Excel sheets, which is regularly use for qualitative analysis (Green and Thorogood 2013).

During the interpretation phase, I kept separate files for each emerging theme and impression I had of the data which I discussed with my supervisors. It was from these impressions that we were able to choose the main themes of the papers we co-wrote with this thesis. In addition, some of these themes will be further explored for future projects after the commencing of this PhD thesis.

3.2.11. ETHICAL CONSIDERATIONS

Social research ethics emphasizes confidentiality as an essential criterion for ethical practice (Green and Thorogood 2013). During my initial visit to Riyadh to conduct the scoping exercise, I was able to 'casually' speak to acquaintances and colleagues about my research questions, however I had to be careful not to share people's opinions and accounts to others and more careful in reporting them without disclosing personal information or using quotes.

During the interviewing process, respect needed to be conveyed to my participants. I was flexible in allowing the setting of their choice to ensure their comfort and more importantly, their sense of empowerment. I also turned off the recordings whenever they requested. Any information disclosed outside the recording time was not included

in the analysis process, even though it often provided rich data and at times contradicted their official, recorded responses. However, this was only encountered in two interviews. I respected these participants' wishes since some of the opinions may have been taken out of context and seen as provocative. Ensuring the safety of my participants was a top-priority, as well as honouring their trust in me.

One participant explained to me that she liked to be prepared for an interview in order to gather her thoughts, and hence requested I go over the topic guide's question prior to recording, to which, I obliged. I was also conscious about not cutting people off or insisting on going through every question within the topic guide, to ensure that participants felt safe to reflect on their own concerns rather than merely answering rehearsed questions that reflect my own perspective. Although several participants felt comfortable sharing personal stories and reflecting on their own sex-related views or practices, I was aware that probing further was not only unnecessary for the aim of my research but could be exploitative of the trust the participants have given me. Being from Saudi Arabia provided me with awareness on cultural sensitivity, especially on how to speak on sexual health matters and what language and terminology to adopt when asking questions. In addition, several participants would ask for validation and directly ask me if their answers were 'correct'. In other instances, they would ask for my views or insist I vocally agree with theirs. I consistently attempted to remain diplomatic and refrain from expressing any personal views. However, in several instances I felt the need to nod and agree, to encourage participants to carry on with their input.

The process of attaining ethics approval at LSHTM was immensely delayed which further delayed the initiation of data collection. Although I was able to start reaching out to potential participants, I was unable to provide them with any potential dates for the interviews without the approval. Additionally, after the delay LSHTM responded by asking for further clarifications regarding the anonymity of my participants and my personal safety in Saudi Arabia. This was clarified and ethical approval was granted. Local ethics from KSU refused to fully process the ethical approval without receiving the final

LSHTM ethics approval. In addition, they requested clarifications surrounding the marital status of participant, to which I had to ensure that questions were not going to be personal in nature, rather that they were directed at policy formulation on the need for sex education for adolescents in the country. In addition, all participants were adults with professional backgrounds related to health, education, policy and religious studies. Ethics approval was granted from London School of Hygiene and Tropical Medicine (LSTHM) (Ref. No. 12064) on March 27, 2017 and from King Saud University (Ref. No. 17/0273/IRB) on March 30, 2017 **(Appendix 11 and 12)**. Some participants required further clarifications from the MoE whom were very helpful and responsive in providing me with official letters to confirm their support and approval for data collection. These letters were issued on April 17, 2017. However, the request for these additional documents, further delayed some of the interviews.

3.3. REFLEXIVITY AND POSITIONALITY

Reflexivity involves a 'self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as a researcher' (England 1994). Being aware of one's positionality within the research process has been emphasized as an integral part of research (Bourdieu and Wacquant 1992; Ritchie et al. 2013).

Although I consider myself a non-reflective anxious person who regularly uses avoidance as a coping mechanism, pursuing a PhD forced me to reflect on my intellectual and interpersonal dispositions and their effect on my research process.

I had some personal reasons for carrying out research in this area, resulting from my clinical experience as I explained in my introduction. Declaring my interest in sex education was met with enthusiasm by my friends and colleagues. However, on a couple of occasions I was advised to steer away from this field so as not to be labelled as controversial. I was once even directly accused by a male acquaintance of not knowing

anything about this topic since I had never married, which he followed with 'if you need help learning about it you can come and talk to me'. The frustrations of facing a patriarchal system which limits women's professional capacity by objectifying them is a common struggle my female colleagues and myself have had endless 'rant sessions' about. Yet, I was adamant about pursuing this topic and continued to emphasize the importance of exploring local problems from local perspectives.

Embarking on this PhD journey has by far been the most difficult experience in my life. Although not physically demanding, the mental strain of being forced to revisit my beliefs and reinterpret my own identity was a daunting experience. Before initiating this project, I had come into London with a set of dispositions stemming from my background and identity. I am an Arab Muslim, who identifies strongly with her race and religion. Growing up in Saudi Arabia, I was exposed to one interpretation of Islamic teachings which I wholeheartedly believed in, naively assuming it was the absolute truth. Foucault, known for his theories on knowledge-power relationships argues that dominant power relations influence which voices become labelled as credible and hence become the 'truth' (Foucault 1978). In Saudi Arabia, the conservative, *Wahhabi*, Islamic discourse seemed to become the ultimate truth and anything that deviates from it becomes vilified. During the early stages of this project, I found myself immersed in reading on Islamic views on different sex-related topics. I was also introduced to 6th, 7th and 8th century Arabic poetry, which made me realize the restrictive exposure I previously had on history and religion. In addition, being away from my country and living in a multicultural city like London, provided me with an array of cultural beliefs, intellectual stances, political opinions and philosophical views.

Taking a step back to try and revisit my religious and social convictions related to sexual health was a daunting and lonely process. I was aware that I was becoming more accepting of unconventional ways of living, yet, it made me fear losing 'my identity'.

Yet, as one friend pointed out, this identity 'shake up' provided me, with the opportunity to shed off any predetermined beliefs and actively chose which ones I would like to adopt. Many aspects of my intellectual and spiritual identity have been reshaped during this journey and I have tried to be as aware of these changes and their impact on my research as possible.

My positionality gave me a complex combination of being an 'insider' and 'outsider' within this project. I am a young, never-married female, coming from a middle-class family with Syrian roots. I have a Syrian-infused Arabic accent and an American-infused English accent which usually clears up the assumption that I had spent time living in the U.S. as a child. I am clinically trained and have an MPH from Boston University, meaning I spent time in a democratic hub. I was always aware of the influence of the positionality on my professional and social image. I speculated that I may be perceived as a liberal woman, or worse, a Western-brain-washed student, and worried that my professional authority may be undermined due to my age and gender combination. Although not quite a 'third culture kid' (Useem and Downie 1976), the bilingual and bicultural personality meant that I continuously dipped in and out of the Saudi/Arab culture and 'Western' British/American one. The quick changes in language was easy, it was the changing of expressed convictions, expectations, and mannerism that were more complicated. Telling my British friends how much I appreciate my progressive father for 'allowing' me to travel on my own and pursue higher education was met by perplexed looks since to them, my father was not progressive, but merely doing what is perceived as 'normal'. At home, I would be asked to curb some of my feminist views as they may be perceived as perpetuating neo-colonial Western ideas of what freedom entails, but more importantly to not 'embarrass' my parents. This may have had a role in teaching me to be more observant and not jump to expressing opinions before judging if it would be well received.

Having these complex positions made me an 'insider' and 'outsider' within my research. Insiders are those who may have an 'emic perspective', which is defined as 'the

perception of those who are members of a particular culture or group, or in anthropological terms, the 'native' point of view' (Holloway and Todres 2003). Speaking the language and knowing my way around the system while being aware of the cultural etiquettes of respecting those in higher positions and different genders facilitated my data collection process. However, sometimes participants would express opinions in lax, generic terms and add phrases indicating their awareness that I shared their culture such as 'you know' or 'something like that'. They would also insert colloquial phrases and prayers that could only be understood specifically in the Saudi context. Being familiar with the dialect, the idioms, the sense of humour and the meanings of long pauses enabled me to understand what was 'unspoken'. However, this meant that I would sometimes fail to probe or insist on a clearer definition of what was spoken.

I was also an 'outsider' since I was living away from Saudi Arabia for a few years and not viewing the quick political and social changes within the country, which provided me with some 'ignorance' to genuinely raise my curiosity during interviews. I was also made aware of this 'outsider' position when a few participants expressed worry about my agenda and explicitly told me not to make 'us' look bad in front of the 'them', referring to my London based institute.

I found myself again within this positionality of insider-outsider complex during the analysis phase, especially when having to provide my non-Arabic speaking co-investigator with appropriate context of what was being said.

My positionality may have also had limitations on my study project. As a woman, I personally felt more comfortable with female participants and I could sense a stronger rapport between them and myself. They usually shared more personal stories than the male participants who usually seemed more uncomfortable when discussing specific topics that may be to sexually explicit. I noticed myself to have a more stern and serious tone and facial expressions when interviewing men in comparison to women. Yet, I

regularly attempted to be as serious with my female participants and steer the conversations away from personal stories.

My gender had further impact on the research process. At the time of the data collection phase, women were still banned from driving which meant that I needed to use my family driver. Coordinating with my mother on the times I needed the driver proved frustrating at times, since many participants would provide me with short notice regarding their preferred meeting time and place. Transportation networks companies including *Uber* and *Careem* were actively working at the time, which facilitated transport to interview sites. In addition, many of the official offices with the governmental agencies were segregated by gender. Most male offices were lenient in allowing women in and I was able to interview a few male participants at their offices. However, others were stricter. For example, in order to gain the additional documents from the MoE, I was directed to a specific office in the Northern part of Riyadh where I was assured is where the female offices reside. When I tried to walk in, a security guard informed me I was in the wrong building. He seemed to panic and shout out that women were not allowed in. I kept walking towards him in order to explain to him what office I was looking for, but he kept yelling at me to get out of the building. He then came outside to speak to me and instructed me to wait outside until he can arrange for someone to answer my inquiries. A young employee came out to meet with me and promised to help me out. However, he lectured me in a preachy manner about the importance of modesty for Muslim women. According to him, my Syrian accent pardoned me from needing to cover my face (since most Syrian women do not cover their face). However, he scolded me for wearing a *abaya* that had red designs on it and lectured me on how good Muslim women should not draw attention to themselves. He asked about my marital status and upon learning I was single, continued to pray for me to marry God-fearing Muslim man that will properly cover me up. I felt patronized and belittled.

Although most of my interactions with the male participants were comfortable, engaging and compelling, reminders of my gender and positionality as a young, Arab, single

woman would surface from time to time. One participant, a male teacher, whom I asked to help me recruit more teachers from his school, informed me that he had a potential participant who is helpful and would be keen to be interviewed. He later sent me a message with a screenshot of his colleague's message apologizing to participate since his colleague's wife overheard the phone conversation between them and forbade her husband from speaking to *that female doctor* about such an inappropriate topic. I replied with a polite 'God bless you for trying', but it made me feel uncomfortable.

My positionality as a clinician also impacted my research. Firstly, it provided me with a sense of confidence and authority to speak about sex-related topics. As a woman who has never been married, speaking overly about sex-related subjects may be perceived as indecent or blatant.[§§§§] Secondly, it provided me with perceived sense of legitimacy as most of my participants insisted on addressing me as 'Dr. Nour' and vocalized feeling and I was safe to be disclosing information related to sexual health matters to a physician. They sometimes started their answers with, 'it's ok since you're a doctor' before using technical sex-related terminology. Yet, my profession might have affected their answers since many of them would focus heavily on the medical and clinical health outcomes when speaking to me. It might also reflect some of the power dynamics between myself and participants. Some teachers among the participants were worried about saying the 'wrong thing' and seemed to stress over articulating a correct definition of sexual health and continuously asked for my validation on whether their answer was correct or not. At other times, the power dynamic was apparent in the larger context. A few participants insisted on reflecting their institution's view but more commonly they made sure their answers went hand in hand with the popular religious discourse. This

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[§§§§] Although, since reaching the age of 32 without ever being married, which according to the Saudi Authority for Statistic would categorize me as a spinster or عانس, I am not as worried about being perceived as controversial in comparison to my youthful, non-spinster days.

was apparent when some would say 'are you trying to get me in trouble?' or insist on rephrasing their answers.

A few participants asked me directly if I was going to ask any political questions and recurrently mentioned how they trusted me since I am 'a good Saudi citizen' and 'a good Muslim who is doing this project to better her country'. I was aware that some of the participants may be wary of my agenda, especially since I was based in London and my project is related to such a taboo topic. My clinical background also influenced my discomfort at the initial stages of my research. I was unfamiliar with qualitative research methodologies, and was continuously told that my initial drafts sounded very clinical and that 'my voice' was not coming through. This was a difficult task to attain, as I was used to medical writing with short, referenced statements affirming scientific facts. However, attending multiple training courses in qualitative methodology and having supervisors with experience in this type of research has been helpful in guiding me through this process. Other difficulties I had to face where the ongoing bureaucratic hurdles that can impede and delay production immensely. Gaining ethics approval as mentioned above was not as easy process. In addition to the long delays from LSTHM, gaining approval from the Saudi Cultural Bureau proved to be somewhat difficult due to strict adherence to regulations that are specific to lab-based projects and quantitative studies. In addition, unfortunately some of the required paperwork was unclear and difficult to attain. Having personal connections 'back home' with colleagues who went through similar journeys proved useful and I had to ask personal favours and plough through several telephone calls and endure some uncomfortable interactions.

This journey has impacted me greatly but because I had expected impediments and had attempted to prepare well for them, I was able to overcome many of those so called 'anticipated obstacles' smoothly. It was, unsurprisingly, the unanticipated ones that were more difficult to face. I knew at some point that the stress of managing this PhD project would reach an overwhelming limit, but I had not prepared for experiencing

panic attacks as a result of it. Gaining perspective on the lonely process of 'drowning in your own data' made me more aware of how to set up future projects.

With all the hardships faced in this journey, the response rate and enthusiasm to speak about the topic by the majority of my participants was moving. So was the positive feedback I gained from sharing my work with my supervisors, colleagues and audiences in different conversations and conferences. I am forever grateful for all the support I received throughout this time.

Having a comprehensive awareness of one's positionality and biases is impossible. Yet, I have tried to be reflexive throughout this project and provide some examples of how my dispositions situated me within this project.

Chapter Four-Paper 'How should school-based sex education be provided for adolescents in Saudi Arabia? Views of Stakeholders'

Chapter overview

The next three chapters will present the findings of this thesis in a paper style format. This chapter will present the paper titled 'How should school-based sex education be provided for adolescents in Saudi Arabia? Views of Stakeholders', which presents stakeholders' views on who formulate and deliver the programmes, to which audience, what topics should be included and what delivery mode should be adopted.

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed <u>for each</u> research paper included within a thesis.

SECTION A – Student Details

Student ID Number	1512875	Title	Dr.
First Name(s)	Nour		
Surname/Family Name	Horanieh		
Thesis Title	Stakeholders' Assessment of the Need for Sexual Health Education among Adolescents in Saudi Arabia: An Exploratory Study		
Primary Supervisor	Prof. Kaye Wellings		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*		Was the work subject to academic peer review?	

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Journal of School Health
Please list the paper's authors in the intended authorship order:	Nour Horanieh, Wendy Macdowall, Kaye Wellings
Stage of publication	Ready for Submission

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I am the primary investigator of the paper. I conducted all of the interviews and edited their transcription process and translated relevant parts for other co- investigators to take part in the analysis process.

SECTION E

Student Signature	
Date	21-10-19

Supervisor Signature	
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HOW SHOULD SCHOOL-BASED SEX EDUCATION BE PROVIDED FOR ADOLESCENTS IN SAUDI ARABIA? VIEWS OF STAKEHOLDERS

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ABSTRACT

Although sex education has been found to improve young people's sexual and reproductive health, no formal programme exists in Saudi Arabia.

This study aims to assess the views of stakeholders on the need for sex education programmes for adolescents in Saudi Arabia; the suggested provision and views on the current information provided in the curricula.

We conducted 28 semi-structured interviews with policy-makers, healthcare providers, teachers and school staff; and religious scholars. Thematic analysis was applied.

Unanimity was expressed on the need for formal school-based sex education programmes. Differences were made the formulating and delivering entities; especially surrounding the role of religious scholars in the design stage. The target audience was classified in accordance to proximity to age of marriage and gender. Tension was evident over including information deemed 'encouraging' of 'sinful' premarital sexual exploration. Although scientific and religious messaging strategies were viewed as non-contradictory, tension was observed on where emphasis should lie. Information within the 2013 national curricula was criticized by several participants as inaccurate, promoting 'othering' of Western society and inciting fear. However, more recent curricula have omitted several of the criticized passages and may provide an opportunity to update and expand sexual health related topics within the curricula.

INTRODUCTION

Comprehensive sex education (CSE) has been shown to play a central role in enabling young people to have safe relationships and ensure a positive, healthy transition into adulthood. (WHO 2006; WHO 2019). Research demonstrates an association between receipt of school-based sex education and lower likelihood of risky sexual behaviour among young people (UNAIDS 2018; Macdowall et al. 2015). Yet, despite the evidence

of favourable effects, implementing school-based programmes continues to be a source of contention worldwide. Detractors fear such programmes may encourage young people to engage in premature sexual activity (Lindberg and Maddow-Zimet 2012) and there are concerns over cultural appropriateness (Haberland and Rogow 2015; Cok and Gray 2007; Wahba and Roudi-Fahimi 2012; Javadnoori et al. 2012; El-Tholoth et al. 2018)

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While in many countries comprehensive, rights-based sex education programmes have increasingly been adopted, (UNAIDS 2018) such trends are by no means universal. In Saudi Arabia, no dedicated school-based sex education programme currently exists. Provision is limited to selected areas covered in biology/science and Islamic Jurisprudence textbooks aimed at students between the ages of 12 and 18 (Saudi Arabia MoE 2013). However, the available information is sparse and selective, and the emphasis is mainly on physiological and pathological aspects of sexual health (Saudi Arabia MoE 2019.

Empirical evidence of the extent of sexual health-related knowledge of young people is scarce in Saudi Arabia. Yet, from the available data, low sexual health knowledge and misconceptions surrounding contraception and STI transmission have been reported among young people, despite the shift of reported main sources of sexual health information from classmates to the Internet (Raheel, Mahmood and BinSaeed 2013; Alquaiz, Kazi and Al Muneef 2013; ALquaiz, Almuneef and Minhas 2012; Badahdah 2010; Sheeha 2010; Turki et al. 2013). Furthermore, studies show pupils reporting negative attitudes from teachers when discussing sexual health matters within classrooms (AlQuaiz et al. 2013).

In this paper we aim to explore the views of those likely to be involved in designing and implementing any sex education programmes in Saudi Arabia. We specifically report the views of key stakeholders who should be responsible for formulating and delivering

sexual health information to adolescents, to which specific audiences, which topics should be addressed and what approach should be taken.

METHODS

DESIGN

We carried out a qualitative study using semi-structured interviews.

SAMPLE

We used a purposive sampling strategy to identify men and women involved in professional activity related to either adolescent health or education, or provision of sexual and reproductive health care. The recruitment strategy aimed to select participants who would be likely to influence the formulation and/or implementation of any future school-based sex education programme in Saud Arabia.

A total of 28 stakeholders were interviewed and they were categorized into four groups: policy-makers (n=7); social and healthcare providers (n=10); teachers and other school staff (n=9); and religious scholars (n=2). Schools included two girls' schools and two boys' schools. Public and private schools were approached within each gender. Recruitment was done through contacting key informants, followed by snowball sampling to identify Potential participants. Contact was through phone calls, WhatsApp messages and e-mails. We used pseudonyms to anonymize participants and ensure confidentiality. In the case of religious scholars, they were referred to as religious scholar 1 and 2 to avoid deductive disclosure.

DATA COLLECTION

Interviews were conducted in Riyadh, Saudi Arabia between March and June 2017. Depending on the participants' preference and feasibility, interviews were carried out either face to face (n=20), or by phone (n=8) in either English or Arabic.

The average duration of interviews was 45 minutes, which were recorded with the permission of participants and transcribed verbatim in the language of the interview. Participants were provided with an information sheet and a consent form. Copies of the documents were provided via email in phone interviews and verbal consent was affirmed prior to recording.

A topic guide was drafted and piloted which included open- ended questions encouraging participants to describe their main concerns regarding the status of sexual health and sex education in Saudi Arabia, as well as questions on the favourable approach to provision of sex education in the country.

The primary investigator (PI) collected and reviewed all Science and Islamic Jurisprudence textbooks from grade 9-12 and identified all texts related to sexual health. The reviewed books were the 2013 edition. Copies of some of the texts related to STIs and human development were extracted from these books were presented during the interviews to the stakeholders- who were not aware of the type of information included in the national curricula. The texts were available to prompt where detailed discussion about current provision were raised.

ANALYSIS

The majority of interviews were conducted in Arabic but seven were conducted in English and four additional transcripts were translated by the PI to allow non-Arabic speaking investigators to take part in analysis. Eleven transcripts were independently coded by all three co-investigators and discrepancies were discussed and resolved, after

which a coding frame was formulated. The coding frame resulting from this process was used by the primary investigator to chart the remaining 17 interviews on Excel sheets and relevant segments were translated into English to enable all investigators to carry out subsidiary charting. Although analysis was done in English, specific use of Arabic language was retained to preserve local expressions and cultural nuances which would otherwise be lost. We adopted a modified grounded theory approach, establishing codes a priori derived from the topic guide, followed by inductively identifying themes which emerged from participants' accounts (Glaser and Strauss 1967).

ETHICAL APPROVAL

Approval was obtained from the ethics committees of London School of Hygiene and Tropical Medicine (Ref. No. 12064) and King Saud University (Ref. No. 17/0273/IRB).

FINDINGS

Unanimity that sex education was required in Saudi Arabia was based on several criteria. Sex education was considered necessary to prevent adverse sexual health outcomes, like sexual abuse and exploitation, and STIs. It was also seen as needed to address the increasing prevalence of mental health conditions among young people, attributed partly to failure to meet emotional needs in adolescence. However, it was mostly viewed as important in order to preserve social values: to uphold Islamic moral codes and to protect the family unit. On the whole, the favoured concept of sex education was framed in terms of disease prevention and family protection rather than health promotion.

Contextual characteristics of the country held to be contributing to the need for sex education included the growing presence of women in the public sphere and their increased educational attainment and engagement within the workforce. These changes were observed to have led to increased interaction between the sexes, previously censured by social and legal regulations.

> *The genders are mixing, there are more outlets, if communicating has become so easy, not as forbidden as before, I'm positive people are engaging in sexual actions.* Ms. Sarah, health provider.

The emergence of a pluralistic culture, in which values relating to personal freedoms, gender rights and sexuality regarded as more typical of the Western world sat uneasily alongside traditional ideologies more typical of the local culture, was thought to be unsettling to young people. At the same time religious beliefs, long relied on as restraining influences on sexual behaviour, were said to be weakening within society.

> *They* [adolescents] *are moving more towards the Western model of life, and some of them are confused. There is a duality in their way of thinking, from one side they are going with the very traditional stream but suddenly they flip and go with the very open stream.* Ms. Maha, health provider.

The increased availability of mobile phones among young people and the growing prevalence of use of social media in Saudi Arabia were seen to be increasing exposure to sexually explicit images.

> *A child now, or an adolescent in their room, can view these things through a small phone in their pocket without constrains or limits* Religious scholar 1.

Concern was expressed about the effect of these images on young people's expectations, especially that depicting violence and what were deemed as sinful or culturally inappropriate sexual acts like masturbation and same sex activities.

VIEWS ON WHO SHOULD DELIVER SEX EDUCATION

Asked for their views on the most appropriate providers of sex education, participants made a distinction between the designing and delivering entities. The general opinion was that governmental bodies, specifically the ministries of Health and Education (MoH and MoE), should assume the lead in formulating any proposed programme to ensure smooth implementation. Several participants feared that adopting programmes

designed by agencies outside the country would reflect 'Western' ideologies and have the potential to undermine local values.

Conflicting views were expressed within and between accounts over the role of religious clergies and scientists both in designing and delivering sex education programmes. Engaging religious scholars in the design phase was seen by some as necessary to ensure that information provided was in line with Islamic teachings, with the proviso that scholars needed to be from the 'moderate' school of thought. In fact, being a 'moderate' was recurrently suggested as a criterion for choosing any individual to be involved in the design phase. Those belonging to extreme approaches described by one participant as متأسلمين, roughly translated as *Muslimised* were viewed as posing a threat to the 'true' Muslim identity as were those, described as ultra-liberal.

> *"Muslimised" are those that portray Islam in an incorrect way, they show that Islam is a religion of extremism, a religion that forbids women and adolescents from asking questions*. Ms. Rana, ministry official.

The need to find a middle ground between 'conservative' and 'liberal' streams of Saudi society was a recurring theme.

> *You need representatives from both streams, and they need to be moderate, don't bring on any extremes from either the Islamists or the liberals.* Ms. Reem health provider.

Other participants, especially those in clinical roles, maintained that religious scholars had no place in the design of the factual content of programmes, and that reliable scientific evidence needed to be conveyed to pupils, as opposed to religious belief. They did, however, acknowledge the role of religious figures in delivering information in order to instil values that helped ensure healthy lifestyles, strong family ties and societal cohesion.

The knowledge should be cooked by the scientists, given to the preacher to spread in a nice way, according to the values and the religion. Ms. Asma, health provider.

Within the school system, teachers were seen as most obviously suited to conveying sex education information. Participants who were teachers themselves spoke of a degree of unease in the classroom when addressing sexual matters, yet this was not seen as entirely negative. An element of *haya'* - which translates to shyness or modesty - was described as a positive quality to be nurtured as an Islamic virtue. Hence, it was not inappropriate for it to be observed by pupils.

Where such reticence was thought to be of concern was where it led to evasion of discussion or glossing over important topics.

> *There is a lot of shyness, but I think it's good for this shyness to stay, but it's important to [for teacher] to be explicit in explaining the definitions.* Mr. Mohammed, teacher.

Some of the teachers within the stakeholders however, suggested recruiting visiting physicians or health educators or even school counsellors to alleviate the task of delivering sensitive information from teachers. Few stakeholders proposed suggested utilizing peer education to make discussing sensitive information less awkward among students.

> *Students would accept this information from the counsellor, she's like a mother to the girls, they turn to her, more than teachers*. Ms. Layla, teacher.

VIEWS ON WHO SHOULD BE TARGETED

Participants saw sex education as needing to be age-appropriate, audience-specific and presented incrementally through what was described as a 'multi-dose' approach within the school pathway. Audience categorization was described in relation to age and divided into three distinct stages; pre-schoolers (ages 3-5), prepubescent (ages 10-12) and adolescents (ages 12-18). However, age-appropriateness tended to be construed, not so much in terms of maturation and development, but in terms of proximity to age at marriage. This was especially true when referring to the older age group. The closer

students were to graduating secondary school, the greater the likelihood that they were seen as 'close to marital age'. Despite a general perception that age at marriage was increasing in the country, there was concern to ensure that those who would marry young were prepared and equipped with necessary knowledge. This applied especially to girls in the last grade of secondary school.

> *Even though marriage is currently delayed until after university, I support giving information around maternal and women's health at secondary school.* Ms. Salma, ministry official.

In this way, and because of the heterogeneity in terms of development and maturation in any classroom, participants hinted at the subtle ways in which information on, for example, family planning and harm reduction strategies could be provided – ostensibly legitimately - to pupils who could perhaps need it outside of the context of preparation for marriage. Framing sex education as preparatory guidance for marriage was viewed as a strategy to facilitate its acceptance in Saudi society.

Gender was another categorizing scheme chosen by some stakeholders, although since schools are completely segregated by gender, female teachers focused on girls' issues while male teachers focused on boys'. In addition, some stakeholders suggested the need for a core curriculum for school children supported by specifically targeted components for those perceived as 'high risk' groups.

> *General programme should be in schools but special audience like scholarship students, those about to get married and you might be surprised by this, but soldiers need special programmes*. Mr. Mohammed, teacher.

Adolescents with special needs and developmental delays were also identified as target groups requiring sex education outside the conventional school system.

One of the most common mentioned topics was hygiene, which seemed to be a general, non-controversial term. However, descriptions of the term revealed it to be more laden than first appeared. Definitions often went beyond physical cleanliness to moral and ethical propriety.

> *We need to talk about cleanliness in practices meaning the correct behaviour in practicing sexual life and satisfying those needs.* Mr. Ahmed, ministry official.

Female participants tended to describe hygiene more in physiological terms and several asserted a link between poor feminine and menstrual hygiene and infections that lead to compromised fertility. Such a view was observed among female teachers and may reflect misconceptions surrounding gynaecological infections and their long-term effects on reproduction. In addition to hygiene, almost all participants agreed that pre-schoolers required information on naming body parts and recognizing and reporting sexual abuse. Prepubescent children were viewed as needing information about puberty, especially since there was criticism over the way in which it is currently covered. The emotional and sensational changes in adolescence, including feelings of sexual arousal were seen as needing greater attention. In this context, the topic of masturbation generated the greatest diversity of views in relation to timing of delivery and content. Although not currently included in the Science or Islamic Jurisprudence textbooks, several participants identified masturbation as a topic requiring caution against since many saw it as causing serious negative physical and psychological outcomes. However, when asked about their opinion on this matter, clinicians expressed the need for frank and neutral discussion of the practice, dispelling myths about its consequences.

> *I've read about how masturbation harms people and how physicians say that the negative effects are exaggerations but I read that it can turn into an addiction and can make a husband reluctant to be with his wife*. Religious scholar 2.

I explain to young people that everyone has feelings. What you do with them is what matters. Do you go and engage in sexual activity with somebody, or masturbate, or brush it aside? When it comes to masturbation, I explain the, "etiquette". If you are going to be doing it, it's okay; it's not harmful, but it's something to do in private. Ms. Lama, healthcare provider.

Sex education, in general, was seen as needing to incorporate moral as well as factual instruction, though there was less agreement on the nature of advice to be given. The idea of providing harm reduction advice was clearly contentious, some believing that adherence to religious teachings was sufficient to prevent young people from engaging in 'illicit' sexual activities, others emphasizing that STIs were not limited to pre or extra marital sexual relationships. The topic of harm reduction further illustrated the contention surrounding science vs religion approach and reveals an underlying theme of how participants define 'science'. Several participants only supported providing scientific information that strengthens the moral-based message.

We provide information about the medical complications in addition to the moral ones, for example sodomy, even with condom use, can cause rectal prolapse and condoms are not 100% safe, tears can happen. Religious scholar 2.

Others however believed in the need to provide scientific information with limited censorship, since moral-based messages, may not be sufficient to deter adolescents form engaging in premarital sexual activity. However, even among those who supported providing science-based information insisted on the need to promote Islamic values and ethics.

Sometimes a person needs to have sex education even if it includes something that seems like a justification for an illegitimate situation. Like drug use prevention, they say one route of AIDS transmission is sharing contaminated needles between users, it does not mean they're encouraging drug use as long as it is done with single needle use, it is a preventative measure. So, for condom use,

you can present it as general knowledge, but without implicitly endorsing the legitimacy of illegal relationships. Religious scholar 1.

Thoughts about what should be taught in sex education also differed according to gender. Although attention to the risks of extramarital sex were seen as appropriate for boys from the adolescent age group, the topic was mentioned less often in relation to girls within the same age group. When addressed however, it revealed many of the social attitudes towards female sexual desire and activity. A health educator insisted that girls can be emotionally blackmailed into engaging in sexual activity, but since preserving female virginity is still highly expected from women who have not yet married, some girls may opt for engaging in non-penetrative sex to preserve their virginity and avoid unwanted pregnancy and believing their chances of contracting an STI would be close to none in this case.

Girls open up their hearts and may engage in oral sex or anal sex or foreplay with direct skin contact [genital], *thinking they're in the safe zone.* Mr. Saad, healthcare provider.

In addition, family planning was held to be an important topic for female adolescent students and those about to marry. Several physicians expressed concern over misconceptions about oral contraception (OCPs) and recommended provision of information on use and possible side effects, especially since OCPs are sold over the counter.

They're worried the pills will cause infertility, so they don't use it, and then you get a teenager with an unwanted pregnancy [referring to married teenagers]. Ms. Safa, healthcare provider.

The recurrent differentiation between appropriate topics for males vs females may highlight some of the society's gendered views toward sexuality and sexual rights. Generally, men were viewed as hypersexual; incapable of controlling their sexual urges and hence tolerance towards their possible engagement in 'illegal' sexual activity was

perpetuated throughout several accounts. Women on the other hand were viewed as mostly victims, in need of protection. Hence, several participants believed that providing safe sex information was not just necessary for the prevention of infections in men but for their future wives as well.

However, accounts revealed a shifting discourse in relation to women's sexual and reproductive rights. For example, a physician emphasized the importance of extending information about contraception to male students as well.

> *Many people think it's always the woman that has to pop a pill or something, but there are more options, they're not just for her, but for him as well... So, I think educating them* [boys] *on their rights with respect to sexual health is very, important and lacking.* Ms. Lama, healthcare provider.

In addition, almost all participants believed that ensuring sexual satisfaction is a religious spousal right and duty and believed that the lack of satisfaction can negatively impact marital harmony, causing divorce or adultery. Yet, many participants believed that going into 'too much detail' about sexual satisfaction may be too sexually explicit for school age pupils. Of those who believed in its importance, there seemed to be a gender difference of the way to describe it. Male participants worded the topic as 'sexual compatibility' between spouses. While female participants seemed to focus more on the need to emphasize female sexual satisfaction as a woman' within marriage. In fact, some female participants disclosed, exasperatedly, personal stories about women within their professional or personal circles, complaining of lack of sexual satisfaction with their husbands.

> *I can't remember any case where she* [female patient] *came complaining that "she's" not satisfied, I feel bad for the poor things* [women] *If she was educated and raised that its fine to express her feelings as him, it* will *be fair for her, she will know when to seek medical advice for her sake, or at least for* both *of them.* Ms. Maram, healthcare provider.

The focus on the inclusion of emotional and relational perspectives within the curriculum for both boys and girls may provide a glimpse of the changing expectations of men and women within marriage and society in Saudi Arabia.

VIEWS ON HOW SEX EDUCATION PROGRAMMES SHOULD BE PRESENTED

Opinions on how to present sex education information tended to polarise around the science vs religion divide. Some participants leaned towards the adoption of a religious lens, focusing on morality and fostering pride in Islamic practices. Others favoured a pragmatic approach presenting scientific, non-judgemental facts and accepting that society, in the words of two participant, 'is not angelic'. Yet, none believed in the exclusivity of one approach over the other.

Since many of the stakeholders, apart from the school setting educators and staff, were unaware of how information is presented, copies of the 2013 version of Islamic Jurisprudence and Science books from the intermediate and secondary levels were provided to them. Participants looked at the chapter related to the reproductive system in the Science book. A female science teacher believed that the diagrams depicting the stages of labour were too graphic[*****]. Yet, almost all healthcare providers described being impressed with the information related to the stages of human development stages and the associated diagrams and illustrations.

However, a specific passage related to STIs, extracted from the current 8th grade science textbook, where students are usually between the ages 13 and 14, made a few participants uncomfortable. The text reads:

[*****] The stages of labour are presented as anatomical illustrations of the sagittal view of the pelvis.

'Sexually transmitted diseases are transmitted during the sexual contact and are caused by bacteria or viruses. Antibiotics are used to treat diseases caused by bacteria like gonorrhoea and syphilis. A person infected with gonorrhoea can develop infertility due to the destruction of the reproductive organs. As for syphilis t, the bacteria would attack a person's heart vessels and nervous system which will result in the destruction of organs that cannot be repaired. Genital Herpes is a chronic viral disease that causes pain and ulcers in the reproductive organs and it is transmitted through sexual contact or from mother to child during delivery. There is no treatment or vaccine for Herpes but symptoms can be treated by anti-viral medications.' (Saudi MoE 2019b)

A healthcare provided seemed shocked and uncomfortable with this passage.

> *Firstly, I think it's scary information. I think it would make anyone who would like any relationship to stay away. Is this a recent book? It's interesting, because syphilis and so on, are not as widespread as they were before. Number two, the style of providing information is quite creepy. I can just visualize somebody with all of their organs being destroyed. I think the style and the content is not appropriate for a young person. The content is not up-to-date…It definitely needs a lot of reworking.* Ms. Lama, healthcare provider.

Within the 10th grade Islamic Jurisprudence textbook, where students are between the ages of 15 and 16, adultery and homosexuality are described as sins associated with several negative physical and emotional outcomes including STIs and HIV. A copy was provided to a physician who highlighted how exclusive linkage between STI and 'sins' of adultery and homosexuality can skew adolescents sense of risk and further promote stigma and shame towards any individual with an STI.

> *This is scientifically incorrect, in Saudi Arabia, almost all women [with HIV], got AIDS from their husbands so we cannot say that STIs comes from adultery…If I get gonorrhoea from my husband I did not commit a sin! This is very scary!* Ms. Asma, healthcare provider.

Stakeholders among the healthcare provider group continuously criticized the fear-based tactics which may promote a negative image of sex. However, most of the teachers within the stakeholders however, did not share the same views.

Other inaccuracies identified by participants in the existing texts stemmed from information presented about who was at risk, and in particular the tendency towards 'othering' Westerners. A copy of text extracted from the Islamic jurisprudence textbook contained this paragraph: [sic] *Western media is still focusing on the disease of the century, AIDS, and its alarming numbers that shows how prevalent this disease is amongst them, which reflects their moral decline into a deep abyss that predicts their close end. This disease has caused panic to spread among Western societies, and there have been demonstrations to close "the houses of corruption" and night clubs and such places that promote obscenity.* (Saudi MoE 2013) . A female physician took issue with this text.

> *The tone used isn't correct and the fact mentioned is wrong... They say "amongst them" as if they are all bad... This sounds like the opinion of one person but it shouldn't be written in books because the student will be brought up, even outside the context of HIV, to believe that he is good, while the ones outside are not.* Ms. Maram, healthcare provider.

It was pointed out that access to the Internet enabled pupils to dispute such information and distrust other information provided within the textbooks. However, the teachers interviewed were less likely to view such text as exaggerating the truth about Western societies and believed that a growing emphasis on individual rights was directly related to increasing rates of STIs and unintended teenage pregnancies. Answers to the question of how material should be presented also drew comment relating to language, terminology and directness. Some participants expressed frustration with what they described as 'abnormal' ways of educating young children about their bodies, referring to the common practice in the Middle East of using euphemisms to refer to genitals.

'*Ayb'*, which means vice or shame but also can be used to describe a physical deformity is sometimes used to name both male and female genitalia. A health promotion expert emphasized the need to give genitalia their correct names, shorn of any negative or inappropriate connotations.

> *You shouldn't give it [genitalia] an unnatural name; your eye for example, would you give it a different name?* Ms. Reem healthcare provider.

Learning about the names of genitalia was also viewed as an essential step in teaching children on identifying and reporting sexual abuse.

Opinions on whether sex education should be part of the current curricula or should be managed in an extracurricular context also differed but were less trenchantly expressed. There was a preference for providing a general health promoting educational programme in which sexual health could be taught alongside other life skills in a less didactic manner. Several participants, however, believed that delivering sex education information within a formal, assessment-based programme would ensure delivery. Another popular opinion was to present the information through a premarital preparatory course. Yet, the ultimate decision on the optimal approach was seen as the responsibility of the implementing ministry.

DISCUSSION

Our data reveals a general consensus among participants on the need for a school-based sex education programme in Saudi Arabia. A range of reasons were identified to support this need which heavily focused on the social and political contextual changes within the country including effects of globalization and modernization suggested by the expanding women's roles, increasing use of social media among youth and mixing of genders in public spaces. Provision of sex education was seen, essentially as a measure for

preventing adverse health outcomes and a protecting the family unit rather than a health promotion initiative.

Differences in opinions were observed in relation to who should be involved in the design phase of the programme, especially around including religious scholars in the formulation phase or limiting it to educators and scientists. However, recurrent emphasis on recruiting individuals representing the 'moderate' voice from both Islamic and liberal streams of society, may provide a glimpse on the policy making process and steps required for an issue to reach the political agenda. It further reflects the science-religion tension observed in our accounts. Although scientific and religious viewpoints were not seen as contradictory, where the emphasis should lie was more contentious. Presenting scientifically accurate information was described as vital for any sex education programme, however, definitions on what constitutes 'scientific' varied. Many non-clinical stakeholders demanded either censoring scientific material undermining morality or only using scientific information deemed supportive of moral-based messaging. This tactic has been regularly used by religious societies that linked disease to moral transgressions. (Wellings, Mitchell, and Collumbien 2012, 10-11). However, some stakeholders, including a religious scholar, insisted on the need to provide scientific information even when seemingly contradicting moral-based messaging since the latter may be ineffective for those with weaker religious convictions.

Teachers were viewed as the ideal delivery force yet; lack of training and proficiency was highlighted by many stakeholders including those form the school setting educator group. In fact, teachers repeatedly expressed preference in deferring this responsibility to those with higher levels of expertise. The contention noticed within our results about the ideal delivering entity has been reported in the literature, with teachers and students describing being uncomfortable discussing such matters in the classroom and preferring external educators (Pound, Langford, and Campbell 2016)

Almost all of our stakeholders agreed on the need to for any sex education programme to address topics related to puberty, hygiene and identifying and reporting sexual abuse. Many expressed a preference in incorporating other life skills training as well as delivering sex education in a 'multi-dose', incremental approach. These suggestion are consistent with international guidelines for sex education programmes (UNAIDS 2018).

Many stakeholders believed in the need to include emotional and relational perspectives within any programme to better equip young people for healthy, lasting marital relationships. Yet, conflict was observed when discussing more controversial topics like harm reduction strategies and sexual satisfaction within marriage fearing promoting premarital sexual exploration. Tension between acknowledging youth's engagement in premarital sexual activity and upholding Islamic values has been reported in studies conducted in similar religious context (Latifnejad Roudsari et al. 2013; Zaabi et al. 2019; Tabatabaie 2015). Several participants suggested framing sex education as premarital preparatory course which has been adopted in neighbouring countries like Turkey and Egypt (Wahba and Roudi-Fahimi 2012; Cok and Gray 2007). However, others insisted on the need for mandatory, assessment-based programmes in schools to ensure delivery.

Research related to sexual health and education are sparse in Saudi Arabia. Yet, the limited published research emphasizes the low burden of STIs in the country (Memish et al. 2015; Madani 2006; Filemban et al. 2015) in spite of growing evidence of poor sexual health knowledge and increasing premarital sexual activity among youth (AlQuaiz et al. 2013; Alquaiz et al. 2012; Filemban et al. 2015; Rahee et al. 2013; AL-Malki 2014; Madani 2006). Further, increased acceptability for sex education from adolescents has been reported (El-Tholoth et al. 2018). Most of these studies assert the link between low sexual health knowledge and lack of school-based programmes and provide recommendation in favour of implementing 'comprehensive' sex education programmes (AlQuaiz et al. 2013; Alquaiz et al. 2012; Filemban et al. 2015; Raheel et al. 2013; AL-Malki 2014; Madani 2006; El-Tholoth et al. 2018). However, these recommendations usually fail to identity topics to include in sex education programmes

beyond puberty and STIs and do not comment on appropriated delivery modes. In addition, although most of these studies highlight the need to be culturally appropriate and religiously sensitive, they neglect to explore what this entails and how it could be achieved (El-Tholoth et al. 2018).

To our knowledge, this is the first study to explore views of key stakeholders in Saudi Arabia on provision of a school-based sex education programme. The diverse background of participants can be seen as a strength, especially since the opinions of religious scholars are rarely captured within studies in the MENA region. The personal and professional background of the PI, a young, clinically-trained woman raised in Saudi Arabia, may be seen as both a strength and a weakness. On the one hand, it facilitated execution of the ethics and recruitment processes, and provided a ready understanding the local culture, religion and colloquial idioms. On the other hand, her clinical training and the assumption of shared religious and cultural beliefs on the part of stakeholders may have influenced expression of their opinions, a suspicion which was strengthened by requests from participants to know whether their responses were 'correct'. Further limitations included the timing and setting of the research, which took place exclusively in Riyadh, before the announcement of reforms extending women's rights in the country - to drive and attend public events, for example. These changes may have influenced participants' opinions, who at times expressed worry about challenging strict social norms. In addition, the key informants who assisted in the recruitment of participants to the study admitted having selected those they described as 'open minded', on the grounds that they would feel more willing to speak about such a sensitive topic. Hence, the sample was less likely to have captured those who might oppose implementation of a sex education programme.

A further limitation is the rapidly changing landscape in the country including the changes to the school curricula over the course of our study. The textbooks revised were of the 2013 edition, and although texts relatd to sexual health within the Science

textbook did not undergo change in consecutive editions, including the most recent 2019 version, the Islamic Juripsrudence books did.

The passage describing one of the negative health outcomes of adultery as physical diseases and proclaiming Western media being in a mode of panic within the 2013 textbook was completely omitted in the 2016 version. This passage had been strongly criticized by our stakeholders who found the describing of the West as morally inferior to Muslims problematic.

In the 2016 version STIs are described as being negative health outcomes of adultery as the passage states: '[Adultery] causes many physical ailments which were not previously known like syphilis, gonorrhoea, and AIDS, which has no treatment to this day and it is a cause of death since, when present, the body cannot battle any diseases, however simple' (Saudi MoE 2016).

The same version also describes STIs as a negative health outcome of homosexuality; [Sic] 'Sodomy is one of the most important causes of becoming infected with dangerous diseases and its spread in society, like the infectious AIDS that has distressed the world and its treatment has exhausted the world to the extent that many communities have demanded isolating those afflicted with sexual aberration [homosexuality] in specific places' (Saudi MoE 2016).

The current Islamic jurisprudence book in its 2019 edition, also describes STIs as a negative consequence to adultery and homosexuality but provides it as footnote; '*some of these diseases that have recently developed are AIDS and Syphilis and others*'. However, an additional negative outcome of adultery and homosexuality has been introduced in this edition which is '*bringing dishonour/shame onto oneself, family and whole tribe*' (Saudi MoE 2019a).

The current state of flux in Saudi Arabia is reflected in the rapidly changing views within school curricula. Hence, providing strong evidence for the formulation of any future sex

education programme in the country should be a priority. The views not only of stakeholders but those of young people and parents should be explored as a next step.

Our research highlights the complexity of adopting a generic form of 'comprehensive' sex education without understanding the local context, social expectations and definitions. This is especially true in Saudi Arabia, a country undergoing fast-pace political and social changes.

CONCLUSION

Western centric programmes, although provide evidence-based recommendations that can be helpful in guiding local sex education programme, are only doubtfully transferrable to the Saudi context. Many of the international guidelines frame sex education through individualistic rights' perspective that focus on rights to equality and non-discrimination among other rights. Within Saudi Arabia, some forms of sexual activity are not only socially frowned upon, religiously prohibited but also legally impermissible. Hence, reframing some of the rights may be necessary for feasibility and acceptability. Furthermore, our results highlight the importance of understanding local context, and recognize the views of those responsible for formulation and implementation for any sex education programme in regards to the needs of adolescents but more importantly their perception of different sexual rights and their local definitions. Participants favoured society-inclusion approach rather than an individualistic one. Prevention was heavily focused on protecting the family unit and in turn the larger community.

Formulating a culturally sensitive programme poses challenges, especially since local Islamic religious beliefs and regulations are tightly knitted into every aspect of life, hence moral messages are deemed necessary to include alongside scientific facts in any proposed programme. In addition, designing a standalone sex education programme was perceived as difficult. Rather, delivering this type of education covertly within a larger health promotion programme or as a premarital preparatory course were popular

suggested strategies. Topic choice should be based on the local needs and social definitions and hence further studies are needed to explore the needs of adolescents before designing a proper sex education programme in Saudi Arabia.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

REFERENCES

AL-Malki, Basim Matar. 2014. "Knowledge and Awareness of Sexually Transmitted Disease among Male University Students in Taif, Saudi Arabia -." *International Journal of Medical Science and Public Health* 3 (3): 342–48.

AlQuaiz, AlJohara M., Ambreen Kazi, and Maha Al Muneef. 2013. "Determinants of Sexual Health Knowledge in Adolescent Girls in Schools of Riyadh-Saudi Arabia: A Cross Sectional Study." *BMC Women's Health* 13: 19. https://doi.org/10.1186/1472-6874-13-19.

Alquaiz, Aljoharah M., Maha A. Almuneef, and Hafsa R. Minhas. 2012. "Knowledge, Attitudes, and Resources of Sex Education among Female Adolescents in Public and Private Schools in Central Saudi Arabia." *Saudi Medical Journal* 33 (9): 1001–9.

Badahdah, Abdallah M. 2010. "Stigmatization of Persons with HIV/AIDS in Saudi Arabia." *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society* 21 (4): 386–92. https://doi.org/10.1177/1043659609360873.

Cok, Figen, and Lizbeth Ann Gray. 2007. "Development of a Sex Education Programme for 12-year-old to 14-year-old Turkish Adolescents." *Sex Education* 7 (2): 127–41. https://doi.org/10.1080/14681810701264466.

El-Tholoth, HossamS, FahadD Alqahtani, AbdullahA Aljabri, KhalidH Alfaryan, Fares Alharbi, AlbaraaA Alhowaimil, Ali Alkharji, Abdulrahman Alrwaily, Ali Obied,

and Tala Al-Afraa. 2018. "Knowledge and Attitude about Sexually Transmitted Diseases among Youth in Saudi Arabia." *Urology Annals* 10 (April): 198. https://doi.org/10.4103/UA.UA_14_17.

Filemban, Sanaa M., Yasser A. Yasein, Magdy H. H. Abdalla, Raafat Al-Hakeem, Jaffar A. Al-Tawfiq, and Ziad A Memish. 2015. "Prevalence and Behavioral Risk Factors for STIs/HIV among Attendees of the Ministry of Health Hospitals in Saudi Arabia." *The Journal of Infection in Developing Countries* 9 (04). https://doi.org/10.3855/jidc.5964.

Glaser, B, and A Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago, IL: Aldine Publishing Company.

Haberland, Nicole, and Deborah Rogow. 2015. "Sexuality Education: Emerging Trends in Evidence and Practice." *Journal of Adolescent Health*, International Conference on Population and Development, 56 (1, Supplement): S15–21. https://doi.org/10.1016/j.jadohealth.2014.08.013.

Javadnoori, Mojgan, Robab Latifnejad Roudsari, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2012. "Female Adolescents' Experiences and Perceptions Regarding Sexual Health Education in Iranian Schools: A Qualitative Content Analysis." *Iranian Journal of Nursing and Midwifery Research* 17 (7): 539.

Latifnejad Roudsari, Robab, Mojgan Javadnoori, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2013. "Socio-Cultural Challenges to Sexual Health Education for Female Adolescents in Iran." *Iranian Journal of Reproductive Medicine* 11 (2): 101–10.

Lindberg, Laura Duberstein, and Isaac Maddow-Zimet. 2012. "Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes." *Journal of Adolescent Health* 51 (4): 332–38. https://doi.org/10.1016/j.jadohealth.2011.12.028.

Macdowall, Wendy, Kyle G. Jones, Clare Tanton, Soazig Clifton, Andrew J. Copas, Catherine H. Mercer, Melissa J. Palmer, et al. 2015. "Associations between Source of Information about Sex and Sexual Health Outcomes in Britain: Findings from

the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." *BMJ Open* 5 (3): e007837. https://doi.org/10.1136/bmjopen-2015-007837.

Macdowall, Wendy, Kaye Wellings, Catherine H. Mercer, Kiran Nanchahal, Andrew J. Copas, Sally McManus, Kevin A. Fenton, Bob Erens, and Anne M. Johnson. 2006. "Learning About Sex: Results From Natsal 2000." *Health Education & Behavior* 33 (6): 802–11. https://doi.org/10.1177/1090198106289003.

Madani, Tariq A. 2006. "Sexually Transmitted Infections in Saudi Arabia." *BMC Infectious Diseases* 6 (1): 3. https://doi.org/10.1186/1471-2334-6-3.

Memish, Ziad A., Malak Almasri, Aziz A. Chentoufi, Jaffar A. Al-Tawfiq, Ali M. Al-Shangiti, Kenan M. Al-Kabbani, Badriah Otaibi, Abdullah Assirri, and Saber Yezli. 2015. "Seroprevalence of Herpes Simplex Virus Type 1 and Type 2 and Coinfection With HIV and Syphilis: The First National Seroprevalence Survey in Saudi Arabia." *Sexually Transmitted Diseases* 42 (9): 526–32. https://doi.org/10.1097/OLQ.0000000000000336.

Pound, Pandora, Rebecca Langford, and Rona Campbell. 2016. "What Do Young People Think about Their School-Based Sex and Relationship Education? A Qualitative Synthesis of Young People's Views and Experiences." *BMJ Open* 6 (9): e011329. https://doi.org/10.1136/bmjopen-2016-011329.

Raheel, Hafsa, Muhammad Afzal Mahmood, and Abdulaziz BinSaeed. 2013. "Sexual Practices of Young Educated Men: Implications for Further Research and Health Education in Kingdom of Saudi Arabia (KSA)." *Journal of Public Health (Oxford, England)* 35 (1): 21–26. https://doi.org/10.1093/pubmed/fds055.

Saudi Arabia, Ministry of Education. 2019a. *Islamic Jurisprudence-Level 6-Secondary Education*. Ministry of Education, Saudi Arabia. 2019- Riyadh-1438H. ISBN: 978-603-508-411-6

Saudi Arabia, Ministry of Education. 2019b. Science for 8th Grade, First Semester. McGraw Hill Education. Obekan, 2019. ISBN: 978-603-508-228-0

Saudi Arabia, Ministry of Education 2015. *Islamic Jurisprudence for the 10th grade.* Riyadh. ISBN: 978-9960-48-462-4

Saudi Arabia, Ministry of Education. 2013. *Islamic Jurisprudence-Level 6-Secondary Education*. Riyadh-1434H. ISBN: 9960-19-347-0

Sheeha, Mounira Al. 2010. "Awareness and Use of Contraceptives Among Saudi Women Attending Primary Care Centers in Al-Qassim, Saudi Arabia." *International Journal of Health Sciences* 4 (1): 11.

Tabatabaie, Alireza. 2015. "Constructing the Ideal Muslim Sexual Subject: Problematics of School-Based Sex Education in Iran." *Sex Education* 15 (2): 204–16. https://doi.org/10.1080/14681811.2014.992066.

Turki, Rola, Khalid Sait, Nisreen Anfinan, Sayed Sartaj Sohrab, and Adel Mohammed Abuzenadah. 2013. "Prevalence of Human Papillomavirus in Women from Saudi Arabia." *Asian Pacific Journal of Cancer Prevention: APJCP* 14 (5): 3177–81.

UNAIDS. 2018 "UN Urges Comprehensive Approach to Sexuality Education | UNAIDS." 2018. http://www.unaids.org/en/resources/presscentre/featurestories/2018/january/2018 0110_sexuality-education.

Wahba, Mamdouh, and Farzaneh Roudi-Fahimi. 2012. "The Need for Reproductive Health Education in Schools in Egypt," 8.

Wellings, Kaye, Mitchell Kirstin, and Collumbien Martine. 2012. *Sexual Health: A Public Health Perspective: A Public Health Perspective*. McGraw-Hill Education (UK).

WHO. 2019. "WHO | Adolescents Sexual and Reproductive Health." 2019. http://www.who.int/reproductivehealth/topics/adolescence/en/.

WHO. 2006. "WHO | Defining Sexual Health." 2006. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sh/e n/.

Zaabi, Omar Al, Margaret Heffernan, Eleanor Holroyd, and Mervyn Jackson. 2019. "Islamic Parents' Attitudes and Beliefs towards School-Based Sexual and Reproductive Health Education Programmes in Oman." *Sex Education* 19 (5): 534–50. https://doi.org/10.1080/14681811.2018.1553708.

CHAPTER FIVE- PAPER 'Abstinence versus Harm Reduction Approaches to Sexual Health Education: Views of Key Stakeholders in Saudi Arabia'

CHAPTER OVERVIEW

This chapter presents the findings of the paper titled 'Abstinence versus Harm Reduction Approaches to Sexual Health Education: Views of Key Stakeholders in Saudi Arabia' and relays its results to the overall thesis. This qualitative study aims to explore key stakeholders' perspectives on the need for sexual health education for adolescents and their views on adopting an abstinence-only or a harm reduction model in any proposed programme through semi-structured interviews. This paper was submitted to the Journal of Sex Education and was published on October 18th 2019.

RESEARCH PAPER COVERSHEET

Please note that a cover sheet must be completed <u>for each</u> research paper included within a thesis.

SECTION A – Student Details

Student ID Number	1512875	Title	Dr.
First Name(s)	Nour		
Surname/Family Name	Horanieh		
Thesis Title	Stakeholders' Assessment of the Need for Sexual Health Education among Adolescents in Saudi Arabia: An Exploratory Study		
Primary Supervisor	Prof. Kaye Wellings		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Journal of Sex Education		
When was the work published?	18-10-2019		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	N/A		
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Stage of publication	

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For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I am the primary investigator of the paper. I conducted all of the interviews and edited their transcription process and translated relevant parts for other co-investigators to take part in the analysis process.

SECTION E

Student Signature	
Date	21-10-19

Supervisor Signature	
Date	21-10-19

Chapter Six- Paper Barriers and Facilitators for Formulation and Implementation of a Sex education Programme in Saudi Arabia: Stakeholders' Perspective

Chapter overview

This chapter presents the final paper looking at the anticipated barriers and facilitators for sex education design and implementation in Saudi Arabia. In this paper I applied the Walt and Gilson Framework (Policy Triangle) in order to help guide categorizing and reporting the data. I focused exclusively on one angle of the Policy Triangle, *context.*

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SECTION A – Student Details

Student ID Number	1512875	Title	Dr.
First Name(s)	Nour		
Surname/Family Name	Horanieh		
Thesis Title	Stakeholders' Assessment of the Need for Sexual Health Education among Adolescents in Saudi Arabia: An Exploratory Study		
Primary Supervisor	Prof. Kaye Wellings		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

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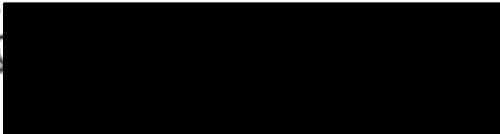
SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Critical Public Health
Please list the paper's authors in the intended authorship order:	Nour Horanieh, Wendy Macdowall, Kaye Wellings
Stage of publication	Ready for Submission

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper.	I am the primary investigator of the paper. I conducted all of the interviews and edited their transcription process and translated relevant parts for other co- investigators to take part in the analysis process.

SECTION E

Student Signature	
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Date	21-10-19

BARRIERS AND FACILITATORS FOR FORMULATION AND IMPLEMENTATION OF A SEX EDUCATION PROGRAMME IN SAUDI ARABIA: STAKEHOLDERS' PERSPECTIVE

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ABSTRACT

We examined the views of 28 stakeholders on anticipated barriers and facilitators to formulating and implementing a school-based sex education programme in Saudi Arabia. We conducted semi-structured interviews with policy-makers; healthcare providers; teachers and religious scholars. We used the Walt and Gilson policy triangle framework to guide our analysis. We report on facilitating and hindering factors related to *context,* specifically structural, situational, cultural and global factors. Distinguishing between barriers and facilitators proved difficult as many factors served as potentially easing and hindering implementation simultaneously. Most of the barriers were related to predicted societal resistance addressing sex-related topics. The hierarchical nature of the governing system in Saudi Arabia was viewed as potentially easing implementation or obstructing it due to its top-down nature. The current social and governmental changes were described as increasing 'openness' and were seen as providing a window of opportunity for possible implementation and social acceptability. Findings from this study maybe useful for policymakers to develop and implement school-based sex education programmes in Saudi Arabia and other similar contexts.

KEYWORDS: adolescents, sex education, Saudi Arabia, Islam, barriers, facilitators.

BACKGROUND

Adolescence has increasingly been recognized as a distinct stage within the life course characterized by multiple physical, behavioural, and psychological changes alongside shifting social expectations and responsibilities. Those within this age group are prone to specific health risks related to mental health, violence and injuries, alcohol, drug and tobacco use in addition to sexual health (WHO 2018). The United Nations Population Fund (UNFPA) emphasizes the need to provide comprehensive sex education as a basic human right and recommends that programmes adhere to its guidelines in delivering scientifically accurate information on contraception, childbirth and sexually transmitted infectious (STIs) in an age appropriate and culturally relevant manner (UNFPA 2018). Comprehensive sex education has been shown to delay or reduce sexual activity and decrease risk behaviours (Chin et al. 2012; Macdowall et al. 2015; Kågesten et al. 2014). Yet, multiple challenges exist in implementing such programmes around the world.

As is the case with many neighbouring countries, no official sex education programme exists in Saudi Arabia. Biological aspects of reproduction are covered within the national Science Curriculum (Saudi Arabia MoE 2019a), while religious information on issues related to sex and reproduction are addressed in the Islamic Jurisprudence curriculum (Saudi Arabia MoE 2019b).

Although young people make up the majority of the population in the MENA region, limited research exploring their sexual health needs exists. Studies conducted in Saudi Arabia are scarce and reveal a general lack of sexual health knowledge among adolescents and recommend introducing sex education in schools. These studies, however, fail to assess feasibility and acceptability of implementing such programmes (Alquaiz et al. 2012; Raheel et al. 2013; El-Tholoth et al. 2018). Literature that identifies barriers for the provision of school-based sex education programmes generally report on attitudes of teachers, students and parents which may be limited to locally specific, school-related themes (Pound, et al 2016; Wight et al. 2002). In addition, many of these

studies may not be applicable in the Saudi context, which has unique features in being a high-income country, ruling by Islamic law under an absolute monarchy, where the king has final authority over the three branches of the government; legislative, executive, and judicial. He is also the prime minister over the council of ministers and presides over the *Shura* council (Consultative Council)[†††††]. The Council of Senior Scholars (Council of Senior Ulama) is the country's highest religious body that advises on religious matters and is responsible for formulating *fatwas*[‡‡‡‡‡] (Council of Ministers of Saudi Arabia 1992). A national healthcare system exists, and the Ministry of Health (MoH) is responsible for providing health services at primary, secondary and tertiary levels, including public health services, free of charge to all Saudi nationals (Almalki et al. 2011). The economy of Saudi Arabia is among the top 20 in the world and is heavily dependent on oil. 'Saudi Vision 2030' was launched in 2016 in order to diversify the country's economic resources and to develop public service sectors including education (Vision 2030 2016). The MoE has been redesigning the school curricula and has announced its plans to introduce physical education to girls' schools in 2017 (Paul 2017). However, no plans for introducing sex education have been announced within the curricular or extracurricular programmes.

In this paper we explore the views of stakeholders on anticipated barriers and facilitators for the possibility of implementing sex education for adolescents in Saudi Arabia. We examine these views using the health policy framework provided by Walt and Gilson (Walt and Gilson 1994) .

[†††††] The consultative council is an advisory body to review laws and regulation and provide suggestions related to the annual reports presented by the ministries.

[‡‡‡‡‡] Religious legal opinion

METHODS

SAMPLE

This was a qualitative study using semi-structured interviews.

We adopted a purposive sampling strategy. We recruited participants from professional backgrounds involved in adolescent health or education, who were viewed as potentially influencing implementation of a possible school-based sex education programme in Saudi Arabia. The primary investigator (NH) identified key informants in July, 2016 who were contacted via email and WhatsApp messages. Snowball sampling followed with further identification of potential participants.

Twenty-eight stakeholders were recruited and were categorized into four groups: policy-makers (n=7); social and healthcare providers (n=10); teachers and other school staff (n=9); and religious scholars (n=2). We chose to use pseudonyms to anonymise our participants and ensure their confidentiality. Religious scholars were referred to as religious scholar 1 and 2 to prevent deductive disclosure.

DATA COLLECTION

Interviews took place between March and June 2017 in the capital city of Riyadh. They were conducted either face to face at a venue of the participant's choice (n=20), or via telephone (n=8). All interviews were recorded with participants' permission and transcribed verbatim.

The duration of the interviews averaged 45 minutes. All participants were provided with information sheets prior to initiating the interviews and given consent forms, which emphasized their right to withdraw at any time. Copies of both documents were emailed to participants interviewed by phone and reviewed prior to starting the recording.

Participants were given the option to conduct the interview in either Arabic or English.

A topic guide was used during interviews and contained themes related to sexual health and sex education. Stakeholders were asked about their views on the current state of sex-related information in schoolbooks in addition to their views on the need for formal sex education programmes. At the end of the interviews, participants were directly asked what they believed to be the barriers and facilitators to implementing such programmes.

ANALYSIS

Seven interviews were conducted in English and an additional four of the Arabic transcripts were translated to English by the PI to allow non-Arabic speaking investigators to take part in the analysis process. However, the rest of the transcripts were kept in their original language in order preserve the local expressions that would lose their cultural relevance if translated. Only relative quotes were translated from Arabic to English.

To guide our analysis we used the Walt and Gilson framework, also known as the health policy triangle, which is a simplified visual depiction of the complex inter-relationships of the factors affecting health policies (Walt and Gilson 1994). The framework asserts the importance of assessing the *content* of the policy, the *processes* of policymaking, and the different roles and influences of *actors* within a specific *context* where all these factors interact. In regards to the barriers and facilitating factors of sex education in Saudi Arabia, we report on the factors related specifically to *context* within the Walt and Gilson Framework. Context denotes systemic factors that can influence health policy that can be categorised into structural, situational, cultural and global factors. For structural factors we adopted the definition of somewhat stable elements within the country's structure specifically the governmental, legal religious institutes, and the healthcare and educational systems. Factors influencing policy that are somehow transient are described as situational. These are sometimes referred to as 'focusing

events' and are usually related to the 'here' and 'now' (Buse, Mays, and Walt 2012). Cultural factors are unique to each setting and may be related to formal societal hierarchy or social dynamics. Global factors include international or exogenous factors that can directly impact or indirectly pressure countries or states to implement a health policy or influence social acceptability to health policies (Buse, Mays, and Walt 2012).

Initially, a two-step approach was taken to manage the data. Within the first step we analysed the data according to the main variables of the Walt and Gilson Policy Triangle Framework that is context, content, process and actors (figure 1). For the purpose of looking at factors which might help or hinder the introduction of a sex education programme, we organising the data specifically on characteristics of the *context* in Saudi Arabia, that is, structural, situational, cultural and global. Data were extracted and charted on Excel sheets. We then used an inductive approach using thematic analysis to identify emerging themes. We paid attention to the language, tone and context of stakeholders' responses and we revised the field notes to contextualise the accounts. Data requested to be 'off the record' was not included within the analysis.

ETHICAL APPROVAL

Ethical approval was gained in March, 2017 by London School of Hygiene and Tropical Medicine (Ref. No. 12064) and King Saud University (Ref. No. 17/0273/IRB).
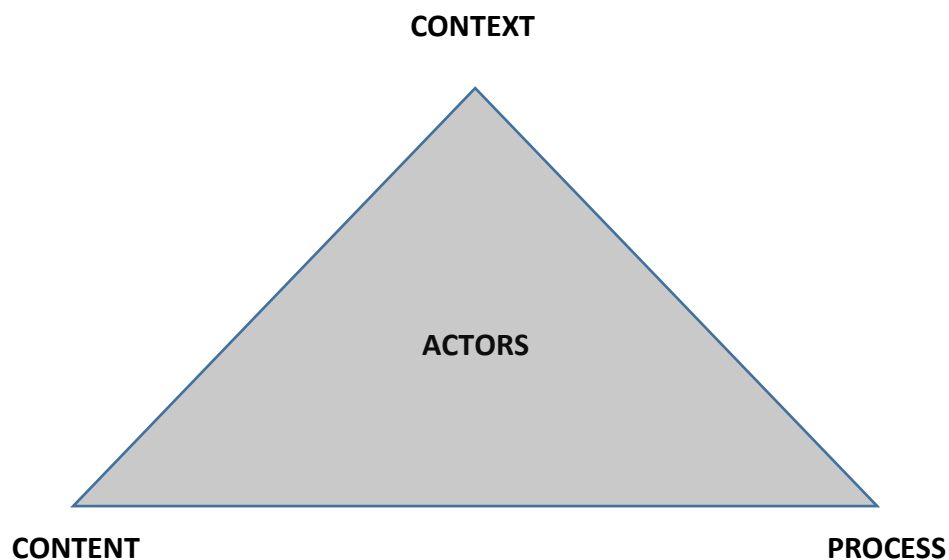
Figure 1: Walt and Gilson Policy Framework (Walt and Gilson 1994)

FINDINGS

Stakeholders unanimously agreed on the need for sex education but quickly identified a number of anticipated barriers and facilitators for programme design and implementation. These factors were elicited in response to direct questions, but more commonly were spontaneously and implicitly mentioned throughout accounts.

STRUCTURAL FACTORS

The most frequently identified factors mentioned as facilitating or hindering the implementation of sex education programmes in the country could be categorised as structural.

The hierarchical nature of the governmental system in Saudi Arabia was described as facilitating acceptance of any proposed sex education programme.

> *If the MoE approved something then all the schools will have that curricula, whether parents disagree or not, it's the higher decision.* Ms. Rana, healthcare provider.

Some participants asserted that if a governmental body shows enthusiasm in adopting an initiative, the notion of obstacles become obsolete. Yet, the top-down approach was also seen as sometimes presenting frustrations. Such a view was prevalent among stakeholders who had experience of recommending interventions that had been halted by those in more senior positions.

> *They want some kind of order from the court, from the government. They are not brave to do that.* Mr Ahmed official at policymaking agency.

Other barriers were described in relation to the infrastructure of the healthcare system, which was particularly pertinent since school health had only recently become part of the MoH's jurisdiction as of 2017. Although many stakeholders mentioned this move as a potential facilitator to implementing health education programmes, inadequate inter-ministerial communication and weak collaborations were described as possibly hindering this process.

Barriers were also perceived in relation to the public health field in the country, which was described as being embryonic and having weak training schemes. The predominant public health focus was also criticized for being biomedical as opposed to preventative.

> *The concept of prevention is still in its infancy... The slogan of the MoH which was issued in 2010 says "Patients First". That's not the Ministry of Health that's the Ministry of hospitals.* Mr. Ahmed, official at policymaking agency.

This participant also criticized the predominant culture of seeking validation through *'quick wins'* and evaluating public health interventions by advertisement size and budget expenditure rather than health outcomes.

Discussions regarding infrastructure extended to the absence of relevant data. Several participants with a research and/or policy background articulated their dissatisfaction with the limited availability of reliable data related to adolescent health and sexual health, which was identified as a significant impediment to developing a strategy for sex education. Without the numbers, it was claimed, a true assessment of the 'problem' could not be made nor could a demand for school-based sex education programmes be raised. Even those with no research background identified the lack of data as a barrier and made veiled reference to the lack of transparency on the part of the MoH in sharing numbers with the public. Hence, many believed in the urgency of conducting research to properly evaluate the situation and frame the argument for sex education in an evidence-based approach.

> *When the numbers appear, the decision-makers and the general public's attention will be caught and they will try and identify the reasons for these problems and find solutions.* Mr. Khaled, official at policymaking agency.

Although lack of data regarding STI levels was highlighted, several stakeholders assumed that these rates were on the rise based on their professional observations. Clinicians reported seeing increasing numbers of young patients with STI complications and teachers described noticing increased boasting from students about dating.

> *I'm not sure what the abortion or STD rates are, I do not have evidence but I assume there must be many cases and I do not know if they are cared for. Even for domestic violence we do not have past surveys so we cannot compare but we hear more about it and there is a hotline*

you can call, you would not have that without a problem. Ms. Norah, healthcare provider.

So many girls now have relationships and they boast about it… It's increasing. Ms. Suha, school setting educator.

However, neither STI rates, nor out-of-wedlock teenage pregnancies - issues acknowledged to be the drivers of sex education initiatives in the West - were believed to be reaching alarming rates. Hence, whilst some pondered the wisdom of acting before STI and teenage pregnancies were seen to warrant intervention, the argument for sex education provision was more commonly seen against a backcloth of increasing divorce rates, marital disharmony, mental health disorders among adolescents and child sex abuse cases.

Researchers among the stakeholders anticipated further barriers in carrying out necessary formative sexual health research. They described regularly omitting what might be perceived as controversial questions to ensure approval from ethics committees, which may highlight the lack of clear guidelines on researching sensitive topics.

I made a conscious decision not to [include topics related to sexual health] *because I knew I would have a very hard time getting the other stuff through IRB.* Ms. Rana, healthcare provider.

Criticism of the weak infrastructure extended to the educational system, specifically to governance and quality control. Several stakeholders described a lack of standardization in teaching quality and resources across schools, especially between public and private and urban and suburban schools. Further, the MoE's direction prioritizing academic attainment over providing life skills, was a common criticism.

Schools outside of Riyadh are just in the goons basically, teachers still hit, education-wise it's not very focused on the students, its's hard to ask questions and to be understood. Ms. Rana, healthcare provider.

Yet, many praised the recent efforts in introducing educational programmes that promote critical thinking and encourage physical activity. Yet, the allocated time and manpower for these programmes was believed to be insufficient, mostly by teachers among the stakeholders.

> *The ministry has spectacular programmes but teachers are exhausted from their workload; how can we expect them to deliver a full programme properly?* Ms. Suha, school setting educator.

A significant structural factor influencing the ease of introducing sex education was the preparedness of teachers to deliver sensitive information. Although several stakeholders insisted that the single sex school setting in the country[§§§§]could facilitate the delivery of sex education, teachers themselves, described their discomfort when delivering topics related to sexual health even in same sex classrooms.

> *A lot of times teachers feel embarrassed and may superficially deliver part of the information without going into details, and if the student asks, she'll tell her to ask her mother! That's not ok, you should teach her the correct information so she does not go and seek incorrect information somewhere else.* Ms. May, school setting educator

> *Boys have so many questions within this topic but there is no time to address them within the class time.* Mr. Omar, school setting educator.

Lack of training was also a concern voiced by healthcare workers, who identified the unpreparedness of the health sector in meeting the sexual health needs of adolescents. It was believed that if the resources lack, raising awareness was futile.

[§§§§] Schools in Saudi Arabia are segregated by gender, including staff.

There is no sexual medicine training in Family Medicine or OBGYN…Anything a physician does that has to do with sexual medicine are personal discretions. Ms. Norah, healthcare provider.

The lack of Arabic resources was also highlighted as a failure on the parts of the public health and educational systems.

The resources in Arabic are limited. They get their information from social media or people's experience rather than scientific sources. Ms. Sarah, healthcare provider.

Situational Factors

Although most of the legislations related to women's right****** were not yet declared, the country's new announced Vision 2030 was cited in almost all interviews as impacting the political aspects of the country and the social norms. The term 'open' was recurrently mentioned in almost all accounts to describe both the legislative and social changes and viewed as facilitating implementation from the top level and acceptability from the bottom community level.

The government's decision to limit the jurisdictions of the 'religious police' and the relaxation of some of the strict gender segregation rules within public places were cited as examples of political openness. In addition, the announcement of new legislations including the anti-sexual harassment law was provided as proof of active measures taken by the government in addressing some of the sexual health related issues in the country.

****** The ban on women driving was lifted in September 2017 and activated in July 2018, Women were also allowed to enter stadiums and cinemas. As of July 2019 women at the age of 21 are allowed to apply for and renew their passports and are also officially considered legal guardians alongside men over their children.

Furthermore, several teachers and policymakers mentioned the introduction of new educational, school-based programmes focusing on equipping students with decision making skills and promoting values of tolerance, acceptance and warning against radical extremism. Stakeholders mentioned the increase in women's educational attainment and their expanding roles within the workforce as a reflection of the country's move towards 'modernity'. Modernity was usually used to describe the country's expanding economic growth, the technological application of services and most importantly, the political changes in women's autonomy and rights. Most stakeholders seemed supportive of this move and expressed exasperation at some of the past restrictions on women's rights, mobility and presence within the public sphere.

Others, describing themselves as more conservative, were not necessarily supportive of the change but accepted it as essential to the prosperity of the country.

> *We cannot live in a closed-up society, closed societies head towards extinction.* Mr. Abdullah, school setting educator.

The increased openness was also linked to the weakening effects of the ultraconservative religious rhetoric in the country. It was unclear which stakeholders saw as coming first, a change in society which led to a mistrust in the religious institute or a planned governmental tactic towards moderation. Some participants working in policy described the introduction of governmental initiatives to gently prime the public before introducing legislative changes.

> *We've noticed a drastic change since 2005. In fact, there are new legislations in the country and these laws did not come into life until the way of thinking changed...The idea is to change the norms within society.* Ms. Najla, healthcare provider.

Regardless of their personal stance on these liberating legislations, the majority of stakeholders believed that the current move towards modernity and moderation would ensure the support of governmental institutes, including the MoE and the MoH, to

implement sex education programmes. In addition, some stakeholders focused on the effect of increased societal awareness and education on their acceptance of receiving information related to taboo topics like STIs.

> *People used to have reservations when talking about STI, but now, there's more openness and people listen and accept, awareness increased.* Ms. Faten, official at policymaking agency.

Other identified situational factors included changing family dynamics and the rise of individualism.

> *The family has become nuclear, there's social autism. The family itself has turned into individual members.* Ms. Najla, healthcare provider.

According to stakeholders this new reality meant a decrease in parental supervision and involvement, which was viewed as a possible facilitator for parental support for school-based sex education programmes since it alleviates the responsibility off the parents.

Some stakeholders reflected on the perceived rise in divorce rates and unhappy marriages as a sign of poor sexual health knowledge among the public and suggested framing the need for sex education as a preparatory course for healthy marital relationships.

CULTURAL FACTORS

Religion seemed to be the dominant identified theme within cultural factors, however, we struggled in classifying it. On the one hand religion seemed to be a cultural factor that directly affects the predominant discourse on 'sex' within the country and the social sexual attitudes and behaviours. On the other hand, religion is an integral part of the governing system in Saudi Arabia.

Regardless of how stakeholders described religion in terms that might be interpreted as a structural or as a cultural factor, they continuously differentiated 'true Islam', from

what they described as restrictive 'misinterpretations' adopted by the conservative religious scholars and introduced in the early 1980s by the *Sahwa*†††††† movement.

> *So, religion or "religion" is a big influencer on education, I emphasize this with italics or in bold, because a lot of "religion", I think is a misinterpretation that's used to steer education because of certain agendas*. Ms. Hana, healthcare provider

One of the religious scholars emphasized the possibility of revisiting specific religious opinions and reinterpreting them according to new evidence or current circumstances, like introducing restrictions on marriage age for women. The general Islamic stance is that reaching puberty is sufficient for a girl to be fit for marriage. Yet, since scientific evidence has linked negative health outcomes, like maternal mortality and premature births, to early marriage and childbirth, this scholar believed that religious regulations can and should be altered.

> *It is allowed from an Islamic perspective to forbid what is permissible if it results in public benefit.* Religious scholar 1.

> *The new issues that arise need revisiting, and need a joint approach from clinicians, religious scholars and educators to formulate a proper new Islamic rule*. Ms. Amal, school setting educator.

This regulatory strategy within Islamic law was described as a tactic for easing the argument for sex education implementation, especially when supported by moderate religious leaders.

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†††††† The Islamic Awakening movement is an ultraconservative Islamic ideology that developed in the 1960s and 1970s and was influenced by Muslim Brotherhood and Salafi ideologies and influenced the religious discourse in Saudi Arabia throughout the 1990s up until recent years. (Lacroix 2011)

The stance taken by religious figures was not, however, seen as always consistent and public trust in them had reportedly been shaken since many so-called 'celebrity preachers' who had previously insisted on following a restrictive approach in their views had drastically changed their positions.

> *There are so many contradictions in their views, they are not credible, they kept forbidding things through the past era and they kept forbidding and forbidding.* Ms. Norah healthcare provider.

The same equivocation was seen in a tendency among participants themselves to use religious scriptures selectively to defend different points of view, some insisting on the duty of religion to convey information in a non-paternalistic way, others believing that sex education needed to be free of messages that may promote sinful activities. Nevertheless, several participants predicted public resistance to sex education programmes if they were not approved by trusted Islamic scholars and suggested engaging with moderate scholars and urging them to temper some of the restrictive views.

Social resistance was the most commonly identified obstacle across all stakeholders' groups; topics related to 'sex' were described as sensitive, particularly when presented to unmarried youth. Many participants voiced concern about parents fearing these programmes would encourage premarital sexual exploration.

> *How can you present this issue without it being viewed as a call for decadence?* Mr. Ahmed, official at policymaking agency.

Other stakeholders, however, viewed sex education as an essential need that should not be ignored due to its sensitivity.

> *Sex education is taboo and the health information our teenagers have* [about sex] *is a disaster... Our whole society is trying to ignore the elephant in the room [sex].* Ms. Najla, healthcare provider.

When sex education was conceptualised in the context of preventing child sexual abuse, it was viewed as being supported by society. Sexual abuse was somehow excluded from the overarching 'taboo' nature of sex-related topics.

GLOBAL FACTORS

Almost all of our stakeholders saw a strong link between 'globalization' and the newly observed openness in societal norms, political stances and religious tolerance. Openness was described as 'exposure to the world'. The term 'globalization' was used in several accounts to highlight the current state of fast pace exchange of ideas, goods and services with the world. The increased use of the Internet and social media in the country was the main factor identified in allowing exchange of ideas. Yet the convenience with which children and young people were accessing the Internet on their mobile phones was perceived, by many, as a threat due to the availability of un-monitored, unfiltered and inaccurate information regarding sexual health matters. Anxiety was expressed in relation to explicit images distorting expectations and creating sexual arousal among young people. Hence, many stakeholders believed that highlighting the fact that unofficial sources exist can help frame the argument for the need for formal sex education as an eminent matter to policymakers.

> *If we provide them with the right information they won't go and seek it from unreliable sources.* Mr. Salem, official at policymaking agency.

The expanding overseas scholarship programme in Saudi Arabia was viewed as not only exposing an entire cohort of young people to other cultures but also in shaping their identity and ideals.

> *Many people have travelled and studied abroad and have become influenced by other cultures. In the time of globalization and exposure to social media, many young people's views have changed and are*

rebelling against their families… Some girls now say "this is my life".

Ms. Zaina, healthcare provider.

Although the majority of stakeholders seemed to focus on the transfer of ideas from the 'West', other accounts referred to the effect of exposure to the 'regional' globe; i.e. neighbouring cultures. The turmoil within the Arab region was flagged by some as a cautionary tale to emphasize the need to prioritize young people's health issues on any political agenda.

> *Youth have been marginalized. It's only more recently that we're seeing more attention being given to them, and I think a big reason for this is the Arab Spring; that all sort of came about with the actions of young people.* Ms. Hana, healthcare provider.

Many believed the reasons for these revolutions were young people's frustration with increasing unemployment rates which lead to delays in marriage, lack of family stability and unmet sexual health needs.

> *The rise in economic, social, political and health problems are all facilitators to formulate such programmes. If you ask what does politics have to do with this? Maybe the reason for the rise of Arab revolutions was the inability of youth to feed their sexual urges, maybe these are cries for help, for a legitimate right to gain quality of life measures.* Ms. Raghad, official at policymaking agency.

Exchange of ideas with neighbouring countries may also have had an effect on the previously mentioned perceived change in the religious discourse in the country. Effects of globalization; regional and global; were described as not only affecting youth in challenging the status quo but also in influencing parents' attitudes towards personal rights.

> *The culture of vice, the culture of 'do not ask that question' is slowly changing, at least among the educated, some people now encourage*

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their kids to ask questions. This is possibly due to social media outlets,
or revolutions in the Arab world or what's happening globally, but
whether we like it or not the society is changing. Ms. Raghad, official
at policymaking agency.

Globalization was viewed as not only having an impact on the population of young people, but also at a governmental level. In this context, exchange of commerce and adoption of international standards were deemed a step towards modernity and development.

In Vision 2030, they are trying to meet Singapore status, which I see it
as a good change. **Ms. Rana, healthcare provider.**

Stakeholders working within policymaking agencies believed that the country's political position within the world and its treaties' agreement can influence the adoption of sex education programmes. These stakeholders listed examples of other adopted interventions by the MoH and the MoE in collaboration with organizations like the WHO and UNICEF. They believed in the need to learn from other countries' success stories rather than reinventing the wheel.

Divorce rates in Malaysia have declined since men and women cannot
get married until they prove they received a training course and are
qualified for marriage; we should adopt this policy. Religious scholar 1.

Although gaining academic experience in the West alongside the increasing economic and political collaborations with Western countries were favourably viewed, adopting liberal ideals were criticized as being signs of 'Westernization', especially those related to sexual freedoms. Fear of westernization was common among those stakeholders who had more restrictive opinions on including controversial topics like safe sex strategies.

The painful thing is that sex education that is implemented in the world
is almost completely lacking moral guidance because morality and

social norms differ from society to society. Freedom in the West has excessive value. Religious scholar 2.

Those with more lenient stances towards providing more comprehensive programmes seemed to be more accepting of the changing identity among youth. They did however hint at the need to frame the argument for sex education cautiously and insisted on the need to gain support of moderate policy makers.

DISCUSSION

Through examining the views of stakeholders in Saudi Arabia, we have shown the main barriers and facilitators for sex education implementation within the Saudi context. There were strong themes to emerge from our data, yet categorizing them into distinct factors which serve to ease and which hinder sex education implementation proved difficult.

The main barriers identified related to the cultural sensitivities surrounding sex-related topics in Saudi Arabia. Stakeholders were apprehensive of parental reaction, as well as teachers' comfort levels in delivering sex education. Although the term 'resistance' was used to describe the anticipated societal response, stakeholders were quick to point out that the public had a history of expressing discontent with several controversial legislations despite eventually accepting them with minimal opposition. This was mainly attributed to the hierarchical nature of policy-making in the country and the public's trust in governmental legislations, which was the main identified facilitator.

However, these factors came full circle and were described through a different lens in other accounts. For example, although cultural factors were at first sight perceived as barriers, during this context of rapid change stakeholders believed a large proportion of society may welcome sex education. On the other hand, the top-down approach in governance was described as possibly hindering sex education from being prioritized on

the political agenda since it needed to be proposed by those within the higher levels of government rather than being pushed from the community level, especially since participants expressed concern over policymakers possibly dismissing contentious issues, like sex education.

Other barriers, however, were more clearly defined and related mainly to structural factors of the health and education infrastructure. These included weak inter-ministerial communication and collaboration, inadequate training schemes, lack of standardization in education and lack of available sexual health data. The latter also acted as concurrent barrier and facilitator since on the one hand without the required data, an argument for sex education could be difficult to justify, yet limited evidence was described as providing an opportunity to explore the need for sex education.

The majority of the reported structural barriers hindering sex education implementation can also obstruct other public health initiatives as well. The limited literature surrounding health policy-making in Saudi Arabia, identified the weak public health infrastructure and its embryonic stage as failing to address the growing burden of non-communicable diseases in the country (Almalki et al. 2011; Bcheraoui et al. 2015; Bawazir et al. 2019; Al Asmri et al. 2019). The centralized nature of governance was also reported as hindering the provision of public health services, as it limits the autonomy of health facilities within different regional directorates (Bawazir et al. 2019; Al Asmri et al. 2019).

Other barriers were positioned more proximally to sex education, mostly due to opposition to introducing such a taboo topic and the sensitivities surrounding discussing these matters in school settings. Literature from other high-income countries, assessing feasibility of sex education in school settings from the perspective of students, parents and teachers have reported similar obstacles to the ones identified by our stakeholders, mainly relating to the lack of teacher training and educational standardizations. (Pound et al. 2016; Buston et al. 2002; Wight et al. 2002). Observers in other Islamic contexts

do, however, report similar cultural barriers, especially related to the sensitivity of sex-related topics and the worry of belittling Islamic beliefs when delivering sex education information. (Javadnoori et al. 2012; Latifnejad Roudsari et al. 2013; Zaabi et al. 2019; Farrag and Hayter 2014). In line with the suggestions of our stakeholders, strategies in framing sex education as a premarital preparatory course have been adopted in several Arab and Muslim-majority countries (Wahba and Roudi-Fahimi 2012). Further, this may be an entry point strategy to introduce sex education incrementally or indirectly. The use of ambiguity and indirectness has been reported as possible strategy to introduce sensitive topics within sex education programmes in Saudi Arabia (Horanieh, MacDowall, and Wellings 2019).

To our knowledge, this is the first study to look into the feasibility of implementing sex education in Saudi Arabia. One of the strengths of our study is the diversity in the professional backgrounds of stakeholders. Research within the MENA region, shies away from gaining the perspectives policymakers and focuses on assessing the viewpoints of parents, students and teachers (Javadnoori et al. 2012; Latifnejad Roudsari et al. 2013; Zaabi et al. 2019; Farrag and Hayter 2014). Our participants can be viewed as representing those working within the higher levels of government, in addition to those working 'on the ground', such as teachers and healthcare workers hence facilitating and hindering factors were assessed from the theoretical and practical perspectives.

The background of the PI, being a young, Saudi, female physician proved to be simultaneously be strength and limitation. Being a 'local' facilitated the recruitment process and understanding the native dialect and cultural norms. However, having a clinical background may have influenced some of the stakeholders' answers. In addition, the PI informed participants that the study was part of her PhD thesis in a UK based university and this may have made some wary of her agenda.

The timing and setting of the interviews were of importance. This was a sensitive period between the announcements of the new Vision 2030 that provided general goals, yet

specific plans were not known to the public nor to professionals working closely with different ministries. Hence, although as noted above, participants described a sense of imminent changes occurring, no one had anticipated the speed nor the extent of the new legislations. All interviews took place exclusively in Riyadh, the capital city and where the main governmental bodies are based, which facilitated recruiting those working with policy-making agencies. Yet accounts of teachers and healthcare workers based in a large capital city like Riyadh may not represent the experiences of those in rural areas. In addition, most of our participants were described as being 'open minded' by key informants, and their agreement to discuss such a topic may have meant that we captured the opinions of those more likely to be supportive of sex education. An additional limitation stemmed from the need to translate Arabic quotes containing local colloquial descriptions into English. Some of these expressions could not easily translate to English and may have lost some of their meaning.

Limitations were also related to the chosen analysis framework. We chose to exclusively report on the context-related factors within the Walt and Gilson framework since the majority of the identified obstacles and facilitators were related to *context*. We address many of the *content*-related data in companion paper that looks at how sex education programmes should look like in Saudi Arabia. Although the Walt and Gilson Framework proved useful as an organizing tool, we faced difficulties in clearly categorizing many of the factors into their designating groupings. Many health policy framework are Eurocentric and focus on high-income democratic countries. Frameworks that apply to other settings usually focus on low and middle-income countries. The juxtaposition of Saudi Arabia being a high-income country and an Islamic monarchy makes finding an appropriate health policy framework that can readily fit Saudi's context difficult.

Our findings in framing sex education as a preventative measure against child sex abuse and marital instability may be of interest to policymakers in easing the passage of school-based sex education programmes in Saudi Arabia. Further, the feasibility of reinterpreting religious principles in formulating new guidelines may be usefully

considered in promoting cultural tolerance towards discussing sensitive sexual health matter. The fast-pace of implementation of unanticipated legislations like the ones related to women's rights were reflected in our participants' observations of the country's move towards modernity. The present time of rapid change can be viewed as providing an opportunity to raise the issue of school-based sex education in Saudi Arabia. The country has announced its investment in young people's education, from revamping school curricula to encouraging young people to specialise in fields of education that were previously viewed as futile like arts, media and cyber security (REF). Some of the current factors related to the educational infrastructure may provide prospects for implementation, such as the single sex setting, the authority of the MoH over school health and the introduction of extracurricular programmes. However, the lack of teacher training could hinder delivery. As our stakeholders highlighted, recruiting health educators may ease the delivery of this type of information and has been reported to be favoured by students in other settings (Pound et al. 2016). The reported lack of data highlight the need for further studies in order to explore the views of adolescents not only on the ideal content and delivery mode of any proposed sex education programme but also to further assess the barriers for feasibility and acceptability of such programmes from students' perspective.

CONCLUSION

Our study has shown a general support for the need for sex education for adolescents in Saudi Arabia as expressed by stakeholders. Barriers and facilitators were identified in relation to the context of the country specifically the cultural sensitivity of discussing sex-related topics with non-married young people. Yet the current fast-pace of contextual changes related to governmental and social openness were viewed as providing a window of opportunity for facilitating implementation and delivery with minimal opposition. Emphasis was placed on the need to frame sex education as a

promoter of healthy marital relationships and a preventative measure against child sexual abuse for the topic to be prioritized on the political agenda. This framing strategy may provide an entry point for further sex education implementation. The top-down governance approach was believed to ensure implementing sex education programmes in school-setting. These findings can be of use for decision making agencies in Saudi Arabia interested in adopting sex education strategies as well as in countries and communities with similar settings.

FUNDING

REFERENCES

Al Asmri, Mushabab, Mohammed J. Almalki, Gerry Fitzgerald, and Michele Clark. 2019. "The Public Healthcare System and Primary Care Services in Saudi Arabia: A System in Transition." *Eastern Mediterranean Health Journal*. https://doi.org/10.26719/emhj.19.049.

Almalki, M., G. Fitzgerald, and M. Clark. 2011. *Health Care System in Saudi Arabia: An Overview*.

Alquaiz, Aljoharah M., Maha A. Almuneef, and Hafsa R. Minhas. 2012. "Knowledge, Attitudes, and Resources of Sex Education among Female Adolescents in Public and Private Schools in Central Saudi Arabia." *Saudi Medical Journal* 33 (9): 1001–9.

Alswaidi, Fahad M., and Sarah S. J. O'Brien. 2009. "Is There a Need to Include HIV, HBV and HCV Viruses in the Saudi Premarital Screening Programme on the Basis of Their Prevalence and Transmission Risk Factors?" *Journal of Epidemiology & Community Health*, January, jech.2009.093302. https://doi.org/10.1136/jech.2009.093302.

Bawazir, Amen, Khaled Al-Surimi, Salem Suwaidan, Ali AlShehri, Ali AlFarhan, and Mostafa Abolfotouh. 2019. "Capacity and Readiness of Primary Health Care Centers for Implementation of the Basic Strategy for Prevention and Control of Non-Communicable Diseases in Saudi Arabia. A Case Study from the Ministry of National Guard-Health Affairs, Riyadh, Saudi Arabia." *Saudi Medical Journal* 40 (6): 614–18. https://doi.org/10.15537/smj.2019.6.24164.

Buse, Kent, Nicholas Mays, and Gill Walt. 2012. *Making Health Policy*. 2 edition. Maidenhead: Open University Press.

Buston, Katie, Daniel Wight, Graham Hart, and Sue Scott. 2002. "Implementation of a Teacher-Delivered Sex Education Programme: Obstacles and Facilitating Factors." *Health Education Research* 17 (1): 59–72. https://doi.org/10.1093/her/17.1.59.

Chin, Helen B., Theresa Ann Sipe, Randy Elder, Shawna L. Mercer, Sajal K. Chattopadhyay, Verughese Jacob, Holly R. Wethington, et al. 2012. "The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services." *American Journal of Preventive Medicine* 42 (3): 272–94. https://doi.org/10.1016/j.amepre.2011.11.006.

Council of Ministers of Saudi Arabia. 1992. "Basic Law of Governance." https://laws.boe.gov.sa/BoeLaws/Laws/Viewer/1013378e-27a4-4ca6-a3a8-cd416f569437?lawId=1e087b6f-ad20-4e03-ad03-a9a700f161b6.

El-Tholoth, HossamS, FahadD Alqahtani, AbdullahA Aljabri, KhalidH Alfaryan, Fares Alharbi, AlbaraaA Alhowaimil, Ali Alkharji, Abdulrahman Alrwaily, Ali Obied, and Tala Al-Afraa. 2018. "Knowledge and Attitude about Sexually Transmitted Diseases among Youth in Saudi Arabia." *Urology Annals* 10 (April): 198. https://doi.org/10.4103/UA.UA_14_17.

Farrag, Shewikar, and Mark Hayter. 2014. "A Qualitative Study of Egyptian School Nurses' Attitudes and Experiences Toward Sex and Relationship Education." *The Journal of School Nursing* 30 (1): 49–56. https://doi.org/10.1177/1059840513506941.

Horanieh, Nour, Wendy MacDowall, and Kaye Wellings. 2019. "Abstinence versus Harm Reduction Approaches to Sexual Health Education: Views of Key Stakeholders in Saudi Arabia." *Sex Education*, September. https://researchonline.lshtm.ac.uk/id/eprint/4654367/.

Javadnoori, Mojgan, Robab Latifnejad Roudsari, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2012. "Female Adolescents' Experiences and Perceptions Regarding Sexual Health Education in Iranian Schools: A Qualitative Content Analysis." *Iranian Journal of Nursing and Midwifery Research* 17 (7): 539.

Kågesten, Anna, Jenita Parekh, Özge Tunçalp, Shani Turke, and Robert William Blum. 2014. "Comprehensive Adolescent Health Programs That Include Sexual and Reproductive Health Services: A Systematic Review." Review-article. Http://Dx.Doi.Org/10.2105/AJPH.2014.302246. November 12, 2014. http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302246.

Kingdon, John. 2010. *Agendas, Alternatives and Public Policies.* Updated 2nd edition. Harlow: Longman Classics.

Latifnejad Roudsari, Robab, Mojgan Javadnoori, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2013. "Socio-Cultural

Challenges to Sexual Health Education for Female Adolescents in Iran." *Iranian Journal of Reproductive Medicine* 11 (2): 101–10.

Macdowall, Wendy, Kyle G. Jones, Clare Tanton, Soazig Clifton, Andrew J. Copas, Catherine H. Mercer, Melissa J. Palmer, et al. 2015. "Associations between Source of Information about Sex and Sexual Health Outcomes in Britain: Findings from the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." *BMJ Open* 5 (3): e007837. https://doi.org/10.1136/bmjopen-2015-007837.

Paul, Katie. 2017. "Saudi Arabia to Introduce Physical Education for Schoolgirls." *Reuters*, July 11, 2017. https://uk.reuters.com/article/uk-saudi-education-women-idUKKBN19W1DT.

Pound, Pandora, Rebecca Langford, and Rona Campbell. 2016. "What Do Young People Think about Their School-Based Sex and Relationship Education? A Qualitative Synthesis of Young People's Views and Experiences." *BMJ Open* 6 (9): e011329. https://doi.org/10.1136/bmjopen-2016-011329.

Raheel, Hafsa, Muhammad Afzal Mahmood, and Abdulaziz BinSaeed. 2013. "Sexual Practices of Young Educated Men: Implications for Further Research and Health Education in Kingdom of Saudi Arabia (KSA)." *Journal of Public Health (Oxford, England)* 35 (1): 21–26. https://doi.org/10.1093/pubmed/fds055.

Saudi Arabia, Ministry of Education. 2019. *Islamic Jurisprudence-Level 1-General Preparation-Secondary Level*. Riyadh-1427H: Ministry of Education, Saudi Arabia.

Saudi Arabia, Ministry of Education. 2019. *Science-Second Grade-Intermediate Education-First Semester*. Riyadh-1437H.

UNFPA. 2018. *International Technical Guidance on Sexuality Education*. 138. UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO. /publications/international-technical-guidance-sexuality-education.

Wahba, Mamdouh, and Farzaneh Roudi-Fahimi. 2012. "The Need for Reproductive Health Education in Schools in Egypt," 8.

Walt, G., and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9 (4): 353–70. https://doi.org/10.1093/heapol/9.4.353.

WHO. 2018. "Adolescents: Health Risks and Solutions." World Health Organization. 2018. http://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions.

Wight, Daniel, Gillian M. Raab, Marion Henderson, Charles Abraham, Katie Buston, Graham Hart, and Sue Scott. 2002. "Limits of Teacher Delivered Sex Education: Interim Behavioural Outcomes from Randomised Trial." *BMJ* 324 (7351): 1430. https://doi.org/10.1136/bmj.324.7351.1430.

Zaabi, Omar Al, Margaret Heffernan, Eleanor Holroyd, and Mervyn Jackson. 2019. "Islamic Parents' Attitudes and Beliefs towards School-Based Sexual and Reproductive Health Education Programmes in Oman." *Sex Education* 19 (5): 534–50. https://doi.org/10.1080/14681811.2018.1553708.

CHAPTER SEVEN- DISCUSSION

CHAPTER OVERVIEW

This research aimed to explore stakeholders' views on the need for sex education for adolescents in Saudi Arabia and identify the anticipated barriers and facilitators for implementing school-based sex education programmes in the country.

In this section, I summarise the main findings of this thesis, discuss the policy implications of these findings and describe the strengths and limitations of the research.

7.1. SUMMARY OF MAIN FINDINGS

Stakeholders unanimously agreed on the need for some form of sex education for adolescents in Saudi Arabia. The basis for this support emerged as relating to demographic changes including an expanding youth population and the postponement of marriage; 'globalization' and the interaction with other cultures and ideologies through the use of the Internet, trends reported in the literature focused on the sexual health needs of young people in other countries in the MENA region, discussed in **Chapter Two**. Stakeholders also identified context-specific changes within the political and social spheres that are shaping Saudi youth's identity. These changes were described as a noticed 'openness' manifest in, for example, a weakening of the authority of religious police and expansion of the rights of women. Openness was also observed in changing societal attitudes and behaviours and in increased tolerance towards discussion of formerly taboo topics freely as well as increased interaction between genders in public spaces.

Despite acknowledging the need for sex education, concern was raised for the need to restrict topics covered, taking into consideration religious and social norms in the design and implementation of such programmes.

Many believed that sex education should not be formulated as a reactive solution to a problem, but rather as a preventative strategy aimed at reducing rates of divorce and marital disharmony.

In terms of appropriate agencies to design and deliver sex education programmes, the perception was that sponsoring of programmes by governmental agencies was necessary for implementation and acceptability. The involvement of religious scholars and imams was considered valuable in terms of presenting the curricula. Nevertheless, tension was apparent between the presentation of sex education through a scientific or a moral lens. The tension between approaches informed by religion and science pervaded the accounts of stakeholders. Almost all stakeholders believed in the positive role of religion and the importance of promoting Islamic values in any programmes even though religious belief was perceived as weakening among young people. Extreme ideologies that promote non-tolerance, judgement and ostracizing those who have committed 'mistakes' were heavily criticized by almost all stakeholders which was evident of the recurrent theme of promoting 'real Islam' and avoiding 'misinterpretations'.

Teachers were viewed as the ideal agents to deliver sex education, yet their lack of training in teaching sensitive topics was seen as a barrier to be overcome before they were seen as equipped to do so. Delegating the responsibility to visiting health educators or school counsellors were suggested tactics to limit awkwardness that may be felt by the students as well as the teachers.

Although the scope of this research focused on the adolescent age group as the target population for sex education, stakeholders believed that sex education should extend beyond this age limit. Participants differentiated between needs of boys and girls in ways which perpetuated many of the widely accepted traditional gender roles in conservative communities. Stakeholders' accounts further highlighted the gender differences in sexual expectations and social tolerance towards engaging in premarital sex. 'High risk'

groups, for example, military school students and male scholarship students about to study abroad, were identified as 'high risk groups' because of a concern that they may be exposed to other cultures that do not censure premarital sex or who socially condone it and hence may be at risk of failing to adhere to Islamic regulations of abstaining from sex until marriage.

Topics on which there was consensus that they should be included in any sex education programme in Saudi Arabia included human developmental stages, puberty, hygiene and information on protection against sexual abuse and violence. The expressed wisdom of providing information incrementally was consistent with international guidelines of the need for sex education information to be age appropriate and delivered in a scaffolding manner.

All stakeholders believed in the necessity to uphold Islamic values and teach students the Islamic regulations of marriage and adultery. Issues relating to the framing of sex education was more contentious. Many believed that too much emphasis was placed on fear tactics and negative representations of sex. Contention was magnified when inquiring about the inclusion of harm-reduction approaches. Stakeholders were visibly uncomfortable, recurrently changing their positions on the subject. Categories of abstinence and harm reduction were not seen as binary, but instead fell along a continuum. Positions taken varied according to topic, audience and timing. Hence, answers often seemed ambiguous, and at times participants seemed uncertain of where they stood on the issue. Ambiguity was not limited to the answering of this question but appeared to be a strategy to package sensitive information. The use of indirectness as a delivery method ran somewhat counter to international guidance of the need for clear and direct messages within sex education programmes.

Harm itself was conceptualized differently from conventional public health discourse. It was not restricted to physical harm in the form, for example, of STIs but damage to one's faith and honour and to the family's reputation. 'Safety' in relation to 'safe sex' was

construed additionally in terms of social and moral protection. Ensuring adolescents understand the social, legal and religious repercussions of engaging in 'illicit' sexual activity, like premarital sex, was viewed as constituting harm limitation approaches.

In terms of facilitative approaches to framing sex education, presenting the subject as premarital preparation was seen as a plausible strategy for the introduction of more contentious topics like sexual satisfaction, contraception and STIs. This was described as either a first step before introducing more comprehensive sex education programmes or as a strategy to implicitly relay otherwise controversial messages.

Barriers and facilitators were sometimes difficult to categorize into distinct groups. In many cases factors were seen as simultaneously hindering and facilitating sex education implementation. Cultural factors for examples, including social norms were seen to hinder acceptability of sensitive topics. Yet, since the country was going through fast pace social changes, society was assumed to be less resistant to such programmes. Structural factors like the top-down governance nature in the country were also viewed as hindering and easing sex education implementation since it ensures implementation with minimal public opposition but also makes it very unlikely that policies could be promoted at the community level. Another example within the structural factors acting concurrently as an obstacle and facilitator was the lack of data on sexual health needs of adolescents. On the one hand, participants believed that without the required data no argument could be made for the need of such programmes; on the other hand, lack of data provided an opportunity for research.

Other structural factors however were more distinctly viewed as barriers. These were mostly related to the weak education and public health infrastructure evident in the weak training schemes, in addition to the limited inter-ministerial collaboration and communication.

7.2. POLICY IMPLICATIONS

7.2.1. SEX EDUCATION PROGRAMME IMPLEMENTATION

The MENA region has continuously undergone multiple political, economic and social changes. The turmoil witnessed over recent years which was evident within the Arab Spring has had an extensive impact on the physical and mental health of young people in the region. Displacement and exposure to war and violence has also impacted their educational and employment opportunities (AlBuhairan 2015; DeJong et al. 2017; Selwaness and Roushdy 2019). Although Saudi Arabia has been in a relatively stable state politically, it has been going through large expedited changes on both the political and social fronts. The MoE announced its intention to redesign the national education curricula during the summer of 2019 to support the values and goals proposed within the 'Vision 2030' plan. News outlets reported on the changes that were evident in the History curricula which now include topics on ancient civilizations that inhabited the Arabia peninsula and their influence on the art and architecture of the region. In addition, lessons on the role Saudi Arabia played within Islamic history and its battles against the Ottoman invasion have been introduced.

The Minister of Education had also announced the ministry's plans to remove the 'deep-seated influence of the Muslim Brotherhood' from all curricula and 'fight off extreme ideology' (Alsharq AlAwsat Newspaper 2018). As mentioned in **Chapter Four**, many of the texts in the Islamic Jurisprudence books that were criticized by stakeholders, have been removed. The omitted texts were mostly related to the 'othering' language focusing on promoting the West's moral inferiority. It is not clear how these decisions came into play but it does illustrate a move to promote a more tolerant view towards other cultures. However, the statement 'bringing shame upon one's self, family and tribe' has been added as a negative outcome of adultery and homosexuality, thus potentially perpetuating some of the cultural norms surrounding honour and its relation to sex.

Against this backcloth of change and reform, my findings are likely to be of interest to the Saudi MoE and specifically the departments dealing with curricula formulation. The science textbooks for the intermediate and secondary levels have not undergone any changes, yet many of the stakeholders expressed concern over some of the information presented and language used. These reservations may be heeded by the MoE, the Ministry of Health (MoH) and other governmental agencies, and observed by academic institutions and educational organizations interested in introducing sex education within schools in Saudi Arabia.

My findings will hopefully be of use in other MENA countries, specifically the Gulf Council Countries (GCC), which have similar political systems as well as cultural norms. Further, results can be of assistance to international organizations in the formulation of general guidelines for sex education programmes. Understanding how different societies define public health terms can help anticipate why some programmes would not be adopted or how they could be altered. The findings can be of great use in Muslim-majority countries but equally importantly to organizations working directly with Muslim communities around the world, struggling to adapt a culturally sensitive sex education programme. There is abundant literature on barriers to delivering sex education to Muslim communities living in Western societies with reported tension between acknowledging the need to deliver essential sex education information and fearing opposition (Wong 2012; Al-Dien 2010; Smerecnik et al. 2010; Tabatabaie 2015). In the UK, state funded schools are required to teach some elements of sex education or sex and relationship education (SRE) which are presented in national science curricula. However, parents can withdraw their children from additional lessons included within the Personal, Social, Health and Economic Education (PSHE), which include topics related to safe sex and gay rights (Tabatabaie 2015; PSHE Association 2017). Findings from this research may help schools to develop strategies to deliver sensitive information that may be more appropriate and acceptable to specific faith groups as well as religious leaders in the community.

7.2.2. INFRASTRUCTURAL READINESS FOR SEX EDUCATION

The emphasis on the lack of data and the weak public health infrastructure in Saudi Arabia should prompt encouragement and support for more research and training within this field. Furthermore, the limited training schemes for both education staff and medical professionals in sexual health should be addressed.

The new Vision 2030 emphasizes the need to invest in youth and highlights the need for a healthy society. Talks of privatizing health care may jeopardize the current universal free healthcare for HIV and STIs treatment. Hence, focusing on improving the public health services through strengthening its infrastructure as well as its transparency in conducting research and sharing data related to sexual health is vital for any sex education to be based on evidence. The collaborative work between the MoH and the MoE is also of utmost value for any programme to be formulated and implemented in school settings. The frustration expressed by stakeholders with the way public health initiatives are measured and how quickly educational programmes dissolve prompts the need for any sex education programme to be accompanied by up to date national studies measuring current sexual health knowledge, attitudes and practices of adolescents to tailor the programme specifically to their needs. Programmes should also be evaluated and results should be disseminated and shared to identify gaps.

Another important implication is the current insistence on linking negative health outcomes to 'illicit' sexual relationships within school books. This may provide a false sense of protection as mentioned by a number of stakeholders. Having multiple sexual partners is a risk factor for STI acquisition but, since both polygamy and divorce are permissible in Islam, Muslims may have multiple simultaneous or serial 'legitimate' sexual partners while still being at risk of contracting and spreading STIs. Hence, raising this issue in any future sex education programme may be of importance to ensure

awareness of risk and prevention within Saudi society. Awareness of the importance of STI screening, not only prior to marriage, may be warranted.

The announcement of offering tourist visas to Saudi Arabia will allow an influx of tourists from all different religious and cultural backgrounds, which may magnify the effects of 'globalization' as identified by stakeholders. It may also impact stigma towards those living with HIV. Migrant workers applying for work visa are expected to produce an HIV test proving their negative status and would be deported in case they become positive. This has not been imposed on tourist visa applicants and hence people living with HIV would be able to visit the country without fear of deportation. Hence, promoting tolerance and limiting stigma may be warranted.

7.3. STRENGTHS AND LIMITATIONS

One of the main strengths of this study was the use of qualitative methodology. Most of the literature from Saudi Arabia related to sex education is quantitative in nature and qualitative studies are not regularly encouraged. This may be due to the prevalent views that quantitative studies are superior to qualitative since the latter's findings are believed to not be generalizable. It may also be due to ethical constrictions. In **Chapter Three** (methodology) I spoke about some of the issues I faced while choosing a theoretical framework. The choice made, the Walt and Gilson Framework, proved in some respects difficult to use. 'Fitting' my data seemed forced at times and hence I chose to use the framework only as a guide to help organize my data. I highlighted in **Chapter Six** how many factors did not fit neatly into the Walt and Gilson categories. Health policy analysis frameworks are often formulated with Western, high income, democratic countries in mind and may neglect the effect of culture and religion on governance and policymaking. There is a body of research that looks at how these frameworks may be of use in low- and middle-income countries where external funding plays a key role in policymaking, which does not apply to the Saudi context. The juxtaposition of Saudi

Arabia being a high income country and an Islamic monarchy presents challenges in terms of finding an appropriate health policy framework that can readily fit the Saudi context.

In addition, little is known on how health policies are formulated in Saudi Arabia and the role of evidence in policy agenda setting and in policy implementation. Many guidelines in Saudi Arabia are adopted from either international guidelines or North American ones, since many of the physicians are trained there and they usually adopt what they are familiar with. Highlighting the lack of more inclusive frameworks should prompt research within the Arab Gulf context to understand the policy-making process and to develop or build on existing policy frameworks.

The setting of the study was restricted to Riyadh, the capital of Saudi Arabia where the main headquarters of governmental agencies are located. This greatly facilitated meeting stakeholders within the different ministries. Riyadh is also home to some of the largest tertiary healthcare centres and the main universities. Although the setting facilitated recruiting and interviewing policy stakeholders, for the other stakeholder groups; healthcare providers, school staff and educators and religious scholars, it does mean that the sample was restricted and could be skewed towards the opinions to those working in larger cities with larger allocations of resources. In addition, most of the interviewed physicians had undergone some clinical training in North America or Australia.

The sample presented both strengths and limitations to the study. On the one hand, stakeholder groups included the voices of those usually not represented in health policy literature, like religious scholars. It also allowed me to capture views of those in policy implementing agencies and those on the ground delivering the policies, like healthcare providers and teachers. Yet, those who were recruited were usually enthusiastic about joining the study. At times I felt that mentioning the name of the key informant who provided me with the participants' information made stakeholders feel pressured to

join. Key informants as well as participates usually emphasized that they were only recommending those with 'open minds' who would agree to take part in such a study. Furthermore, most of the participants began their interview with asserting how important this topic is and applauded me for conducting this study. This may mean I only captured the views of those more supportive of sex education. I had approached participants who refused to take part of the study but they mainly apologized for having busy schedules rather than informing me that they do not discuss such matters. The voice of adolescents and young people was missing from the data to their exclusion form the sample. This was a conscious decision due to the anticipated obstacles in gaining ethical approval and to the time constraints of a PhD. I also decided to assess the views of those involved in design and delivery of sex education as a first step prior to gaining the views of young people.

 A further limitation related to the difficulty of putting into words key concepts relevant to the study in such a way that I could be sure that I and stakeholders were sharing the same meaning. In the papers, I make reference to the ambiguity apparent in the accounts of many stakeholders. Indirectness may not be exclusive to Arabic speakers. Evading answering questions on culturally sensitive topics has been universally observed as a tactic to avoid negative consequences, especially if questions are perceived to pose threat to the interviewee (Brown and Levinson 1987). This is usually to 'save face' and has been discussed in 'politeness theory' (Brown and Levinson 1978), where indirectness is utilized when avoiding discussing 'taboo' topics. Hence, answers may have reflected what participants perceived as socially acceptable or what agrees with the vision of their professional institutions.

English and Arabic were used simultaneously in many interviews, although the majority of stakeholders spoke almost exclusively in Arabic. English 'technical' terminology or literal translations of Arabic terms was a feature of some of the conversations. The use of English words and expressions can highlight the global influence on the local professional setting and the lack of equivalent Arabic terms which do not cause

discomfort. Being fluent in both Arabic and English and being comfortable using these two languages interchangeably meant that I felt at ease during the interviewing process. I had not anticipated difficulties as I had assumed that analysing the data in English without translating the transcripts would be an easy task. However, since both of my supervisors/co-authors were English speaking, explaining some of the Arabic terms and colloquial phrases highlighted the difficulty in attempting to relay the data to an English speaking academic audience. Many of the Arabic words were loaded with cultural meanings that could not be conveyed with literal translations. *Ayb* for example, is a word that literally translates to 'vice' and 'shame'. Yet, it can also be used to describe a deformity or defect. The word is usually used to refer to something that can be culturally unconventional or something shameful or simply impolite. ثقافة العيب or culture of vice as I chose to translate it, usually described the negative prevalent culture of doing something or avoiding something out of worry of offending society or being controversial, more than going against God's commands. Hence not everything that is *ayb* is *haram*. This was one of the arguments used by stakeholders when attempting to explain how sex education may be perceived as taboo culturally but is not, according to their view, forbidden to discuss and spread. Relaying this information to a non-Arab audience and explaining how loaded many of the terms are with cultural and religious hidden meanings continues to be a difficult task and was a limitation to this thesis.

As mentioned earlier, the timing of the fieldwork was also important. To claim that Saudi Arabia has undergone 'fast-pace' changes may be an understatement. The extensive legislative changes that have occurred over the past two years can be described as seismic and have taken not only the international community by surprise but the local community as well. Globalization and openness to the world is now likely to expand due to Saudi Arabia's new tourism visa expansion whereby as many as 49 countries will be allowed to apply for a tourist visa upon arrival. Many of the strict social rules may not be applicable to foreign visitors including allowing non-married men and women to share a

hotel room. This may have further implications on the local youth's sexual attitudes and behaviours.

Other limitations related to my positionality were discussed within the reflection section in **Chapter Three** (methodology).

7.4. FUTURE RESEARCH

Due to the absence of the voices of adolescents within this study, assessing the views of this group would be of great value before any future sex education programme can be implemented. Gaining the perspective of adolescents and young people is of utmost importance to understand the current beliefs, attitudes and practices in addition to their opinions on the need for sex education and what their preferred delivery mode is for such programmes. Assessing the views of parents would provide an additional perspective on the topics required in any future sex education programme in Saudi Arabia. Further, since many of the stakeholders expressed worry about parental opposition to sex education, it would be necessary to properly assess where parents stand on this issue.

Further, research aimed at understanding the policy-making process in Saudi Arabia, especially health policies would be beneficial to provide further evidence on facilitators for implementation of any sex education programme in the country. Although the findings highlighted many of the anticipated barriers and facilitators, the elaboration of these factors is, in the absence as yet of a national sex education curriculum, hypothetical. Should such a curriculum be implemented, research will be needed on how they are addressed.

As mentioned in **Chapter Three** (methodology) the discourse on sex is changing within the Arab region and in Saudi Arabia. I would like to assess the effect of language and terminology choice on the local discourse of sex and how this would affect the formulation of sexual health policies and its translation into practice.

Furthermore, many of the topics within the school textbooks continue to focus on promoting traditional gender roles and rights and may seem to be in contradiction of some of the newly implemented laws. Assessing the effect of this dichotomy on youth's cultural and Islamic identity would be of interest.

7.5. CONCLUSION

This thesis has explored the need for sex education for adolescents in Saudi Arabia through the perspective of stakeholders in the country. The majority of participants agreed on the need for some form of sex education for young people. Although a school-based programme was favoured to ensure an easier access to the target population, specific topics deemed too sensitive were suggested to be delivered in alternative settings as community-based programmes as well as pre-martial courses. The thesis also explored the views of stakeholders on how a school-based programme should look like as well identified potential barriers and facilitators to implementing such programmes. The current dynamic, changing political and social context of Saudi Arabia, seems to provide a favourable setting for the initiation of discussing the need for sex education in the country publicly and push for it to reach the policy agenda.

The findings of this thesis assert the need for public health initiatives, especially sex education, to be context specific, which cannot be achieved by providing general guidelines for such programmes to merely be 'culturally appropriate'. Throughout this thesis I highlight how ill-fitting some of the international sex education guidelines can be in local context, especially when limiting the measure of outcomes on SITs and unplanned teenage pregnancies. Further, heath policy analysis frameworks tend to be Euro-centric and not easily applicable in other settings. Hence, more studies on health policy-making in Saudi Arabia are warranted.

International guidelines focus on the need for sex education programmes be culturally appropriate and highlight the importance of clear, direct messages that present sex education as a basic human right. However, in many communities, indirectness can be viewed as sign of respect, especially when topics are considered taboo, hence indirect massaging strategies can be utilized to package otherwise sensitive sexual health information in any programme. However, as highlighted, the rapid pace of change in Saudi Arabia alongside the effects of Western influences on young people may allow for more direct messages. Hence, the voices of adolescents and parents should be captured as a next step to gain a better view of the actual needs and desires of adolescents as well as their current sexual health knowledge levels and practices. This can help formulate a tailored programme based on evidence and can increase parental support for such programmes. In addition, other topics like intimate partner violence, domestic violence and violence against women, should also be assessed.

Although this thesis highlights the uniqueness of the Saudi context, findings can be of use in similar countries in the region, specifically the Arab Gulf States. Many of the structural factors like those related to infrastructure and training may be relevant in diverse settings. Furthermore, many of the findings may be applicable in other Muslim communities around the world, especially pertaining to the contextualization of the terms 'harm' and 'safe sex' that were explained through an Islamic lens.

REFERENCES

'The Health Practitioners Law,' Kingdom of Saudi Arabia. Released by Royal Decree No. m/59 of December 6, 2005, Accessed May 27, 2019." 2005.

Abdel-Fattah, Moataz, Tamer Hifnawy, Tarek I. El Said, Maha M. Moharam, and Mahmoud A. Mahmoud. 2007. "DETERMINANTS OF BIRTH SPACING AMONG SAUDI WOMEN." Journal of Family & Community Medicine 14 (3): 103.

Abdullah, Rasha A. 2007. The Internet in the Arab World- Egypt and Beyond. Peter Lang Publishing, Inc., New York, 29 Broadway, 18th floor, New York, NY 10006.

Abo-Elfetoh, Nagah M., and Mohamed M. Abd El-Mawgod. 2015. "Violence against Wives: A Silent Suffering in Northern Saudi Community." The Journal of the Egyptian Public Health Association 90 (3): 87–93. https://doi.org/10.1097/01.EPX.0000467223.22719.36.

Abolfotouh, Mostafa A., Abdullah A. Alabdrabalnabi, Rehab B. Albacker, Umar A. Al-Jughaiman, and Samar N. Hassan. 2013. "Knowledge, Attitude, and Practices of Infertility among Saudi Couples." International Journal of General Medicine 6: 563–73. https://doi.org/10.2147/IJGM.S46884.

Abu-Lughod, Lila. 1998. Remaking Women: Feminism and Modernity in the Middle East. Princeton University Press. http://www.jstor.org/stable/j.ctt7sck7.3.

Adamczyk, Amy, and Brittany E. Hayes. 2012. "Religion and Sexual Behaviors Understanding the Influence of Islamic Cultures and Religious Affiliation for Explaining Sex Outside of Marriage." American Sociological Review 77 (5): 723–46. https://doi.org/10.1177/0003122412458672.

Adimora, Adaora A., Moses V. Goldmon, Tamera Coyne-Beasley, Catalina B. Ramirez, Gilbert A. Thompson, Danny Ellis, Joe L. Stevenson, Jerry M. Williams, Daniel L. Howard, and Paul A. Godley. 2017. "Black Pastors' Views on Preaching about Sex: Barriers, Facilitators, and Opportunities for HIV Prevention Messaging." Ethnicity & Health, July, 1–15. https://doi.org/10.1080/13557858.2017.1346180.

Ahmad, NoorAni, S. Maria Awaluddin, Hasimah Ismail, Rahama Samad, and NikRubiah NikAbdRashid. 2014. "Sexual Activity among Malaysian School-Going AdoAdolescents: What Are the Risk and Protective Factors?" Asia-Pacific Journal of Public Health 26 (5 Suppl): 44S-52S. https://doi.org/10.1177/1010539514544700.

Ahmed, Sameera; Abu-Ras. 2014. "Prevalence of Risk Behaviors among U.S. Muslim College Students." Journal of Muslim Mental Health 8 (1). http://dx.doi.org/10.3998/jmmh.10381607.0008.101.

Al Asmri, Mushabab, Mohammed J. Almalki, Gerry Fitzgerald, and Michele Clark. 2019. "The Public Healthcare System and Primary Care Services in Saudi Arabia: A System in Transition." Eastern Mediterranean Health Journal. https://doi.org/10.26719/emhj.19.049.

Albalawi, Abdulsalam (2019). Individual freedom, openness, unemployment and housing crisis… Reasons for marriage abandonment. Special committee to study preventative measures for spinsterhood and divorce in Saudi Arabia. لحرية الفردية لجنة خاصة لدراسة مكافحة العنوسة والانفتاح والبطالة وأزمة السكن.. أسباب للعزوف عن الزواج والطلاق , *Alriyadh* 9 July, 2019.

Al-Eissa, Majid A., Hassan N. Saleheen, Nesreen S. Al-Wallan, Monera Y. AlKashan, Norah J. AlSubaie, and Maha A. Almuneef. 2018. "Prevalence of Sexual Abuse Among Secondary School Students in Saudi Arabia." Violence and Victims 33 (5): 855–70. https://doi.org/10.1891/0886-6708.VV-D-17-00018.

Al‐Eissa, M. A., H. N. Saleheen, S. AlMadani, F. S. AlBuhairan, A. Weber, J. D. Fluke, M. Almuneef, and K. L. Casillas. 2016. "Determining Prevalence of Maltreatment among Children in the Kingdom of Saudi Arabia." Child: Care, Health and Development 42 (4): 565–71. https://doi.org/10.1111/cch.12325.

Al Eissa, Majid, and Maha Almuneef. 2010. "Child Abuse and Neglect in Saudi Arabia: Journey of Recognition to Implementation of National Prevention Strategies." Child Abuse & Neglect 34 (1): 28–33. https://doi.org/10.1016/j.chiabu.2009.08.011.

Al Lily, Abdulrahman E. A. 2011. "On Line and under Veil: Technology-Facilitated Communication and Saudi Female Experience within Academia." Technology in Society 33 (1): 119–27. https://doi.org/10.1016/j.techsoc.2011.03.005.

Al-Badawi, Ismail A., Abdulrahman Al-Suwaine, Murad Al-Aker, Lina Asaad, Alwaleed Alaidan, Asma Tulbah, Marie Fe Bohol, and Adnan R. Munkarah. 2011. "Detection and Genotyping of Human Papilloma Virus in Cervical Cancer Specimens from Saudi Patients." International Journal of Gynecological Cancer: Official Journal of the International Gynecological Cancer Society 21 (5): 907–10. https://doi.org/10.1097/IGC.0b013e318214219f.

AlBuhairan, F, R Areemit, A Harrison, and M Kaufman. 2012. "Adolescent Psychosocial Development and Evaluation: Global Perspectives." In Özdemir Ö, Ed. Complementary Pediatrics. BoD – Books on Demand.

AlBuhairan, Fadia S. 2015. "Adolescent and Young Adult Health in the Arab Region: Where We Are and What We Must Do." Journal of Adolescent Health 57 (3): 249–51. https://doi.org/10.1016/j.jadohealth.2015.06.010.

AlBuhairan, Fadia S., Hani Tamim, Mohammad Al Dubayee, Shahla AlDhukair, Sulieman Al Shehri, Waleed Tamimi, Charbel El Bcheraoui, Mohi Eldin Magzoub, Nanne de Vries, and Ibrahim Al Alwan. 2015. "Time for an Adolescent Health Surveillance System in Saudi Arabia: Findings From 'Jeeluna.'" The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 57 (3): 263–69. https://doi.org/10.1016/j.jadohealth.2015.06.009.

Albuhairan, Fadia, and Tina Olsson. 2014. "Advancing Adolescent Health and Health Services in Saudi Arabia: Exploring Health-Care Providers' Training, Interest, and Perceptions of the Health-Care Needs of Young People." Advances in Medical Education and Practice. September 4, 2014. https://www.dovepress.com/advancing-adolescent-health-and-health-services-in-saudi-arabia-explor-peer-reviewed-fulltext-article-AMEP.

Al-Darwish, Abdulaziz Ahmed, Abdullah Fouad Al-Naim, Khalid Saleh Al-Mulhim, Nasser Khaled Al-Otaibi, Mohammed Saad Morsi, and Ansari Mukhtar Aleem. 2014. "Knowledge about Cervical Cancer Early Warning Signs and Symptoms, Risk Factors and Vaccination among Students at a Medical School in Al-Ahsa, Kingdom of Saudi Arabia." Asian Pacific Journal of Cancer Prevention: APJCP 15 (6): 2529–32.

Alderman, Elizabeth M., Jessica Rieder, and Michael I. Cohen. 2003. "The History of Adolescent Medicine." Pediatric Research 54 (1): 137–47. https://doi.org/10.1203/01.PDR.0000069697.17980.7C.

Al-Dien, Muhammad M. Zain. 2010. "Perceptions of Sex Education among Muslim Adolescents in Canada." Journal of Muslim Minority Affairs 30 (3): 391–407. https://doi.org/10.1080/13602004.2010.515823.

Aldosari, Hala. 2017. The Effect of Gender Norms on Women's Health in Saudi Arabia. Arab Gulf States Institute in Washington.

Aldosari, Hala. 2017. The Effect of Gender Norms on Women's Health in Saudi Arabia. Arab Gulf States Institute in Washington.

The General Authority for Statistics (GaStat), Saudi Arabia. 2016. "Chapter 03 | Education and Training." Text. General Authority for Statistics. May 30, 2016. https://www.stats.gov.sa/en/413-0.

The General Authority for Statistics (GaStat), Saudi Arabia. 2017. "Gender Statistics." Text. General Authority for Statistics. 2017. https://www.stats.gov.sa/en/1039.

The General Authority for Statistics (GaStat), Saudi Arabia. 2017. "Gender Statistics." Text. General Authority for Statistics. 2017. https://www.stats.gov.sa/en/1039.

Alhayat Newpaper. 2016. "Mansour and Fatimah's Lineage Incompatability to Aloyayna Judge. «تكافؤ النسب» من منصور وفاطمة إلى «قاضي العيينة» - جريدة الحياة" October 10, 2016. http://www.alhayat.com/article/780057/%D8%AF%D9%88%D9%84%D9%8A%D8%A7%D8%AA/-%D8%AA%D9%83%D8%A7%D9%81%D8%A4-%D8%A7%D9%84%D9%86%D8%B3%D8%A8-%D9%85%D9%86-%D9%85%D9%86%D8%B5%D9%88%D8%B1-%D9%88%D9%81%D8%A7%D8%B7%D9%85%D8%A9-%D8%A5%D9%84%D9%89-%D9%82%D8%A7%D8%B6%D9%8A-%D8%A7%D9%84%D8%B9%D9%8A%D9%8A%D9%86%D8%A9-.

Alhumeidan, M. 2016. "A clarification about the rates of spinsterhood in Saudi Arabia." Text. General Authority for Statistics. November 2, 2016. https://www.stats.gov.sa/en/news/127.

Alhusain, F, F Alkaabba, N Alhasan, S Alotaibi, S Breakeit, E Musaudi, and A Alhasan. 2018. "Patterns and Knowledge of Contraceptive Methods Use among Women Living in Jeddah, Saudi Arabia." Saudi Journal for Health Sciences 7 (2): 121–26.

Ali, H. K., and A. Naidoo. 1999. "Sex Education Sources and Attitudes about Premarital Sex of Seventh Day Adventist Youth." Psychological Reports 84 (1): 312. https://doi.org/10.2466/pr0.1999.84.1.312.

Ali, Kecia. 2015. Sexual Ethics and Islam: Feminist Reflections on Qur'an, Hadith and Jurisprudence. Oneworld Publications.

Al-Iryani, Buthaina, Yahia A. Raja'a, Gerjo Kok, and Bart Van Den Borne. 2009. "HIV Knowledge and Stigmatization among Adolescents in Yemeni Schools." International Quarterly of Community Health Education 30 (4): 311–20. https://doi.org/10.2190/IQ.30.4.c.

ALMalki, Basim. 2014. "Knowledge and Awareness of Sexually Transmitted Disease among Male University Students in Taif, Saudi Arabia." International Journal of Medical Science and Public Health 4 (2): 1. https://doi.org/10.5455/ijmsph.2014.070120141.

Almalki, M., G. Fitzgerald, and M. Clark. 2011. Health Care System in Saudi Arabia: An Overview.

Almaslami, Faisal, Syed Mohammed Aljunid, and Khalid Ghailan. 2018. "Demographic Determinants and Outcome of in Vitro Fertilization (IVF) Services in Saudi Arabia." *Journal of Intenational Medical Research* 46 (4): 1537–44. https://doi.org/10.1177/0300060517749329.

Al-Mass, Afnan A., Batol S. Al-Shahrani, Areej N. Al-Mweisheer, Sana A. Tulbah, Sahar Syed, Razique Anwer, and Shafiul Haque. 2018. "User Experience, Knowledge and Practice of Oral Contraceptive: A Study from Riyadh, Saudi Arabia | Abstract." 2018. https://www.amhsr.org/abstract/user-experience-knowledge-and-practice-of-oral-contraceptive-a-study-from-riyadh-saudi-arabia-4999.html.

Almazrou, Sarah, Basema Saddik, and Hoda Jradi. 2019. "Knowledge, Attitudes, and Practices of Saudi Physicians Regarding Cervical Cancer and the Human Papilloma Virus Vaccine." *Journal of Infection and Public Health*, September. https://doi.org/10.1016/j.jiph.2019.09.002.

Al-Mozaini, Maha A., Michael K. Mansour, Abdullah A. Al-Hokail, Magid A. Mohmed, Munirah A. Bin Daham, Hail M. Al-Abdely, Husn H. Frayha, et al. 2014. "HIV-Care Outcome in Saudi Arabia; a Longitudinal Cohort." Journal of AIDS & Clinical Research 5 (11). https://doi.org/10.4172/2155-6113.1000370.

Almuneef, Maha. 2019. "Long Term Consequences of Child Sexual Abuse in Saudi Arabia: A Report from National Study." Child Abuse & Neglect, March. https://doi.org/10.1016/j.chiabu.2019.03.003.

AlQuaiz, AlJohara M., Ambreen Kazi, and Maha Al Muneef. 2013. "Determinants of Sexual Health Knowledge in Adolescent Girls in Schools of Riyadh-Saudi Arabia: A Cross Sectional Study." BMC Women's Health 13: 19. https://doi.org/10.1186/1472-6874-13-19.

Alquaiz, Aljoharah M, Maha A Almuneef, and Hafsa R Minhas. 2012. "Knowledge, Attitudes, and Resources of Sex Education among Female Adolescents in Public

and Private Schools in Central Saudi Arabia." Saudi Medical Journal 33 (9): 1001–9.

Al-Quaiz, Al-Joharah M., and Hafsa M. Raheel. 2009. "Correlates of Sexual Violence among Adolescent Females in Riyadh, Saudi Arabia." Saudi Medical Journal 30 (6): 829–34.

Alriyadh Newspaper. 2019. "Special committee to study preventative measures for spinsterhood and divorce in Saudi Arabia. لجنة خاصة لدراسة مكافحة العنوسة والطلاق," July 9, 2019. http://www.alriyadh.com/1764982.

Alsehaimi, Aref. 2016. "A Systematic Review of Literature on Child Sexual Abuse in Saudi Arabia." Journal of Childhood & Developmental Disorders 2 (2). https://doi.org/10.4172/2472-1786.100022.

Al-Serouri, A. W., M. Anaam, B. Al-Iryani, A. Al Deram, and S. Ramaroson. 2010. "AIDS Awareness and Attitudes among Yemeni Young People Living in High-Risk Areas." Eastern Mediterranean Health Journal = La Revue De Sante De La Mediterranee Orientale = Al-Majallah Al-Sihhiyah Li-Sharq Al-Mutawassit 16 (3): 242–50.

Alsharq AlAwsat Newspaper. 2019. "New Saudi Controls to Decrease Child Marriages ضوابط سعودية للحد من زواج القاصرات." January 10, 2019. https://aawsat.com/home/article/1539201/%D8%B6%D9%88%D8%A7%D8%A8%D8%B7-%D8%B3%D8%B9%D9%88%D8%AF%D9%8A%D8%A9-%D9%84%D9%84%D8%AD%D8%AF-%D9%85%D9%86-%D8%B2%D9%88%D8%A7%D8%AC-%D8%A7%D9%84%D9%82%D8%A7%D8%B5%D8%B1%D8%A7%D8%AA.

--- --- ---. 2018. "Saudi Curricula is freed from the Muslim مناهج السعودية تتحرر من قبضة الإخوانٍ Brotherhood's grip." April 23, 2018. https://aawsat.com/home/article/1245911/%D9%85%D9%86%D8%A7%D9%87%D8%AC-%D8%A7%D9%84%D8%B3%D8%B9%D9%88%D8%AF%D9%8A%D8%A9-%D8%AA%D8%AA%D8%AD%D8%B1%D8%B1-%D9%85%D9%86-%D9%82%D8%A8%D8%B6%D8%A9-%D8%A7%D9%84%D8%A5%D8%AE%D9%88%D8%A7%D9%86%C2%BB.

Al-Shaikh, Ghadeer K., Eman M. Almussaed, Amel A. Fayed, Farida H. Khan, Sadiqa B. Syed, Tahani N. Al-Tamimi, and Hala N. Elmorshedy. 2014. "Knowledge of Saudi

Female University Students Regarding Cervical Cancer and Acceptance of the Human Papilloma Virus Vaccine." Saudi Medical Journal 35 (10): 1223–30.

Alsibiani, Sharifa A. 2014. "Use of Misoprostol for Self-Induced Medical Abortions among Saudi Women: A Call for Attention." Gynecologic and Obstetric Investigation 78 (2): 88–93. https://doi.org/10.1159/000363238.

Alsubaie, Ali. 2019. "Exploring Sexual Behaviour and Associated Factors among Adolescents in Saudi Arabia: A Call to End Ignorance." Journal of Epidemiology and Global Health 9 (March): 76–80. https://doi.org/10.2991/jegh.k.181210.001.

Alswaidi, F. M., and S. J. O'Brien. 2010. "Is There a Need to Include HIV, HBV and HCV Viruses in the Saudi Premarital Screening Program on the Basis of Their Prevalence and Transmission Risk Factors?" Journal of Epidemiology and Community Health 64 (11): 989–97. https://doi.org/10.1136/jech.2009.093302.

Alswaidi, Fahad M., and Sarah S. J. O'Brien. 2009. "Is There a Need to Include HIV, HBV and HCV Viruses in the Saudi Premarital Screening Programme on the Basis of Their Prevalence and Transmission Risk Factors?" Journal of Epidemiology & Community Health, January, jech.2009.093302. https://doi.org/10.1136/jech.2009.093302.

Alzahrani, Ahlam. 2011. "Women's Sexual Health in Saudi Arabia: A Focused Ethnographic Study." Phd, University of Sheffield. http://etheses.whiterose.ac.uk/1436/.

Alzahrani, Turki A., Bahaa A. Abaalkhail, and Iman K. Ramadan. 2016. "Prevalence of Intimate Partner Violence and Its Associated Risk Factors among Saudi Female Patients Attending the Primary Healthcare Centers in Western Saudi Arabia." Saudi Medical Journal 37 (1): 96–99. https://doi.org/10.15537/smj.2016.1.13135.

Ameri, Zahra, Fahimeh Mirzakhani, Amir Reza Nabipour, Narges Khanjani, and Mark J. M. Sullman. 2016. "The Relationship Between Religion and Risky Behaviors Among Iranian University Students." Journal of Religion and Health, December. https://doi.org/10.1007/s10943-016-0337-1.

Arnett, J. J. 2000. "Emerging Adulthood. A Theory of Development from the Late Teens through the Twenties." The American Psychologist 55 (5): 469–80.

Askool, Sanaa Saleh. 2013. "The Use of Social Media in Arab Countries: A Case of Saudi Arabia." In Web Information Systems and Technologies, edited by José Cordeiro

and Karl-Heinz Krempels, 201–19. Lecture Notes in Business Information Processing. Springer Berlin Heidelberg.

Awaluddin, Maria, Noor Ani Ahmad, Noridah Mohd Saleh, Aris Tahir, Noraida Mohd Kasim, Noor Axlin Mohammad Sapri, and Nik Rubiah Nik Abdul Rashid. 2015. "Prevalence of Sexual Activity in Older Malaysian Adolescents and Associated Factors | Journal of Public Health Aspects." Journal of Public Health Aspects. http://dx.doi.org/10.7243/2055-7205-2-1.

Awaluddin, S Maria, Noor Ani Ahmad, Noridah Mohd. Saleh, Tahir Aris, Noraida Mohd Kasim, Noor Azlin Muhammad Sapri, and Nik Rubiah Nik Abdul Rashid. 2015. "Prevalence of Sexual Activity in Older Malaysian Adolescents and Associated Factors." Journal of Public Health Aspects 2 (1). https://doi.org/10.7243/2055-7205-2-1.

Badahdah, A. M., and C. E. Foote. 2010. "Role of Shame in the Stigmatization of People with Human Immunodeficiency Virus: A Survey of Female College Students in 3 Arab Countries." Eastern Mediterranean Health Journal = La Revue De Santé De La Méditerranée Orientale = Al-Majallah Al-Ṣiḥḥīyah Li-Sharq Al-Mutawassiṭ 16 (9): 982–87.

Badahdah, A. M., and N. Sayem. 2010. "HIV-Related Knowledge and AIDS Stigma among College Students in Yemen." Eastern Mediterranean Health Journal = La Revue De Santé De La Méditerranée Orientale = Al-Majallah Al-Ṣiḥḥīyah Li-Sharq Al-Mutawassiṭ 16 (8): 901–6.

Badahdah, Abdallah M. 2010. "Stigmatization of Persons with HIV/AIDS in Saudi Arabia." Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society 21 (4): 386–92. https://doi.org/10.1177/1043659609360873.

Badran, W., N. Moamen, I. Fahmy, A. El-Karaksy, T. M. Abdel-Nasser, and H. Ghanem. 2006. "Etiological Factors of Unconsummated Marriage." International Journal of Impotence Research 18 (5): 458–63. https://doi.org/10.1038/sj.ijir.3901452.

Balbeesi, Amal, and Saad Mohizea. 2017. "Knowledge and Misconceptions of Saudi Women about Sexually Transmitted Infections." Journal of Egyptian Public Health Association 92 (December): 235–39. https://doi.org/10.21608/EPX.2018.22045.

Barakat, Richard, Maurie Mrkman, and Marcus Randall. 2009. "Principles and Practice of Gynecology Oncology." In Principles and Practice of Gynecologic Oncology, Fifth Edition, 623–81. Lippincott Williams &Wilkins.

Barbour, B, and P Salameh. 2009. "Knowledge and Practice of University Students in Lebanon Regarding Contraception. - PubMed - NCBI." East Mediterr Health J 15 (2): 387–99.

Barnawi, Fatima Hamza. 2015. "Prevalence and Risk Factors of Domestic Violence Against Women Attending a Primary Care Center in Riyadh, Saudi Arabia." Journal of Interpersonal Violence, May. https://doi.org/10.1177/0886260515587669.

Batrawy, Aya. 2015. "Saudi Spinsters: A New Generation of Women Are Breaking with Tradition and Making Their Own Choices on Education, Careers - and Even Marriage | The Independent." January 21, 2015. https://www.independent.co.uk/news/world/middle-east/saudi-spinsters-a-new-generation-of-women-are-breaking-with-tradition-and-making-their-own-choices-9993481.html.

Bawazir, Amen, Khaled Al-Surimi, Salem Suwaidan, Ali AlShehri, Ali AlFarhan, and Mostafa Abolfotouh. 2019. "Capacity and Readiness of Primary Health Care Centers for Implementation of the Basic Strategy for Prevention and Control of Non-Communicable Diseases in Saudi Arabia. A Case Study from the Ministry of National Guard-Health Affairs, Riyadh, Saudi Arabia." Saudi Medical Journal 40 (6): 614–18. https://doi.org/10.15537/smj.2019.6.24164.

Bcheraoui, Charbel El, Marwa Tuffaha, Farah Daoud, Hannah Kravitz, Mohammad A. AlMazroa, Mohammad Al Saeedi, Ziad A. Memish, Mohammed Basulaiman, Abdullah A. Al Rabeeah, and Ali H. Mokdad. 2015. "Access and Barriers to Healthcare in the Kingdom of Saudi Arabia, 2013: Findings from a National Multistage Survey." BMJ Open 5 (6): e007801. https://doi.org/10.1136/bmjopen-2015-007801.

Bello, Abdulmajeed Hassan. 2011. "The Punishment for Adultery in Islamic Law and Its Application in Nigeria." *Journal of Islamic Law and Culture* 13 (2–3): 166–82. https://doi.org/10.1080/1528817X.2012.733132.

Benagiano, G., S. Carrara, and V. Filippi. 2010. "Social and Ethical Determinants of Human Sexuality: 1. The Need to Reproduce." Minerva Ginecologica 62 (4): 349–59.

Bennett, Sylvana E., and Nassim P. Assefi. 2005. "School-Based Teenage Pregnancy Prevention Programs: A Systematic Review of Randomized Controlled Trials." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 36 (1): 72–81. https://doi.org/10.1016/j.jadohealth.2003.11.097.

Bersamin, Melina M., Deborah A. Fisher, Samantha Walker, Douglas L. Hill, and Joel W. Grube. 2007. "Defining Virginity and Abstinence: Adolescents' Interpretations of Sexual Behaviors." Journal of Adolescent Health 41 (2): 182–88. https://doi.org/10.1016/j.jadohealth.2007.03.011.

Bourdieu, P., and L. Wacquant. 1992. An Invitation to Reflexive Sociology. London: Polity Press.

Brown, Penelope, and Stephen C. Levinson. 1978. Politeness: Some Universals in Language Usage. Vol. 8. Cambridge: Cambridge University Press. Pages 311-323.

Buse, Kent, Nicholas Mays, and Gill Walt. 2012. Making Health Policy. 2 edition. Maidenhead: Open University Press.

Buston, Katie, Daniel Wight, Graham Hart, and Sue Scott. 2002. "Implementation of a Teacher-Delivered Sex Education Programme: Obstacles and Facilitating Factors." Health Education Research 17 (1): 59–72. https://doi.org/10.1093/her/17.1.59.

Caskey, Rachel, Stacy Tessler Lindau, and G Caleb Alexander. 2009. "Knowledge and Early Adoption of the HPV Vaccine among Girls and Young Women: Results of a National Survey." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 45 (5): 453–62. https://doi.org/10.1016/j.jadohealth.2009.04.021.

Choices, N. H. S. 2015. "Cervical Screening - NHS Choices." April 6, 2015. http://www.nhs.uk/Conditions/Cervical-screening-test/Pages/Introduction.aspx?url=Pages/what-is-it.aspx.

Chin, Helen B., Theresa Ann Sipe, Randy Elder, Shawna L. Mercer, Sajal K. Chattopadhyay, Verughese Jacob, Holly R. Wethington, et al. 2012. "The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services." American Journal of Preventive Medicine 42 (3): 272–94. https://doi.org/10.1016/j.amepre.2011.11.006.

Chulov, Martin. 2018. "'I Feel Free like a Bird': Saudi Women Celebrate as Driving Ban Lifted | World News | The Guardian." The Guardian, June 24, 2018. https://www.theguardian.com/world/2018/jun/24/saudi-arabia-women-celebrate-as-driving-ban-lifted.

Cok, Figen, and Lizbeth Ann Gray. 2007. "Development of a Sex Education Programme for 12-year-old to 14-year-old Turkish Adolescents." *Sex Education* 7 (2): 127–41. https://doi.org/10.1080/14681810701264466.

Council of Ministers of Saudi Arabia. 1992. "Basic Law of Governance." https://laws.boe.gov.sa/BoeLaws/Laws/Viewer/1013378e-27a4-4ca6-a3a8-cd416f569437?lawId=1e087b6f-ad20-4e03-ad03-a9a700f161b6.

Council of Ministers, Saudi Arabia. 2013. "Law of Protection from Abuse- Royal Decree No. M/52."

Dalacoura, Katerina. 2014. "Homosexuality as Cultural Battleground in the Middle East: Culture and Postcolonial International Theory." *Third World Quarterly* 35 (7): 1290–1306. https://doi.org/10.1080/01436597.2014.926119.

Dartnall, Elizabeth, and Rachel Jewkes. 2013. "Sexual Violence against Women: The Scope of the Problem." Best Practice & Research. Clinical Obstetrics & Gynaecology 27 (1): 3–13. https://doi.org/10.1016/j.bpobgyn.2012.08.002.

Dbais, Fatima. 2018. "Implemnting the anti-harassment Law as of today in Saudi Arabia." Okaz, June 8, 2018. http://www.okaz.com.sa/article/1647655?ts=1558977740.

DeJong, Jocelyn, Farah Sbeity, Jennifer Schlecht, Manale Harfouche, Rouham Yamout, Fouad M. Fouad, Seema Manohar, and Courtland Robinson. 2017. "Young Lives Disrupted: Gender and Well-Being among Adolescent Syrian Refugees in Lebanon." Conflict and Health 11 (1): 23. https://doi.org/10.1186/s13031-017-0128-7.

DeJong, Jocelyn, and Francesca Battistin. 2015. "Women and HIV: The Urgent Need for More Research and Policy Attention in the Middle East and North Africa Region." Journal of the International AIDS Society 18 (1): 20084.

Dejong, Jocelyn, Bonnie Shepard, Farzanah Roudi-Fahimi, and Lori Ashford. 2007. "Young People's Sexual and Reproductive Health in the Middle East and North Africa." Population Reference Bureau PRB. http://www.prb.org/Publications/Reports/2007/MENAYouthReproductiveHealth.aspx.

DeJong, Jocelyn, Rana Jawad, Iman Mortagy, and Bonnie Shepard. 2005. "The Sexual and Reproductive Health of Young People in the Arab Countries and Iran." Reproductive Health Matters 13 (25): 49–59.

Denzin, Norman, and Yvonna Lincoln. 2005. The SAGE Handbook of Qualitative Research. SAGE.

Dialmy, Abdessamad. 2010. "Sexuality and Islam." The European Journal of Contraception & Reproductive Health Care: The Official Journal of the European Society of Contraception 15 (3): 160–68. https://doi.org/10.3109/13625181003793339.

Eisner, Manuel, and Lana Ghuneim. 2013. "Honor Killing Attitudes Amongst Adolescents in Amman, Jordan." *Aggressive Behavior* 39 (5): 405–17. https://doi.org/10.1002/ab.21485.

El Bcheraoui, Charbel, Marwa Tuffaha, Farah Daoud, Mohammad A. AlMazroa, Ziad A. Memish, Mohammad Al Saeedi, Mohammed Basulaiman, Abdullah A. Al Rabeeah, and Ali H. Mokdad. 2013. "Low Uptake of Periodic Health Examinations in the Kingdom of Saudi Arabia, 2013." 2013. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4535092/.

Eldoseri, Halah M., and Phyllis Sharps. 2017. "Risk Factors for Spousal Physical Violence Against Women in Saudi Arabia." Journal of Interpersonal Violence, March, 0886260517696861. https://doi.org/10.1177/0886260517696861.

El Gelany, Saad, and Ola Moussa. 2013. "Reproductive Health Awareness among Educated Young Women in Egypt." International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics 120 (1): 23–26. https://doi.org/10.1016/j.ijgo.2012.07.027.

El Hamri, Najat. 2010. "Approaches to Family Planning in Muslim Communities." The Journal of Family Planning and Reproductive Health Care 36 (1): 27–31. https://doi.org/10.1783/147118910790291019.

El-Kak, Faysal. 2013. "Sexuality and Sexual Health: Constructs and Expressions in the Extended Middle East and North Africa." Vaccine 31 Suppl 6 (December): G45-50. https://doi.org/10.1016/j.vaccine.2012.10.120.

El-Meliegy, Amr, Danny Rabah, Kutaiba Al-Mitwalli, Taymour Mostafa, Tarek Hussein, Mohamed Istarabadi, Yao Lei, and Sirel Gurbuz. 2013. "A 6-Month, Prospective, Observational Study of PDE5 Inhibitor Treatment Persistence and Adherence in Middle Eastern and North African Men with Erectile Dysfunction." Current Medical Research and Opinion 29 (6): 707–17. https://doi.org/10.1185/03007995.2013.791263.

El-Rouayheb, Khaled. 2005. Before Homosexuality in the Arab-Islamic World, 1500-1800. Chicago: University of Chicago Press. https://www.press.uchicago.edu/ucp/books/book/chicago/B/bo3613572.html.

El-Tholoth, HossamS, FahadD Alqahtani, AbdullahA Aljabri, KhalidH Alfaryan, Fares Alharbi, AlbaraaA Alhowaimil, Ali Alkharji, Abdulrahman Alrwaily, Ali Obied, and Tala Al-Afraa. 2018. "Knowledge and Attitude about Sexually Transmitted Diseases among Youth in Saudi Arabia." Urology Annals 10 (April): 198. https://doi.org/10.4103/UA.UA_14_17.

England, Kim V. L. 1994. "Getting Personal: Reflexivity, Positionality, and Feminist Research*." The Professional Geographer 46 (1): 80–89. https://doi.org/10.1111/j.0033-0124.1994.00080.x.

Fageeh, Wafa M K. 2013. "Sexually Transmitted Infections among Patients with Herpes Simplex Virus at King Abdulaziz University Hospital." BMC Research Notes 6 (July): 301. https://doi.org/10.1186/1756-0500-6-301.

Fageeh, Wafa M. K. 2014. "Sexual Behavior and Knowledge of Human Immunodeficiency Virus/Aids and Sexually Transmitted Infections among Women Inmates of Briman Prison, Jeddah, Saudi Arabia." BMC Infectious Diseases 14: 290. https://doi.org/10.1186/1471-2334-14-290.

Farih, Manal, Della Freeth, Khalid Khan, and Catherine Meads. 2015. "Sexual and Reproductive Health Knowledge and Information-Seeking Behavior among Middle Eastern Female University Students: A Systematic Review." International Journal of Sexual Health, April. http://www.tandfonline.com/doi/abs/10.1080/19317611.2015.1023961.

Farrag, Shewikar, and Mark Hayter. 2014. "A Qualitative Study of Egyptian School Nurses' Attitudes and Experiences Toward Sex and Relationship Education." The Journal of School Nursing 30 (1): 49–56. https://doi.org/10.1177/1059840513506941.

Fergusson, David M., Geraldine F. H. McLeod, and L. John Horwood. 2013. "Childhood Sexual Abuse and Adult Developmental Outcomes: Findings from a 30-Year Longitudinal Study in New Zealand." Child Abuse & Neglect 37 (9): 664–74. https://doi.org/10.1016/j.chiabu.2013.03.013.

Filemban, Sanaa M., Yasser A. Yasein, Magdy H. H. Abdalla, Raafat Al-Hakeem, Jaffar A. Al-Tawfiq, and Ziad A Memish. 2015. "Prevalence and Behavioral Risk Factors for STIs/HIV among Attendees of the Ministry of Health Hospitals in Saudi Arabia."

The Journal of Infection in Developing Countries 9 (04). https://doi.org/10.3855/jidc.5964.

Fonner, Virginia A., Kevin S. Armstrong, Caitlin E. Kennedy, Kevin R. O'Reilly, and Michael D. Sweat. 2014. "School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis." PLOS ONE 9 (3): e89692. https://doi.org/10.1371/journal.pone.0089692.

Foucault, Michel. 1978. The Repressive Hypothesis. A History of Sexuality: 1. Penguin Books 1998, Page 309.

Freud, Sigmund. 1949. Three Essays on the Theory of Sexuality. Three Essays on the Theory of Sexuality. Oxford, England: Imago Publ. Co.

Gakidou, E. n.d. "Increased Educational Attainment and Its Effect on Child Mortality in 175 Countries between 1970 and 2009: A Systematic Analysis. - PubMed - NCBI." Accessed May 14,2016. http://www-ncbi-nlm-nih-gov.ezproxy.bu.edu/pubmed/?term=increased+educational+attainemnt+and+its+effect+on+child+mortality+in+175+countries.

Gale, Nicola K., Gemma Heath, Elaine Cameron, Sabina Rashid, and Sabi Redwood. 2013. "Using the Framework Method for the Analysis of Qualitative Data in Multi-Disciplinary Health Research." BMC Medical Research Methodology 13 (1): 1. https://doi.org/10.1186/1471-2288-13-117.

Ghandour, L.A., Mouhanna, F., Yasmine, R. and El Kak, F. Factors associated with alcohol and/or drug use at sexual debut among sexually active university students: cross-sectional findings from Lebanon. *BMC Public Health* **14,** 671 (2014). https://doi.org/10.1186/1471-2458-14-671

George Dalmida, Safiya, Natasha Aduloju-Ajijola, Dora Clayton-Jones, Tami L. Thomas, Ricardo J. Erazo Toscano, Rashunda Lewis, Terri Fleming, Shirley Taylor, and Macie Lunyong. 2018. "Sexual Risk Behaviors of African American Adolescent Females: The Role of Cognitive and Religious Factors." Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society 29 (1): 74–83. https://doi.org/10.1177/1043659616678660.

Glasby, Jon. 2011. Evidence, Policy and Practice: Critical Perspectives in Health and Social Care. Policy Press.

Glaser, B, and A Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago, IL: Aldine Publishing Company.

Gökengin, Deniz, Fardad Doroudi, Johnny Tohme, Ben Collins, and Navid Madani. 2016. "HIV/AIDS: Trends in the Middle East and North Africa Region." International Journal of Infectious Diseases 44 (March): 66–73. https://doi.org/10.1016/j.ijid.2015.11.008.

Graham-Harrison, Emma, and agencies. 2019. "Saudi Arabia Allows Women to Travel without Male Guardian's Approval." *The Guardian*, August 2, 2019, sec. World news. https://www.theguardian.com/world/2019/aug/01/saudi-women-can-now-travel-without-a-male-guardian-reports-say.

Green, Judith, and Nicki Thorogood. 2013. Qualitative Methods for Health Research (Introducing Qualitative Methods Series) (p. IV). SAGE Publications. Kindle Edition. SAGE Publications.

Haberland, Nicole, and Deborah Rogow. 2015. "Sexuality Education: Emerging Trends in Evidence and Practice." *Journal of Adolescent Health*, International Conference on Population and Development, 56 (1, Supplement): S15–21. https://doi.org/10.1016/j.jadohealth.2014.08.013.

Hamel, Ronald Philip. 2002. The Roman Catholic Tradition: Religious Beliefs and Healthcare Decisions. Park Ridge Center for the study of health, faith, and ethics.

Hardin, Amy Peykoff, Jesse M. Hackell, and Committee on Practice and Ambulatory Medicine. 2017. "Age Limit of Pediatrics." Pediatrics 140 (3): e20172151. https://doi.org/10.1542/peds.2017-2151.

Hessini, Leila. 2007. "Abortion and Islam: Policies and Practice in the Middle East and North Africa." Reproductive Health Matters 15 (29): 75–84. https://doi.org/10.1016/S0968-8080(06)29279-6.

Holder, David W, Robert H DuRant, Treniece L Harris, Jessica Henderson Daniel, Dawn Obeidallah, and Elizabeth Goodman. 2000. "The Association between Adolescent Spirituality and Voluntary Sexual Activity." Journal of Adolescent Health 26 (4): 295–302. https://doi.org/10.1016/S1054-139X(99)00092-0.

Holloway, Immy, and Les Todres. 2003. "The Status of Method: Flexibility, Consistency and Coherence." Qualitative Research 3(3) 345-357. https://doi.org/DOI: 10.1177/1468794103033004.

Horanieh, Nour, Wendy MacDowall, and Kaye Wellings. 2019. "Abstinence versus Harm Reduction Approaches to Sexual Health Education: Views of Key Stakeholders in

Saudi Arabia.” Sex Education, September. https://researchonline.lshtm.ac.uk/id/eprint/4654367/.

Hughes, Jan N. 2012. “Teacher-Student Relationships and School Adjustment: Progress and Remaining Challenges.” Attachment & Human Development 14 (3): 319. https://doi.org/10.1080/14616734.2012.672288.

Islamweb. 2011. “Financial Rights of Women.” Islamweb. November 29, 2011. https://www.islamweb.net:443/en/article/168457/financial-rights-of-women.

Javadnoori, Mojgan, Robab Latifnejad Roudsari, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2012. “Female Adolescents’ Experiences and Perceptions Regarding Sexual Health Education in Iranian Schools: A Qualitative Content Analysis.” Iranian Journal of Nursing and Midwifery Research 17 (7): 539.

Jennison, M. Harr, Allan B. Coleman, Richard B. Feiertag, Robert B. Kugel, William B. Forsyth, Andrew Rinker, Sprague W. Hazard, Effie O. Ellis, and Sarah H. Knutti. 1972. “Age Limits of Pediatrics.” Pediatrics 49 (3): 463–463.

Joseph, Natalie Pierre, Jack A Clark, Howard Bauchner, Jared P Walsh, Glory Mercilus, Jean Figaro, Caroline Bibbo, and Rebecca B Perkins. 2012. “Knowledge, Attitudes, and Beliefs Regarding HPV Vaccination: Ethnic and Cultural Differences between African-American and Haitian Immigrant Women.” Women’s Health Issues: Official Publication of the Jacobs Institute of Women’s Health 22 (6): e571-579. https://doi.org/10.1016/j.whi.2012.09.003.

Jradi, Hoda, and Amen Bawazir. 2019. “Knowledge, Attitudes, and Practices among Saudi Women Regarding Cervical Cancer, Human Papillomavirus (HPV) and Corresponding Vaccine.” Vaccine 37 (3): 530–37. https://doi.org/10.1016/j.vaccine.2018.11.065.

Jradi, Hoda, and Amen Bawazir. 2019. “Knowledge, Attitudes, and Practices among Saudi Women Regarding Cervical Cancer, Human Papillomavirus (HPV) and Corresponding Vaccine.” Vaccine 37 (3): 530–37. https://doi.org/10.1016/j.vaccine.2018.11.065.

Kågesten, Anna, Jenita Parekh, Özge Tunçalp, Shani Turke, and Robert William Blum. 2014. “Comprehensive Adolescent Health Programs That Include Sexual and Reproductive Health Services: A Systematic Review.” Review-article. Http://Dx.Doi.Org/10.2105/AJPH.2014.302246. November 12, 2014. http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302246.

Kahhaleh, J. G., M. El Nakib, and A. R. Jurjus. 2009. "Knowledge, Attitudes, Beliefs and Practices in Lebanon Concerning HIV/AIDS, 1996-2004." Eastern Mediterranean Health Journal = La Revue De Santé De La Méditerranée Orientale = Al-Majallah Al-Ṣiḥḥīyah Li-Sharq Al-Mutawassiṭ 15 (4): 920–33.

Kaivanara, Marzieh. 2016. "Virginity Dilemma: Re-Creating Virginity through Hymenoplasty in Iran." Culture, Health & Sexuality 18 (1): 71–83. https://doi.org/10.1080/13691058.2015.1060532.

Khaliq, Amir. 2012. The Saudi Healthcare System: A View from the Minaret. Vol. 13. https://doi.org/10.12927/whp.2012.22875.

Khondker, Habibul Haque. 2011. "Role of the New Media in the Arab Spring." Globalizations 8 (5): 675–79. https://doi.org/10.1080/14747731.2011.621287.

Khraif, Rshood, Asharaf Abdul Salam, Abdullah Al-Mutairi, Ibrahim Elsegaey, and Ali Ajumah. 2017. "Dynamics of Contraceptive Use: A Study of King Saud University Women Staff, Riyadh." Middle East Fertility Society Journal 22 (1): 18–26. https://doi.org/10.1016/j.mefs.2016.09.006.

King, R., S. Warsi, A. Amos, S. Shah, G. Mir, A. Sheikh, and K. Siddiqi. 2017. "Involving Mosques in Health Promotion Programmes: A Qualitative Exploration of the MCLASS Intervention on Smoking in the Home." Health Education Research 32 (4): 293–305. https://doi.org/10.1093/her/cyx051.

Kingdon, John W. 2010. Agendas, Alternatives, and Public Policies, Update Edition, with an Epilogue on Health Care. 2 edition. Boston: Pearson.

Kim, Christine, and Robert Rector. 2010. "Evidence on the Effectiveness of Abstinence Education: An Update." The Heritage Foundation. 2010. https://www.heritage.org/education/report/evidence-the-effectiveness-abstinence-education-update

Kohler, Pamela K., Lisa E. Manhart, and William E. Lafferty. 2008. "Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 42 (4): 344–51. https://doi.org/10.1016/j.jadohealth.2007.08.026.

Kristo, Branko, Ljubica Cuk, and Ivanka Krzelj. 2016. "Parents' Attitudes on the Introduction of Health Education in the Education System." Materia Socio Medica 28 (4): 278. https://doi.org/10.5455/msm.2016.28.278-282.

Labi, N. 2007. "The Kingdom in the Closet". May 1, 2007. http://www.theatlantic.com/magazine/archive/2007/05/the-kingdom-in-the-closet/305774/.

Latifnejad Roudsari, Robab, Mojgan Javadnoori, Marzieh Hasanpour, Seyyed Mohammad Mehdi Hazavehei, and Ali Taghipour. 2013. "Socio-Cultural Challenges to Sexual Health Education for Female Adolescents in Iran." Iranian Journal of Reproductive Medicine 11 (2): 101–10.

Lindberg, Laura Duberstein, Isaac Maddow-Zimet, and Heather Boonstra. 2016. "Changes in Adolescents' Receipt of Sex Education, 2006–2013." Journal of Adolescent Health 0 (0). https://doi.org/10.1016/j.jadohealth.2016.02.004.

Lindberg, Laura Duberstein, and Isaac Maddow-Zimet. 2012. "Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes." *Journal of Adolescent Health* 51 (4): 332–38. https://doi.org/10.1016/j.jadohealth.2011.12.028.

Locock, Louise. 2003. "Ethical Dimensions of Health Policy.M Danis, C Clancy and LR Churchill (Eds). New York: Oxford University Press, 2002, Pp. 395, £42.50 (HB) ISBN: 0-19-514070-2." International Journal of Epidemiology 32 (4): 671–72. https://doi.org/10.1093/ije/dyg196.

Lukes, Steven. 2004. Power: A Radical View. Second edition. Houndmills, Basingstoke, Hampshire : New York: Palgrave.

Macdowall, Wendy, Kyle G. Jones, Clare Tanton, Soazig Clifton, Andrew J. Copas, Catherine H. Mercer, Melissa J. Palmer, et al. 2015. "Associations between Source of Information about Sex and Sexual Health Outcomes in Britain: Findings from the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)." *BMJ Open* 5 (3): e007837.

Macdowall, Wendy, Kaye Wellings, Catherine H. Mercer, Kiran Nanchahal, Andrew J. Copas, Sally McManus, Kevin A. Fenton, Bob Erens, and Anne M. Johnson. 2006. "Learning About Sex: Results From Natsal 2000." Health Education & Behavior 33 (6): 802–11. https://doi.org/10.1177/1090198106289003.

Madani, Tariq A. 2006. "Sexually Transmitted Infections in Saudi Arabia." BMC Infectious Diseases 6 (1): 3. https://doi.org/10.1186/1471-2334-6-3.

Maffi, Irene. 2017. "Abortion in Tunisia after the Revolution: Bringing a New Morality into the Old Reproductive Order." Global Public Health 0 (0): 1–12. https://doi.org/10.1080/17441692.2017.1284879.

Mahmodi, Yaghob, and Sina Valiee. 2016. "A Clinical Trial of the Effect of Sexual Health Education on the Quality of Life of Married Muslim Women in Iran." Women and Birth: Journal of the Australian College of Midwives 29 (1): e18-22. https://doi.org/10.1016/j.wombi.2015.08.001.

Massad, Joseph A. 2007. Desiring Arabs. University of Chicago Press.

Maynard Rebecca A., Christopher Trenholm, Barbara Devaney, Amy Johnson, Melissa A. Clark, John Homrighausen andEce Kalay, 2007. First-Year Impacts of Four Title V, Section 510 Abstinence Education Programs," Mathematica Policy Research Reports 493c4d9f30eb468db9e36ac52, Mathematica Policy Research.

Mazroa, Mohammed A. A. l., Ibrahim A. Kabbash, Sanaa M. Felemban, Gwen M. Stephens, Raafat F. Al-Hakeem, Alimuddin I. Zumla, and Ziad A. Memish. 2012. "HIV Case Notification Rates in the Kingdom of Saudi Arabia over the Past Decade (2000–2009)." PLoS ONE 7 (9). https://doi.org/10.1371/journal.pone.0045919.

McQueston, K. 2013. "The Efficacy of Interventions to Reduce Adolescent Childbearing in Low- and Middle-Income Countries: A Systematic Review. - PubMed - NCBI." Accessed May 14, 2016. http://www-ncbi-nlm-nih-gov.ezproxy.bu.edu/pubmed/?term=the+efficacy+of+interventions+to+reduce+adolescent+childbearing+in+low.

Memish, Ziad A., Sanaa M. Filemban, Sabirah N. Kasule, and Jaffar A. Al-Tawfiq. 2015. "Knowledge and Attitudes about HIV/AIDS in Illegal Residents in the Kingdom of Saudi Arabia." Journal of Global Infectious Diseases 7 (3): 103. https://doi.org/10.4103/0974-777X.161744.

Memish, Ziad Ahmed, and Mohammad Y. Saeedi. 2011. "Six-Year Outcome of the National Premarital Screening and Genetic Counseling Program for Sickle Cell Disease and β-Thalassemia in Saudi Arabia." Annals of Saudi Medicine 31 (3): 229–35. https://doi.org/10.4103/0256-4947.81527.

Mensch, Barbara S., Barbara L. Ibrahim, Susan M. Lee, and Omaima El-Gibaly. 2003. "Gender-Role Attitudes among Egyptian Adolescents." Studies in Family Planning 34 (1): 8–18. https://doi.org/10.1111/j.1728-4465.2003.00008.x.

Miyamoto, K, and A Chevalier. n.d. "Improving Health and Social Cohesion through Education - OECD." Accessed May 14, 2016. https://www.oecd.org/edu/ceri/improvinghealthandsocialcohesionthroughedu cation.htm.

Moghadam, Valentine. 2013. "Women, Work and Family in the Arab Region: Toward Economic Citizenship." *Expert Group Meeting for Middle East and North Africa, Doha*.
https://www.researchgate.net/publication/276195474_Women_work_and_fa mily_in_the_Arab_region_Toward_economic_citizenship.

Mohammadi, Mohammad Reza, Kazem Mohammad, Farideh K. A. Farahani, Siamak Alikhani, Mohammad Zare, Fahimeh R. Tehrani, Ali Ramezankhani, and Farshid Alaeddini. 2006. "Reproductive Knowledge, Attitudes and Behavior among Adolescent Males in Tehran, Iran." International Family Planning Perspectives 32 (1): 35–44. https://doi.org/10.1363/ifpp.32.035.06.

Mohanna, F., J. DeJong, K. Afifi, B. Nazha, and H. Zurayk. 2017. "Student Support for Reproductive Health Education in Middle Schools: Findings from Lebanon. Sex Education, 17(2), 195-208." 2017. https://www.popline.org/node/660770.

Morgan, David L. 1996. "Focus Groups." Annual Review of Sociology 22 (1): 129–52. https://doi.org/10.1146/annurev.soc.22.1.129.

Muammar, Tarfah, Patricia McWalter, Abdullah Alkhenizan, Mohamed Shoukri, Alia Gabr, and Abdulaziz AlDanah Bin. 2015. "Management of Vaginal Penetration Phobia in Arab Women: A Retrospective Study." Annals of Saudi Medicine 35 (2): 120–26. https://doi.org/10.5144/0256-4947.2015.120.

Mubashar, H., M. Almushait, B. Sukit, A. Shaamash, S. Handady, and N. Almutawa. 2016. "Knowledge, Attitude and Practice of Contraceptives among Saudi Women in Aseer Region, Saudi Arabia." Bangladesh Journal of Medical Science 15 (3): 430– 34. https://doi.org/10.3329/bjms.v15i3.25288.

Muhammad, Noor Azimah, Khadijah Shamsuddin, Zaharah Sulaiman, Rahmah Mohd Amin, and Khairani Omar. 2016. "Role of Religion in Preventing Youth Sexual Activity in Malaysia: A Mixed Methods Study." Journal of Religion and Health, January, 1–14. https://doi.org/10.1007/s10943-016-0185-z.

Mumtaz, Ghina, Nahla Hilmi, Willi McFarland, Rachel L. Kaplan, Francisca Ayodeji Akala, Iris Semini, Gabriele Riedner, Oussama Tawil, David Wilson, and Laith J. Abu-Raddad. 2011. "Are HIV Epidemics among Men Who Have Sex with Men

Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis." PLOS Med 8 (8): e1000444. https://doi.org/10.1371/journal.pmed.1000444.

Musallam, Basim. 1983. Sex and Society in Islam: Birth Control before the Nineteenth Century. http://hdl.handle.net/2027/heb.00923.0001.001.

Musiimenta, Angella. 2013. "Social and Institutional Issues in the Adoption of School-Based Technology-Aided Sexual Health Education Program." Online Journal of Public Health Informatics 5 (2): 213. https://doi.org/10.5210/ojphi.v5i2.4654.

Mustafa, Yassar, Diya Baker, Preeti Puligari, Teresa Melody, Joyce Yeung, and Fang Gao-Smith. 2017. "The Role of Imams and Mosques in Health Promotion in Western Societies—a Systematic Review Protocol." *Systematic Reviews* 6 (February). https://doi.org/10.1186/s13643-016-0404-4.

Napier, David, Michael Depledge, Michael Knipper, Rebecca Lovell, Eduard Ponarin, Emilia Sanabria, and Felicity Thomas. 2017. "Culture Matters: Using a Cultural Contexts of Health Approach to Enhance Policy-Making." World Helath Organization Regional Office for Europe. ISBN: 978 92 890 5233 7.

National Family Safety Program-Saudi Arabia. 2016. Accessed September 30, 2016. http://nfsp.org.sa/index.php/component/phocadownload/category/7-2012-04-03-11-28-16#.

National Legislative Bodies/National Authorities. 1961. "Egypt: Law No. 10/1961, on the Combating of Prostitution." Refworld. 1961. https://www.refworld.org/docid/5492d8784.html.

National Legislative Bodies/National Authorities. 1961. "Egypt: Law No. 10/1961, on the Combating of Prostitution." Refworld. 1961. https://www.refworld.org/docid/5492d8784.html.

Okaz. 2015. "رفع سن الطفل إلى 14 سنة في المنشآت الصحية Increasing the Age of Childhood to 14 in Healthcare Centres." Http://Akhbaar24.Argaam.Com. March 12, 2015. http://akhbaar24.argaam.com/article/detail/206488.

Otto, Jan Michiel, ed. 2010. Sharia Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present. Law, Governance, and Development. Leiden: Leiden University Press.

Paul, Katie. 2017. "Saudi Arabia to Introduce Physical Education for Schoolgirls." Reuters, July 11, 2017. https://uk.reuters.com/article/uk-saudi-education-women-idUKKBN19W1DT.

Phillippi, Julia, and Jana Lauderdale. 2018. "A Guide to Field Notes for Qualitative Research: Context and Conversation." Qualitative Health Research 28 (3): 381–88. https://doi.org/10.1177/1049732317697102.

Population Council. 2017. "Survey of Young People in Egypt 2009-2014." 2017. https://www.popcouncil.org/research/survey-of-young-people-in-egypt-2009-and-2014-datasets.

Population Reference Bureau PRB. 2010. "Are Imams in Egypt Prepared to Help Stop the Spread of HIV/AIDS?" May 4, 2010. https://www.prb.org/imams/.

Pound, Pandora, Rebecca Langford, and Rona Campbell. 2016. "What Do Young People Think about Their School-Based Sex and Relationship Education? A Qualitative Synthesis of Young People's Views and Experiences." BMJ Open 6 (9): e011329. https://doi.org/10.1136/bmjopen-2016-011329.

PSHE Association. 2017. "Personal, Social, Health and Economic Education (PSHE) Curricula." 2017. https://www.pshe-association.org.uk/curriculum-and-resources/curriculum.

Raheel, Hafsa, Muhammad Afzal Mahmood, and Abdulaziz BinSaeed. 2013. "Sexual Practices of Young Educated Men: Implications for Further Research and Health Education in Kingdom of Saudi Arabia (KSA)." Journal of Public Health (Oxford, England) 35 (1): 21–26. https://doi.org/10.1093/pubmed/fds055.

Ritchie, Jane, Jane Lewis, Carol McNaughton Nicholls, and Rachel Ormston. 2013. Qualitative Research Practice: A Guide for Social Science Students and Researchers. Second edition. London: SAGE Publications Ltd.

Roudi-Fahimi, Farzaneh, and Shereen El Feki. 2011. "Facts of Life. Youth Sexuality And Reproductive Health in The Middle East And North Africa, Population Reference Bureau." PRB. www.prb.org/reports/2011/facts-of-life.aspx.

Rouzi, Abdulrahim A. 2013. "Facts and Controversies on Female Genital Mutilation and Islam." The European Journal of Contraception & Reproductive Health Care 18 (1): 10–14. https://doi.org/10.3109/13625187.2012.749982.

Saleh, Ramzia Hisham, and Rocci Luppicini. 2017. "Exploring the Challenges of Divorce on Saudi Women." *Journal of Family History* 42 (2): 184–98. https://doi.org/10.1177/0363199017695721.

Said, Edward W. 1978. Orientalism. London: Vintage Books.

Sait, Khalid H. 2009. "Attitudes, Knowledge, and Practices in Relation to Cervical Cancer and Its Screening among Women in Saudi Arabia." Saudi Medical Journal 30 (9): 1208–12.

Sanders, S. A., and J. M. Reinisch. 1999. "Would You Say You 'Had Sex' If...?" JAMA 281 (3): 275–77.

Santelli, John S., Leslie M. Kantor, Stephanie A. Grilo, Ilene S. Speizer, Laura D. Lindberg, Jennifer Heitel, Amy T. Schalet, et al. 2017. "Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact." *Journal of Adolescent Health* 61 (3): 273–80. https://doi.org/10.1016/j.jadohealth.2017.05.031.

Santelli, John, Mary A. Ott, Maureen Lyon, Jennifer Rogers, and Daniel Summers. 2006. "Abstinence-Only Education Policies and Programs: A Position Paper of the Society for Adolescent Medicine." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 38 (1): 83–87. https://doi.org/10.1016/j.jadohealth.2005.06.002.

Saudi Arabia, Ministry of Defence and Aviation. Accessed April 23, 2016. http://www.moda.gov.sa/Lists/Faculties/DisPItem.aspx?ID=17.

Saudi Arabia Ministry of Education Official Website 2019. Www.Moe.Gov.Sa.

Saudi Arabia, Ministry of Education. 2019a. *Islamic Jurisprudence-Level 6-Secondary Education*. Ministry of Education, Saudi Arabia. 2019- Riyadh-1438H. ISBN: 978-603-508-411-6

Saudi Arabia, Ministry of Education. 2019b. Science for 8th Grade, First Semester. McGraw Hill Education. Obekan, 2019. ISBN: 978-603-508-228-0

Saudi Arabia, Ministry of Education 2015. *Islamic Jurisprudence for the 10th grade.* Riyadh. ISBN: 978-9960-48-462-4

Saudi Arabia, Ministry of Education. 2013. *Islamic Jurisprudence-Level 6-Secondary Education*. Riyadh-1434H. ISBN: 9960-19-347-0

Saudi Arabia Ministry of Health Official Website 2019. http://www.moh.gov.sa/Pages/Default.aspx.

Saudi Arabia Ministry of Health 2019. "Infectious Diseases - HIV/AIDS." Accessed October 13, 2019. https://www.moh.gov.sa/en/HealthAwareness/EducationalContent/Diseases/Infectious/Pages/AIDS1.aspx.

Saudi Arabia, Ministry of Interior. Accessed April 23, 2016. https://www.moi.gov.sa/wps/portal/Home/sectors/civilaffairs/contents/!ut/p/z1/rZFBb4JAEIX_Cj14NDOwW1mPG9KyWG2rFpW9mAXZdltBRELa_vqi8dImYki6t0nevH3fG5CwApmr2ryqyuxytW3mSA7WGFAqbOo8MPp8j3zqjDzuBY4_cWF5Eng-F9QdI7Kxf4sBF-FsOCUEOQHZvr8ACTLJq6J6gygxtdlaSmtlykMPf42WKnt4SMvaJOnBso9rRWI2EKkNOnHMkNrDhGhUsY0k1lqnzFVpkg7PEVsynCJeeBxhrkoYXeNoijLv-73kDc0ur9LPClZdcJZHoJYvOP0rQM4aAScLIdyp88Tss6DtFtdQo6Yq92KGuwHMO_R-xYz8o1llO5kVWZgx8tX3l_2Pmfh-0Vm2fpzwmx_hIDss/dz/d5/L2dBISEvZ0FBIS9nQSEh/.

Saudi Census. 2019. "الهيئة العامة للإحصاء General Authority for Statistics." 2019. https://www.stats.gov.sa/ar.

Saudi General Authority for Statistics. 2016. "General Authority for Statistics, Kingdom of Saudi Arabia." 2016. http://www.stats.gov.sa/.

Saudi Press Agency SPA. 2019. " أنظمة المملكة تحظر وتجرم جميع أشكال التمييز العنصري / عام 'The Kingdom's Laws Prohibit and Criminalize والكراهية والتعصب وكالة الأنباء السعودية All Forms of Racial Discrimination, Hatred and Intolerance.'" March 21, 2019. https://www.spa.gov.sa/1902159?lang=ar&newsid=1902159.

الهزاني يدشّن بلجنة الأفلاج برنامج "نبيه " لحماية الأطفال من التحرش والإيذاء " Saudi Press Agency. 2018. AlHazzani Implements 'Nabeeh' Programme to Protect Children وكالة الأنباء السعودية from Harassment and Abuse." November 21, 2018. https://www.spa.gov.sa/1844200.

Saudi Vision 2030 2016. Accessed May 14, 2016. http://vision2030.gov.sa/en/node.

Sawyer, Susan, Peter Azzopardi, Dakshitha Wickermarathne, and George Patton. 2018. "The Age of Adolescence - The Lancet Child & Adolescent Health." The Lancet 2 (3): 223–28. https://doi.org/10.1016/S2352-4642(18)30022-1.

Sheeha, Mounira Al. 2010. "Awareness and Use of Contraceptives Among Saudi Women Attending Primary Care Centers in Al-Qassim, Saudi Arabia." International Journal of Health Sciences 4 (1): 11.

Sedgh, Gilda, Jonathan Bearak, Susheela Singh, Akinrinola Bankole, Anna Popinchalk, and Bela Ganatra. 2016. "Abortion Incidence between 1990 and 2014: Global, Regional, and Subregional Levels and Trends - The Lancet." The Lancet 388 (10041): 258–67. https://doi.org/10.1016/S0140-6736(16)30380-4.

Selwaness, Irene, and Rania Roushdy. 2019. "Young People School-to-Work Transition in the Aftermath of the Arab Spring." International Journal of Manpower, June. https://doi.org/10.1108/IJM-02-2018-0041.

Serour, G. I. 2013. "Ethical Issues in Human Reproduction: Islamic Perspectives." Gynecological Endocrinology: The Official Journal of the International Society of Gynecological Endocrinology 29 (11): 949–52. https://doi.org/10.3109/09513590.2013.825714.

Shalev, Ofra, Nehami Baum, and Haya Itzhaki. 2013. "'There's a Man in My Bed': The First Experience of Sex Among Modern-Orthodox Newlyweds in Israel." Journal of Sex & Marital Therapy 39 (1): 40–55. https://doi.org/10.1080/0092623X.2012.675021.

Sharifi, Mahboubeh, Soroor Arman, Samereh Abdoli, and Shahnaz Kohan. 2016. "Iranian Parents' Experiences about Children Sexual Training: Control, Restriction and Education," 11.

Sheeha, Mounira Al. 2010. "Awareness and Use of Contraceptives Among Saudi Women Attending Primary Care Centers in Al-Qassim, Saudi Arabia." International Journal of Health Sciences 4 (1): 11.

Shirazi, Kambiz Karimzadeh, and Mohammad Ali Morowatisharifabad. 2009. "Religiosity and Determinants of Safe Sex in Iranian Non-Medical Male Students." Journal of Religion and Health 48 (1): 29–36. https://doi.org/10.1007/s10943-008-9174-1.

Shirpak, Khosro Refale, Eleanor Maticka-Tyndale, and Maryam Chinichian. 2007. "Iranian Immigrants' Perceptions of Sexuality in Canada: A Symbolic Interactionist Approach." Canadian Journal of Human Sexuality 16 (3/4): 113–28.

Smerecnik, Chris, Herman Schaalma, Kok Gerjo, Suzanne Meijer, and Jos Poelman. 2010. "An Exploratory Study of Muslim Adolescents' Views on Sexuality: Implications for Sex Education and Prevention." BMC Public Health 10: 533. https://doi.org/10.1186/1471-2458-10-533.

Smith, Joanna, and Jill Firth. 2011. "Qualitative Data Analysis: The Framework Approach." Nurse Researcher 18 (January): 52–62.

Smoak, Natalie D., Lori A. J. Scott-Sheldon, Blair T. Johnson, and Michael P. Carey. 2006. "Sexual Risk Reduction Interventions Do Not Inadvertently Increase the Overall Frequency of Sexual Behavior: A Meta-Analysis of 174 Studies with 116,735 Participants." 2006. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2474799/.#

Stranger-Hall, Kathrin F., and David Hall. 2011. "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S." 2011. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0024658.

Tabatabaie, Alireza. 2015. "Constructing the Ideal Muslim Sexual Subject: Problematics of School-Based Sex Education in Iran." Sex Education 15 (2): 204–16. https://doi.org/10.1080/14681811.2014.992066.

The Guardian. 2019. "Saudi Arabia Appoints Its First Female Ambassador to US." February 24, 2019. https://www.theguardian.com/world/2019/feb/24/saudi-arabia-appoints-its-first-female-ambassador-to-us.

The Independent 2015. "Saudi Spinsters: A New Generation of Women Are Breaking with Tradition." 2015. The Independent. January 21, 2015. http://www.independent.co.uk/news/world/middle-east/saudi-spinsters-a-new-generation-of-women-are-breaking-with-tradition-and-making-their-own-choices-9993481.html.

The Peninsula. 2015. "Ministry, HMC Hold Diabetes Workshop for Imams." The Peninsula, November 10, 2015. https://thepeninsulaqatar.com/article/10/11/2015/Ministry,-HMC-hold-diabetes-workshop-for-imams

The Lancet. 2016. "Our Future: A Lancet Commission on Adolescent Health and Wellbeing." February 11, 2016. http://thelancet.com/commissions/adolescent-health-and-wellbeing.

The Lancet. 2016. "Our Future: A Lancet Commission on Adolescent Health and Wellbeing." February 11, 2016. http://thelancet.com/commissions/adolescent-health-and-wellbeing.

The World Bank. 2019. "Saudi Arabia: Economic Update - April 2019." World Bank. February 1, 2019. https://www.worldbank.org/en/country/gcc/publication/saudi-arabia-economic-update-april-2019.

Thomas, M. H. 2000. "Abstinence-Based Programs for Prevention of Adolescent Pregnancies. A Review." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 26 (1): 5–17.

Tomkins, Andrew, Jean Duff, Atallah Fitzgibbon, Azza Karam, Edward J. Mills, Keith Munnings, Sally Smith, et al. 2015. "Controversies in Faith and Health Care." Lancet (London, England) 386 (10005): 1776–85. https://doi.org/10.1016/S0140-6736 (15) 60252-5.

Uecker, Jeremy E., Nicole Angotti, and Mark D. Regnerus. 2008. "Going Most of the Way: 'Technical Virginity' among American Adolescents." Social Science Research 37 (4): 1200. https://doi.org/10.1016/j.ssresearch.2007.09.006.

Underhill, Kristen, Don Operario, and Paul Montgomery. 2007a. "Systematic Review of Abstinence-Plus HIV Prevention Programs in High-Income Countries." PLoS Medicine 4 (9). https://doi.org/10.1371/journal.pmed.0040275.

Underhill, Kristen, Paul Montgomery, and Don Operario. 2007b. "Sexual Abstinence Only Programmes to Prevent HIV Infection in High Income Countries: Systematic Review." BMJ, July. https://doi.org/10.1136/bmj.39245.446586.BE.

UNAIDS 2018. "UN Urges Comprehensive Approach to Sexuality Education". 2018. http://www.unaids.org/en/resources/presscentre/featurestories/2018/january/20180110_sexuality-education.

UNFPA. 2013. "UNFPA Strategy on Adolescents and Youth | UNFPA - United Nations Population Fund." 2013. http://www.unfpa.org/resources/unfpa-strategy-adolescents-and-youth.

UNFPA. 2018. International Technical Guidance on Sexuality Education. 138. UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO. https://www.unfpa.org/publications/international-technical-guidance-sexuality-education

UNICEF. 2011. "Knowledge, Attitudes and Practices Survey, Healhty Lifestyles (in Occupied Palestinian Territory)." 2011. http://www.undp.org/content/dam/papp/docs/Publications/UNDP-papp-research-KAPB%20study.PDF.

United Nations. 2019. "Youth." 2019. https://www.un.org/en/sections/issues-depth/youth-0/.

Useem, Ruth Hill, and Richard D. Downie. 1976. "Third-Culture Kids." Today's Education.

Valenti, Jessica. 2018. "It's Ironic, but under Trump Abstinence-Only Sex Education Is Back | Jessica Valenti." The Guardian, March 14, 2018, sec. Opinion. https://www.theguardian.com/commentisfree/2018/mar/14/trump-lies-abstinence-only-sex-education.

Vasagar, Jeevan, and education editor. 2012. "Revealed: What Children Are Being Told about Abortion." The Guardian, March 23, 2012, sec. World news. https://www.theguardian.com/world/2012/mar/23/abortion-what-children-schools.

Vu, Milkie, Hadiyah Muhammad, Monica E. Peek, and Aasim I. Padela. 2018. "Muslim Women's Perspectives on Designing Mosque-Based Women's Health Interventions—An Exploratory Qualitative Study." *Women & Health* 58 (3): 334–46. https://doi.org/10.1080/03630242.2017.1292344.

Wagner, Glenn J., Frances M. Aunon, Rachel L. Kaplan, Yashodhara Rana, Danielle Khouri, Johnny Tohme, and Jacques Mokhbat. 2012. "A Qualitative Exploration of Sexual Risk and HIV Testing Behaviors among Men Who Have Sex with Men in Beirut, Lebanon." PLOS ONE 7 (9): e45566. https://doi.org/10.1371/journal.pone.0045566.

Wahba, Mamdouh, and Farzaneh Roudi-Fahimi. 2012. "The Need for Reproductive Health Education in Schools in Egypt," 8.

Walt, Gill, Jeremy Shiffman, Helen Schneider, Susan F. Murray, Ruairi Brugha, and Lucy Gilson. 2008. "'Doing' Health Policy Analysis: Methodological and Conceptual Reflections and Challenges." Health Policy and Planning 23 (5): 308–17. https://doi.org/10.1093/heapol/czn024.

Warsy, A. S., M. H. Al-Jaser, A. Albdass, S. Al-Daihan, and M. Alanazi. 2014. "Is Consanguinity Prevalence Decreasing in Saudis?: A Study in Two Generations." African Health Sciences 14 (2): 314–21. https://doi.org/10.4314/ahs.v14i2.5.

Waugh, Earle H. 1999. The Islamic Tradition: Religious Beliefs and Healthcare Decisions. Park Ridge Center for the Study of Health, Faith, and Ethics.

Wellings, Kaye, and Rachel Parker. 2006. Sexuality Education in Europe. A Reference Guide to Policies and Practices |. https://hivhealthclearinghouse.unesco.org/library/documents/sexuality-education-europe-reference-guide-policies-and-practices.

Wellings, Kaye, Kirstin Mitchell, and Martine Collumbien. 2012. Sexual Health: A Public Health Perspective. Maidenhead, UK: Open University Press, 2012.

Wheeler, Stephanie B. 2010. "Effects of Self-Esteem and Academic Performance on Adolescent Decision-Making: An Examination of Early Sexual Intercourse and Illegal Substance Use." The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine 47 (6): 582–90. https://doi.org/10.1016/j.jadohealth.2010.04.009.

WHO. 2019. "WHO | Adolescents Sexual and Reproductive Health." WHO. 2019. http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/.

———. 2018. "Adolescents: Health Risks and Solutions." World Health Organization. 2018. http://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions.

——— 2017b. "WHO | Sexual Health and Its Linkages to Reproductive Health: An Operational Approach." WHO. 2017. http://www.who.int/reproductivehealth/publications/sexual_health/sh-linkages-rh/en/.

———. 2011. "Knowledge, Attitudes, and Practices Regarding Cervical Cancer Screening among Physicians in the Western Region of Saudi Arabia." Saudi Medical Journal 32 (11): 1155–60.

———. 2010. "WHO | Developing Sexual Health Programmes." WHO. 2010. http://www.who.int/reproductivehealth/publications/sexual_health/rhr_hrp_10_22/en/.

WHO. 2006. "WHO | Defining Sexual Health." 2006. http://www.who.int/reproductivehealth/publications/sexual_health/defining_sh/en/.

Wight, Daniel, Gillian M. Raab, Marion Henderson, Charles Abraham, Katie Buston, Graham Hart, and Sue Scott. 2002. "Limits of Teacher Delivered Sex Education: Interim Behavioural Outcomes from Randomised Trial." BMJ 324 (7351): 1430. https://doi.org/10.1136/bmj.324.7351.1430.

Wild, Verina, Hinda Poulin, Christopher W. McDougall, Andrea Stöckl, and Nikola Biller-Andorno. 2015. "Hymen Reconstruction as Pragmatic Empowerment? Results of

a Qualitative Study from Tunisia." Social Science & Medicine 147 (December): 54–61. https://doi.org/10.1016/j.socscimed.2015.10.051.

Wong, Li Ping. 2012. "An Exploration of Knowledge, Attitudes and Behaviours of Young Multiethnic Muslim-Majority Society in Malaysia in Relation to Reproductive and Premarital Sexual Practices." BMC Public Health 12 (October): 865. https://doi.org/10.1186/1471-2458-12-865.

World Bank. 2017. "Fertility Rate, Total (Births per Woman) - Saudi Arabia." 2017. https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SA.

Zaabi, Omar Al, Margaret Heffernan, Eleanor Holroyd, and Mervyn Jackson. 2019. "Islamic Parents' Attitudes and Beliefs towards School-Based Sexual and Reproductive Health Education Programmes in Oman." Sex Education 19 (5): 534–50. https://doi.org/10.1080/14681811.2018.1553708.

APPENDICES

APPENDIX 1-COURSES, CONFERENCES AND PRESENTATIONS

Prior to collecting the data, I enrolled in the core modules at LSHTM including:, Basic Epidemiology, Reviewing the Literature and Principles of Social Sciences, History and Health, in addition to attending Health Policy, Process and Power which I joined as a seminar leader for 3 years. I also attended supplementary courses at LSTHM and other educational institutes and undertook training in qualitative interviewing and qualitative data analysis.

I presented preliminary findings from my thesis during an oral presentation at the Second Adolescent and Youth Health Conference in Muscat, Oman in October 2018 titled 'Abstinence Versus Harm Reduction as Protective Sexual Health Strategies: Views of Key Stakeholders in Saudi Arabia'.

I was part of a panel discussion 'Innovation in Adolescent Health' at the Youth Forum in the Arab Region in Asilah, Morocco in December 2018.

I also presented an oral presentation at the titled 'Views of key stakeholders in Saudi Arabia on protective sexual health strategies' at the Qualitative Health Research Network Conference in London, UK in March 2019.

Appendix 2-Text Examples

Islamic Jurisprudence Seventh Grade Teacher's Book 2013
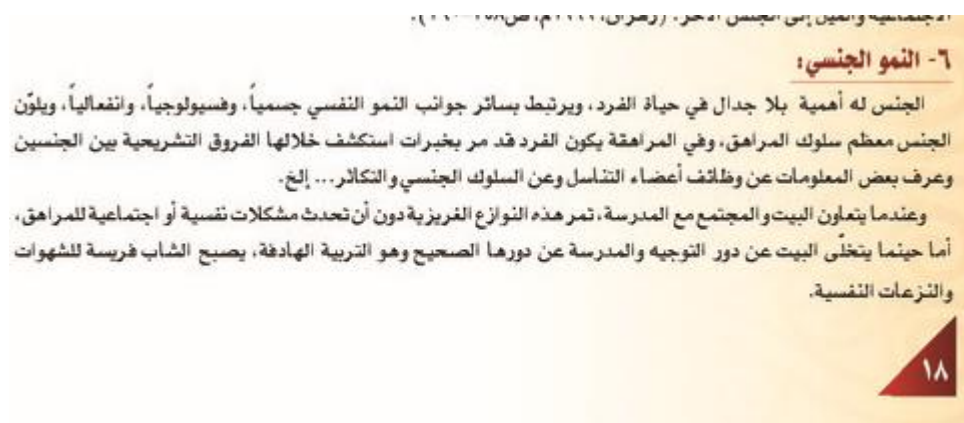
The book gives an introduction to teachers about the different types of maturation adolescents go through, one of which is sexual maturation:

Without a doubt, sex is important in the individual's life, and it is related to all aspects of the psychological maturation whether physically, physiologically and emotionally and it colors (affects) most of the adolescent's behavior. During adolescence, the individual would have passed through several experiences where he would have discovered the anatomical differences between the two sexes and developed some knowledge about the roles of the reproductive organs, reproduction, sexual behavior, etc...

When the house (family) and society cooperate with the school, then these types of instinctive desires would pass without causing any psychological or social problems for the adolescent, but when the house gives up its role in guiding and the school gives up its correct role in purposeful upbringing (education), then the young man will become a victim of temptations and psychological desires.

Negative outcomes of adultery (pre-marital and/or extra-marital).

1. *Mixing of lineages: if a woman becomes pregnant through adultery then she enters the baby onto her husband's lineage and he will see them and be is seclusion with them[‡‡‡‡‡‡].*

2. *Destruction of offspring: as women mostly kill their unborn child and if the baby lives it will be deprived of love and affection and will be psychologically distraught and may turns into a social degenerate.*

[‡‡‡‡‡‡] In Islam, a man and a woman should not sit in seclusion alone if they are not married or part of the relatives who one is allowed to sit alone with (maharem).

3. *Inviolability of persons/defilement of women*

4. ***Cause of mental and physical illnesses****- During our time, new chronic diseases that were not known before are spreading like Syphilis and Gonorrhea and such diseases. The most known causes for the spread of these diseases is the practice of "obscenity"* (adultery), *and this has caused panic around the entire world. Western media is still focusing on the disease of the century, AIDS, and its alarming numbers which shows how prevalent this disease is amongst them, which is a reflection of their moral decline into a deep abyss that predicts their close end. This disease has caused panic to spread among Western societies, and there have been demonstrations to close "the houses of corruption" and night clubs and such places that promote obscenity.*

فمن القرآن : قوله تعالى : ﴿فَلَمَّا جَاءَ أَمْرُنَا جَعَلْنَا عَالِيَهَا سَافِلَهَا وَأَمْطَرْنَا عَلَيْهَا حِجَارَةً مِّن سِجِّيلٍ مَّنضُودٍ ۝ مُّسَوَّمَةً عِندَ رَبِّكَ وَمَا هِيَ مِنَ الظَّالِمِينَ بِبَعِيدٍ ۝﴾ (١).

فعاقب تعالى قوم لوط بما لم يعاقب به غيرهم، وجمع عليهم أنواعاً من العذاب، ثم أخبر أن هذه العقوبة ليست ببعيدة ممن تشبه بهم في فعلهم.

قال ابن القيم رحمه الله : «ولم يثبت عن النبي ﷺ أنه قضى في اللواط بشيء؛ لأن هذا لم تكن تعرفه العرب، ولم يرفع إليه ﷺ» (١).

وقد أجمع الصحابة على قتله. قال ابن قدامة رحمه الله : «إن الصحابة أجمعوا على قتله وإنما اختلفوا في صفته -أي كيفية قتله-» (٢).

وقد ذهب بعض الصحابة إلى أنه يحرق بالنار، وقيل : يرجم بالحجارة، وقيل : يُرمى من شاهق وقيل غير ذلك.

آثاره على الفرد والمجتمع

للواط آثار سيئة على الفرد والمجتمع الذي يرتكب فيه، ومنها :

١ـ أنه قلبٌ للفطرة وهدمٌ للأخلاق وانتكاسة بالإنسانية إلى الحضيض. إذ الميول الفطرية تكون بين الرجال والنساء لا بين الرجال والرجال.

٢ـ إماتة الغيرة في المفعول به، وإفساد حال الفاعل والمفعول به.

٣ـ الجناية على أسرة المفعول به، بل على المجتمع بأسره بهذه الفعلة القبيحة الشنيعة.

٤ـ أنه من أكبر أسباب زوال النعم وحلول النقم؛ فإنه يوجب اللعنة والمقت من الله وإعراضه عن فاعله وعدم نظره إليه.

(١) سورة هود : آية ٨٢-٨٣.
(٢) زاد المعاد ٥/٤٠.
(٣) المغني ١٢/٣٥٠.

٥ـ أنه يحدث الهمّ والغمّ ويُسوّد الوجه ويطمس نور القلب ويُذهب الحياء الذي هو حياة القلوب. ويورث الحماقة والمهانة وازدراء الناس واحتقارهم.

٦ـ أنه من أبرز أسباب الإصابة بالأمراض الخطرة وانتشارها في المجتمع، ومن هذه الأمراض : مرض الإيدز المعدي الذي أقلق الغرب وأقض مضاجعهم حتى طالبوا بعزل المصابين بالشذوذ الجنسي في أماكن مخصصة.

٧ـ تعجيل العقوبة في الدنيا بأنواع العقوبات كما عاقب الله قوم لوط بعقوبات لم تجتمع لغيرهم : مِنْ طَمْس أعينهم، وقلب ديارهم، وإهلاكهم بالصيحة، ورجمهم بالحجارة وتدميرهم؛ لكفرهم وإتيانهم الفاحشة. وعذابُ الآخرة أشد وأبقى ـ نسأل الله السلامة والعافية (١).

الوقاية والعلاج

١ـ تقوية الإيمان بالله باتباع أوامره واجتناب نواهيه، وملء القلب بمحبته (سبحانه وتعالى)، والتضرع واللجوء إليه لصرف ذلك عنه.

قال تعالى : ﴿كَذَلِكَ لِنَصْرِفَ عَنْهُ السُّوءَ وَالْفَحْشَاءَ إِنَّهُ مِنْ عِبَادِنَا الْمُخْلَصِينَ﴾ (٢).

٢ـ تيسير أمور الزواج، وحث القادر على التزوج تحصيناً لفرجه، ومن لم يقدر فعليه بالصوم ليقي نفسه من ثوران الشهوة . قال ﷺ : «يا مَعْشَرَ الشَّبَابِ مَنِ اسْتَطَاعَ مِنكُمُ الْبَاءَةَ

(١) للاستزادة حول آثار اللواط انظر الكتب التالية :
ـ الجواب الكافي لابن قيم الجوزية.
ـ مرض الإيدز الطاعون الجديد، د. خالص جلبي.
ـ الفاحشة : عمل قوم لوط، محمد بن إبراهيم الحمد.
ـ الأمراض الجنسية عقوبة إلهية، د. عبدالحميد قضاة.
ـ أقول شمس الحضارة الغربية من نافذة الشذوذ، لمصطفى فوزي غزال. وغيرها.
(٢) سورة يوسف : آية ٢٤.

Negative outcomes of homosexuality (Sodomy)

1. *It is an overturns innateness (against nature) and destruction of morality, a retrogression of humanity as natural tendencies are between men and women and not men and men.*

2. *Killing honour within the one receiving the act and corruption of both the one receiving and giving.*

3. *It is a felony to the whole family of the one receiving the act and the entire society with this ugly, hideous act.*

4. *It is one of the main reasons for the elimination of blessings and the occurrence of indignations and abomination. God would not look at those acting on this.*

5. *It is a cause of sorrow, grief and worry and it obliterates the light of the heart as well removes modesty and causes insult and disrespect upon those who practice it*

6. *One of the main reasons to become infected with dangerous diseases and its spread in society. One of these diseases is AIDS which is highly contagious which has worried the West and they could not sleep until they demanded isolating those diseased with sexual aberration* (homosexuality) *in separate spaces.*

7. *Expedites the punishment from God as He has done with the people of Lot.*

Effects of adultery:

1. *Mixing of lineages: if a woman becomes pregnant through adultery then she enters the baby onto her husband's lineage and he will see them and be is seclusion with them and can inherit what does not belong to him and deprive others from this right.*

2. *Destruction of offspring: as women mostly kill their unborn child.*

3. *Inviolability of persons/defilement of women*

4. Causes the weakening of the heart since it brings sorrow and worry

5. Causes many physical ailments that were not known before like syphilis, *gonorrhoea, and AIDS, which has no treatment to this day and it is a cause of death since when present in the body, it cannot battle any of the diseases even if it they are simple.*

الوحدة السادسة : الحدود

الحِكمة من تحريم اللواط وآثاره على الفرد والمجتمع

للواط آثار سيئة على الفرد والمجتمع منها :

1. أنه قَلْبٌ للفطرة وهدم للأخلاق وانتكاسة بالإنسانية إلى الحضيض ، إذ الميول الفطرية تكون بين الرجال والنساء لا بين الرجال والرجال .

2. إماتة الغيرة في المفعول به ، وإفساد حال الفاعل والمفعول به .

3. الجناية على أسرة المفعول به ، بل على المجتمع بأسره بهذه الفعلة القبيحة الشنيعة .

4. أنه من أكبر أسباب زوال النعم وحلول النقم ، فإنه يوجب اللعنة والمقت من الله وإعراضه عن فاعله وعدم النظر إليه .

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(1) سورة هود الآيتان 82 – 83 .

(2) أخرجه أحمد 4/464(2732) ، وأبو داود في كتاب الحدود ، بابٌ فيمَنْ عملَ عملَ قوم لوط 4/158(4462) ، والترمذي في أبواب الحدود ، باب ما جاء في حَدُّ اللُّوطيُّ 4/57(1456) ، وابن ماجه في كتاب الحدود ، باب مَّن عمِلَ عملَ قوم لوط 2/856(2561)، وصححه الحاكم في المستدرك على الصحيحين 4/395 ، والضياء في الأحاديث المختارة 12/204 ، وابن عبد الهادي (المحرر في الحديث ص 624) ، والألباني في إرواء الغليل (2350) ، وقال ابن القيم: احتجَّ الإمامُ أحمدُ بهذا الحديثِ ، وإسنادُهُ على شرطِ البخاريِّ.اهـ (الجواب الكافي ص170).

(3) المغني لابن قدامة المقدسي 12/350 .

(4) زاد المعاد لابن قيم الجوزية 5/40 .

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5. أنه يحدث الهمّ والغمّ ، ويسود الوجه ، ويطمس نور القلب ، ويذهب الحياء الذي هو حياة القلوب ، ويورث الحماقةَ والمهانةَ وازدراءَ الناس واحتقارَهم .

6. أنه من أبرز أسباب الإصابة بالأمراض الخطرة وانتشارها في المجتمع ، مثل : مرض الإيدز المعدي الذي أقلق العالم ، وأعياهم علاجه ، حتى طالبت كثير من المجتمعات بعزل المصابين بالشذوذ الجنسي في أماكن مخصصة .

7. تعجيل العقوبة في الدنيا بأنواع العقوبات كما عاقب الله قوم لوط بعقوبات لم تجتمع لغيرهم: من طمس أعينهم ، وقلب ديارهم ، وإهلاكهم بالصيحة ، ورجمهم بالحجارة وتدميرهم؛ لكفرهم وإتيانهم الفاحشة .

Negative effects of Sodomy

1. *It is an overturns innateness (against nature) and destruction of morality, a retrogression of humanity as natural tendencies are between men and women and not men and men.*

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2. *Killing honour within the one receiving the act and corruption of both the one receiving and giving.*

3. *It is a felony to the whole family of the one receiving the act and the entire society with this ugly, hideous act.*

4. *It is one of the main reasons for the elimination of blessings and the occurrence of indignations and abomination. God would not look at those acting on this.*

5. *It is a cause of sorrow, grief and worry and it obliterates the light of the heart as well removes modesty and causes insult and disrespect upon those who practice it*

6. ***One of the main reasons to become infected with dangerous diseases and its spread in society. One of these diseases is AIDS which is highly contagious which has worried the West and they could not sleep until they demanded isolating those diseased with sexual aberration* (homosexuality) *in separate spaces.***

7. *Expedites the punishment from God as He has done with the people of Lot.*

الحكمة من تحريم الزنا

لا يخفى على عاقل ما في الزنا من الآثار السيئة، والمفاسد الوخيمة، على الأفراد والمجتمعات.

والمتأمل في حال المجتمعات الغربية التي انتشرت فيها هذه الفاحشة يدرك عظمة التشريع الرباني

الذي حذر المسلمين من مقاربته فضلاً عن الوقوع فيه.

فمن مفاسد هذه الجريمة:

١. اختلاط الأنساب الذي يبطل معه التعارف والتناصر على إحياء الدين، وتفكك الأسر،

وضياع الأولاد.

٢. انتشار الأمراض في المجتمع(١)، ولهذا جاء في الحديث: «وما ظهرت الفاحشة في

قوم قط إلا ابتلاهم الله بالأمراض والأوجاع التي لم تكن في أسلافهم»(٢).

٣. القضاء على النكاح الذي هو من أهم مقاصد الشريعة.

٤. إدخال العار على الأسرة بل والقبيلة برمتها.

نشاط

Negative effects of adultery

1. *Mixing of lineage which revokes championing the revival of religion and breaks families and abandonment of children.*

2. ***The spread of diseases in society and that is why the Hadith was said 'whenever obscenity appears among a people God has tested them with diseases and ailments that was not among their ancestors'.*** The diseases are mentioned in a footnote*: some of these diseases that have recently developed are AIDS and Syphilis and others.*

3. *Elimination of marriage which is one of the most important purposes of Islam.*

4. *Bringing shame upon one's family and whole tribe.*

حَدُّ اللواط

ذهب جمهور الفقهاء أن حَدَّ اللواط، كحد الزنى.

من خلال دراستك لموضوع حَدِّ الزنى، وضِّح حَدَّ اللواط بالتفصيل.

حَدُّ اللواط للمحصن:

....

حَدُّ اللواط لغير المحصن:

....

وقال بعض العلماء: عقوبة اللواط: القتل، فيقتل الفاعل والمفعول به، سواء أكانا محصنين أم غير محصنين.

قال شيخ الإسلام ابن تيمية رحمه الله: (والصحيح الذي اتفقت عليه الصحابة: أن يقتل الاثنان الأعلى والأسفل، سواء كانا محصنين، أم غير محصنين. فإن أهل السنن رووا عن ابن عباس رضي الله تعالى عنهما، عن النبي ﷺ

قال: «من وجدتموه يعمل عمل قوم لوط، فاقتلوا الفاعل والمفعول به»(١)،(٢).

الحكمة من تغليظ عقوبته

حرم الله اللواط وغلظ في عقوبته لما له من آثار سيئة على الفرد والمجتمع:

فهو انتكاسة في الفطرة، وفساد في الطبع، يقتل الفضيلة، ويهدم الأخلاق، يورث في نفس مرتكبه الرذيلة والدناءة، فيقضي على الحياء، ويميت الغيرة في النفوس.

من ارتكب هذه الجريمة لم يزل يعير بها بين الناس في حياته، ولم يفارق خزيها مخيلته حتى وفاته. ولا يقف عارها على مرتكبها فقط، بل يمتد ليشمل الأسرة والقبيلة برمتها.

وإذا ظهر اللواط في مجتمع فإن الله يعاجل أهله بالعقوبة، فتحل الكوارث والأسقام، وتنتشر الأوبئة والأمراض، ويخيم الظلم ويعم الفساد في الأرض، نسأل الله السلامة والعافية.

نشاط

٢/ ما أسباب الوقوع في جريمة اللواط؟ وما سبل الوقاية من ذلك؟

God has forbade sodomy and has made its punishment severe due to its negative effects on the individual and society it is a retrogression for innateness/instinct and corruption in nature. It also destroys moral and causes vice and vileness to develop in the perpetrator and destroys modesty and kills jealousy and honour in souls.

Whoever has committed this crime will be disgraced and blamed by people in his life and will not be free from humiliation until death. The dishonour is not limited to the perpetuator but his family and whole tribe.

If sodomy appears in a society then God will expedite His punishment and catastrophes, ailments and epidemics will spread and darkness and corruption will prevail in the land. We ask God good health and safety.

الأمراض المنقولة جنسيًا يقصد بالأمراض الجنسية الأمراض التي تنتقل من شخص إلى آخر خلال الاتصال الجنسي، وتسمى اختصارًا (STDs). وتنتج هذه الأمراض بسبب البكتيريا أو الفيروسات.

ومن الأمراض الجنسية التي تسببها البكتيريا السيلان والسفلس (الزهري). وتُستعمل المضادات الحيوية لعلاج تلك الأمراض التي تسبب الضرر للمصاب بها؛ فقد يصاب مريض السيلان بالعقم بسبب تدمير الأعضاء التناسلية، أما مريض السفلس (الزهري) فتهاجم البكتيريا أوعيته القلبية وجهازه العصبي؛ مما يؤدي إلى تدمير أعضاء الجسم التي لا يمكن تعويضها.

وأما قوباء الأعضاء التناسلية (الهربس) فهو مرض فيروسي مزمن يسبّب آلامًا وتقرّحات في الأعضاء التناسلية. وينتقل هذا النوع من القوباء عن طريق الاتصال الجنسي، أو من الأم المصابة إلى ابنها خلال عملية الولادة. ولا يوجد علاج أو طعم للوقاية من الإصابة بالقوباء، ولكن يمكن علاج الأعراض بالأدوية المضادة للفيروسات.

ماذا قرأت؟ لماذا يجب علاج الأمراض الجنسية في مراحلها الأولى؟

Sexually transmitted diseases are those diseases that are transmitted from one person to the next during the sexual contact and are abbreviated as STDs. These diseases are caused by bacteria or viruses. Bacterial diseases like gonorrhoea and syphilis, and antibiotics are used to treat these diseases that cause harm to the infected individual. A person infected with gonorrhoea can develop infertility because of the destruction of the reproductive organs as for the syphilis patient, the bacteria would attack his heart vessels and his nervous system which will result in the destruction of bodily organs that cannot be repaired while genital Herpes is a chronic viral disease that causes pain and ulcers in the reproductive organs and it is transmitted through sexual contact or from mother to child during delivery and there is no treatment or vaccine for Herpes but symptoms can be treated by anti-viral medications.

APPENDIX 3- SCOPING EXERCISE

I first met with a researcher who provided feedback on the first draft of the proposal, which initially contained interviews with adolescents. She vocalized her concern regarding conducting focus groups in schools, since she had faced several obstacles to gain approval to reach school children.

One of the highlights of our talk was her mention of the importance of women's health and rights within a formal sexual education program, but she mentioned how difficult it is to break free from the conservative religious speech that is imbedded in the Saudi's educational system. Gender roles are dictated by traditional social and religious norms and deviating from them can be problematic.

She also encouraged the adoption of a clear definition of sexual education and emphasized the importance of incorporating "communication" into this. In her view, many of the marital problems that occur in Saudi Arabia are related to poor communication skills between spouses. I understand this concern since gender segregation is implemented in almost every aspect of social life which makes interaction with men and women very limited. Many young women may not have any experience talking to men outside of their families which may make communication with their future husbands difficult. Hence, focusing on training young students on proper communication skills may be beneficial.

I then conducted an informal interview with a manager from a local organization that predominantly focuses on children's rights. Upon explaining to her the aim of my study, she said that introducing a formal sexual education programme in schools is "necessary". According to her, many cases of sexual violence and blackmail among young women could be reduced with increasing knowledge about risky sexual behaviour, and introducing young people, especially young women to the appropriate channels for seeking help. The manager felt the lack of research regarding sexual education and health is problematic. She estimated the cases of sexual harassment at 10,000 but thinks that most cases are underreported due to their sensitive nature. She believes the public is in denial of the existence of these issues and that young engage in risky sexual behaviour. The prevalence of risky sexual practices, according to her, is higher than expected but is still within the average rate globally. She insisted that there is an obsession with

sex within the society due to the *conservative nature of the country that makes talking about it very uncomfortable. She mentioned that she has met mothers who refuse to believe that their daughters could be interested in talking to men or accept the fact that many of their daughters are masturbating and exploring their sexuality. She also mentioned that the general discourse on sex refuses to accept that sexual urges are normal among young people, especially in girls. She highlighted the lack in general activities that youth can engage in like sports which are still looked at as unnecessary and unimportant which provides more time to 'obsess over sex'.*

In addition to lack of knowledge and proper channels of correct scientific information, she spoke of the public focus on religious speech when tackling sexual health issues, seeing them as moral issues. I told her about a previous conversation I had last year with a medical director at a primary health care center in Riyadh who believed that the main reason for the youth engaging in risky sexual behavior is the "weakness of their religious values" and how the main message she gives in her educational campaigns in school is to strengthen the religious values. She was not surprised and emphasized the difficulty of breaking free from the religious speech, '*People focus more on religion than fixing wrong behavior*'. She also spoke about the importance of teaching young people communication skills. In her view, poor communication is the main reason for failed marriages, and marriage counseling is not accepted as a formal field of study which allows incompetent individuals to give informal advice, often based on their own personal experiences rather than scientific evidence. In addition, she spoke about the traditional gender roles in Saudi society and, despite the many changes occurring in the community, the difficulty of addressing them through formal educational programs. She stated that she does not believe in equality between sexes, claiming that women and men can never be equal since they are different physically and emotionally. She also believed that the greatest enemy for women are women themselves and she preferred for her husband to be 'the man'. She focused on the need for women to stand up for each other and support one another even when they have opposing opinions. It is interesting to explore the meaning of equality and women's rights among Saudi women, especially when these terms are heavily influenced by Western ideology.

We also spoke about the nature of sexual activities adolescents may be engaged in, where she informed me that more girls are engaging in sexual activities, most likely anal sex, in order to keep the hymen intact. She believed that these activities were on the rise and attributed this

increase to the shift of male attitude on casual dating, which is frowned upon in Saudi society, since boys were pressuring girls to go out with them and engage in sexual activities, otherwise they would leave them.

We also spoke about the current sources of sex education in the country. Asked about the current informal channels of knowledge people seek information from, she criticized the Internet forums used, especially those focusing on women, believing that they present false, misleading information. She did say, however, that people are now more aware of information sources, searching the internet for their questions and concerns regarding sexual health matters. She also told me about an organization called *Mawada* that offers pre-marital 'training' at the high school level, but says that it is heavily influenced by an Islamic discourse and that it does not focus on women's mental needs. She also told me about other national and local organizations that address issues about physical, emotional and sexual violence in children.

Having experienced difficulty in finding data on unplanned pregnancies and abortion, and references to official national laws regarding abortion for married women, I asked the manager about the program's data on abortion and teen pregnancies (outside of marriage). She informed me that a programme called the National Family Safety Programme (NFSP) handles cases of young women who are pregnant out of wedlock but she has no access to such data. She also told me that there are no official laws for this population, since it is not acceptable for women to have children outside a legal marriage, and theoretically, pregnancies do not occur in non-married women in Saudi Arabia.

I was not able to identify documents regarding laws on rape and sexual assault during this time, although there were several *fatwas* in that regard that varied according to school of thought and time. However, they all find the rapist deserving of a punishment that ranges between flogging and execution coupled with a financial penalty. However, a couple of widely reported rape cases, where the victim was found guilty and sentenced to flogging raised the conversation within the public about how these cases are approached in the country. Speaking to several people, it seemed that individuals usually try to find loopholes to ensure the best outcome for these women and their children. Pregnant women are dealt with differently according to age and gestational age. If the pregnancy is less than 4 months, and is presented as a sexual assault the woman, at any age, can gain access to an abortion (that is legal in case of rape or incest). If

the pregnancy is more than 4 months and the woman is younger than 18 years of age, she is referred to "protective homes" run by the government usually for juveniles that escaped home or found guilty of a crime, until she gives birth. The child is then taken away from her and put into an orphanage. If the man who impregnated (whether consensually or by force) admits to it, they are both taken to court and usually the judge encourages them to marry in order to keep the child. If the woman is over 18 years of age, she cannot be admitted to these homes, but probably jail, and sentenced to 100 lashes as punishment for engaging in non-marital sex. The child is also taken away from her and put into an orphanage. However, if the case is presented as a rape case, she would most probably not be deserving of the punishment.

I later visited infectious diseases consultant and asked him about the rates of STI and HIV cases in Saudi Arabia, since I was not able to access this information easily. He informed that there are 4,000 new cases of HIV, and between 40,000 to 50,000 cases of other STIs. It is important to note that the 4,000 cases of HIV were Saudi citizens, since the major criticism is that HIV cases usually come from abroad and are not "home grown".

We also discussed the success of HIV clinics in Riyadh, where he reflected on the social and systemic changes in the country regarding people living with HIV. Resistance, according to him, was not only from the public but also from the medical community to test pregnant women for HIV and to allow HIV positive women to marry and carry children. [§§§§§§]

His view was that testing should not be limited to pregnant women but to all. When I told him that a published paper claimed that due to the low prevalence of HIV, premarital HIV screening is not cost-effective, although the authors do admit that this may be one of the very few culturally acceptable ways to test for HIV and encourage to keep it, he said that it would be shameful to *talk about cost-effectiveness in this country, and was strongly opposing to moving towards an American model of privatizing healthcare.*

[§§§§§§] Pregnant women are not regularly screened for HIV in the country, however some hospitals have their own guidelines implement perinatal HIV screening.

Stigma seemed to be still prevalent and guilt among patients as well. The physician informed me that he usually does not ask patients on how they became HIV positive, yet, many patients make up stories about passing out and receiving blood in a hospital abroad which caused their HIV transmission. I personally thought that, with this approach, there could be a missed opportunity for open dialogue on risky sexual practices and behavior but from what I've witnessed at his clinic, patients have a very personal rapport with him. When he does not ask these questions directly, they eventually open up about the routes of transmission and their risky behavior.

Upon discussing the effects of knowledge on risky sexual practices, he told me that the majority of new cases are within the younger generation and that low knowledge is a major cause of that. I also asked him about the most common route of transmission, believing it to be still via heterosexual sex to which he agreed. He also believed that more men are having sex with men in the country and disclosed his detestation to forcing gay men to marry women.

I talked to him about the difficulty of addressing homosexuality in Saudi Arabia, especially among gay men themselves who may not identify as gay but enjoy having sex with men occasionally. He told me that that does happen although more and more people are becoming more vocal about their practices and sexual orientation. The programme at his hospital offers to help individuals to find suitable spouses, since the majority of HIV positive patients find it difficult to marry. The consultant told me that one of his gay patients asked him to find him a suitable partner. He told me that this was a unique incident that he hadn't faced before, since the majority of gay men would not admit to being gay and never ask to find a partner, but he would not be able to do so as homosexuality is illegal in the country. I assumed that there would be much guilt related to having HIV from anal sex and many may see their diagnosis as a punishment, so I as well was surprised at this story of this man, embracing his diagnosis and still wanting to live a fulfilled life with a partner, not a wife but a male partner. According to him lesbianism is also on the rise, although the risk of transmitting STIs and HIV is not as high in gay women when compared to gay men. The majority of the new cases are males, since many of them do receive the infections from prostitutes either upon travel or less likely domestically. The consultant suggested looking at social media to see what the current conversations are about sexual health and education and STIs and HIV. He says more people are speaking about these

subjects publicly and some doctors are addressing these issues and using social media platforms to engage with the younger generation who needs this type of information.

I was also able to briefly meet up with another infectious disease consultant and had a quick conversation with him. The majority of the conversation reflected similar opinions to the previous physician but he made an interesting point of introducing sexual education programs at the age of 18 since, in his opinion, young men cannot attain a national ID card and cannot travel to neighboring countries where there is easier access to sex workers gender mixing. This opinion however reflects the widespread belief that sexual encounters do not usually occur inside of Saudi Arabia but are exclusively practiced during travel.

I was able to meet with a social worker, whose clinic I joined to observe some of the cases and the main concerns of HIV patients. Unfortunately, because it was the first clinic after Eid Alfitr (main Islamic holiday after Ramadan), it was a slow clinic with limited number of patients, most of which came for a short follow up to renew their medications. The social worker was busy coordinating a few appointments for some new patients but I was able to have a brief conversation with her.

She was finally able to sit down for a few minutes, she took a deep breath, removed her niqab and told me how enthusiastic she is about my proposal and was eager to tell me about all the activities the clinic provides at the hospital. She is basically the matchmaker of the patients, I overheard her tell the consultant that they're all invited to a new wedding, when he asked who it was, she said it's one of your daughters and she's marrying another doctor's son. I was confused at the beginning but then I figured out that this is how they refer to their patients, as their children. She informed me of an annual workshop they plan usually at the last week of November, right before world's AIDS day on December 1st, to make sure their activities do not interfere with any activities planned for the AIDS day. This workshop has been running since 2004.

She also told me about a charity organization sponsored by the Ministry of Social Affairs called *'Manaa'* that is based in Riyadh and focuses on the needs of AIDS patients within the city. There are also several other NGOs in the country focused on supporting HIV positive individuals and AIDS patients. She also informed me of the clinic called عيادة الفحص و المشورة which translates to 'the clinic for examining and advising/providing advice', so that it will not be blatantly called an

STI or AIDS clinic to ensure confidentiality and encourage people to visit it for testing. This clinic was found in 2011, and a few awareness campaigns have been launched by the MOH to encourage the public to test for HIV. She also informed me that the government does support AIDS patients financially. There are specific categories of diseases that make patients eligible for financial support in addition to free airfare if the patients live away from the city of the treating hospital. In order to qualify for these benefits, patients need to fill an official form and specify their diagnosis. Many patients feel reluctant to write AIDS or HIV on the form, since they're worried about their confidentiality being breached and so they opt not to take advantage of these benefits. The social worker informed me that one of the clinicians suggested writing down P 24 as the diagnosis instead of AIDS/HIV. P24 antigen is the viral protein found in the blood at the first few weeks post infection in HIV. She informed me that patients felt more comfortable after they started writing down P 24 as the diagnosis. This was not the case unfortunately for the airfare that many patients are still not taking advantage of. This shows how HIV stigma is still extremely problematic in the country. When I made this comment to her and she strongly agreed and told me that some people who work at the hospital would refuse to shake her hand once they find out that she works at the HIV clinic which reflects on the widespread stigma among healthcare professionals.

I also tried to steer the conversation on the causes of HIV transmission in Saudi Arabia. The social worker believes that education is key in decreasing the rates of HIV, especially for young people. She informed me that she gave her nephew advice on safe sex practices prior to going on a trip abroad with his friends. I was surprised about how blunt she was in her conversation, and also surprised she didn't advise him against engaging in any sexual activities.

She also talked about how many people receive their information from informal sources via social media and the internet, and so providing a formal programme can be beneficial to present correct and practical information. She thinks this information should be introduced during puberty, since she thinks this is the time where sexual exploration starts.

The social worker also conducts counselling sessions and group therapy sessions as well. According to her experience, group sessions were not very successful. They were more successful for women than men, and many of them kept in touch outside of the setting of the group session. For the men, she noticed that many of them were not comfortable disclosing

information in front of other men who come from different "tribes" or regions from Saudi. They were worried about tarnishing their tribe or family's name if they confessed to being engaged in risky sexual behavior that may been seen as "deviant" from the norm, especially for those who have sex with men. She tried encouraging them to use only their first names during meetings but still found it difficult to make them comfortable to open up. This was a very important point to take into consideration, as I did not think of this limitation upon planning my focus group sessions.

This scoping exercise helped me build a network of some key informants that helped me identify stakeholders. It also provided me with a glimpse on how the interviews may go, and what obstacles I would be facing during the data collection phase. It also provided me with a general idea on what common beliefs are held within Saudi society. In addition, I was able to learn about some of the regulations related to sexual health that I would not be able to easily obtain through formal channels.

Introduction

- Profession? *Could you tell me a little about you and your professional role?*
- Work with children/adolescents?
- Interest in Sexual Health?

Sexual Health

- Most concerning Need: *What is currently of most concern, in your view? Why?*
- Definition: *What comes to mind when I say sexual health? What topics? Can you define it?*
- Current Situation*: in relation to sexual health? Do you notice any trends?*
- Changing Evidence:

  How have things changed would you say, and how are they changing?

  What's the evidence for this? What do you think about those trends? Do you see any as favourable?

  Why do you say that? (Reasons) Could you tell more?
- Young People: *What about young people? Do you see changes there?*

Sexual Education

- Definition: *Can you tell me what sexual education means to you?*
- Current situation*: Could you describe what you consider to be the current situation with regard to sexual health education in Saudi Arabia?*
- Who/How/What/Where:

  Who: agency/main providers?

  How: in what context and using what material?

  What: topics that are taught? As far as you're aware? (where appropriate-STIs, contraception, sexual violence, sexual satisfaction/pleasure/dysfunction)

  Where: Context: where and in which areas of the curriculum?

- Views on current information and delivery methods: *what are your views on the current information? Why do you say that?*
- Views of adolescents on this type of information: *From your experience what do adolescents think of this information? What are the types of problems or questions they have?*
- Role of media
- Influences on education

Needs

- Ideal programme what are the needs that the programme should focus on
- Who/what/where/how
- Role of parents: *what should the role of parents be? How involved? What do you think they would feel about such a program?*
- Obstacles: *what are they? Do you think they can be overcome?*
- Enhancing factors: *what are they? How can we make use of them?*

Information Paper

Introduction
I would like to invite you to participate in this research study titled Stakeholders' Assessment of the Need for Sexual Health Education Among Adolescents in Saudi Arabia: An Exploratory Study.
Please take the time to read the information provided below before agreeing to take part in this study.

What is the purpose of this study?
The purpose of this study is to explore the views of different stakeholders on the current sexual health needs of adolescents in Saudi Arabia and their opinions on the provision of a school-based sexual education program in the country. In addition to identifying their views on the enhancing and inhibiting factors on the provision of such a program in the country.

Who is carrying this study?
The study is part of a PhD project led by Dr. Nour Horanieh, based at London School of Hygiene and Tropical Medicine. The study is funded by King Saud University where Dr. Horanieh works as a lecturer at of the faculty of Family and Community Medicine.

How will the study be conducted?
The research will be conducted in the form of a face-to-face or phone interview and will take between 45 minutes to an hour to complete. The interview will be audio-recorded, and later transcribed with your permission.

Will your participation remain confidential?
Yes, all of the interviews will be confidential and anonymised. As soon as I start the recording, I will not address you by your name during the interview. All transcriptions of the recordings will not include your name on them or your place of work. The recordings and transcripts will be anonymized, by being given unique numerical codes and safely stored at London School of Hygiene and Tropical Medicine in London, United Kingdom.

How will the results of this study be used?
The results of this research will be written up as my final PhD thesis. In addition, parts of this study will be submitted for publication.

What are some of the risks expected from participating in this study?
Even with anonymization, there may be a small chance of someone recognizing who you are or where you work from your input, especially if you work in a small organization that has specific roles. I will anonymize all the interviews and remove your name and name of organization from them to reduce this risk to the best that I can.

What are some of the benefits of participating in this study?
Up to my knowledge, this is the first qualitative study looking specifically at stakeholders in Saudi Arabia to explore their views on the need of a sexual education program for adolescents in the country. Your input will be extremely valuable as this study will help understand whether such a program is needed in the country and explore the inhibiting and enhancing factors for the provision of such a program.

For further inquiries please contact me:
Nour Horanieh Email: nhoranieh@ksu.edu.sa, nour.horanieh@lshtm.ac.uk
Phone: +966504120171

نموذج معلومات البحث

- **مقّدمة:**

أود دعوتكم للمشاركة في هذا البحث تحت عنوان: تقييم أراء المختصين عن حاجة التثقيف الصحي الجنسي للمراهقين في المملكة العربية السعودية. الرجاء مراجعة النموذج التالي قبل الموافقة على المشاركة في البحث.

- **ما الغرض من البحث؟**

الغرض من البحث هو فهم و دراسة آراء المختصين في مجال الصحة, و التعليم للمراهقين عن الوضع الحالي للتثقيف الصحي الخاص بالصحة الجنسية في المملكة لهذه الفئة العمرية, و معرفة وجهات نظرهم في صياغة و تقديم برنامج دراسي مختص للمراحل المتوسطة و الثانوية في المملكة. بالإضافة إلى معرفة العوامل المساعدة و المثبطة لهذا البنامج.

- **من الذي سيقّوم بالبحث؟**

هذا البحث هو جزء من رسالة الدكتوراة الخاصة بالمبعثة المبتعثة من جامعة الملك سعود: الدكتورة: نور حورانيه في جامعة لندن (London School of Hygiene and Tropical Medicine). و تمت الموافقة على البحث من قبل كلتا الجامعتين.

- **ماهي آلية البحث؟**

سيتم جمع البيانات عن طريق مقابلات شخصية أو عبر الهاتف و ستتطلب مدة المقابلة ما بين ٤٥ دقيقة إلى ساعة. و سوف يتم تسجيل المقابلات صوتيا ونسخها من بعد ذلك.

- **هل ستبقى المعلومات سرية؟**

نعم. المقابلات المسجلة و المنسوخة سوف تعامل بسرية تامة و لن يتم نسخ أي اسم شخصي أو معلوما ت شخصية لصاحب الشأن. إضافةً سوف يتم مسح أي معلومات شخصية من التسجيلات الصوتية. و سوف يتم تعريف كل مقابلة برقم خاص دون اللجوء لاستخدام أي معرفات شخصية. و سوف يتم تخزين المعلومات في جامعة لندن تحت إشرافي المباشر و لن يعطى أحد رموز الدخول لهذه المعلومات إلا أنا (د. نور حورانية) و المشرف الدراسي على هذا البحث. و لن يتم نشر الحوارات كليا إنما ستؤخذ اقتباسات من الحديث دون التعريف هن هوية المشترك.

- **ما هي بعض الفوائد من المشاركة في هذا البحث؟**

على حد علمي يعتبر هذا البحث الأول من نوعه في المملكة العربية السعودية حيث أنه يرتكز على مبادئ البحث النوعي لفهم الأراء المختلفة عن التثقيف الصحي للمراهقين في المملكة العربية السعودية. مشاركتكم في هذا البحث ذات قيمة لفهم احتياجات المراهق الصحية و الاجتماعية من منظور محلي و تحديد مدى احتياج برامج توعية مدرسية للتثقيف الصحي الجنسي. بالإضافة سيتم نشر النتائج ضمن مقالات علمية في المجلات العلمية المختصة.

للاستفسار الرجاء التواصل مع د. نور حورانيه
٠٥٠٤١٢٠١٧١
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Consent Form

LONDON
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&TROPICAL
MEDICINE

Stakeholders' Assessment of the Need for the need of
Sexual Health Education Among Adolescents in Saudi
Arabia: An Exploratory Study

Participant serial number:

Consent to be interviewed by Dr. Nour Horanieh:
Please check boxes below
I agree to take part in this study.

I confirm that I have read the information sheet/ had the information
sheet read to me, and I have had the opportunity to consider the
information, ask questions and have these answered satisfactorily.

I understand that the interview will be recorded and written out
word-for-word later. The recording will be securely stored in
accordance with the Data Protection Act.

I understand that my participation is voluntary and that I am free
to withdraw at any time, without giving a reason and all provided
data will be destroyed in that case.

I understand that anything I say will be treated confidentially and will
only be used for research purposes, in accordance with the Data
Protection Act.

I consent for my quotes to be used in published papers and presentations
as long as I am anonymized.

Name of participant (optional)	Date	Signature

Name of researcher	Date	Signature

نمودج الموافقة:

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تقييم أراء المختصين عن حاجة التثقيف الصحى الجنسى
للمراهقين فى المملكة العربية السعودية

أوافق على المشاركة فى البحث

أقر بأنى قرأت نموذج المعلومات و أعطيت الفرصة للاستفسار و التوضيح.

أعلم بأن المقابلة سيتم تسجيلها و نسخها حرفياً و تخزينها حسب قانون
حماية المعلومات فى المملكة المتحدة.

أعلم بأنه يحق لى الانسحاب من المقابلة فى أى وقت و يتم حذف
كل التسجيلات الخاصة بالمقابلة من دون إعطاء أى توضيح عن سبب الانسحاب.

أعلم أنه سيتم التعامل مع المعلومات التى سأوفرها بكامل السرية.

أوافق على نشر مقتبسات من حوارى المسجل فى المقالات العلمية
شرط أن أكون مخفى الهوية كلياً.

التوقيع	التاريخ	اسم المشترك (اختيارى)

التوقيع	التاريخ	اسم الباحث

240

APPENDIX 9- TRANSCRIBER CONTRACT

CONTRACT
Transcriber

3/5/2017

Dear xxxxx,

I am pleased to offer you a contract as transcriber in relation to my PhD research work titled *Stakeholders' Assessment of the Need of Sexual Health Education for Adolescents in Saudi Arabia: An Exploratory Study*. I am asking you to assist with transcription of audio-recorded interviews.

Transcription is expected to be verbatim. No translation is required, even during overlap of languages.
The first 3 interviews should be sent to the Principle Investigator (PI) for revision. In case the quality of the transcriptions does not meet the standard of the PI, and both PI and transcriber would like to continue the contract, the transcriber will be expected to take the PI's feedback and re-transcribe the interviews at no extra cost.
Final date for delivery of the completed work is July 30th, 2017.
The conditions of service will be those set out in the attached *Guidelines for Transcription* and *Confidentiality Agreement*.
Either party on an immediate basis may terminate the contract prior to its expiration date. Termination should be conveyed via email addressed to the PI on this specified email:
nour.horanieh@lshtm.ac.uk

The payment per completed interview is $1 per audio minute, which will be paid upon completion of the entire agreed amount of transcriptions.
If you accept this offer, please sign and return one copy of this letter to me.

Yours sincerely,
Nour Horanieh M.B.B.S, M.P.H
PhD Candidate
London School of Hygiene and Tropical Medicine

ACCEPTANCE OF OFFER AND DECLARATION

I accept the offer of appointment under the conditions stipulated therein.
I hereby declare that I will conform to the functions entrusted to me; the outlined data protection principles; and ethical principles for this research project. I will respect the confidentiality of the recordings and transcripts to ensure the safety of all participants as well as my own and the research team by exercising discretion and conscience to my fullest.

Name (please print): _____

Signature: _____ Date: _____

Appendix 10- Statement of confidentiality transcriber

General Statement of Confidentiality for Transcribers

<u>Name of Transcriber:</u>
xxxx

<u>Title of Research Study:</u>
Stakeholders' Assessment of the Need for Sexual Health Education for Adolescents in Saudi Arabia: An Exploratory Study.

An important part of conducting research is having respect for privacy and confidentiality. In signing below, you are agreeing to respect the participant's right to privacy and that of the people and organizations that may be included in the information collected. Such information may include interviews and field notes via audio recordings. You are asked to respect people's right to confidentially by not discussing the information collected in public, with friends or family members. The study and its participants are to be discussed only during research meetings with the Principal Investigator: **Dr. Nour Horanieh.**
In signing below, you are indicating that you understand the following:

- ✓ I understand the importance of providing anonymity and confidentiality to research participants.
- ✓ I understand that the research information may contain references to individuals or organizations in the community, other than the participant. I understand that this information is to be kept confidential.
- ✓ I understand that the information collected is not to be discussed or communicated outside of research meetings with the Principal Investigator or others specifically identified by the Investigator.
- ✓ When transcribing audio recordings, I will be the only one to hear the recordings and I will store these recordings and transcripts in a secure location at all times.
- ✓ I understand that the data files (electronic and hard copy) are to be secured at all times (e.g., not left unattended) and returned to the Principal Investigator as encrypted files when the transcription process is complete and will be destroyed and permanently deleted off my personal computer.
- ✓ I understand that I will receive the audio files via an encrypted Google Drive file and will not save any of the files on my computer or record them on any other device while playing.
- ✓ I understand that in the case any audio file is saved on my personal computer, I will make sure it is permanently deleted and not saved.
- ✓ I understand that I will not keep any copies of the recorded and/or transcribed interviews in my procession.
- ✓ I understand that the principal interviewer has the right to take legal action against any breach of confidentiality that occurs in my handling of the research data.

In signing my name below, I agree to the above statements and promise to guarantee the anonymity and confidentiality of the research participants

Name of Transcriber (please print): _____

Signature of Transcriber: _____ Date: _____

APPENDIX 11-ETHICS APPROVAL LSHTM

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT
United Kingdom
Switchboard: +44 (0)20 7636 8636

www.lshtm.ac.uk

Observational / Interventions Research Ethics Committee

Dr Nour Horanieh
LSHTM

27 March 2017

Dear Nour,

Study Title: Stakeholders' Assessment of the Need for Sexual Health Education Among Adolescents in Saudi Arabia: An Exploratory Study

LSHTM Ethics Ref: 12064

Thank you for responding to the Observational Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Investigator CV	NOUR_HORANIEH_CV_2017	25/01/2017	01
Information Sheet	consent-form-Nour-Horanieh-01	26/01/2017	01
Information Sheet	Information Paper02	25/03/2017	02
Protocol / Proposal	Topic Guide 02	25/03/2017	02
Protocol / Proposal	Topic Guide 02	25/03/2017	02
Protocol / Proposal	Nour_Horanieh_Porosal_Ethics_02	25/03/2017	02
Covering Letter	Clarificatoins for Ethics	25/03/2017	01

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

All aforementioned forms are available on the ethics online applications website and can only be submitted to the committee via the website at: http://leo.lshtm.ac.uk

Additional information is available at: www.lshtm.ac.uk/ethics

Yours sincerely,

Professor John DH Porter
Chair

APPENDIX 12- ETHICS APPROVAL KSU

المملكة العربية السعودية
جامعة الملك سعود (034)
ص. ب. ٧٨٠٥ الرياض ١١٤٧٢
هاتف : ٤٦٧.١١ ٤٦٧٠٠١١ +
فاكس : ٤٦٧١٩٩٢ ١١ ٩٦٦+

King Saud University

المدينة الطبية الجامعية

29.03.2017 (30.06.1438)
Ref. No. 17/0273/IRB

To:	Ms. Nour Horanieh
	Principal Investigator
	PhD Student
	London School of Hygiene and Tropical Medicine
	Email: nhoranieh@ksu.edu.sa

Subject:	**Research Project No. E-17-2380**
Project Title:	"stakeholders Assessment of the Need for a Sexual Health Education Program for Adolescents in Saudi Arabia: An Exploratory Study"
CC:	Kaye Wellings
	Co-Investigator

Type of Review:	Expedite
Date of Approval:	29 March 2017
Date of Expiry:	29 March 2018

Dear Ms. Nour Horanieh,

I am pleased to inform you that your above-mentioned research project was reviewed and approved on 29 March 2017 (30 Jumaada-II 1438). You are now granted permission to conduct study given that your study does not disclose patient identity and poses no risk to the patients.

Please be advised that the custodianship of all data generated by this study is shared between Principal Investigator and King Saud University

As principal investigator, you are required to abide by the rules and regulations of the kingdom of Saudi Arabia and the research policies and procedures of the KSU IRB. If you make any changes to the protocol during the period of this approval, you must submit a revised protocol to the IRB for approval prior to implementing the changes. Please quote the project number shown above in any future correspondence or follow-ups related to this study.

We wish you success in your research and request you to keep the IRB informed about the progress and final outcome of the study in a regular basis. If you have any question, please feel free to contact me.

Thank you!

Sincerely yours,

Dr. Ayman Al-Eyadhy
Chairman, Institutional Review Board
King Saud University College of Medicine
King Saud University Medical City
P.O. Box 7805 Riyadh 11472 K.S.A.
E-mail: aleyadhy@ksu.edu.sa

/braezell