Abstinence versus Harm Reduction Approaches to Sexual Health Education: Views of Key Stakeholders in Saudi Arabia

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Abstract

We elicited the views of key stakeholders on the need for sex education for adolescents and the appropriate model to adopt in Saudi Arabia. Semi-structured interviews were conducted in Riyadh, Saudi Arabia, with 28 stakeholders: policy-makers; social and healthcare providers; teachers and school staff; and religious scholars. Interviews were recorded and transcribed verbatim. Thematic analysis was conducted to identify emerging themes. Stakeholders saw the need to provide sex education. Opinions fell across a spectrum of model preference: abstinence-only or harm reduction. The conceptualisation of harm incorporated social risks. Silences and avoidance marked the boundaries between what was permitted and what was prohibited. In determining the form of any sex education curriculum in Saudi Arabia, caution is needed in assuming the ready transferability of Western-based models of sex education since in Saudi Arabia harm is conceptualised as damaging personal reputation, social structure and physical health. Religious doctrine and scientific evidence are perceived as non-conflicting sources for formulating a culturally sensitive program. Local idiom characterised by indirectness and ambiguity offer challenges and possibilities for conveying sensitive messages. Findings from this study can be useful for communities with similar religious beliefs or social traditions intending to formulate an acceptable sex education programme.

Keywords: adolescents, sex education, Saudi Arabia, Islam, harm reduction, abstinence.

Introduction

Approaches to sex education have tended to polarise between those promoting abstinence and those supporting harm reduction. Originally applied in the field of substance misuse, an abstinence-based model endorses a zero-tolerance attitude, pointing to absolutist principles relating to behaviour, while a harm reduction model accepts that risk behaviours may take place and defines objectives in terms of preventing possible harms (UNESCO 2018) . In the context of young people's sexual behaviour, an abstinence-based model generally favours waiting until marriage to have sex while a harm reduction model acknowledges adolescence and youth as periods of potential risk taking and encourages preventive measures aimed at reducing harms associated with early sexual activity like sexually transmitted infections (STIs) and unplanned pregnancies (Santelli et al. 2017; Canadian Paediatric Society 2008; Goldman 2015; UNESCO 2018)

Which model is optimal in sex education programmes remains contentious. The abstinence-only model tends to be supported in contexts where religious beliefs are stronger and non-procreative sexual practices and partnerships are censured. Even in societies which are at least partially secular, albeit may still be greatly influenced by Judaeo-Christian influences, ideological debate continues over provision of sex education and the design of programs (Lemon 2018; Miller 2018). Conflicting views reflect not only the strength of religious beliefs and differing values, but also cultural norms and political persuasions (Santelli et al. 2017). In Western type cultures sexual health related debates have become an identity marker for political parties and their campaigns, with those on the political right preferring more conservative applications (Stranger-Hall and Hall 2011).

Such value-laden positions are typically concealed within pragmatic discussion concerning the scientific evidence of which model is likely to be most effective in increasing

the health and well-being of individuals and society. Advocates and opponents of each model have each tended to garner empirical evidence in support of their preferred option, often selectively dismissing studies as flawed, or embracing them as valid, according to their stance on the issue. Those endorsing an abstinence-based model have pointed to studies showing that providing advice on fail-safes such as contraception and condom use for safer sex encourages young people to engage in sexual activity (Kim and Rector 2010). Advocates of a harm reduction model, by contrast, have drawn on studies showing that comprehensive sex education does not accelerate onset of sexual activity (Stranger-Hall and Hall 2011; Santelli et al. 2006; Kirby 2008; Underhill, Operario, and Montgomery 2007) and further, that failing to provide information on harm reduction strategies puts young people at greater risk of adverse outcomes when they do become sexually active (Kohler et al. 2008; Chin et al. 2012).

Sex education in Saudi Arabia: existing provision

In contexts where sex education is not an established subject in the curriculum, debate about possible approaches to its teaching is relatively nascent. In Saudi Arabia, as in most Islamic countries (DeJong et al. 2005) there are no large national programmes on sexual health and sex education is not given dedicated space within the national school curriculum. Material related to sexual matters is presented through the biology and Islamic Jurisprudence curricula (Saudi Arabia MoE 2019).

It is by no means certain that sex education will become an integrated part of the school curriculum in Saudi Arabia. There are signs of apprehension at the possibility of a Western-style sex education being adopted. On the Islam Q&A website (Islam Questions and Answers 2015) sex education in the West has been described as becoming 'an

obsession and madness'. On another website, unmarried young people are strongly discouraged (*makrooh*) from accessing websites providing sex education or forbidden to (*haram*) if the aim is to seek sexual arousal (Islamweb 2004). Nevertheless, from the limited research, there is increasing recognition of the need for sex education in the country, as is the case elsewhere in the Middle East and North Africa (MENA) region (Raheel et al. 2013; Alquaiz et al. 2012; AlQuaiz et al. 2013). The number of young people is increasing. Almost 60% of Saudi Arabia's population of 31 million are aged under 30 and 15% are aged between 10 and 19 years (Alghamdi 2018) and the mean age of first marriage is 25.3 and 20.4 among Saudi males and females respectively (Alghamdi 2017) Studies conducted in 1988 and 2004 have previously reported the mean age of first marriage of Saudi females as 18.2 and 19 respectively, indicating a progressive delay of marriage over the years (Babay Zainab A. et al. 2004; Jabbar and Wong 1988). Empirical evidence is incomplete, but what there is shows the incidence of STIs to be also increasing (Alothman, Mohajer, and Balkhy 2011) as are rates of pre-marital sexual activity among young people (DeJong et al. 2005; Alquaiz et al. 2012; AlQuaiz et al. 2013). The latest report on STI and HIV prevalence in Saudi Arabia states 6.2% and 0.05% prevalence respectively (Filemban et al. 2015).

Contextual influences on sex education provision

Sensitivities surrounding sex-related issues in Islamic and Muslim-majority countries would seem to create both challenges and opportunities for the provision of sexual and reproductive health information (Wong 2012). Scriptural support is generally for prevention messages that are consonant with religious convictions and accepted topics for sex education are limited to the institution of marriage (Madani et al. 2004). This is reflected in the Islamic Jurisprudence texts used in the school curriculum. In the Islamic jurisprudence

curricula for the secondary education level (ages 15-18) , the topic of adultery *(zinah)* is introduced as one of the prohibited *kaba'er,* or major sins, the technical definition of which is given as 'penetrative vaginal intercourse between a man and a woman that are not married to each other' (Saudi Arabia MoE 2019, p250). *Zinah* encompasses both premarital and extramarital sexual intercourse, albeit premarital receives a less harsh punishment. There is no reference to other sexual practices apart from anal sex which is implicitly mentioned when referring to the sin of *liwat* (derived from Lot) or homosexuality. Oral sex, masturbation and non-penetrative sexual practices are not mentioned. The text identifies *zinah* as the main cause of the spread of sexually transmitted infections (STIs) and provides no advice on protective measures other than abstaining from sexual intercourse until marriage. Another chapter, dedicated to family related provisions, introduces Islam's views on sterilisation and family planning. The first of which is forbidden, the second permissible only with the aim of spacing births to married couples, but no practical information exists on the different medical and natural forms of contraception (Saudi Arabia MoE 2019, p 54-57). In addition, when presenting legislation and rights related to marriage (*nikah)*, sexual intercourse is presented as a spousal right for both men and women. Lack of sexual satisfaction within a marriage creates grounds for divorce for either partner (Saudi Arabia MoE 2019, p 69). Although society may frown upon women who demand separation due to their husbands' sexual incompatibility, Islamic law preserves their right to divorce. This emphasises the Islamic stance that the goal of sex within marriage should not be merely procreation but also pleasure, and sheds light on the tension between ideal Islamic legislature regarding sex and gender and societal practices and customs that may frown upon women seeking separation due to sexual dissatisfaction.

In this respect, the presentation of sexual rights within marriage in Islamic scriptures can be differentiated from the more restrictive Catholic interpretations where sexual expression 'for purely pleasurable ends' is censured and the proper function of sex is strictly seen as procreation. (Foucault 1978, 15-36). Foucault differentiated between the sexuality of Eastern civilisation which he described as *ars erotica,* which prioritised pleasure and allowed sexuality creative expression, and that of Western civilisations which he characterised by *scientia sexualis,* which subjected sexuality to scientific scrutiny and 'normalising interventions' (Foucault 1978, 53-73). Such a distinction can arguably be applied to modern Saudi Arabia only in the limited context of marital sex.

Before embarking on developing any programme of sex education in Saudi Arabia, it will be important to explore the views of those likely to be guiding and implementing the curriculum. As part of a wider research exercise aimed at exploring the perceived need for sex education in Saudi Arabia, and the factors likely to shape provision, we carried out qualitative interviews to elicit opinions of key stakeholders in the country. In this paper, we report on their views on the relative merits of adopting abstinence-based and harm reduction models within a hypothetical sex education programme, and on the sources of knowledge and beliefs that underpin those positions.

Methods

Our study took the form of a qualitative investigation using semi-structured interviews.

Sample

A purposive sampling strategy was used. Participants recruited were professionally involved in activity related to adolescent health or education or sexual and reproductive healthcare

and all could be seen as influencing policy formulation or implementation relating to possible sex education curricula in Saudi Arabia. Key informants were identified by the PI in July, 2016. Most were personal acquaintances who connected the PI with further informants and recommended potential participants. Recruitment of participants commenced in February 2017 first through emails, phone calls and messages, followed by snowball sampling to identify further participants identified by those initially recruited. Recruitment continued until thematic saturation was reached, meaning no new themes were emerging from the interviews. Twenty eight participants were interviewed from four categories of stakeholders: policy-makers (n=7); social and healthcare providers (n=10); teachers and other school staff (n=9); and religious scholars (n=2). Throughout this paper, we have used pseudonyms to protect the confidentiality and anonymity of our participants.

Data collection

Interviews took place in Riyadh, Saudi Arabia between March and June 2017. They were conducted face-to-face at a venue of the participant's choice (n=20), or by telephone (n=8) and in either English or Arabic depending on participants' preference. All interviews were conducted by the primary investigator (NH), a young Saudi female physician as part of a doctoral thesis.

Interviews averaged 45 minutes in duration. They were recorded with the permission of participants and transcribed verbatim. Information sheets and consent forms were provided to participants either physically or via email in the case of face-to-face and phone interviews respectively. All documents were available in both English and Arabic. A recorded verbal confirmation of consent was taken where interviews were conducted by phone.

A topic guide was used to structure interviews, focussing on broad themes of sexual health and sex education. Participants were asked to describe their perceptions of the need for sex education, what an ideal sex education programme would comprise, and what the barriers and facilitators to such programmes in Saudi Arabia might be. Of specific relevance to the data reported in this paper, we elicited participants' views on sexual health approaches relating to harm reduction and abstinence. In many cases, views on these models were ventured spontaneously but where not, prompts and probes were used to elicit responses.

Analysis

Seven interviews were conducted in English as medical sciences are taught in English in Saudi Arabia and many clinicians communicate in English within their professional settings. An additional four were translated into English by the first author to allow non-Arabic speaking investigators to contribute to identifying themes. We used a modified grounded theory approach by beginning our analysis with codes established a priori from our interview guide (Glaser and Strauss 1967). All three researchers (NH, KW and WM) independently coded the eleven transcripts in English, following which discrepancies were discussed and resolved, and an agreed coding frame developed. The coding frame was then used by the first author to chart the material from the remaining 17 interviews on Excel sheets, translating relevant sections into English and thereby enabling all the investigators to contribute to the creation of subsidiary charts. All analysis was done in English but specific use of Arabic language was retained to preserve local expressions describing cultural nuances which would otherwise be lost.

Data on the respective merits of adopting abstinence-only and harm reduction strategies were extracted from answers to questions on the subject and from spontaneous references made by participants. The main identified themes were: the need for sex education; the nature of harm and protection; the role of science and religion; and ambiguity and avoidance. These themes were added to the chart. Specific attention was paid to the language, tone and context of participants' responses and field notes were used to contextualise their accounts.

Ethical approval

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

Findings

Key characteristics of participants are described in Table 1.

Table 1: Characteristics of Participants

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
Gynecologist	Female	Face-to-face	English
Paediatric Consultant	Female	Face-to-face	English
School Setting Educators and Staff- Intermediate and Secondary School Levels (students aged 12-18)			
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

Need for Sex Education

The need for sex education for adolescents was universally acknowledged by participants. Justification for this was provided by a wide range of reasons, including changing social norms in Saudi society. Words such as “open” and “modern” were used to describe apparent shifts in society. Although data collection took place three months before any of the recent reforms were announced, including lifting the ban on driving for women, anticipation of imminent change was expressed by many participants. Several described the trend as inevitable. Globalisation, increased travel opportunities, expanding overseas scholarships programmes, and the use of social media and the Internet were identified as factors that have increased exposure to Western culture, ideologies and lifestyles.

Increased STI incidence was also mentioned as a rationale for provision of sex education despite the absence of routinely collected data. For example, Dr. Sarah, reported seeing increasing number of patients with complications of undiagnosed STIs such as pelvic inflammatory disease, in what she termed ‘virgin abdomens’, indicating that STIs are underdiagnosed and reported in the country. A growing worry about sexual exploitation and abuse of young children was also repeatedly mentioned as a pressing reason to adopt sex education programmes. In addition, several participants postulated that the increasing age of marriage may allow a longer duration of possible sexual exploration between unmarried partners. Another reason for providing sex education identified by participants was the perceived increase in divorce rate attributed to poor communication skills and sexual incompatibility between spouses.

Despite a near consensus that sex education was needed, views on an optimal approach differed widely. Opinions tended to fall across a spectrum rather than into clear-cut categories of support for harm reduction or abstinence. Furthermore, preferred models could not be predicted from the background and training of participants.

Support for an Abstinence-Based Model

The importance of upholding traditional values relating to sexual conduct was unanimously voiced and none of the participants, irrespective of their stance in terms of approach, expressed support for the right to have sex outside the context of marriage. In accounts favouring an abstinence-based model to sex education though, opinions were more commonly grounded in religious teaching. Abstinence until marriage-related messages were held to be most congruent with religious beliefs. Individuals engaging in sexual encounters outside of marriage were seen as failing to adhere to Islamic rules of sexual conduct and dismissed by some as 'sinners'. Implicit in these accounts was the notion that knowledge of which behaviours were forbidden was enough to protect young people, hence providing information on reducing their potential harm was unnecessary.

> *It's known to young people that illicit relationships are haram, so if a person is straight (levelled) he'll avoid these relationships. Plus, adultery and homosexuality are forbidden in the religion.* Mr. Ali, school setting educator.

As a result, a harm reduction model was seen as more appropriate in the relatively secular Western world than in an actively religious society like Saudi Arabia and adopting

this model risked appearing to endorse a Western notion of sexuality. Some participants were highly critical of individual freedoms prevalent in the West.

> *I often go to the States [USA], may God reward them for all the great things they did for humanity, including freedom. But this freedom will swallow them whole if they don't recognise where to stop.* Ms. Huda, school setting educator.

Opposition to the use of harm reduction strategies was often justified on the familiar grounds that providing information on preventing adverse outcomes of sexual conduct that was forbidden would thereby appear to condone, and even encourage, it. Words such as *rationalising, legitimising* and *allowing* were typically used to describe how such messages may be interpreted by adolescents.

> *If I provide the student with information on harm reduction methods, it's like I'm telling him indirectly to go and perform.* Ms. Iman, official at a policy making agency.

Harm reduction messages were seen as not only encouraging, but also creating awareness of, censured sexual activity in hitherto innocent audiences.

Support for a Harm Reduction model

Justification for holding softer views on harm reduction tended to draw more on scientific evidence than religious belief. The role of sex education, it was considered, should be not to pass judgement but rather to present the scientific facts.

You're not telling them to go have sex, you're just telling them that HIV and STDs can be prevented if he uses a condom…you're not saying "before marriage or after marriage" that's not your role, you're sharing scientific information. Dr. Amal, social and healthcare provider.

An indirect style of speech is widely recognised as characterising Arabic dialogue in general and Saudi dialogue in particular (Zaharna 1995; Tawalbeh and Al-Oqaily 2012). In this context it served to increase the range of possible interpretations of what was said, enabling advice given ostensibly in one context to be applied in another.

Personal faith was strongly evidenced among all participants but many, particularly those in close contact with young people, described a weakening of religious belief within society, such that adherence to religious tenets could no longer be relied on to sanction conduct. In tandem with this, they witnessed growing confidence in scientific evidence as a means of guiding behaviour,

People don't have faith in the messages of haram and halal… If you want to convince them you won't tell them, God said this, you will tell him in the United States, a study showed this. People will probably say this is not true, but if we will put scientific theory above God's words. Mr. Omar, school setting educator.

Some kids are not very religious and fear of God's punishment may not prevent them from practicing sexual activity, but providing them with the negative health outcomes can have a stronger effect. Mr. Ahmed, school setting educator.

Rapid cultural transition and increasing exposure of Saudi citizens to a wider range of cultural, social and religious influences was seen as necessitating a more pragmatic stance. Attention was drawn to evidence of the increasing prevalence in Saudi Arabia of behaviours considered as 'irregular' as justification that harm reduction strategies were needed.

> *We know, a million percent, that there are many extramarital relationships. It doesn't mean that we're facilitating it or saying that it's OK, but when it happens, they can be aware that even if they made a mistake at least they're able to protect themselves.* Ms. Rana, school setting educator.

Given the reality that risky behaviors were already practised, advice on protecting their adverse consequences was not seen as incompatible with discouragement of others not to engage in them.

> Sometimes a person needs to have sexual education even if it includes something that seems like a *justification for an illicit action. For example, we need to fight drug use. But when we're told that a reason for HIV spread is sharing contaminated needles, we're not saying - go on and use drugs, but everyone should use their own needle. It's the same for sexual education.* Mr. Abdullah, religious scholar.

Expressions of support for harm reduction messages, however, also drew on Islamic scriptures. Religious texts, it was pointed out, could be interpreted in a way that did not run counter to conveying harm reduction messages; indeed, to do so was a religious imperative (*amanah),* since withholding beneficial knowledge from others is a sin.

Emphasis was put on the value placed by Islam on sexuality and the encouragement of sexual pleasure between spouses, while stopping short of approving pleasure within sexual relationships seen as irregular or illicit.

> *The Quran itself speaks about sex in a more open manner than any other religion. We don't look on it as taboo, it's a nice thing, but do it in the right way [within marriage]. In most religions, In Catholicism or Judaism, it's not a good thing, you do it to have kids, you shouldn't say you enjoy. But for us, it's the opposite, you actually get rewarded if you have intercourse with your husband or wife.* Dr. May, social and healthcare provider.

There was a willingness among some to see extramarital sex, not as a willful flouting of convention, but as a sign of human fallibility. As such, it was suggested, appropriate social responses were forgiveness and inclusion rather than condemnation and ostracism. Attention was drawn to the fact that Muslims are encouraged not to pass judgment on the actions of fellow Muslims. The level of sympathy deemed justifiable, however, had to be commensurate with the degree of agency possessed by individuals. Sympathy was considered appropriate in instances in which individuals were victims, or exploited by others, or unwittingly subjected to risk over which they had little control. Mr. Zaid, a policy maker, shared a story about a man who presented with Hepatitis B he had contracted from his wife whom he married through *zawaj misyar* [1]in South-East Asia. Hence, Mr. Zaid emphasized that that marriage was not protective in instances in which one partner was unwittingly exposed to risk as a result of their partner's behaviour.

[1] Or 'friend's marriage", is a type of Sunni marriage contract which is less formal and accords fewer rights than conventional marriage, usually accommodation and allowance. (Islam Questions and Answers, 2008)

Conceptualising Harm

It became apparent that the term 'harm' had a variety of meanings for participants, not all of which were consistent with use of the term in conventional public health discourse. Harm was often construed as extending beyond health risks to include damage to personal faith, reputation, and to social order. Young people were seen as needing protection against practices that could attract social opprobrium. In such cases, safety was construed as avoiding violations of social convention. Such views were highly gendered. Boys were more commonly seen as needing protection from STIs, girls as needing to preserve their virginity - and thus their honour. As a result, some felt harm reduction strategies to be more appropriate for young men than young women since, as Ms. Dina said, 'boys have nothing to lose', referring to the gender difference in assessing purity, honour and shame, since young women usually disproportionately carry the burden of protecting the family's honour and reputation.

Even clinicians stressed the importance of understanding that 'harm' goes beyond its biomedical definition.

> *I certainly wouldn't promote sexual activity… As a healthcare provider, I would want to ensure the safety of the young person. I have to be very honest about the social repercussions that are associated with these things… at an individual level and at a family and societal level*. Dr. Samah, social and healthcare provider.

In line with this, the term 'safer sex' also had a meaning other than that routinely used in public health. In the following account, the religious scholar, while claiming to recognise diversity, saw safer sex as the avoidance not only of risky practices but of deviant

sexual identities, that is, those not fitting the description of the 'legitimate and procreative couple' (Foucault 1978, 3-14).

> *Look, there are a lot of mistakes that happen under the table, for example, I am all for educating adults about the dangers of lesbianism and homosexuality. In addition to these acts being unnatural, we should tell students about the medical complications, even with condoms. Diversity is natural, and the whole universe is built on coupling and complementary relationships and the enjoyment of men in women, so safe sex can be addressed through sexual education from a moral perspective because all of the sexual deviations can be part of "unsafe sex", so we need to expand the meaning of safe to being safe clinically, morally and socially*. Ms. Noura, religious scholar.

Even the interpretation of which sexual behaviours were harmful drew on social, religious, as well as the health consequences. Islamic scholars differ in their stance towards masturbation, some believing it to be a sin, albeit not as serious as adultery, others seeing it as a permissible as a means of avoiding adultery (Islam Online n.d). For some participants masturbation was problematic, in having the potential to damage marital sexual relationships or compromise sexual function. Others saw masturbation as a risk reduction practice in itself, protecting against pre or extramarital sex and regretted the perpetuation of myths about its harm.

The phrase ثقافة العيب which literally translates to *vice culture* was repeated in most accounts as characteristic of Arab culture where fear of shame and ostracism from going against social norms exceeds the fear of other consequences. This was a difficult phrase to translate as it is loaded with various meanings.

Reconciling Scientific and Religious Perspectives

Scientific and religious perspectives were not seen as necessarily incompatible. Suggestions were made for ways in which harm reduction and abstinence messages could be combined, and scientific knowledge and religious doctrine integrated. Parallels were drawn with similar strategies in drug prevention work, for example, in which hierarchies of preventive messages preserved the need to discourage initiation of harmful practices, encourage cessation where they have begun; and reduce the frequency of the behaviour (Beck 1998).

> *I think it [ideal programme] can be embedded in science or religion, both, you can embed it in both of them … But it has to be taught*. Dr. Maha, social and healthcare provider.

> *You can provide them with the Islamic view on adultery but also indirectly tell them that if this does happen, the lesser of two evils would be using a condom. I mean there is awkwardness in delivering this information but it needs to be given.* Mr. Hassan, school setting educator.

Science and religion, it was held, might come together through collaboration between the relevant ministries and the involvement of both scientists and religious figures to harness the strengths of both. The perception was that the information needed to be scientific and as such should be formulated by scientists, but religious scholars could be used to present it to the public with emphasis on the Islamic moral codes.

Ambiguity and Avoidance

There was evidence throughout the interviewing process of some unease among participants in responding to questions. This was manifest in struggles with putting opinions into words, in body language and - in phone interviews - hesitation and repeated clearing of throats before responding. Phrasing was often indirect, and when direct terms were used in questioning, participants often appeared ill at ease, looking away or lowering their voices, or prefacing explicit or literal sexual descriptions with phrases such as “God forgive us”, and several participants had obvious difficulty in verbalising the word “sex” or “jins” in both English and Arabic.

There was also outright refusal to engage in discussion of some topics, questions being met with evasion or abrupt and negative responses. Prolonged and insistent silences at times forced the interviewer to move on to a different topic. The signalling of areas that were not to be spoken of ‘functioned alongside the things said’, marking the boundary between what was permitted and what was prohibited as effectively as when verbalising the distinction (Foucault 1978, 3-14). This phenomenon, it should be said, was not limited to participants. Homosexuality, for example, was not asked about for questioning for fear of offence, but was spontaneously raised in some responses.

Accounts also revealed considerable revision in the position taken on issues, according to the scheduling of the interview, who participants saw themselves as talking to and who they were talking about. At times, a strongly supportive stance towards harm reduction was initially expressed, only to be later rescinded or hedged with provisos. The converse was also seen, initially a participant would affirm an abstinence-based model but subsequently acknowledge the need for fail-safes. Typically, opinions expressed before recording began were less guarded and more personal; becoming more consonant with

accepted beliefs and social convention when recording began, reverting again as the interview progressed and participants possibly sensed the persuasions of the interviewer. The tenor of views expressed also appeared to be contingent on whether participants were speaking in a professional or personal capacity. They were not asked to reflect on their personal experience, yet many did so, and their accounts were then often marked by prevarication. A teacher, asked to give his view on including harm reduction strategies such as condom use in sex education programmes initially concurred with the idea but, on reflection as a parent, saw it as potentially encouraging risky sexual behaviour, using the analogy of facilitating theft: 'As a father, I don't want anyone to make theft accessible to my children', Mr. Omar. -

Paradoxically, although the lack of directness in accounts at times hindered effective communication, it also allowed latitude in the interpretation of what was said (Zaharna 1995). Some suggested it as a deliberate tactic in framing culturally sensitive messages. Ms. Zahra, an official in a policy making agency enthusiastically answered "Yes, yes!" when asked if harm reduction information should be provided, yet added "but of course without going into needless details" [103] a phrase regularly used in Saudi dialogue to refer to the social expectation to omit terms that may be perceived as inappropriate, while a male official at the Ministry of Health suggested packaging difficult messages behind a façade of those that may be more acceptable.

> [Harm reduction] *can be mentioned in other important topics like, contraception. For example, we can mention condoms as a contraceptive method that also helps in protecting from some diseases.* Mr. Aziz, Official and policy making agency.

Discussion

These data show widespread acceptance by stakeholders of the need for sex education in Saudi Arabia, but divergent opinions on the approach to take. Arguments in favour of abstinence-based models of provision draw more on religious doctrine as the source of authority, while those for harm reduction models draw more on rationality and scientific knowledge, yet these opposing arguments did not emerge as mutually exclusive or incompatible and both are viewed as having a role in legitimising specific stances. A key finding from this study concerns the conceptualisation of 'harm' in the Saudi context. In construing harm needing to be limited, stakeholders mentioned harms to health but placed equal if not greater emphasis on detrimental effects on the reputation and social standing of individuals engaging in specific sexual practices and partnerships, and the damage to societal ties, structure and the Muslim identity.

Many of the points raised by stakeholders have clear implications for the framing and implementation of sexual health education, not only in Saudi Arabia but in other Islamic countries and Muslim communities. They suggest potential discontinuities between current international recommendations on provision of sex education and the norms, values and communicational patterns characterising the Saudi context. Un agencies including WHO and UNESCO have urged adoption of a comprehensive model to sexual health education, which stresses the importance of providing clear information on harm reduction while emphasising the importance of readiness for onset of sexual activity (UNAIDS 2018). Harms relating to sexual health have traditionally included STIs and unplanned pregnancy and more recently have been broadened to include psycho-social aspects such as non-consensual sex, gender inequality, and sexual function. Limited data exists on attitudes within the Middle East and North Africa (MENA) region in adopting comprehensive sex

education and within the available research, views on supporting or opposing harm reduction strategies are still defined within the conventional public health frame (Zaabi et al. 2018; Farrag and Hayter 2014; Hasnain 2005; Mohanna et al. 2017; Tabatabaie 2015) Both international guidelines and local studies rarely focus on damage to social standing and reputation, aspects which it would be essential to address in the Saudi context. These data suggest that sex education programmes which appear to accept practices which in Islamic settings are likely to bring opprobrium on the actor will face obstacles to delivery in Saudi Arabia.

The tension between sex outside of marriage as proscribed and sex within marriage as prescribed in Saudi Arabia creates challenges for comprehensive sex education. The co-existence of imperatives to seek pleasure in marital sex and to avoid danger in extramarital sex generate potentially contradictory messages to young people. Furthermore, the peculiarities of Arabic speech form, its indirect and figurative nature, may seem to be at odds with the transparency often recommended in the delivery of sex education. Yet it also emerges that this very feature, by allowing messages ostensibly intended for application in one context (for example, marital sex) to be taken up in another (for example, premarital sex) may also have advantages in allowing otherwise unacceptable messages to be conveyed covertly. Ambiguity may increase the range not only of possible interpretations of what is said, but also the audiences to which it is directed (Zaharna 1995; Othman et al. 2004).

A major strength of the study is the uniqueness of the data. These are, to our knowledge, the first data on the views of stakeholders on sex education approaches to be reported in Saudi Arabia. A further strength inheres in the diversity of backgrounds of participants. Religious scholars can be difficult to recruit and may withhold disclosing

personal views on sex education for fear of public reaction. The majority of research within MENA region that explores the need for sex education usually focuses on presenting the opinions of adolescents' and parents' views, while shying away from capturing the voices of government personnel in relation to sexual health matters who may have a direct impact on formulating and implementing any possible sex education programme (Zaabi et al. 2018; Alquaiz et al. 2012; Mohanna et al. 2017; Farrag and Hayter 2014). Success in recruiting and engaging these participants may have been partly attributable to the background of the interviewer, a clinically trained Saudi national. At the same time, it is likely that being interviewed by a young Saudi woman about sexual matters in an Islamic setting would have seemed to many unusual, and to some unacceptable. Awareness of the researcher's clinical training in some interviews would almost certainly have influenced responses, possibly increasing disclosure among fellow clinicians in some, and a tendency to express science-friendly opinions in others.

A further limitation stemmed from the need to translate into English the Arabic phrasing and constructions used by stakeholders. Culturally specific concepts and expressions featuring in accounts did not always translate readily into English and the fact that only the first author spoke Arabic meant that their meaning had to be explained to the English-speaking co-investigators, introducing an additional level of interpretation. Limitations also relate to the exigencies of time and space. The study took place exclusively in Riyadh, the capital city of Saudi Arabia - necessarily since the majority of policy-making occurs in the capital. However, the views of residents in a metropolitan city are likely to have been more liberal than those in rural areas, and many participants had been educated abroad, specifically, in North America, Australia and the United Kingdom. It is also likely that the views of those who agreed to take part were different from those who did not. They

may also have been more liberal since key informants who assisted in recruitment emphasised the need to find "open minded people" who would agree to talk about the topic, despite the researcher's plea to the contrary. The research was also carried out just three months before the announcement of major reforms in Saudi Arabia by the newly appointed Crown Prince, including greater educational opportunity, increased representation of women in civil and private sectors, and new legislation to further women's rights.

Although our data points towards a shift towards modernity in Saudi culture, it is important to note that modernity and Westernisation are not viewed as synonymous within Saudi society. Where modernity tends to be viewed as a positive change away from some restrictive traditions hindering progress, Westernisation is viewed more as a negative change towards disapproved social mores. The findings of this study prompt circumspection in assuming that recommendations relating to sex education programmes made by supra-national agencies are universally transferable. In terms of empirical work, a necessary next step in preparing the ground for the design and implementation of a sex education programme in Saudi Arabia should be the inquiry into the views of adolescents and parents as has been done in neighbouring countries (Zaabi et al. 2018; Javadnoori et al. 2012; Mohanna et al. 2017).

Conclusion

The need to address the sexual health needs of adolescents through education is recognised by key stakeholders in Saudi Arabia. There is less agreement on the appropriate approach to be taken, and on the relative merits of abstinence-based and harm reduction models. The conceptualisation of harm differs from that commonly seen in international public health

definitions relating to sexual health and includes detrimental effects of engaging in culturally disapproved behaviours on individual reputations and the social order in addition to biomedical harms. Both scientific evidence and religious doctrine are drawn on as sources of authority guiding an appropriate approach to sex education and though they appear to co-exist uneasily, strategies including both are considered feasible in Saudi Arabia. In addition, local forms of speech and communication that employ ambiguity and indirectness can potentially be utilised in conveying of otherwise culturally sensitive messages. These findings will be of value in countries with similar local traditions and political systems or in communities with similar religious beliefs and views.

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