

**Women's sexual health care in Saudi Arabia: A focused
ethnographic study**

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**A thesis submitted to the University of Sheffield for
degree of Doctor of Philosophy**


2010

**Faculty of Medicine
School of Nursing and Midwifery**

Volume 1

Declaration

This written thesis is my own unaided work

Signed..........

Date..... 29.3.2011

This thesis is dedicated

To my mom

Khadijah Bent Omar

For everything she has done for me through her life

For placing her hopes and dreams in me, which I hope came true

To my husband and my best friend

Masoud Al-Harbi

For everything he gave especially his kindness, love, patience and sacrifices

Truthfully without his support this thesis would not have been possible

To my lovely three children

Renad, Eiad & Randa

For their support, understanding and for their enduring tolerance with my work and studies
over the years

Their love, smile, laughter and even complaints helped me to overcome many difficulties and
challenges which it was an enjoyable for me to exceed over it because they are in my life

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Acknowledgements

My first thanks go to Allah for giving me the strength and ability to conduct this study and for his kindness to ease years of expatriations from my family and country during my study in the UK.

I would like to give great thank and gratitude to my main supervisor Dr Mark Hayter and my co-supervisors Dr Jean Rune and Dr Helen Stapleton for their help and support over the years and for their interest in going through some of my more recondite research discussions and data. I would also like to thank them for their assistance and careful reading of my thesis drafts at all different stages stimulating discussions and contributing ideas for improvements.

My deepest thanks go to every consultant, doctor, nurse and female patient in both hospitals who generously gave their time to this research. Without their support and involvement this project would not have been possible. They make me feel humble and privileged to be entrusted with their views, stories and experiences.

My special appreciations go to my brothers, sisters and friends who instilled confidence in me and provided support and advice throughout my presence in the UK.

Lastly, I would like to thank the Saudi embassy and the Saudi cultural bureau in London for their support, help and advice. They were a helpful source through all the time I spent in the UK.

Abstract

Study aim

This study was conducted to describe how women and health care professionals perceive sexual health and services that are currently provided in Saudi Arabia.

Background

At present, the worldwide health authority, in the form of the World Health Organisation (WHO) has drawn great attention to the importance of improving women's sexual health globally. It is increasingly concerned about women's sexual health and permanently works to shed light on the innovative approaches that are needed to raise women's awareness of risky behaviour, and to help them access the advice and treatment they need to avoid negative health outcomes that would impact on their future lives. Research into women's sexual health in Saudi Arabia will help in identifying possible causes of poor sexual health care that could be used as preventive tools in that, or similar cultures. In addition, it helps to meet women's physiological, emotional and educational needs, which is essential to support good sexual health.

Methods and data

The researcher adopted an exploratory, qualitative method to conduct the study with an ethnographic design. It was undertaken in two governmental hospitals in Jeddah city, namely King Abdulaziz University Hospital and Maternity and Children Hospital. The duration of data collection was two months in each hospital. Women, doctors, nurses, and clinic managers all were participated in the study. Observational notes, document analysis and in-depth interviews were used for data collection. Detailed field notes were recorded of observations in the setting, clinical consultations and the participant's behaviours and

interactions. 40 Interviews were conducted (21 with female patients and 19 with Health care professionals) and 74 consultations were observed. The data analysis was conducted using the framework identified by Holloway and Todres (2006, p. 219), for use in ethnographic research.

Findings

Female participants reported experiencing more difficulties in talking about sexual matters generally, and specifically those that related to sexual intercourse. They also delayed seeking sexual health care as a result of the influence of Saudi social norms around women's sexuality. Plus, appointment issues, long waiting times, low quality of care provided and being dependent upon husbands for transportation were also barriers to accessing sexual health care or advice. Health care professionals tended to avoid initiating discussions about sexual matters in their clinical practices, to respect the cultural norms and avoid offending the patient. Many other barriers to talking about sexual topics in the clinic were also reported by the health care professionals in the current study. Sexual health care and services in Saudi Arabia are limited, lack integration to sexual health education and centre on reproductive health through the provision of obstetrics and gynecology care and contraception.

Discussion

Using the Theory of Reasoned action as a theoretical framework to discuss the findings of the study this chapter sets out how the social norm pressures that are embedded in Saudi culture particularly those related to women and sex significantly influence both health care professionals and women's attitudes and behaviour towards sexual health care. The effect of Islamic guidance on Saudi culture and in participants' lives was very strong and clear. Adopting the concept of holistic sexual health explicitly in Saudi Arabia would be difficult

and problematic. Missing the opportunity to talk about sexual issues in general, and in consultations in particular, put women at the possible risk of poor sexual health.

Conclusion

Multifaceted interventions and programs are necessary to improve the quality of services that provide women sexual health care in Saudi Arabia. Efforts to influence social norms, empower women, enhance health care professionals' roles and functions and more research into women's sexual health is required.

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Abbreviations

Abbreviations	Full name
CS	Cesarean section
CTG	Cardiotocography
ESWL	Extra corporeal shock waves lithotripsy
FD	Female Doctor
FP	Family Planning
FPC	Family planning clinic
HCPs	Health care professionals
HIV	Human Immuno-deficiency Virus
I	Interviewed
ICPD	International conference on population and development
IUD	Intrauterine device
KAUH	King Abdulaziz university hospital
KSA	Kingdom of Saudi Arabia
MCH	Maternity and children hospital
MD	Male doctor
MOH	Ministry of health
MOI	Ministry of Information
N	Nurse
O	Observed
O&GC	Obstetrics and gynecology clinic
P	Page number
PHCC	Primary health care center

PP	Postpartum
PPC	Post partum clinic
Pt	Patient
PUH	Peace upon him
SA	Saudi Arabia
STD	Sexual transmitted disease
STI	Sexual transmitted infection
SVD	Spontaneous vaginal delivery
TPB	Theory of planned behavior
TRA	Theory of reasoned action
UK	United kingdom
UN	United nations
USA	United States of America
WHO	World health Organization

Terms explanations

Terms	Definition
Abaya	Long black dress cover all women body
Allah	God name in Islam
Aurfi marriage	Contract of marriage written on ordinary paper and not registered legally with the government
Fatawa	Interpretations given by Muslims scholars when verses and text of the Quran and Sunnah are not direct or clear
Hadeeth	Saying of prophet Muhammad (PUH)
Hijab	Veil
Jihad	The use of physical force to protect Islam if necessary
Khula	When a women asks for a divorce
Maher	Dowry
Mahram	A man who cannot marry the woman
Melkah	The time when the couple is officially married but still living in their family's house
Mesyar Marriage	Marriage that allows men to put certain condition on their marriage
Nafas	Period after given birth, usually 40 days (postpartum)
Qawamah	The responsibility of the man over the women
Quran	Allah's revelation
Rajm	Sentence to death by stoning
Shariah	Islamic jurisprudence
Shura	Islamic ideology mean "consulting"
Sunnah	Elaborations by prophet Muhammad (PUH)

Taouhid	No god except Allah
Zena	Sexual relations outside of marriage
Taying	An expression refer to sterilization method

Chapter 1: Introduction to the study

1.0 Introduction

This thesis concerns the conduction of a focused ethnography in women's health clinics within two large governmental hospitals in Saudi Arabia (SA). This chapter introduces the study. Firstly, discuss the personal and professional motivation for the study, and introduce the Kingdom of Saudi Arabia where the study has been conducted. It will then provides background information on the status of women in SA and describe the Saudi Arabian health care system. Finally, the chapter will provide a brief summary of the next chapters in the thesis.

1.1 Personal and professional motivation for the study

Thanks to God, the researcher is fortunate to be a Saudi female and wife and mother to three children, who was born into a family that has always encouraged her education and shown openness to other civilizations and cultures. She is married to a husband who continually welcomed and supported her academic and professional career; to the extent that he resigned from a good job in order to travel abroad to join her during her studies as required in the abroad scholarship conditions "availability of the mahram". This fortune is probably not available to some Saudi women. As a woman born and raised in a conservative Arab country, the researcher has a good awareness about the challenges facing women in Saudi Arabia towards sexual health. From the personal experience of marrying and giving birth to two children in Saudi Arabia, the researcher knows there is no simple leaflet or pamphlet about these topics distributed in health care settings; nor is anything given either after giving birth

or near to the time of marriage, which puts women in a difficult situation when dealing with these important parts of their health.

Furthermore, as she previously worked as a clinical nurse and is currently a lecturer at King Abdul-Aziz University in Jeddah, the researcher has always been interested in improving women's health in general, and their sexual health specifically. When working in the Urology Department for two and a half years, the researcher saw a lot of patient in situations that reflected the urgent need for much better sexual health care and education. The researcher's interest in women's sexual health has increased greatly since her Bachelor's degree, when she investigated the impact of mothers performing female circumcision on their daughters as research project. She then took a more focused research direction upon the completion of a masters degree in London (Al-Zahrani, 2006), which was focused on the use of contraception among women in SA, and their views on the provision of contraceptive education by nurses in family planning clinics. However, a specific interest arose during the literature review, when no useful research was found regarding women's sexual health and sexual health care provision in Saudi Arabia, a country that is equal to all European countries in its volume.

Studies in the United Kingdom (UK) in both London and Sheffield provided the opportunity to become oriented to a certain extent about the sexual health care provided for women in the UK, and about how the UK government tries to help women to be well informed. In addition, in the UK, friends, colleagues and professionals from different nationalities, all enquired about women's sexual health in Saudi Arabia. These questions and discussions led to reflections such as: what is the provision of sexual health care for women in Saudi Arabia?

What do women in Saudi Arabia understand and need in terms of sexual health care? To what extent has the role of health professionals developed in relation to sexual health care? As a result of this interest and analysis, the researcher started to realise how women's sexual health care is an important subject that needs to be explored fully in Saudi Arabia.

1.2 The Kingdom of Saudi Arabia

The Kingdom of Saudi Arabia (KSA) is located on the Arabian Peninsula, in the south-west of the continent of Asia. Covering an area of approximately 2,270,000 km², it has a strategic location between three continents and is the largest Arab country in the Northern hemisphere. It is home to many civilizations, and the cradle of divine messages. The culture of Thamood, Elam, and their effects are still present even today in the area known as Madain Saleh, in the Najran Rift. KSA occupies the largest part of the Arabian Peninsula, about 80 percent of the total area, and it is considered to be the world's 14th largest state which gives it an important position in the world.

The KSA is located in the central heart of the world, sharing borders with Iraq, Jordan, and Kuwait to the north, the United Arab Emirates, Qatar, Bahrain, and the Arabian Gulf to the east, the Sultanate of Oman and Yemen to the south, and the Red Sea to the west (Elmadani, 1993; Yousef, 1999). The capital city of KSA is Riyadh which is located in Najd, in the middle of the Kingdom. Saudi Arabia is divided into thirteen zones and five regions: Al-Wosttah in the centre; the Hijaz region, also called "Algharbiah", along the Red Sea which contains the holy cities of Makkah (Mecca) and Madinah (Medina), the port city of Jeddah

and the summer capital of Taif; the Al-Sharghiyah region in the East; Al-Janoob in the South; and the Al-Shamal region in the Northern part of the Kingdom (see figure 1).

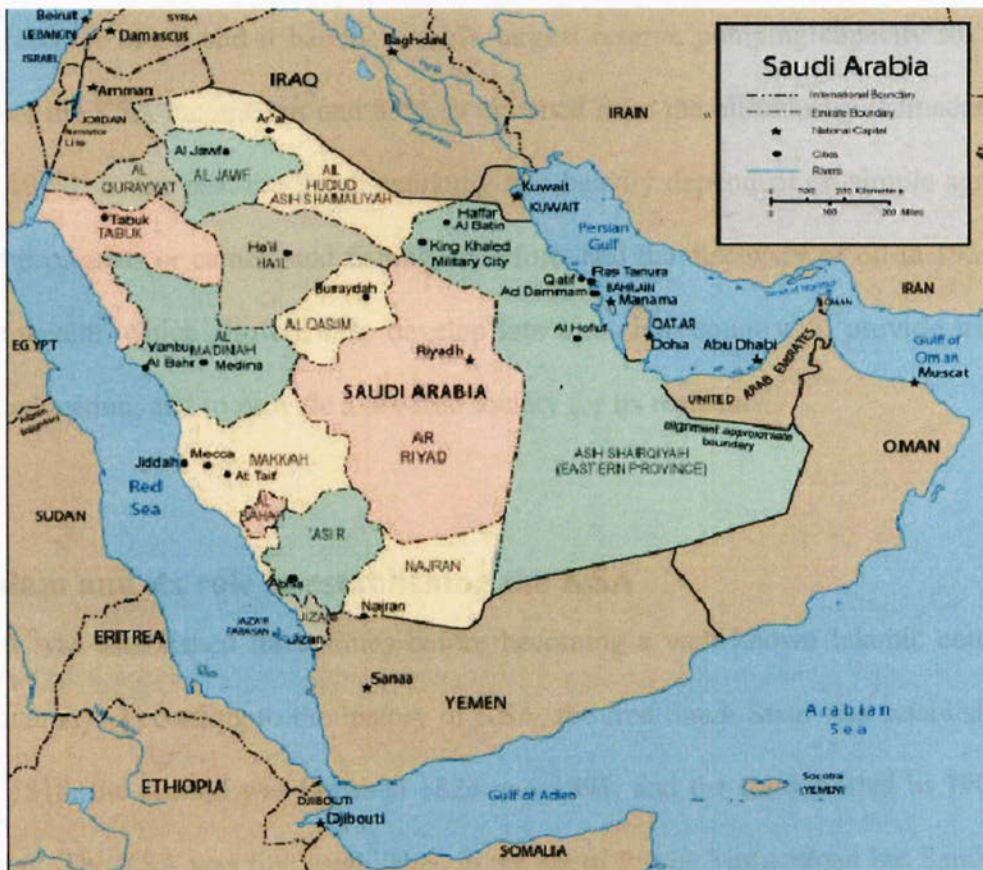


Figure 1: Map of the Kingdom of Saudi Arabia

KSA's climate varies from one region to another due to its different terrain and the influence of high tropical air. However, in general the KSA has a very hot summer, a cold winter and is rainy at winter time particularly in the northern and southern areas.

The KSA means different things to different people around the world. For example, to some it means a land of oil, a land of wealth and a land of money, to others it is a land of the desert,

extreme heat and is symbolized by the camel. It could also mean the birthplace of Islam, a blessed and sacred land that is the Land of the Two Holy Mosques at Mecca and Medina, the two holiest places in Islam for all Muslims around the world. Nowadays, the KSA has become well known as the world's single largest oil exporter, having about one third of the world's reserves of oil and it has the world's largest reserve pumping capacity for oil. The majority of the KSA income, around 85%, is obtained from the oil industry (Elmadani, 1993; Yousuf, 1999). In the past the Saudi economy was heavily dependent on simple agriculture, selling sheep, goats or camels and fishing, therefore, and the discovery of oil in 1936 helped to create wealth, which allowed it to develop into a modern country, to provide free health care and education, and to provide a tax-free society for its residents.

1.2.1 Islam and its role in establishing the KSA

The KSA was established three times before becoming a well known Islamic country and Arab monarchy. According to the history of KSA, the first Saudi State was established from 1744 to 1818, the second was between 1824 and 1891, and the third started in 1902 to the present day. The KSA was first established in the era of Prince Muhammad bin Saud with the support of Islamic leaders called the Al-Wahabiah movement, which strongly emerged under Muhammad Ben Abdelwahab (Al-Rasheed, 2002; Blanchard, 2010). The collaboration was started between the leader of Al-Wahabia and Prince Muhammad bin Saud, aiming to reinstate *Taouhid*, which means no god except *Allah* (Gods name in Islam), and to get rid of shirk or fads (the worship of death individuals, stone or fire or idols with Allah), which existed at that time in the Arabian Peninsula tribes.

The movement was widespread and supported by many tribes, hence the majority of these tribes gave their full support and loyalty to Prince Muhammad bin Saud (Al-Rasheed, 2002). The first Saudi state continued for 67 years. During that time the essential constitution for the country was the *Quran* (Allah's revelation) and *Sunnah* (elaborations by the Prophet Muhammad, Peace upon him (PUH)), and this foundation has been strongly upheld by all Al-Saud leaders to the present date.

After the breakdown of the first, then the second Saudi states, Abdulaziz, one of Al-Saud's sons, was able to establish a third successful Saudi state with the help provided by Islamic leaders and tribes loyal to the Wahabia movement (Al-Rasheed, 2002; Blanchard, 2010). He was able to enter Riyadh on January 17th in 1902, and to overcome his opponents. King Abdulaziz was able to include Ahsa, Qatif, and to found the rest of the Hejaz. On the 8th of January 1926, King Abdulaziz became the ruler of the Hejaz. Finally, on September 23rd in 1932, King Abdulaziz was able to standardize the Royal Decree, which unified the regions and provinces of the state as the Kingdom of Saudi Arabia. This has become the National Day of the KSA (Elmadani, 1993). KSA is the international and official form and abbreviation used locally and internationally; however, some call it Saudi Arabia (SA), and this form will be used throughout this study.

1.2.2 Islam in Saudi Arabia

From the history of SA it is clear that Islam and Islamic leaders have been strongly integrated with Saudi leaders since the establishment of SA. As a consequence, Islam has a great influence in almost every aspect of SA's social life and has become deeply involved in Saudi

policy and politics. Islam is the dominant and official religion in SA and Arabic, the language of the Quran, is the official language. Muslims form the majority of the population and the non-Muslim population of SA is mainly made up of foreign workers with different religious affiliations. The constitution and governance in SA is based essentially on *Shariah* (Islamic Jurisprudence) as stated in the Quran, the *Hadeeth* (sayings of Prophet Muhammad) and the Sunnah. Applying Shariah has promoted legitimacy and power for the Saudi state. The main assembly in SA is the Applying *Shura* council, which is an Islamic Shariah ideology run by Muslim scholars for consulting (similar to parliament in the UK). This council looks at laws proposed by the Council of Ministers and can suggest changes according to the Islamic perspective.

In general Islam and Islamic roles and principles permeate every aspect of Saudi daily life, and also permeate every aspect of the Saudi Arabian state. Saudi law is based on the fact that Islam is one of and the last of the great monotheistic and Abrahamic religions, which was sent to the people through the Prophet Muhammad (PUH), who received his call to become a prophet in the Western Arabian in the city of Mecca.

There are five pillars of Islam which constitute the basic religious duties that every Muslim must perform and these form an essential part of the Saudi teaching curriculum. These are summaries on following the Hadeeth: "*Islam was built on the five, the testimony that there is no god but Allah and that Muhammad is the Messenger of Allah (Al-Shahadah), and held a prayer (Al-Salah), and the delivery of the zakat (Charity), fasting Ramadan (complete abstention from food and drink and sexual intercourse, and avoiding looking at, talking or*

hearing inappropriate things from sunrise until sunset), *and visit the home (Mecca) for those who can afford (pilgrimage)*".

Islam considers health to be a blessing from God to the individual, therefore people are encouraged to consider this blessing by maintaining it, Prophet Muhammad (PUH) said: *"There are two blessings which many people do not appreciate: health and leisure time."* In line with this Hadeeth, Saudi culture and law explicitly propounds guidance as to what constitutes a healthy person from an Islamic point of view and forbids adultery, gambling, drinking alcohol, eating pork, smoking and practicing masturbation or homosexuality. It also states that sexuality should be exclusively within the context of marriage between men and women which is mentioned in the following Hadeeth: *"I pray and I sleep; I fast and I break my fast; and I marry women. Whoever turns away from my way of life is not from me."*

1.3 Women's status from an Islamic perspective

There is a significant amount of discussion, both in the media and beyond (often in the West) about Muslim women and what their position in Islam is. Much of this attention gives the image of Islam as a prison: restricted, narrow, backward and reactionary, particularly in relation to women. At first in writing this section of the thesis, it was uncertain as to which perspective should be adopted to provide an overview of women living in an Islamic culture. Finally, it was decided that, in keeping with an ethnographic study it is worth exploring the status of women from an Islamic rather than a "critical" Western perspective. It will be discussed based on the interpretation of Muslim scholars of the Quran and Hadeeth who have discussed women's issues in their books which have been adopted in the Saudi curriculum

and supported by Saudi TV programmes. This part of the thesis aims to help the reader understand how Saudi women are led to think about themselves, and how Islam in SA provides the social conventions and social norms that strongly influence how women are defined.

1.3.1 Men and women are equal, but different

All Islamic scholars argue that Islam blesses the status of women and helps to give them full social rights and positions which were not there or recognized during the times of deep ignorance in the Arabian Peninsula. They mention that, before Islam, a woman's position ranged from a mere housekeeper to being buried alive for causing 'shame and disgrace'.

There are many verses in the Quran which are frequently used by Muslim scholars to decry what was happening to women at that dark ignorant time:

"And when the girl {who was} buried alive is asked for what sin she was killed"

(Quran-Al-Takweer-8)

"And when one of them is informed of {the birth of} a female, his face become dark, and he suppress grief. He hides himself from the people because of the ill of which he has been informed. Should he keep it in humiliation or bury it in the ground?"

Unquestionably, evil is what they decide" (Quran-Al-Nahl-58).

Women are told that the Quran provides the guarantee of women's rights and to raise their status. For example, according to Islam, women are equal to men in reward:

"whoever does righteousness, whether male or female, while he is a believer-we will surely cause him to live a good life, and we will surely give them their reward in the hereafter according to the best of what they used to do" (Quran-Al-Nahl-97).

Fundamentally, Islam declares that men and women are *equal but different*, and that each of them is a facilitator for the work on this earth according to their creation and that they are a compliment to each other:

"It is he who created you from one soul and created from it its mate that he might dwell in security with her and when he cover her {allusion for copulation} she carries a light burden... "(Quran-Al-Aaraf-189).

"O mankind, indeed we have created you from male and female and made you people and tribes that you may know one another" (Quran-Al-Hujuraat-13).

1.3.2 Islam and gender roles

Islam discusses both women's and men's roles and rights in the community and the family and how the individual, the family, and community are all very important in Islam which Muslims are asked to think about and to prioritize. Accordingly, Muslim scholars argue that the provisions of the laws and principles of Islam take all of these aspects in to account, and that one should not be at the expense of the other in any matter. For instance, there are verses in the Quran and Hadeeth that encourage a woman to be the leader and the coordinator in her home and encourage her to maintaining her chastity:

“And abides in your houses and do not display yourselves as was the display of the former times of ignorance. And establish prayer and give zakah and obey Allah and his messenger. Allah intends only to remove from you the impurity of sin, o people of prophet's household, and to purify you with extensive purification” (Quran-Al-Ahzab-33).

All scholars use this verse to argue that a woman should primarily stay at home but that she has the right to go out for justified needs, such as learning, working to earn essential money or a livelihood for herself and her family, or for voluntary work, worship, and other reasons. However, different Muslim scholars, both in the past and the present, agree and stress that a woman's going out should be in parallel with her leadership and motherhood role at home and not be the reason for the ruin of her home, her family, or her community.

There is also the condition that women should adhere to when there is a need to go out, this includes wearing the veil *“Hijab”* and demure dress that covers the entire body and which should not be transparent. It should also be broad so that her body is not revealed. They support their word by stating this verse, and other similar verses in the Quran:

“And tell the believing women to reduce {some} of their vision and guard their private parts and not to expose their adornment except that which {necessarily} appears therefore and to wrap {a portion of} head covers over their chests...”(Quran-Alnoor-31).

Women are only allowed to remove the hijab in front of "**Mahrams**". A mahram is a man who cannot marry her and they are mentioned in this verse in the Quran:

"And not expose their adornment except to their husbands, their fathers, their sons, their husbands' sons, their brothers, their brothers' sons, their sisters sons, their women that which their right hands process or those male attendant having no physical dress or children who are not yet aware of private aspect of women. And let them not stamp their feet to make known what they conceal of their adornment"
(Quran- Alnoor-31).

1.3.3 Islam and Polygamy

Polygamy means marrying more than one wife. Muslim scholars argue that, before Islam, men were able to marry more than one wife, and as there was no adherence to how many wives a man could have in any other religion, the number of wives was unlimited (Philips & Jones, 2005). They argue that as Islam came and made it clear that this practice should be limited to four and be controlled and allowed only for a reasonable reason and with ability to perform justice between wives.

However, at the present time Muslim scholars strongly support polygamy arguing that it provides a solution to the dramatic increase of spinsters, of divorcees inside the country and of widows due to the wars in Islamic countries such as Afghanistan, Palestine and Iraq. Some notable Muslim scholars actually encourage Muslim women to help in arranging other marriages for their husbands, and to accept polygamy as a show of solidarity for the unmarried Muslim women around the world.

1.3.4 'Man over the woman': "Qawamah"

Muslim scholars argue that Islam is more lenient with women in some noticeable aspects than with men because Allah knows about his creatures. For example, the congregational prayer is not obligatory for women as it is for men. Women are not actually asked or required to perform the five daily prayers in the mosque and they have the choice of praying in the mosque if they want to but will still have the same rewards if they do them at home, while choice is not possible for men. In addition, women are able to break their fast during Ramadan (Ramadan is the ninth month according to the Arabic calendar) if they have their monthly period or if they are pregnant or breastfeeding.

"Whoever is ill or on a journey then an equal number of other days, Allah intends for you ease". (Quran-Al-Baqarah-185)

Jihad (the use of physical force to fight for the defence of Islam, in order to protect its teaching or take out enemy territory that has been usurped) is not required of women, but at the same time they are not deprived of it and do not prevent it. Women are also given the full rights of ownership, lease, sale, purchase, and other contracts and no one can take or inherit their money without their full consent:

"O you who have believed, it is not lawful for you to inherit women by compulsion...."

(Quran- Al-Nisa-34).

In fact, a woman is not responsible for bringing money to the family and expenditure is the husband or the father's responsibility throughout a woman's life. In Islam, the male is

considered to be in command of the family and is obliged to take care of his wife financially, even if she is working or is rich,

"Men are in charge of women by right of what Allah has given one over the other and what they spend from their wealth..." (Quran-Al-Nisa-34).

Similarly, the Prophet said:

"...If I ordered to bow down to anyone I will ordered the women to bow down to her husband".

This emphasizes the responsibility of the man over the woman, "**Qawamah**", which is supposed to offset women's obedience to their husband on condition of their rights. Many scholars agree about the importance of the full preference of men over women that is based on the many responsibilities that men carry out for the women and for the family.

1.4 Women in Saudi Arabia

It is obvious that the influences of the Islamic leaders are significantly built into SA's governmental and social structures, and are central to the country's state-supported interpretation of Islam, which is solely derived from the literal reading of the Quran and Sunnah by Muslim scholars. The position of women in SA is greatly affected due to the fact that many Muslim scholars adopt an extreme interpretation of the Quran and Sunnah that avoids any consideration of developing social contexts and resists any change especially when it comes to issues such as dealing with women's lives and behaviour (Hamdan, 2005).

There are many examples that will be discussed here to show how women's position is influenced and affected by the interpretation of Islam in SA. For instance, although changing

the colour of the hijab and the necessity of wearing a veil covering the face Saudi women are expected to wear a long wide black *abaya* to cover all their body and to wear a veil covering their face when leaving the house for any reason.

In 2005, a Saudi female director produced a film called "Women without shadow" discussing Saudi views on the hijab. Doctor Ayied Al-Gharni (a modest Muslim scholar in SA) was interviewed; he explained that covering the face might be not required and is actually still a cause of controversy among Islamic scholars. This small film and statement caused uproar in SA and there was the threat of bloodshed from some well known Saudi scholars for both the director and the Islamic scholar doctor who provided interpretations of the Quran and Hadeeth in the film.

Muslim scholars prioritize home leadership for women, and the need for the *mahram's* consent for a women's participation in every aspect of life, such as work, marriage and travel (Al-Asmari, 2008). This could explain why women in SA form only a small percentage (5%) of the Saudi workforce (Al-Asmari, 2008). It is important to note that after the inauguration of King Abdullah's government there were attempts to create more opportunities for women to work. One of these unsuccessful attempts was in 2006 when the government unanimously allowed only Saudi women to work as saleswomen in shops catering for women, such as those selling women's clothing, lingerie, and cosmetics.

However, this decision was suspended due to strong criticism from those opposed to the government's plan, including many Muslim scholars and the Ministry of Labour. Fear of

society's corruption, which was "expected" to happen due to women working, and fear of taking the women from their basic and important work in the home were the main reasons given by Muslim scholars (the Middle East Media Research Institution, 2006).

Similar to other Arab and Islamic countries, many in Saudi society believe that women are the honour and chastity of the family; this could explain why so many Arab communities limit or control women going out from their homes. It is highly shameful in Saudi society, for instance, to call a woman loudly by her first name in public places, or in a male gathering.

In general, segregation of men and women is the strategy used to assure women's chastity, which is an obvious practice and way of life in SA. All government schools in SA are segregated from primary school to university. Many companies or restaurants have been asked under Saudi policy to have a segregated women's section with its own separate entrance for women. Many Saudi families when visiting together during parties will practice segregation with the men in one area and the women in another.

Unfortunately segregation has even reached Saudi law, which limits women's full rights to citizenship compared to men. For instance, any man aged 24 or above has the right to receive a loan from the government for improving the quality of or for building a house, while a Saudi woman cannot have this right unless she is a widow or divorced, or in her forties and unmarried (Saudi Credit and Saving Bank web site, 2009). As a result of this law some desperate women give their land to their husband or another male relative in order to be able to get the loan from the government to build a house.

It is also very difficult for Saudi women to get married to a non-Saudi even if she is in love and desperate to marry. Indeed, in 2007 a new reform in Saudi citizenship laws allowed non-national women who have been married or divorced by a Saudi man to apply easily for Saudi citizenship. On the other hand, Saudi women nationals married to non-Saudi husbands have no right to pass their citizenship on to their husband or even to her children; however, their sons, but not their daughters, are allowed to apply for citizenship only at the age of 18 but to the researcher's knowledge there is no guarantee of getting citizenship.

Initially, female education in SA was completely rejected by Saudi scholars and the community, and it was necessary to convince and assure them that the purpose of educating a girl is to teach her Islamic teaching and to be a good mother (Prokop, 2003). Furthermore, before 2009, there were no state educational facilities available to women similar to those available to men in subjects such as engineering, law, and many other specialties that women might wish to study. It is only since 2005 that women's education has changed from being controlled by members of the conservative religious scholars (Prokop, 2003; Hamdan, 2005), who had insisted on supervising the education of girls throughout the country since 1960, to coming under the administration of the Ministry of Higher Education which had controlled male education from the start. In fact, the Ministry of Higher Education agreed to consider sending women abroad to finish their studies in high-demand subjects, which probably would have been impossible if women's education was still under Islamic control.

Moreover, although in 2008 the government lifted the ban on women drivers, in reality women still do not yet drive in big cities in SA like men. Consequently, women depend heavily on their husbands or other Mahrams for transportation, while some women's

husbands or guardians (their "*Mahram*") have to hire a driver who is usually a foreign male. In 2005 the SA government started its first step towards elections by holding Local governmental elections for municipal councils. Women could not vote or be nominated at that time like men but the current government promises that women will be able to participate in the next election which has been postponed to date.

Because of the continuous pressure from King Abdullah to change and improve, in February 2009 he increased the number of those on the Shura Council in SA to 170 members, comprising of scholars, the experienced and competent; however, none of them were female and women's involvement at Shura Council is represented by six women who serve as parliamentary advisors on women's issues. On the other hand King Abdullah made a strong and courageous change when Nora Fayeze was appointed to the post of Deputy Minister of Education for Girls, which is the first time that a woman has occupied a position in the Government of SA (Arab news, 2009). It can be concluded that to date there have been some changes in women's position in SA, due to changes in the lifestyle of the Saudi community, the efforts of the present government under the guidance of King Abdullah, and because of the international human rights movement. However, in general the position of women in SA is a cause of great debate and much remains to be done, however, hopefully, we may be moving towards a much brighter future and position for women, eventually.

1.5 Overview of the Health care system in SA

The health care system in SA has two main sectors: firstly the governmental sector which can be classified into three categories (the Ministries of Health, Military, and Education); and

secondly the private sector (Al-Osimy, 1994; WHO, 2006b; WHO, 2006c). The state health care system in SA offers free universal national health care coverage and services through the supervision of a number of governmental agencies (Al-Omar & Chowdhury, 1999; WHO, 2006b). The Ministry of Health (MOH) was established in 1951 and is considered to be the main government agency responsible for the supervision of health care services and hospitals, in both the public and private sectors in the country (Al-Osimy, 1994; MOH, 2008).

The proportion of specific outlay allocated to the health sector has been increased by the Saudi government over the years. The MOH budget in 2008 was 5.6% and in 2009 was 6.2% of the total national budget (MOH, 2008). The MOH aims to provide free preventive, prenatal, postnatal, emergency, and basic services and care to every Saudi national and expatriate working within the public sector (Mobaraki & Soderfeldt, 2010).

According to MOH statistics, in 2008 the MOH operated more than 220 hospitals and 1,986 primary health care centres (PHCs), which are both free of charge to the general public (MOH, 2008). Most MOH health care services are in large cities, such as Riyadh, Jeddah and Dammam and a few are located in the small towns and the countryside of the Kingdom. Figure 2 shows the increased number of PHCs. The PHCs are similar to general practices (GPs) in the UK; each PHC provides primary health care services within a catchment area for a defined population (Al- Yousuf et al, 2002).

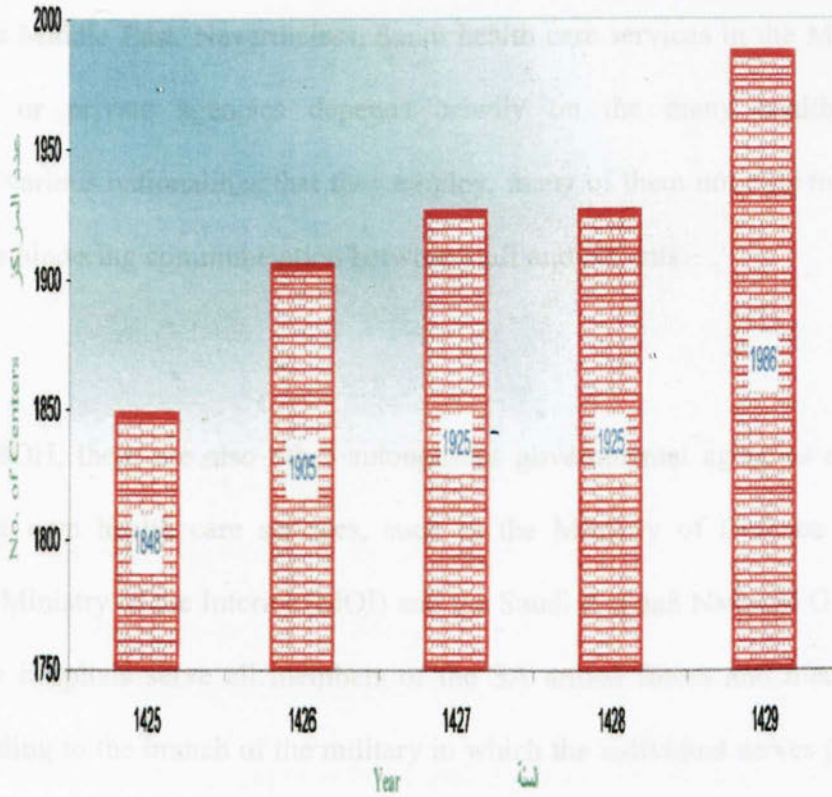


Figure 2. The increased number of PHCCs. Source (MOH, 2008. P.124).

In fact, in 1970 the Saudi government developed the first plan for the renaissance of the Kingdom in many aspects, including health care (Al-Osimy, 1994). At that time the government started to pay significant attention to setting up and improving the health care of the country. Consequently it is not surprising that, after all these years of continuous effort and with the commitment of the government to funding the health sector, that SA's health care system has achieved notable successes, particularly in the virtual eradication of most epidemic diseases, in decreasing the mortality and morbidity rates and in increasing life expectancy (WHO, 2006c; MOH, 2008).

Saudi health care at the present time has become one of the most advanced health care services in the Middle East. Nevertheless, Saudi health care services in the MOH and other governmental or private agencies depends heavily on the many health professional expatriates of various nationalities that they employ, many of them not able to speak Arabic languages thus hindering communication between staff and patients.

Besides the MOH, there are also other autonomous governmental agencies delivering and financing their own health care services, such as the Ministry of Defence and Aviation (MODA), the Ministry of the Interior (MOI) and the Saudi Arabian National Guard (SANG). These military hospitals serve all members of the SA armed forces and members of their families according to the branch of the military in which the individual serves (Al- Yousuf et al, 2002; Walston et al, 2008). These military hospitals are operated to professional western standards and their workers hold accredited certificates, some of them from developed countries such as the UK, USA, and Australia.

With much government attention and more generous funding for the military sector and its workers, it is therefore not surprising that the military hospitals are fully equipped with new and highly sophisticated technology, which has the effect of giving a unique high quality of care and service free to those who are allowed to receive health care in these hospitals (Walston et al, 2008). In addition, there are many other autonomous government agencies, but the most important of them is the Ministry of Higher Education (MHE). The MHE runs and funds the main four teaching hospitals that provide primary and tertiary health care and provides the right supervised opportunities for practical training in the fields of medicine, nursing and other health sciences students (Walston et al, 2008).

Today, private health services, including hospitals and clinics, continue to grow due to the increase in demand for health services where individuals can obtain a quick and high quality of care, although paid for by the patients themselves (Barrage et al, 2007). The MOH has devised a plan to alleviate pressure on public hospitals and to ensure that all workers in companies have access to health coverage. Therefore, in the 1980s, the MOH ordered all companies to provide compulsory health insurance for all their expatriate workers; the companies pay for an extensive package of services according to their choice of private hospitals.

1.5.1 Health care challenges and demands

It is clear that the supervision, operation and funding support for each governmental agency in SA is different from the others. For instance, the MOH provides 60% of the total health care and services in the country while the rest is provided by other autonomous governmental agencies or the private sector (See Figure 3). The MOH has the biggest burden, which may affect the quality of care given in MOH facilities. Al-Ahmadi & Roland (2005) conducted a comprehensive literature review of 31 articles, aiming to present an overview of the quality of primary care in SA. They found that there was a clear and substantial variation in the quality of Saudi primary care services and that poor quality of care was found in some of the centres due to managerial and organizational factors.

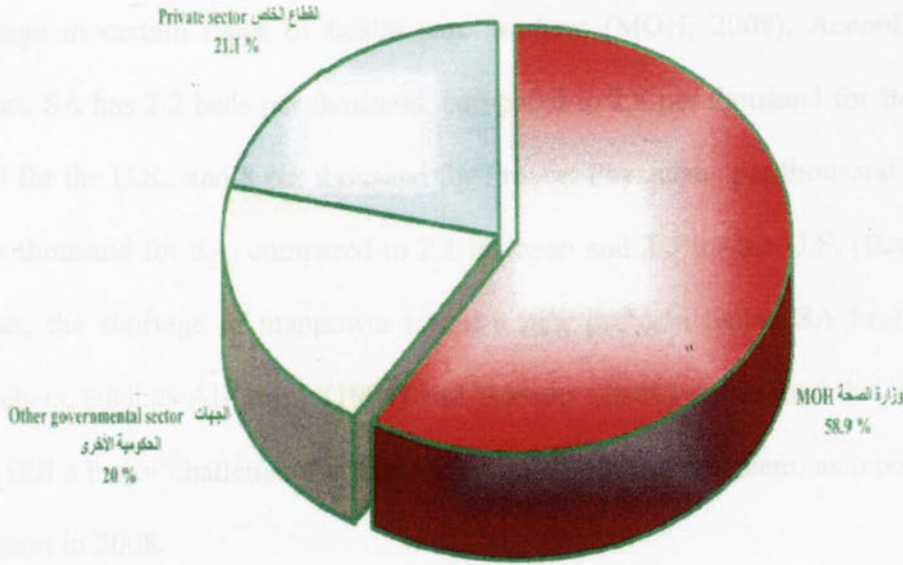


Figure 3. Number of beds in various health sectors (MOH, 2008, P. 227)

Al-Omar & Chowdhury (1999) argue that the health care system must interact regularly with the surrounding variables, whether social, economic, political, or physical environments, in order to work in the right direction effectively and successfully. The Saudi Arabian General Investment Authority (SAGIA) emphasized that the MOH will continue to concentrate its healthcare provision activities on preventive and curative primary care, simply due to of the increased demand for its health care services (Barrage et al, 2007).

Despite the efforts of the government in increasing the health care budget, there is still need for more expenditure in this sector in order to tackle the substantial increased demand on the health services that results from a large annual population growth. On the other hand, the Saudi government faces another important challenge in increasing the volume of health care workers as well, in order to supply its services with the proper number of workers in each

medical field and to ensure a good standard of patient care. Currently, SA suffers from a severe shortage in certain types of health care workers (MOH, 2008). According to the SAGIA report, SA has 2.2 beds per thousand, compared to 2.8 per thousand for Bahrain, 3.4 per thousand for the U.S., and 8 per thousand for France. Physicians per thousand are low as well: 1.7 per thousand for SA, compared to 2.1 in Japan and 2.5 for the U.S. (Barrage et al, 2007). In fact, the shortage of manpower is not a new problem facing SA health sectors; many researchers, such as Al-Osimy (1994) and Tumulty (2001), mentioned this a long time ago but it is still a major challenge that faces the Saudi health care system, as reported in the last MOH report in 2008.

1.5.2 Sexual health care & services in SA

Sexual health care and services play a vital role towards improving women's health. They help to increase women's awareness about sexual health issues such as helping to control their fertility by using contraceptive methods and how to deal with sexual difficulties and problems. However, sexual health services vary considerably from country to country. For example, in the UK sexual health services are provided for both male and female patients through sexual health clinics or sometimes known as genito-urinary medicine (GUM) clinics. They are usually located at the hospital or as part of another health centre, and provide a range of sexual health services and care including supplying contraceptive method such as emergency contraceptive and condoms, providing advice and information about sexual health issues and problems, testing and providing treatment for sexually transmitted infections (STIs) as well as investigating and treating urinary tract infections (UTIs). In fact the Faculty of Family Planning and Reproductive Health Care (FFPRHC) in the UK provide a national

framework for the standards that all sexual health services and staff working in these services should work to adapt and achieve (FFPRHC, 2006).

Things are very different in SA. Contraception prescription and contraception advice is only available for married couples and only through gynecology and obstetrics clinics (G&OCs) in the hospital or in PHCCs (Yousuf, 1999; Al-Zahrani, 2006; Altaweli, 2010). Some hospitals have established post partum clinic (PPC) and other family planning clinics (FPC) as part of (G&OCs) to provide care that includes contraception prescription, contraception advice and postpartum, post-miscarriage and post-abortion follow up. Moreover, there are no services that offer STI testing like the GUM clinics in the UK and sexual health advice is not available via family doctors. Nor is there any national policy or strategy towards sexual health in SA.

1.6 Summary of the next chapters

Chapter two: provides a literature review in order to obtain information about sexuality and sexual health in general; explores the literature on sexuality and sexual health in SA, particularly that related to women; then introduces the research aims and objectives of the study, and discusses the importance of conducting the study.

Chapter three: is divided into two parts. The first provides a detailed description of the design method and methodology and discusses the epistemological issues around qualitative and quantitative research to provide a rationale for selecting qualitative research through focused ethnography. The second part focuses upon the research setting, the method applied,

details of the sampling, methods of data collection and analysis, including issues such as rigour and the ethical considerations concerning the study.

Chapter four: presents the findings of the ethnography that were obtained from a variety of methods, including interviews, consultation observation, field notes, and document analysis. These findings are presented within three themes (1) Organizations and policy issues, (2) Professional's orientation and attitudes to sexual health and (3) Women's orientations and attitudes to sexual health.

Chapter five: discusses the issues surrounding the findings. It explores the impact and relevance of social norms to the findings and the Theory of Reasoned Action is used as a theoretical framework to explore the significant cultural, gender and professional issues related to sexual health described in the finding chapter. The findings are then discussed in the context of the related literature.

Chapter six: offers a summary of the study and outlines the recommendations for improving women's sexual health in Saudi Arabia, then states the strengths and limitations of the study.

1.7 Summary

This chapter has provided the reasons for conducting the current study by the researcher, given a brief history of SA and how Islam is socially integrated with Saudi culture, discussed women's status in Islam and SA, considered the health care system in SA, its challenges and

demands and then ended with a description of sexual health care and services in SA. The next chapter will deal with sexuality and sexual health in general, and then will focus on the sexual health related research in SA to produce the research aims and objectives for the current study.

Chapter 2: Literature review

2.0 Introduction

This chapter provides the research context of the proposed research and how a review of this literature informs the aims, objectives and research questions of the study. This chapter will firstly explore the concepts and definitions of sexuality and sexual health. This will then be followed by an exploration of the impact of gender on women's sexual health. The next section will explore the literature on sexual health and sexuality in SA particularly that related to women and will include a review of the research studies that have been undertaken in relation to women's sexual health and sexual health care in SA. Finally, the chapter will end by a section that frames the research focus and research questions of the study.

2.1 Sexuality

Sexuality is an important component of individual identity and quality of life and as such is a component of the entire lifespan, and not just the reproductive years. The World Health Organisation (WHO) convened an international technical consultation on sexual health in January 2002; where the definition of sexuality was revised by a group of experts from different parts of the world. They concluded that:

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction”. They also added, “Sexuality is experienced and expressed in thoughts,

fantasies, desires, beliefs, attitudes, values, behaviorus, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors” (WHO, 2006a. p.5).

Poorman (1991) provide a shorter definition of human sexuality: “*sexuality is an integral part of the whole person*”. (P. 633), while Guthrie (1999) goes as far as to claim that “*sexuality is an integral part of the uniqueness of every person*”; therefore, “*to a large extent sexuality determines who we are*” (p. 314).

Despite the fact that much of the literature concludes that sexuality is an inextricable part of a person’s identity it seems that it has also revealed a complex and ill-defined concept of sexuality. Silenzio (2003) argues that the dynamic and multifaceted character of human sexuality refuses to fit neatly into any taxonomy. He argues that translating the concepts of sexuality presents difficulties not only between cultures, but also within the same culture over time. The ambiguity of definitions can result in people interpreting the definitions differently.

It is also necessary to mention that prior to the 1970s, psychologists and ‘sexologists’ frequently construed sexuality as a merely biological phenomenon (Guthrie, 1999). This idea was intended to be in keeping with the biological essentialist view that portrays various human phenomena as being biologically essential or natural to the human condition, rather than a product of culture (Burr, 1995, Burr, 2003; Hayter, 2005). Essentialists believe that

human sexuality is a stable, fixed and unchanging phenomenon (Burr, 1995). Parker and Gagnon (1995) claim that the reason for this view may be that the positivist scientific nature of research was the most dominant at that time. However, Foucault (1979), Parker and Gagnon (1995), Guthrie (1999) and many others viewed sexuality as a social phenomenon. Their view is in agreement with the social constructionist view of sexuality, which states that “*sexuality is primarily a moral issue for human beings, not a biological one*” (Burr, 1995, p.44). Social constructionists also believe that our knowledge is not a direct perception of reality, but rather a product of social process and interactions with people within the culture; therefore, a society influences and configures sexual behaviour and sexual practice through its norms (Burr, 1995). Similarly, Gagnon and Simon (1973) take the view that sexuality is culturally and historically specific and thus affected by the society and time in which it exists. Thus, aspects of sexuality in terms of how it is experienced by an individual and viewed by a society, is open to change and significant social molding.

2.2 Sexual health

An integrated component of sexuality is sexual health, which was broadly defined by the WHO in 1975, as:

“The integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love”. (WHO, 2006a. P.4)

Since the International Conference on Population and Development (ICPD) in 1994, sexual health was generally understood to be an integral part of reproductive health (WHO, 2006a). However, recently there has been a growing recognition that the term 'sexual health' is broader and more encompassing than 'reproductive health' (WHO, 2006a). As a result in January 2002, the WHO arrived at the following definition for sexual health;

“Sexual health is the state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction and 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” (WHO, 2006a. p.5).

It can be seen therefore that sexual health involves much more than medical issues. The WHO acknowledges the interplay of complex social and cultural issues around sexuality and sexual health. Furthermore, WHO's definitions have emphasized that sexual health is an important aspect of sexuality encompassing the mental and spiritual facets of being human as well as the physical. In this vein, changing interpretations of the notion of sexuality have influenced approaches to sexual health but so often cultural diversity leads to difficulties in finding one universally acceptable definition (Pillaye, 1994; Irwin, 1997).

However, a standardized definition of sexual health may appear essential particularly when guidance and evidence based practice are requirements in the provision of sexual health services and education. The problem is that standardized definitions may or may not fit a particular society or culture at any given time. However, the Canadian Guidelines for Sexual Health Education (2003) explain that there are three different approaches that can be considered when defining sexual health:

- (1) Avoid defining the term “sexual health” because our understanding of sexuality is socially constructed and as a result, a non-ideological definition is impossible.
- (2) Define and use the term with caution. Keep in mind that definitions of sexual health can change and should not be taken as rigid rules of conduct
- (3) View the term as an optimistic vision. (p. 18-19).

It is not reasonable to avoid defining the term ‘sexual health’ just because it is socially constructed. Such a position could be potentially devastating on service provision, education and counseling. Serrant-Green (2005) argues that sexual health is recognized by governments, health and social care providers as an area requiring planning, assessment, and service provision that meets the needs of diverse populations. This view is also shared by the Department of Health in the UK (2001), Fenton and Wellings (2001), and by the WHO (2006a). As such it would appear that the second and the third approach towards defining sexual health is more appropriate because they offer a defined but flexible approach for service development that encompasses knowledge development and changes in attitude and behaviours over time. Given this, it is proposed that approaches 2 and 3 of the Canadian

Guidelines for Sexual Health Education are used to inform this study whilst also embracing, as a working definition, the WHO (2006a) definition of sexual health outlined above.

2.3 Impact of gender power on women's sexual health

It can be argued that the almost universal power imbalance between men and women results in women often being at a greater risk of sexual ill health. Subsequently, gender should be recognized as a critical area of focus for women's sexual health. To respond adequately to women's needs, services should take into account the cultural, sexual, and social context of care, and providers need to be sensitive to the effects of gender and perceived power upon individual decision-making (Blanc, 2001). Therefore, this section will begin to examine the meaning of gender and the impact it has on women's sexual health.

The terms "sex" and "gender" are often used interchangeably; therefore, people become confused. 'Sex' refers to the biological differences or characteristics that define humans as female or male (WHO, 2006a). This is largely determined by our genitals, which means whether we have a penis or a vagina. 'Sex' is also used to refer to sexual intercourse: "having sex". This meaning is used not only in daily life but also is used a great deal even in the literature; for instance, Price (2005) explains that "*sex is defined not only as an act between partners but also as behaviours that help individuals to understand or reaffirm who they are*" (P.47). Consequently, some may think that the terms 'sex' and 'gender' mean the same thing. However, 'gender' refers to a set of qualities and behaviours expected from a female or male by society. Gender roles are learned and can be affected by factors such as education or economics (Price, 2005).

Gender roles and expectations are often identified as factors hindering the equal rights and status of women with adverse consequences that affect life, family, socioeconomic status, and health (Njovana & Watts, 1996; Blanc, 2001). For this reason, gender is an important element of sexual health services. The importance of sexual health for both men and women is clearly stated in the literature (WHO, 2003a; WHO, 2006a). Governments, especially those in the developed world, have increasingly come to realize the consequences of poor sexual health for women and the wider community. Therefore adopting sexual health policies and strategies to improve the situation has often become one of their essential health priorities. For this reason, in recent years, women's sexual health has changed from being a matter of personal responsibility to being one of social responsibility too (WHO, 2006a). It has become an important health issue worldwide for many reasons, including the increase in cases of sexually transmitted infections (STIs); the consequences of unwanted pregnancy and abortion (Van-look, 1994; WHO, 2006a; WHO, 2010) and female sexual function, including arousal, and the right to experience sexual desire, orgasms, and satisfying, safe, intimate personal relationships. Nevertheless, sexuality is often dominated by men and many societies feel uncomfortable with the idea of women having, enjoying or being curious about sex (Blanc, 2001)

Women's sexual health, however, is so often under the powerful influence of men. In several studies, it can be seen that men tend to dominate reproductive health decisions, particularly regarding family planning and the number of children; for example, a study by Sahin et al (2003) in the Eastern region of Turkey investigated the reasons for the non use of family planning methods among a total of 518 women aged 15-45 years old, and found that the rate of women not using any form of family planning was 45.2%. One of the reasons given for this was the woman not having the approval of her husband or family leaders (38%). It is

worth noting also that in some developing countries, the decision making may not be shared; in fact, men are much more likely than women to have the ability to determine when, where, and how sexual activity takes place. As a result, women are not able to control their fertility and making sexual choices is not always within their grasp. For instance, according to preliminary results from a nationwide study conducted in Egypt, some women's fears of divorce lead them to continue childbearing even if they want no more children (FHI, 1998b).

Women face many constraints in maintaining their sexual health; for instance, women, particularly those who cannot afford to buy female condoms or to take oral or injectable contraception, have to rely on their partners using a male condom. Very often, they end up putting themselves at a high risk of contracting an STI especially if their partner is unwilling to use a condom (DuGuerny & Sjoberg, 1993; Amaro et al, 2001). Furthermore, there are difficulties in using the female condom because of the cultural stigma attached to women using it, and its high cost has led to male domination and control of sexual encounters (Gollub, 2000). In many cultures, it is perceived that men should control and initiate a sexual encounter and women should always respond positively to their male partner's desire. It is reported that women fear losing their partner or fear provoking their partner's anger and abuse; and this prevents them from having the power to ask their partner to practice safer sex (Wingood & DiClemente, 1998) even if they know that their partner has a number of sexual partners (Fullilove et al, 1990).

Raj et al (2004) assessed the relationship between intimate partner violence (IPV) and sexual risk in terms of safer sex behaviour and intent, individual and gender-based HIV risk factors, and male partner HIV risk, among a lower-income community-based sample of Hispanic

women. They found that abused women were significantly more likely than those who had not been abused in the previous three months to report high STI/HIV risk perceptions, gender-based risk including sexual control by male partners, and male partner risk including male infidelity. Many other studies have claimed that women with less power due to sexual or drug abuse, for example, are at a high risk of poor sexual health (Zierler et al, 1991; Irwin et al, 1995; Raj et al, 2000). These findings clearly demonstrate that gender power in relationships can jeopardize the sexual health of women and it is no different for the women of SA.

2.4 Cultural and Socio-economic factors impacting upon women's sexual health within SA

2.4.1 Frequent childbearing

In SA, sexual health care particularly that related to women is facing challenges. Women in SA tend to have a large number of children (Sebai, 1984; Haque, 1988; Rshood, 2001). Based on the figures from the Population Reference Bureau (PRB), the total fertility rate (TFR) is estimated to be 5.7 children per woman in 2001 and 4.1 in 2007 (PRB, 2001; PRB, 2007). Nevertheless, although SA was able to achieve the lowest maternal mortality ratio (18 per 100,000 births) within the Middle East (Al-Meshari et al, 1995; Fahimi, 2003) it has not yet managed to reduce it to the international standard of not more than five maternal deaths per 100,000 live births.

In SA children mean wealth, therefore, childbearing is encouraged by families (Sufian, 1990a & 1990b). Farrag et al (1983) and Abubaker and Al-Suleiman (1990) reported that the main reason women in their study did not use any form of contraception was due to their desire to have more children. The WHO (2005) reported that maternal mortality rates are greatly increased during and after giving birth. A Saudi study conducted in Riyadh (Anwari et al, 2004), which reviewed all obstetric admissions to the intensive care unit in the armed forces hospital from 1997 till 2002, found that, except for one patient, all the obstetric cases that were admitted during the postpartum period were due to hemorrhage and hypertension complications.

High parity was a risk factor for the development of a post partum hemorrhage in 17% of the cases in Al-Kadri et al's (2009) study at King Abdulaziz Medical City, Riyadh. Shawky and Milaat (2001) reported that most of their study's participants were multiparae (66.7%), who remained at a high risk of a poor pregnancy outcome throughout their reproductive lives. They found them to have twice the risk of a spontaneous abortion, four times the risk of combined fetal death and infant mortality, and to have twice the risk of losing pregnancies at any time during their childbearing years.

Indeed, frequent childbearing can affect women's health in general. Mahfouz et al (1994) reported that iron deficiency (Anaemia) is prevalent among Saudi women, as a result of a high rate of pregnancy and poor birth spacing. The prevalence of anaemia among pregnant women was investigated by many researchers in different parts of SA. For instance, Mahfouz et al (1994) found 31.9% of a sample of 6,539 pregnant women in the Asir region to be

anaemic. Madani et al (1995) also reported anaemia rates of 22.9% in the Taif region, whereas Ghaznawi and Hussein (1988) reported levels of 25.6% in Jeddah City.

It can be argued also that frequent childbearing has put Saudi women at a greater risk of having unsatisfying sexual relationships and experiences. For example, it is well documented that women can experience pain during sexual intercourse after childbirth (Glazener, 1997; Barrett et al, 2000; Oboro & Tabowei, 2002) so her ability to enjoy sex may be affected and that may have negative effects on sexual satisfaction and relationships (Oboro & Tabowei, 2002). Additionally, breastfeeding, raising children, housework and work outside the home can take almost all a woman's energy; factors which can lead to sexual relationships becoming exhausting and not enjoyable (Barrett et al, 2000). The plight of women in such circumstances may not be helped by their lack of autonomy in relation to contraceptive choices. According to the views of Muslim scholars, a woman cannot use contraception without her husband's permission, nor can an abortion or tubal ligation be performed unless there is a danger to her life, and both potential parents must agree in order for it to be performed in a health establishment (Abdul-Jabbar et al, 1988a; Mobaraki & Soderfeldt, 2010). Omran (1992) argues that any type of contraception that helps in spacing pregnancies without harm, and with the permission of both the couple, would be allowed from an Islamic perspective. However, some Muslims consider abortion to be a type of murder, which Islam prohibits:

“And do not kill your children for fear of poverty. We provide for them and for you. Indeed, their killing is ever a great sin” (Quran- Al-Isra-31).

A study conducted to examine the attitude of Saudi families affected with hemoglobinopathies towards prenatal diagnosis and abortion, and to evaluate the effect of education on religious ruling on such attitudes (Alkuraya & Kilani, 2001), found that education about religious ruling significantly affected parents' attitude towards accepting abortion and prenatal diagnosis. It is important to mention that Dabash and Roudi-Fahimi (2008) reported that 98 percent of unsafe abortion cases occur in developing countries, particularly in the area where abortion laws are so restricted. In addition, HCPs in countries where abortion is illegal or seen as sin are hesitant, apprehensive and unwilling to perform abortion to their patients which put women's health at risk (Rahman et al, 1998). Hessini (2007) reported that out of 699,405 abortions and maternal mortality cases in SA for the period 1995 till 2000, there are 927 deaths cases due to unsafe abortion (P.76). It is likely that the incidences of abortion in SA are more than these reported numbers. For example, women who get pregnant outside marriage are more likely to go to a non health professional to carry out an abortion.

The availability of different type and safe methods of contraception can have an impact on the better preservation of women's health. However, the WHO reported that the contraceptive prevalence rate in SA in 2003 was low at 32% (Walker, 2009). Saudi research shows that only 44.4% in Al-Sibai and Khawaja's (1986) study in Al-Khobar were using a method of contraception; 33.6% in Abubaker and Al-Suleiman's (1990) study in Qatife; 19.9% in Madani et al's (1995) study in Taif; 48% in Al-Othman et al's (2002) study in Riyadh; and 44.7% in Shawky and Abalkhil's (2003) study in Jeddah. It seems that the overall contraceptive use in these studies is moderate; however, these percentages could be biased due to the ways that the researchers report contraceptive use in their studies. For example,

Madani et al (1995), Al-Othman et al (2002), and Shawky and Abalkhil (2003), did not provide statistics of past contraceptive use, while Abubaker and Al-Suleiman (1990) consider women whose husband is using a male method of contraception to be a non-user. It can be argued that the issue is not only whether women are using a method of contraception, but also whether they are happy and satisfied, or not, with the method they are using, which was not investigated in these studies.

Despite the fact that family planning and contraceptive advice are provided through women's clinics and services (Al-Zahrani, 2006; Mobaraki & Soderfeldt, 2010), the government has not established national family planning programme that is supported directly by them (Mobaraki & Soderfeldt, 2010). Population Action International (PAI) (1997) reported that SA ranked lowest among the countries in the region in providing accessible contraception due to political restrictions. Knowledge about contraceptives and the correct way of using them would greatly enhance contraceptive use and satisfaction, and reduce the risk of an unplanned pregnancy, which cannot be guaranteed with limited information and services.

2.4.2 Early marriage

In SA early marriage is encouraged as a way for procreation, sexual protection and enjoyment. There is no minimum age of marriage for girls or boys in SA (Rashad et al, 2005; AlMunajjed, 2009), though some interested in women's affairs have proposed a legal age of 18 years (AlMunajjed, 2009). However, most Muslim scholars, particularly in SA and Yemen, argue for the rights of healthy girls and boys as young as 13 who would be criminalized if their right to marriage, which is the only way they are permitted to practice sex in Islam, was

withdrawn. They point out that this law could encourage illegal relationships, from an Islamic point of view, or increase other kinds of marriages such as *Aurfi* marriages, which are not socially acceptable (an *Aurfi* marriage is a contract marriage, written by the bride, groom and two witnesses on ordinary paper and not registered legally with the Government). Early marriage is still one of the most controversial issues within Arab countries (Rashad et al, 2005) and can have a clear impact upon women.

For example, Shawky and Abalkhail (2003) collected data from six primary health care centres in Jeddah city using a structured questionnaire given to 400 married women who have at least one child and who attended the well-baby clinic. They found that out of the 400 women 158 were illiterate, 7.0% were less than 20 years of age, 26.5% of them were married before 16 years of age, 9.8% had their first child before their sixteenth birthday, and only 48 were educated to secondary level or higher. Similarly, a study carried out in Dammam city, located in Eastern Province of SA (Al-Sebai & Al-Khwaja, 1986), assessing parity and associated socio-demographic factors reported that 38.6% of women were illiterate, only 44.4% of the study participants were using contraception, and that 160 were under 20, by which time half of them had already given birth. Rashad et al (2005) argue that even though early marriage is in decline in the Arab countries, it is still present. For instance, in 1996 they found that 7% of Saudi women aged 15 to 19 were married (Rashad et al, 2005). These studies indicate that early marriage and childbearing, and the practice of not educating women, still exist within some families in the Saudi communities.

It is important to note that there is a strong association between childbearing and early marriage, low income and low levels of education (Sufian, 1990a & 1990b; Al-Mubarak &

Adamchak, 1994; Shawky & Milaat, 2001). Women who married during their early teenage years (before 16), and those with a low income, are most likely not to have been educated either because they failed to attend or dropped out of school. Consequently this may have an effect on their awareness of personal and sexual health.

It can also be seen in the literature that young women who have had little education are more likely to have had earlier intercourse and more likely to give birth during adolescence than those who are better educated (Al-Mubarak & Adamchak, 1994; Shawky & Milaat, 2001). A study conducted in Al-Khobar, in Eastern Province of SA (Sufian, 1990b), aimed to explore the relationship between socioeconomic factors and fertility by employing multivariate techniques. It found that a woman's age and her education were the main variables that significantly affect fertility. Educated women attempt to bear fewer children and to use birth control more often than those have little or no education (Abdul-Jabbar et al, 1988a; Sufian, 1990a & 1990b).

2.4.3 Education

Education is considered to be a key factor in empowering and improving women's sexual health. Women who are educated are often in a better position than their counterparts due to more access to sexual information (Taylor, 1995). In addition, they will probably have more control over their fertility and be empowered to make responsible decisions regarding sexuality, thereby reducing the number of unplanned pregnancies and other forms of sexual ill-health (Taylor, 1995). The Saudi ministry of information (MOI) reported that Saudi Government provides free education for both genders from primary school to university level

(MOI, 2002). They also increased the funding allocation for education and human resources development from (US\$12.5 billion in 2002, to US\$25.7 billion) in 2007, to US\$28 billion in 2008, and to \$32.5 billion in 2009 (AlMunajjed, 2009).

However, this education is not compulsory (Yousuf, 1999; AlMunajjed, 2009), and therefore some families decide not to send girls to school (Mobaraki & Soderfeldt, 2010). There is no co-education, but the Government provides education facilities, including buildings and teachers, to both genders (AlMunajjed, 2009) in spite of the fact that this is more expensive. In general, male teachers are not allowed to teach at girls' schools, but their services may become necessary in colleges or universities. In these instances higher precautions are taken to minimize any "unnecessary" mixing between the genders. These may include using data shows which present the male teacher without the need for his actual presence in the classroom. Female students can see and hear their teacher and are allowed to ask questions or share in discussions with the teacher freely.

In addition, there is no sex education within school curricula, not even in universities. This is a taboo subject and the only way health authorities can provide information about it is through hospitals or PHCCs but only to married women due to reasons of conservatism (Yousuf, 1999; Al-Zahrani, 2006; Mobaraki & Soderfeldt, 2010). Fageeh's (2008) study in Jeddah reported that the major source for their study respondents to receive information about STIs were the internet (375: 87%), books (356: 73%), TV/ radio (302: 62%), friends (267: 55%), newspapers/ magazines (243: 50%), and family (180: 37%). The internet may produce unreliable advice, which could misinform the individual.

Therefore, it can be argued that even though today the statistics show an increase in the number of educated females in SA due to the efforts made by the Saudi government, there is no guarantee that these women are educated about their sexual health, or that they are aware of how to maintain and improve their sexual health. That may be because sex education has not featured in educational policy and systems in SA. However, it is worth mentioning that educating women about their sexual health does not occur in a vacuum, nor will happen suddenly by magic, nor will use of only one strategy such as sex education at school improve it. Instead, more fundamentally, it should be a lifelong process.

The WHO (2006a) concur arguing that there is no one plausible reason for women's poor sexual health and that it could be due to one or more reasons ranging from poverty, low levels of education, gender inequality, violence, a lack of comprehensive sex education, greater societal strictness regarding sex and a greater difficulty of access to reproductive health services. Consequently, these women who have a large number of children', do not use contraceptives and so are not able to plan an interval between pregnancies, and have a high possibility of acquiring a sexually transmitted disease and most importantly often have no control over their sexuality. Therefore, improving women's health is a complicated and complex goal that may require a group of solutions concerning all these reasons rather than only one specific strategy that is used at a specific time.

2.4.4 Teenage population growth

Rapid population growth, particularly the increase of the teenage population, is another challenge facing SA in terms of sexual health care. The estimated total population in SA in

July 2006 was 27,019,731. In addition, the demographic is very young, with 63% aged below 24 (Abu-Zinadah, 2000; Madani, 2006), an absolutely critical age in terms of sexual health care and promotion. The desire for sexual activity is expected to start in the teenage period, but it is important to mention that Islam stands for sexual purity and considers all sexual intercourse outside marriage to be sinful (Quran-Al-Nur-2). The penalties of sexual intercourse outside marriage vary from lashes for the unmarried to death for their married counterparts:

“The unmarried women or unmarried man found guilty of sexual intercourse - lash each one of them with a hundred lashes” (Quran-Al-Nur-2).

The lash penalty is frequently used in Saudi law in order to correct behaviour. Recently, in 2009, a Saudi man was held under Saudi law because he talked about his sexual relationships before marriage on the LBC (Lebanon channel). He was found to be guilty of talking about his illegal relationships in public on TV and was given a thousand lashes and sentenced to five years in jail (Al-Harthi, 2009).

There are also economic difficulties which may encourage some young people in SA to initiate sexual intercourse. These include problems men may have in getting a job, and the subsequent difficulty in getting married (Madani et al, 2004; Madani, 2006) due to the high **“Maher”** (dowry) that some families in the Saudi community expect. Therefore, men may stay single longer, until they are able to collect the proper dowry, or may decide not to marry at all because they get used to a single life free from any family responsibilities. It is important to explain that safe sex strategies are rejected in SA due to its incompatibility with

Islamic principles as they are seen as encouraging “*Zena*” (a sexual relationship) outside of marriage (Madani, 2006). Such sexual attitude and behaviour can put young people at greater risk of contracting STIs or HIV/AIDS (Madani, 2006).

2.4.5 The prevalence of HIV/STIs

The number of cases of HIV in SA increased in 2003: 1743 Saudi national and 6064 non-Saudi national HIV cases were reported (Al-Rajhi, 2004; Al-Mazrou et al, 2005a). Most of the reported HIV cases in SA are due to heterosexual intercourse (37.9%) and are among the 20-40 years age group (74.6%) (Madani et al, 2004; Al-Mazrou et al, 2005a; Madani, 2006). According to Madani et al’s (2004) study, the mode of HIV transmission varied among the 340 reported Saudi infected female patients. The majority were due to unknown reasons (142: 41.7%); followed by blood transfusions (86: 25.3%); then marital sex (74: 21.8%); maternal transmission to female babies (27: 7.9%); non-marital sex, (8: 2.4%); and intravenous drug use (3: 0.9%). It seems that the large proportion of female patients who cited ‘unknown’ reasons were more likely to be deliberately concealing acts of illegal sex, which, if they confessed to them, could put the women in a sensitive position socially and legally. A Saudi study in Jeddah, conducted by Fageeh (2008), found that the level of awareness regarding STI protection was higher in males than females due to female lack of knowledge about condom use.

STIs are the second highest cause of healthy life lost for women living in developing countries aged 15 to 45 years (Regional Committee for the Eastern Mediterranean, 2008).

Madani (2006) reported that it was only in the year 2000 that the Saudi MOH allowed STI

data to be available for inspection by the public. Madani (2006) has described the incidence of STIs in SA over a five-year period of surveillance, from January 1995 through December, 1999. A total of 39049 STIs were reported to the MOH from different parts of SA. Many STIs were reported such as nongonococcal urethritis (14557 infections, 37.3%), trichomoniasis (10967 infections, 28.1%), gonococcal urethritis (5547 infections, 14.2%), syphilis (3385 infections, 8.7%), human immunodeficiency virus^a (2917 infections, 7.5%), genital warts (1382, 3.5%), genital herpes (216 infections, 0.6%), and chancroid (78 infections, 0.2%). It is anticipated that the incidents of STIs is higher than the current reported figures in SA as many STIs can be silent – having no clear symptoms which therefore make it difficult for them to be identified, tracked and then reported.

A world report in 2006 highlighted the danger of negative sexual health education, pointing out that in 2005 there were around 67,000 new cases of HIV in the Middle East and North Africa alone (Cheemeh et al, 2006). In light of this striking prevalence of STIs and HIV/AIDS it should be widely recognized within health authorities that no countries are immune to STIs or HIV (Alrajhi, 2004; El Feki, 2006; Cheemeh et al, 2006), and that it is time for countries in this region to develop logical and reliable strategies for preventing the spread of STIs and HIV/AIDS and for improving the sexual health of their people in general.

SA has developed strategies to control the spread of HIV/STIs within the country. For instance, in 2008 SA has enacted a national laws and policy for starting mandating premarital testing for free (heredity disease and HIV only, not including other STIs). Yet only 23% of the total HIV cases reported in SA are Saudi nationals entitled to receive anti-retroviral drugs

and medical health care for free (Walker, 2009). Non-Saudi nationals are sent home after initial treatment, despite the possibility of being treated under health insurance policies. The International AIDS Society (IAS) (2007) reported that the USA, China and SA are among the 13 countries that ban HIV-positive persons from entering their borders as a protective strategy. They argue that this strategy is discriminatory and unreliable as people might lie about their actual health status or run from treatment because they know that these governments will send them back to their home countries; countries which usually have low standards of living and a lack of basic health care. It can be argued that these strategies possibly increase the prevalence of HIV transmission rather than eradicating it.

Madani (2006) claims that Islamic strategies through marriage are the perfect way to stop the prevalence of STIs and HIV, and that consequently will lead to improved sexual health, particularly within Moslem culture. However, although the researcher agrees with Madani that Islamic strategies through marriage are a possible solution, they should not be the only one. Improving sexual health is a bigger issue than merely limiting or decreasing cases of STIs and HIV/AIDS; the topic is more complex than its narrow biological aspect.

2.4.6 Polygamy

Both monogamy and polygamy are legal in SA and also in some other Islamic countries. Polygamy deserves further discussion because its legality without any conditions can put women at risk of negative sexual health consequences, such as the possibility of the transfer of HIV or other STIs to all those in the relationship, or due to living unhappily due to sharing the husband with others. Though Islamic principles allow men to marry more than one (and

up to four wives) (Quran-Al-Nisa-3), the Quran clearly states that if a man does not feel able to manage more than one wife it is better to have only one, *“if you fear that you will not be just, then marry one”* (Quran-Al-Nisa-3). It also acknowledged that it is difficult for men to be fair in their love for more than one spouse even if they try hard to do so:

“You will never be able to deal justly between wives however much you desire (to do so). But (if you have more than one wife) do not turn altogether away (from one), leaving her in suspense” (Quran-Al-Nisa-129).

Polygamy is allowed in certain circumstances, such as when the first wife is sick or cannot have children, or to help women who really need assistance. Islam thinks about the rights of all wives and children, forcing men to take responsibility for their polygamous inclinations and to protect and provide care for their women and children. The Quran also states that there will be strong penalties (on Judgment Day) for those who marry more than one wife and are not able to treat them all equally.

Nevertheless, some Moslem scholars strongly encourage polygamy and this was recently seen in 2007 when the highest Moslem scholar in SA officially sanctioned *Mesyar* marriages. These are marriages that allow men to put certain conditions on their acquiescing bride, such as not having children with her, not providing money or a home, stating particular times each month that he will sleep with her, or not announcing the marriage to his family. These conditions make it easier for men to marry more than one wife without having to take responsibility for their polygamous marriages as Islamic principles require. The ability of

men to marry more than one wife, while being unable to satisfy their wives emotionally, financially or sexually, might encourage women to have a variety of sexual partners, particularly if their religious background is not strong.

Generally, Saudi women who are not sexually happy with their husbands cannot have sex outside marriage and cannot marry another husband because polyandry (having more than one husband) is not legal (prohibited) in Islamic Shariah. Accordingly, women who have practised sexual intercourse outside marriage, on the evidence of four witnesses, will be sentenced to death by stoning, "**Rajm**". No statistical figures have been identified as to how often Rajm has actually been practised in SA; it seems to be a highly secret issue. Moreover, women who have had unhappy married lives due to the consequences of polygamy or other reasons often cannot get a divorce because there is no financial support (particularly for not working women) and/ or they fear losing the right to raise their children, especially if they wish to marry another husband.

There are no penalties in SA law for men who do not treat their wives equally, therefore, women tend to either accept the situation or apply for a divorce. In case of a Saudi women asking for **Khula** (the term used when women ask for a divorce), she has to return the entire dowry to the husband even if she lived with him for 10 years or more. The Arab Human Development Report (AHDR) (2009) identified that inequality in gender rights is one of the most significant obstacles to human development in the Arab region. As such, women in these circumstances may feel compelled to endure lives of sexual and mental misery.

2.5 The Scope of Sexual Health Research in SA

There are a number of limitations surrounding studies of sexual health in SA. Most of the studies reviewed (Sebai, 1974; Farrag et al, 1983; Al-sibai & Khwaja, 1986; Abdul-Jabbar et al, 1988a; Abubaker & Al-Suleiman, 1990; Sufian, 1990a; Sufian, 1990b; Al-Nasser & Bamgboye, 1992; Al-Mubarak & Adamchak, 1994; Madani et al, 1994; Milaat et al, 1996; Al-Nahedh, 1999; Al-Sekai, 1999; Khattab, 2000; Rshood, 2001; Al-Othman et al, 2002; Shawky & Albakhil, 2003; Al-Amaia, 2003) focus on fertility rates, contraceptive use and practice, child spacing or birth interval practices, which means they tend to focus on women's reproductive rather than sexual health.

This view is in agreement with those of many researchers such as Glazener (1997) and Barrett et al (1999) who state that less interest is paid to women's wider sexual health and needs, particularly in non-Western settings and cultures. Many important topics surrounding sexual health, such as informed choice, decision making, sexual satisfaction, the ability of women to discuss wider sexual health issues at different stages, access to information and services, protection against pregnancy, sexual violence, cancer and STIs are potential and important avenues for exploration which have so far been neglected. The most common methodological approach in the literature on sexual health in SA is quantitative. However, this method of research is still an unsatisfactory method when dealing with complex, sensitive and social research topics – such as sexual health. Qualitative approaches allow study participants to express their views, providing rich data that has depth and meaning for the reader, thereby, creating a more detailed understanding of participants' lives and behaviour as they perceive and understand it, an orientation to understanding that appears to have been neglected in contemporary sexual health research within SA.

Some studies in SA have focused on STIs and HIV/AIDS and modes of their transmission which have helped to increase our knowledge about the incidence of STIs and HIV/AIDS (Abolfotouh, 1995; Mahfouz et al, 1995; Al-Nozha et al, 1995; Njoh & Zimmo, 1997; Abdelmoneim et al, 2002; Madani et al, 2004; Alrajhi, 2004; Alrajhi et al, 2004; Alrajhi et al, 2006; Al-Ghanim, 2005; Al-Mazrou et al, 2005a; Al-Mazrou et al, 2005b; Kordy et al, 2006; Madani, 2006). Only one study looked at adolescence knowledge about STIs (Fageeh, 2008), however, none of them discussed sexual behaviour in detail, which is the main way of understanding STIs transmission dynamics. The main areas of enquiry in these studies have focused on numbers and statistics. For instance, no study has attempted to interview those patients with STIs about their own stories, which could inform us about the lived reality of women's lives as well as inform prevention strategies that could be undertaken to protect others, and to identify the medical and psychosocial needs of specific groups.

Four studies, Al-Ghanim (2005) Abolfotouh (1995) Saleh et al (1999) and Abdelmoneim et al (2002) investigated knowledge and attitude towards HIV/AIDS in SA and only one by Fageeh (2008) looked at awareness of variety of STIs among adolescents. Apart from Al-Ghanim's (2005) study which was conducted in Riyadh city and Fageeh's (2008) study in Jeddah, the three other studies, failed to include women amongst those questioned. Abolfotouh's (1995) study used self-administered questionnaires to assess levels of knowledge, attitudes and beliefs about HIV/AIDS among male secondary school students only. While Abdelmoneim's et al (2002) study assessed male bus drivers through structured interview.

Generally, sexual health is a taboo subject in Saudi communities (Al-Ghanim, 2005; Fageeh, 2008), therefore including women in studies about sexuality and its related concepts e.g. HIV/STIs etc is not easy, especially considering the fact that both studies were carried out in the south-western part of SA, one of the most strict and conservative Islamic communities. Other reasons for not including women in these studies may be that Saudi communities consider women to be loyal and pure, seldom becoming involved in sexual relationships outside marriage, unlike men. Consequently they are not considered to be a group at risk. These communities' conservatism means that women rarely talk about these topics, therefore their knowledge, needs and also attitudes and risk behaviour remain completely unknown.

In terms of health professionals one study attempted to assess primary health care physicians' knowledge and attitudes towards HIV/AIDS and this was conducted by Mahfouz et al (1995) in the Asir Region, in southwest SA. Despite the fact that this study failed to include any large scale participation of female physicians, and that its influence was inevitably limited by using self-administered questionnaires, the study results provide valuable data into several gaps in the knowledge of and attitudes towards HIV/AIDS amongst physicians in SA. It was found that physicians lack the knowledge of the modes of transmission and that 6.7% felt that HIV/AIDS is not a health problem facing SA. Furthermore, worryingly, was the fact that physicians failed to mention that infants of mothers with HIV/AIDS, doctors and nurses, and those with multiple sexual partners (92.1%, 61.3% and 57% respectively) are groups at risk of acquiring the disease.

Undeniably these findings deserved more attention from the authors but they did not investigate plausible reasons for this lack of knowledge amongst physicians who are expected

to fulfil an educational role in health services. Therefore these findings call for urgent further research. In fact, a review of the international literature revealed that many health care professionals lack experience in assisting women with sexual health issues, which may be due to their not understanding the expected differences between cultures or due to either a lack of time or knowledge about sexual health topics (Dilloways & Hildyard, 1996; Gott et al, 2004; Hinchliff et al, 2004).

The limited literature on sexual health in SA also reveals unclear and limited sexual health policies in SA. Only Al-Ghanim's study (2005) gives more details on these matters, such as the policy that those with expertise who want to work in SA have to undergo blood tests for STIs before and after arriving in SA. These are routine tests on the blood or its products, such as those done on organ donors, intravenous drug users and patients with any STIs other than HIV/AIDS. Madani's (2006) study also mentions the role of the Government in providing financial help for men to encourage them to marry. None of the studies reviewed described barriers to health care, professional-patient discussions of sexual health related issues, nor did they describe the sexual health service or the contribution of health care professionals in relation to patients' sexual health.

Good communication between health care professionals and patients is essential to facilitating good and satisfactory consultations, particularly if it is considered to be the main method of sexual education provided by health services (Gott et al, 2004). With the many challenges facing SA in terms of sexual health that have previously been discussed, this indicates the need to include sexuality and sexual health as part of holistic care by doctors and nurses. However, health care professionals in all specialties, and particularly those

working in services related to sexual health, need first to develop an awareness of how they themselves and their patients perceive sexual health in order to be able to facilitate the provision of appropriate support.

To conclude, despite the fact that worldwide, women's sexual health care is important to public health concerns; it seems that it is not yet a research and practice priority in SA. This has been seen within those studies carried out in SA. The aims of and the methods of the studies reviewed reveal a gap in relation to our understanding of Saudi Arabian women's perceptions of sexual health issues. It is evident that all the attention is given to women's reproductive health. It is also focused just on knowledge of and attitude towards HIV/AIDS, and the majority of these investigations are restricted to the male population. Subsequently, the lack of research on women's sexual health in SA has meant that little professional information is available to assist women, policy makers and those providing support for the outcomes and expectations of women's sexual health care. In addition, the sexual health care system and health care professionals' perceptions in relation to their contribution in women's sexual health is an area ripe for examination since these aspects are likely to impact upon the quality of care received.

2.6 Framing the research focus and questions

Based on this analysis and review of the literature, the current study will attempt to address the deficit and limitations in these studies by aiming to examine how women and health care professionals perceive sexual health and services that are currently provided.

Specifically the study objectives are to:

- (1) Explore how SA women and health professionals perceive sexual health
- (2) Explore how women and health care professionals perceive the function, nature and use of women's sexual health services
- (3) Describe and examine how women's sexual health care services in Jeddah, SA are designed, implemented and operate
- (4) Describe the role of doctors and nurses within the context of women's sexual health

2.7 The significance of the proposed study

In the UK, patients and service users have become more involved in developing health services (Brown & Macintosh, 2006), including sexual health services. The priority of the UK health care system is to put patients at the heart of all health care services (Pearson & Duncanson, 2006; NHS, 2009) to guarantee that these services and the care provided within them are more acceptable and culturally sensitive (Crawford, 2001). The UK health care system continuously works towards involving and assessing patients needs which means that the care and service development must be built around the needs of the patient rather than the convenience of the health authority (Crawford, 2001; Pearson & Duncanson, 2006). Crawford (2001) argued that by involving local service users, the voice of HCPs may be substantially strengthened and confirmed.

However, unlike the UK, the involvement of patients in research studies is very uncommon in SA, and has not happened before in relation to sexual health care. Therefore this study is

significant as it aims to provide an in-depth understanding of women's perspectives about their sexual health care by describing the barriers to sexual health care, professionals and women's views upon sexual health related issues, the sexual health service and the contribution of health care professionals in relation to women's sexual health. Such knowledge – especially that based upon culturally specific need - can then be utilized by health care providers to improve the sexual health of women.

Furthermore, by exploring and understanding the perceptions women and health care providers hold towards women's sexual health care will help them to play a more prominent role in assessing the quality, acceptability and utilization of sexual health care in SA, which then will help inform and guide Saudi policy on the developments needed in relation to women's sexual health care in SA.

2.8 Summary

At the beginning of this chapter, the concept and the definitions of sexuality and sexual health were explored. The definition that it is proposed to use in the current study was provided. The impact of gender on women's sexual health and the sexual health care challenges in SA were discussed. The limitations and gaps in the Saudi literature, the aims and objectives of the study and the significance of the study were also highlighted. A quantitative approach was used in most of the studies reviewed which is argued to be unsatisfactory and inappropriate when seeking a more in-depth understanding of attitudes and experiences around women's sexual health. In an attempt to address the above point there is a clear need to undertake

research using a methodology able to provide an in-depth understanding about women's sexual health care, a task that the researcher will deal with in the following chapter.

Chapter 3: Methodology

3.0 Introduction

When conducting a research study, the researcher should be closely guided by the particular research question that needs to be solved or explored. Research is the process of thinking for the purpose of seeking and revealing knowledge in a specific area and has a specific justification for being undertaken (Bowling, 2002). As mentioned in the literature review, no clear or sufficiently detailed studies have focused on women's sexual health in SA, which has led to the lack of a clear picture of women's sexual health and the care provided for them. Therefore, given that the intention of this study is to seek an in-depth understanding of women's sexual health in SA, an exploratory, qualitative study using a focused ethnographic design was employed.

The first part of this chapter will discuss the epistemological issues around qualitative and quantitative research to provide a rationale for selecting qualitative research. It will then provide a rationale as to why focused ethnography was selected as an appropriate method to guide the study towards addressing the research questions. The second part of the chapter will focus on the research setting, the methods applied in this study, and details of the sampling, methods of data collection and analysis, including issues such as rigour and the ethical considerations concerning the study.

3.1 Epistemological issues around qualitative and quantitative research

Discussing the epistemological issues surrounding qualitative and quantitative approaches in a research study is a fundamental step to understanding the nature of the study under investigation. There are different epistemological approaches in social research (Snape & Spencer, 2003); however, realism and constructivism are two epistemological approaches that have been the subject of a long-standing debate in social enquiry. Realists, who usually favour the positivist paradigm, believe that there is only one stable, unequivocal and objective social reality for any phenomenon, which will exist independent of the researcher in exactly the same way every time (Parahoo 2006). Therefore, it is possible for them to measure and to analyse this social reality using different quantitative methods such as distributing a questionnaire or conducting an experiment.

Postpositivists and anti-realists have criticised this positivist assumption; they explain that the world is complex, and that multiple social realities and subjectivity do exist (Maykut & Morehouse, 1994); they also stress that human beings are surrounded by social reality, which is difficult to measure in a statistical way. In social research, interaction happens between the researcher and the research study participants and that interaction influences the study findings and therefore the researcher cannot be objective as understood by quantitative researchers (Hammersley & Atkinson, 1995; Silverman, 2000).

The anti-realists agree with the philosophical approach of constructivism. Snape and Spencer (2003) provide a clear definition of what is meant by constructivism when they consider it as

“displaying multiple constructed realities through the shared investigation by the researchers and participants of meaning and explanations” (p.12). In the same manner, according to the philosophical approach of constructivism presented by Guba and Lincoln (1994), the aim of the researcher is to understand how people give meaning to their reality through social interaction. Hence, post-positivists believe that every individual is unique, and that one needs to talk, listen, watch and participate with them in their own natural setting in order for them to be understood (Mason, 2002).

Qualitative studies seek answers to questions about the what, how and why of a phenomenon. It is based on the constructivist and naturalistic position that aims to understand the phenomena as a whole, and tends primarily to provide insight and understanding of a phenomenon from the participants' perspective rather than the researcher point of view (Parahoo, 2006). In qualitative research, the researcher accepts the complexity of the phenomena as a whole (Bowling, 2002). It is argued that the researcher may fail to discover the true nature of the phenomenon if approaching the research setting with a set of stated hypotheses as in quantitative studies, due to being blinded by the assumptions built within them.

There is a serious risk that over-adherence to a stated theory and/or hypothesis keeps the researcher away from seeing the research findings in a broader sense. Parahoo (2006) explains that qualitative research is a holistic approach; the participant has the full opportunity to talk freely about the totality of their experience of a particular phenomenon, in

their terms, and language, not merely constructed through the lens of a researcher generated variable.

In quantitative (positivist) research the researchers starts with a hypothesis (deductive) which needs to be proven or rejected; this approach requires large representative samples to claim generalisability. The positivist researcher often claims that they produce findings that are of more value because they are able to generalise the findings to the wider population (Bowling, 2002). In contrast, qualitative research does not seek to generalize its empirical findings. It seeks to gain understanding of social events or facts of the natural circumstances in people's day-to-day lives and to describe the view of one group at a particular time. Therefore, such studies do not usually involve large numbers of participants and usually the sample sizes are relatively small (Bowling, 2002). Parahoo (2006) explains that the goal of qualitative research is not generalisability, but in providing an in-depth, rich account of the phenomena. A similar view is held by Green and Britten (1998); who argue that generalisability in qualitative research is likely to be conceptual or theoretical rather than numerical.

Furthermore, adopting a qualitative, exploratory approach enables the researcher to enter the setting with the freedom to use all possible senses such as observing, listening and recording in an attempt to gain an in depth understanding of how people perceive and interpret their world and not be limited to the testing of explicit hypotheses. In addition, developing a questionnaire in a multi-cultural setting such as SA for such a complicated and complex topic is not appropriate because some words may not be known, used or may actually mean something different to each participant. In fact every region in SA has different social and

cultural habits that may affect their understanding of questionnaire items. Using face to face interviews has demonstrable advantages over using a questionnaire because it helps to minimize ambiguities that may happen due to interpretations; the study participants have more ability to clarify any unintelligible words from the researcher and the researcher also observe the participants body language.

Respecting human beings as valuable sources of data that can be used to inform our knowledge of a complex social world is a clear strength in qualitative designs and particularly useful when dealing with a sensitive subject such as sexual health. Therefore, based on both Parahoo (2006) and Green and Britten (1998) above, It can be argued that researching the largely ignored subject of women's sexual health in SA needs an approach that allows for an in depth, yet sensitive examination of this complex social and health care phenomena. However, once the general decision that a naturalistic enquiry is the most suited to the study, the next task is to select a particular qualitative approach for the study.

3.2 Ethnography

Ethnography has its history within the field of anthropology and sociology. Sometimes it is called field research, fieldwork or observational study (Mason, 2002). It provides narrative descriptions that help to tell the story and describe what is going on in a particular culture. Considered one of the oldest research methods; it has been used by travellers during ancient times to describe the land, culture and people that they would see during their journey (Holloway & Todres, 2006). The main advantage of ethnography is that it is based on the ability of incorporating a range of methods such interviews and observation to describe and

understand a specific people or group in a natural setting (culture). Unlike experimental studies, ethnography allows us to learn from people rather than studying them or doing an experiment on them (Roper & Shapira, 2000). Yet ethnography is unlike a grounded theory, it tend to focus on examining and exploring the social situation and describing cultural practices within the culture rather than focusing on developing a hypothesis and theory from the data that have been systematically gathered and analysed.

A frequently asked question about ethnographic studies is whether the results are likely to contribute to policy or practice. Without doubt, many ethnographic studies such as Bloor et al (1990), Oyejide and Oke (1995) and Theodorou and Nind (2010) are clear examples of the contribution of ethnographic studies to understanding what is going on in a particular setting to develop policy and practice or program. For example, Bloor et al (1990) conducted an ethnographic study of male prostitution in Glasgow indicated that rent boy activity may be of considerable importance for the spread of HIV infection in the city due to them largely engaging in unprotected sex practices and also because the majority of the boys' clients were covert bisexuals. While Oyejide and Oke (1995) in an ethnographic study discussed home remedies for the treatment of Acute Respiratory infection in Nigeria. They found that families and individuals used a range of 'home remedies' such as herbal drinks or eating specific vegetables believed to relieve a cough which had important implications for the development of health education programs in Nigeria. Theodorou and Nind (2010) conducted an ethnographic study exploring the play interactions of a young child with autism and the strategies adopted by her teachers to facilitate her inclusion in and through play. This study provided helpful data on what teachers can do to enable children with autism to be

successfully included through play and informed the practices within schools caring for autistic children.

On a population level there are also examples of ethnographic research that show how ethnographical studies can help to provide invaluable knowledge to health and health services particularly those related to public health and health promotion, which results in changes in practice, service provision or behaviour. For instance the study conducted by the United States General Accounting Office (GAO) in March 2003 examining the range and scope of the use of ethnography in ten of the federal government studies was found that using ethnographic studies helped fill gaps in what they knew about the community helping to inform the agencies' actions (GAO, 2003).

3.3 Conceptual underpinnings of ethnography

Parahoo (2006) explains that "*ethnographers are interested in how the behaviour of individuals is influenced or mediated by the culture in which they live*" (p.67). Therefore, ethnographers tend to search for meaning that participants make in their lives. These meanings are expressed through verbal and nonverbal cues such as talking, body languages, daily routine practice, style of greeting, interacting with each other in different situations. Verbal and nonverbal cues form part of the norms, attitudes and behaviour of an individual in their culture (WHO, 2009). Therefore, ethnographic study implies that social events and processes must be explained in terms of their relationship to the context in which they occur. As a result enriching our understanding about how people usually behave, what they do and

say in certain situations, what are their beliefs and values, and how they derive meaning from their experience.

Hammersley (1992) explains that the main advantages of ethnography are based precisely on the grounds that it is able to get closer to social reality than other methods. For instance, in contrast to the phenomenology, ethnography will allow the researcher to investigate how and why people behave the way they do instead of relying only on what they say. Being in the cultural setting, the researcher will have adequate flexibility to ask questions or identify a problem which are likely arise from observation to the individual and their cultural surrounding. This approach is useful for explaining social phenomena and it is useful to provide richness in the explanation and understanding of human behaviour (Charmaz, 2000). Therefore, ethnography can be taken as a theoretical perspective that focuses on the concept of culture and its relation to observed behaviour.

Culture plays a crucial role in forming, reflecting and influencing individual beliefs and behaviour (Trafimow et al, 2010; WHO, 2009). In fact there is a complex circular relationship between culture and the individual. Culture controls and sets roles while the individual interprets and conforms to these roles and the information provided from and within the culture, as well as being influenced by other information from outside the culture contexts which may then influence on the culture with time particularly through the availability of power and authority – causing conflict between an individual's own values and the values within an organization or culture (Ruane, 2005).

One of the strength of ethnography is its clarity, so that the reader can understand it by themselves (Spenziale & Carpenter, 2003). On the other hand, it does not attempt to find an immediate solution to the observed problem. In fact the primary aim of the ethnographer must always be to have an open mind to the research setting or group being studied and not to try or to attempt to impose his/her interpretations or understanding the phenomena. However, an open mind should not mean that the ethnographer should have an empty head when conducting the study (Roper & Shapira, 2000). Indeed, ethnography can help both the researcher and the respondents to interact, discuss, learn and clarify any ambiguities. Allowing participants the freedom to say what they think while being observed in their own setting offers added richness and depth to the data collected.

To conclude, ethnographic research was chosen for this study because it provides a useful tool to understand complex situations more fully. Ethnography aims to derive meaning from the culture being studied itself in order to understand the phenomena, and focuses upon the wider surrounding issues. Sexual health is a subject that arouses passion and controversy because it deals with important issues, namely sex, controlling fertility and intimacy which are often mixed with government policy and religion.

Ethnographic research is also particularly appropriate in the hospital clinic setting; where interactions happen that allow a researcher to capture contextual issues around women's sexual health- such as the type and nature of care provided or the service levels and staff involvement. As a result, by adopting an ethnographic approach the researcher can gain insight into issues that may not have been immediately obvious if employing other qualitative

methods - a demonstrable advantage of ethnography over any other qualitative approach in addressing the research questions of this study.

3.4 Issues associated with ethnography

3.4.1 Objectivity

There are a number of issues associated with ethnography, as with all qualitative research, which should be taken into account. One of these issues is that because it relies heavily on the personal experience of the researcher, objectivity is an issue. Researchers rooted to traditional research claim that this issue in ethnographic study shifts the study focus from the study participant to the researcher (Savage, 2006). They also argue that the results produced from using this method are not valid due to threats that could possibly occur from the "reactivity and subjectivity" of the researcher (Spenziiale & Carpenter, 2003). Conversely, it is also argued that the interaction between the study participants and researcher is good and therefore not to be prevented, but instead considered "*as a productive element for formulating questions and understanding answers in the process of research*" (Berkwits & Aronowitz, 1995. P. 410). Nevertheless, Lietz et al (2006) emphasizes the importance of minimizing the effects of the researcher in ethnographic research by ensuring that the researcher prioritises the participant's thoughts, feelings and experiences over that of his/her own.

The participation of the researcher in the setting also introduces concerns about the possibility of the participants amending their interactions, responses or behaviour because of his or her presence. To address this in ethnographic study the researcher immerses themselves

in the study setting for a period of time which helps build trust within the research setting. It is also believed that the longer the time the researcher spends in the setting, the more likely it is that they will become a member of the setting being studied (Burgess 1984; Bowling 2002; Parahoo 2006).

3.4.2 Selectivity and bias

The ethnographer is considered to be the main tool for data collection (Spenziale & Carpenter, 2003). Therefore, there is a possibility that the researcher may introduce a Hawthorne effect on the participant or bias toward perspectives from his or her own culture. This can lead others to question the results produced from any ethnographic study – for example, whether the researcher's observation and analyses are selective and biased or not (Green & Thorogood, 2004). However, there are many possible strategies that can be used by a researcher to overcome any possible bias. For example, field research that involves simultaneous collection and analysis of data and continuous reflexivity is a good way to determine the scope of the impact of the researcher on the research data. Furthermore, Silverman (2006) emphasises that the researcher should work carefully whilst in the setting toward not restricting or manipulating a participant's perceptions of the research topic or even their understanding of it in order to gain credible information from them. These strategies will be discussed at a later point in this chapter when the techniques of qualitative rigour are presented.

3.4.3 Time consuming approach

Time in ethnographic study is also very important for the researcher. It is a hard and time consuming method. A great deal of commitment and effort from the researcher is required in

order to get extensive and valuable data to study (Denzin & Lincoln, 2000; Green & Thorogood, 2004). As mentioned earlier, the ethnographer becomes immersed in the lives of the people they study. Hence, it takes time - perhaps months or even years - in order for the ethnographer to be familiar with the studied culture. Therefore, it is important for any researcher adopting an ethnographic approach to bear in mind that the ethnographer requires a significant amount of time to spend in the field. However, most research in health care overcomes the time issue by carrying out 'focused ethnographies' (Savage, 2006).

3.5 Focused ethnography

Focused ethnography was identified by Spradly in 1980. It is sometimes called mini or micro ethnography (Roper & Shapira, 2000). It differs from traditional ethnography because it aims to examine a small culture or group within an institution such as a hospital, clinic or unit (Holloway & Todres, 2006). Focused ethnography has been widely used in recent years by researchers into health care, because of its usefulness and relevance to health policy and practice. Subsequently, it is increasingly recognized as a helpful methodology to identify the influence and effect of being in or part of the culture on clinical practice.

In focused ethnography, the researcher is guided by a general interest in the topic and enters the field with established specific focused research questions that need to be answered. As such, the researcher will usually be able to accomplish the research within less time than that required for traditional ethnography (Roper & Shapira, 2000; Green & Thorogood, 2004; Savage, 2006). Nevertheless, these questions, which are formulated prior to conducting the study, may be modified or increased as the study develops and progresses. Therefore, Roper

and Shapira (2000) explain that the researcher in focused ethnography is not be limited by preconceived notions of the outcome of the study findings nor the direction of the research – but is merely guided by the foreshadowed questions.

3.6 Methods of data collection in ethnography

3.6.1 Observation

Observation is considered to be central to ethnographic research. The main feature of observation as a method of data collection is its ability to allow all the human senses to gather information and an in-depth understanding of the area of the study (Green & Thorogood, 2004). Observations can range from being completely unstructured to being highly structured. Structured observation is more like a questionnaire used in a survey, where every respondent is asked the same set of questions. But in structured observation, questions are not asked. It is widely used in quantitative studies that use checklists and categories that are prepared in advance (prior to the commencement of the study) to record the observed data. It is usually used when there is a clear idea about what to observe and record. Due to pre-knowledge of the research topic it is possible for the researcher to identify beforehand which behaviors are to be observed and recorded. Therefore it is not difficult to write down the dependent variable on a sheet and then to simply tick during the observation.

Unstructured observation is the informal watching and recording of materials, setting, events, stories and behaviors as they occur in a natural environment. It is flexible throughout the research process as there are no restrictions on what the observer should observe and note, instead everything in the environment under study is worthy and valuable for recording and

monitoring (Holloway & Todres, 2006; Parahoo, 2006). However, unstructured observation may become more specific as to when and where to observe, what specific aspects of the setting or behavior to observe, and how to make and record observations. The aim of unstructured observation is to see as many details, behaviors and interactions in each particular setting as possible, and then to describe all the relevant behaviour that occurs without filtering it through any interpretive process.

Unstructured observation has the advantage of helping someone to gain an in-depth understanding about an unknown topic (Bowling, 2002). Thus this approach seems best suited to the aims of this study. The main aim of conducting the current study is to seek knowledge, to explore and gain understanding about women's sexual health care in SA. Therefore, it is felt that going into the subject fresh, not narrowing the view by having an explicit hypothesis, checklists and being open to seeing everything related to this topic is best for beginning to understand the study setting naturally as it occurs.

3.6.2 Semi-structured, in depth interviews

The semi-structured interview is a research technique used extensively for exploring issues and acquiring information regarding the phenomena being investigated, as it allows the participants to tell their stories in detail (Denzin & Lincoln, 2000; Tod, 2006). In semi-structured interviews the researcher adopts an interview guide rather than prescriptive closed questions (Richie & Lewis, 2003). It is mostly used when there is little or no knowledge or information regarding the research topic (Legard et al, 2003). The researcher will usually listen carefully to the participants and help them, through questioning to talk about what they

consider relevant and important. Interviews are usually audio-taped and accompanied by field notes. It is felt that this kind of interview is valuable in sexual health research because it helps by almost creating a situation whereby there is a 'normal' conversation with the researcher where it is likely that participants are open about more personal issues. Semi-structured interviews also tend to enable participants cultural values, beliefs and norms to be explored by a researcher (Mason, 2002; Tod, 2006).

Furthermore, the importance of in-depth interviews is that they solicit the opinion of the interviewee on a range of pre-determined issues and offer both the interviewer and the interviewee the opportunity to add or clarify any ambiguity that might arise during the interview. However, it should be borne in mind that the interview may become more structured as the study progress as the researcher builds upon and clarifies ideas that have arisen from previous interviews and observations in the field (Legard et al, 2003).

The interviewer during in-depth interviews usually uses a few questions to facilitate the interview and to clarify or to encourage participants to provide further information. Interview guide help the interviewer to manage the interview and remind the researcher about the interview agenda while allowing the researcher to add more questions based on the observations made or questions raised during the interview regarding new topics introduced by the participant (Legard et al, 2003; Tod, 2006). For the purpose of this study, some initial interview guides were developed to facilitate the interviews with women and health care professionals (see Appendix 16 & 17). The interview guides were drawn from the literature review and from the researcher's knowledge of the topic area. However, the guides were

intended to be used flexibly and by the use of open questions and recognizing the need to be able to divert from them, merely formed a framework for the interviews.

3.6.3 Field notes

Field notes are one of the most fundamental and well-known data collection tools used in ethnographic studies (Speziale & Carpenter, 2003). While carrying out fieldwork, the researcher needs to take notes to record the data generated and collected from the field setting. These notes may contain all that has been asked, discussed, seen and heard in the setting including the researcher's thoughts, experiences, feelings, events and comments. The researcher may use either a journal or diary for this purpose. Spradley (1980), Speziale and Carpenter (2003), Parahoo (2006) and Silverman (2006) offer a great deal of advice for the researcher regarding the use of field notes which guide their use in this study. This is summarized below:

- Always take your diary/journal and pen
- Write down the date, time, names and location
- Make an immediate note of anything you see that is interesting for the study.
- Write a short note and extend it as soon as possible
- Write down your thoughts, experiences and feelings about the events.
- Do not jump to conclusions or interpretations straight away.
- Look for more evidence of what you have seen and heard.
- Ask people to confirm things through more observation, and formal and informal interviews.

3.6.4 Participant observation

In ethnography the researcher must be present within the participants' setting; however, the role of the researcher varies according to the theoretical approach of the study. There are four levels or types of participant observation: participant, participant-as-observer, observer-as-participant and observer only (Holloway & Todres, 2006). The objectives of participant observation vary from full participation to partial participation in the activities of those being observed, and from moderate to complete observation of the setting, events and participants' behaviour in their natural setting. Green & Thorogood (2004) and Holloway & Todres (2006) categorise the complete observer role under non-participant observation. Some authors have mentioned that the complete observer role is limited and claim it prevents the researcher from obtaining "insider" information about what it is like to be a member of the cultural group. However, Roper and Shapira (2000) argue that whatever the observer role was it can be very useful and enlightening if done correctly. In this study 'participant observation' was adopted because it was felt that this type of observation helped in collecting more information by immersing the researcher within the study setting more fully.

Once the method of inquiry had been selected and techniques of data collection chosen, the next step was to enter the field to put the methodology into practice. The following section describes this in detail. It presents the conduct of the study from gaining access through to the collection and analysis of data.

Section 2: Entering the Field

3.7 Study setting

This study was conducted in Jeddah, located in the western region of the kingdom of SA, halfway down the Red Sea. The location of Jeddah city is shown in figure 4. It is one of the big, multicultural cities in SA. It is considered the main air, sea and land gateway for pilgrims going to the two Holy Mosques in Mecca and Medina.



Figure (4): location of Jeddah city in Saudi Arabia

Source Wikipedia, the free encyclopedia

The study was conducted in hospital clinics where women can seek sexual health care such as the family planning clinic (FPC) or postpartum clinic (PPC) in two selected government hospitals in Jeddah, namely, King Abdulaziz University Hospital (KAUH) and Maternity and Children Hospital (MCH). There are many governmentally distributed hospitals throughout Jeddah city, some of them under the Ministry of Health, the Ministry of Education or the

government but managed by a private company. Two sites were purposively selected. KAUH which is a teaching hospital managed by the Ministry of higher Education, and the MCH, which is managed by the Ministry of Health. Both hospitals are considered to be big hospitals and provide free care for both Saudi, and with some restrictions, non-Saudi nationals from different parts of the country. These two particular hospitals were selected for the study by the researcher in order to include hospitals that are different in management styles and geographical sites and that possibly target different staff and patients.

3.7.1 KAUH Setting

The obstetrics and gynecology clinic (O&GCs) is located on the ground floor with some other hospital clinics in the building specified mainly for out patients' clinics (OPCs). The foyer of the clinic consists of a large reception area in the form of a semi-circle which distinguishes the O&GCs from the other clinics. In front of this is a large open waiting area for men with chairs placed in the opposite direction of the O&GCs reception to preserve more privacy for women within the clinic. The FPC is located at the left side of this clinic and run by residents and junior doctors being held every Wednesday afternoon from 1pm to 3pm.

3.7.2 MCH Setting

The O&GCs operates five days per week; on Wednesdays the last day of the week there is a clinic call post partum clinic (PPC) that runs specifically for postpartum (PP) and family planning (FP) cases from 9.00am to 3.00 pm. This clinic's location is temporary because the hospital had destroyed the old O&GCs building and started the construction of new one.

There is a small entrance door that leads to a small waiting area containing two doors, one for the O&GCs and one for the Circumcision Department. In the O&GCs there is a long lobby which contains six rooms on the left-hand side: the first room is the biggest and is used for CTG and vital signs by nurses; then there are four gynaecology and obstetrics consultation rooms; then the last room is used as a medical consultation clinic for women only.

3.8 Gaining access

3.8.1 Gaining ethical approval

A summary chart of the process used to gain approval for the current study is presented in Appendix 1. Whilst the researcher was in the UK a letter was sent to both hospitals (Appendix 2) asking them about the possibility of conducting the study in their hospital. The letter also enquired about the local ethics procedures for gaining access. The letter was attached with a supporting letter from the researcher's supervisor (Appendix 3). It is worth mentioning that preliminary discussions took place with the clinic head nurse in both hospitals in March 2007 and both had given their approval, in principle, for the study to take place. After consideration by the appropriate individuals, written approval from both hospitals was provided (Appendix 4 & 5). In addition to gaining approval from the hospitals, ethical approval was also obtained from the University of Sheffield Ethics Committee (Appendix 6).

3.9 Ethical issues within the study design

All research studies with human beings generate ethical concerns and considerations (Polit & Hungler, 1997; Green & Thorogood, 2004). As mentioned before, the ethnographer is interested in understanding people in their own setting; therefore, it is necessary for the researcher to participate with them in that setting. This raises a number of ethical concerns of which the researcher must be aware of and account for when conducting the ethnographic study. These are as follows:

3.9.1 Informed consent

When conducting research that involves human subjects, there are many issues that generate ethical dilemmas: autonomy, confidentiality, privacy and justice. Informed consent, considered one aspect of autonomy, includes discussion of the purposes, aims, objectives and potential benefits of the study (Bowling, 2002). Consent for a research purpose means a person's agreement given for a researcher to include him/her in a research study. The Faculty of Family Planning and Reproductive Health Care of the UK (FFPRHC) state three criteria for consent to participate in a research study, the first is that the person must be competent to make that decision, the second is to have enough information to take the decision and thirdly to be free from duress (FFPRHC, 2001).

Several steps were undertaken in this study in order to obtain informed consent. Firstly, a small presentation was conducted in the clinic to introduce the researcher and the study to clinic staff. Secondly, an invitation letter with information sheet that included information about the research was given to all women and to all clinic staff to read and to keep

(Appendices 7,9,11 & 12). Women were given the Arabic version of the invitation letter and information sheet (Appendices 8, 10 & 14). This information sheet explained to them the aims and objectives of the study and what their participation may entail. In addition, participants were informed that participation in the study is voluntary therefore, they have the right to choose whether to participate or not, and their decision will not affect their treatment or the services they are offered in the hospital. Lastly and not least, before asking any participants to give their written consent (Appendices 13 & 14), the researcher asked the participants if they have read the information sheet carefully and have understood what the study was about and what their involvement entailed.

3.9.2 Dignity, privacy, and confidentiality

Maintaining the dignity, privacy, and confidentiality of the participants presents complex and challenging issues that were carefully considered when conducting this research study, particularly due to its sensitive nature involving sexual health. Therefore, based on the right to privacy, several measures were undertaken:

- (1) Participants were interviewed alone in a comfortable, private environment in the hospital.
- (2) The participants were informed that they had the right to ask recording to stop at any time during the interview.
- (3) They were also informed that they had the right not to answer any questions and could withdraw at any stage without given reasons.
- (4) All the information given was treated as confidential with the data handled only by the research team.

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- (5) The research findings did not identify any of the hospital and the codes “AH” and “BH” was used throughout the findings to refer to the hospitals.
- (6) The research findings did not disclose any of the participants that have taken part in the study; coded numbers or letters were used and no actual names revealed. Appendix 21,22,23,24 provides some details of the study participants representing the given names and the code used when referring to them in the study findings.”
- (7) All the transcripts and records were stored securely in a locked cabinet and were saved also password protected computer.

3.10 Sampling and inclusion criteria

There are different methods of non probability sampling which can be used in qualitative research, such as convenience sampling, purposive sampling, snowball and theoretical sampling. Each method has certain criteria that enable the research to achieve its objectives (Polit & Hungler, 1997). Snowball sampling, for example, is a method started when the researcher approaches one or a group of participants then those participants help the researcher in recruiting other participants and so on. Parahoo (2006) argues that this method is useful when the researcher wants to recruit members of a specific network. Convenience sampling is an uncomplicated technique of sampling where the researcher tends to look to include participants who are easy to contact and to recruit. Whilst, theoretical sampling is more complicated and needs to be set up during the research process to help in developing hypothesis or theory – a process usually employed in grounded theory studies.

Finally purposive sampling which is the most common sampling technique used in qualitative research. Bowling (2002) and Green & Thorogood (2004) explain that purposive sampling aims to involve participants who are more likely to produce detailed information and generate data. As a technique this form of sampling was ideal for this project. Using the purposive sampling of married women, doctors and nurses from within the clinics will be of clear benefit because of the ability of them to discuss topics relevant to the research questions and to maximize the heterogeneity and the diversity of the participants' characteristics. As a result the sampling used and the inclusions criteria were as follows:

- (1) A purposive sampling approach was used to recruit women for in-depth interviews and for observation from each hospital. To participate, women had to be at least 15 years of age, married, Arabic speaking, attending the clinic for family planning or postpartum check up, without mental health problem, and who have not been victim of rape or sexual assault and agree to take part in the study.

- (2) A purposive sample of health care professionals from each hospital, including doctors and nurses who are working in the clinic, as well as the manager and the head nurse of the clinic were also invited to take part in the study.

The decision to include only married women in the study was a difficult, but important one. This was done to respect the sensitivity of the research topic within Saudi culture where married women are expected to have more relevant current experience in sexual health topic than unmarried women. This approach would also safeguard unmarried women who, through participation alone, could be stigmatized and be socially at risk. This sampling decision also

helped to not offend the participating hospitals during the ethical approval process. For the purpose of the study women, doctors, and nurses were asked (1) to allow the observation of the post partum and family planning consultations, and (2) to be interviewed. However, because some practitioners were busy with their work, and also because some women had another appointment or other responsibility, or for any other reasons they refused to be interviewed while agreeing to be observed or vice versa. They were informed that they have the right to give consent to be observed only or just to be interviewed (partial participation). If the study participants and the researcher were not able to perform the interview on the same date; an appointment was arranged to conduct the interview at a convenient day/time in the hospital. Sampling and methods of participation in the study are summarised in table (1).

Women	Women who will attend the clinic for post partum and family planning consultation	They can give consent to be observed and to be interviewed. or to be observed only or to be interviewed only
Doctors and nurses	Staff working in the clinic	They can give consent to be observed and to be interviewed. or to be observed only or to be interviewed only
Clinic head nurse and clinic manager	Responsible for managing the clinic	They can give consent to be observed and to be interviewed

Table 1: Sampling and methods of participation in the study

To ensure that participants were without current mental health problems and had not been victims of rape or sexual assault at the time of attending the clinic the following measures were adopted.

- 1) In SA, patients have at least one physical and mental assessment in the hospital as a routine process when opening a patient file. In addition, during labour (delivery - childbirth) a full medical history has to be done and is found in the patient file. Therefore, the researcher was able to check with clinic staff about these matters before inviting women to participate in the study.
- 2) During the recruitment process, women were asked (in private) if they are being, or have recently been, treated for any mental health problems. For instance, a woman may be being treated successfully for post-natal depression which wouldn't necessarily exclude their participation. However, if they were still under treatment, they were not included in the study. One woman was not included in MCH due to of this reason.
- 3) Women were asked during the recruitment process (again in a private) if their current clinic visit was linked to any type of rape, attack or sexual assault, however, no cases of this type were encountered.
- 4) If a woman had said she has no mental health issues and then during the interview or observation it appeared that maybe then the researcher's professional experience and judgment would be used to halt the interview or to leave the consultation. One observational case for a post partum woman was excluded from this study in KAUH

because during the consultation it was discovered that she was still undergoing mental health treatment.

3.11 Reflections on gaining access and permission for the study

Most people were curious to know why the researcher was conducting such research and the reasons behind choosing it. Some asked if my supervisor was the one who advised such a study and some participants advised caution about the western media and advised the researcher to hold the Quran and Sunnah when on return to the UK indicating that they do not want the West to brainwash her! Some asked about the researchers' marital status and it seemed that this was found to be helpful by some in that – seeming to believe that being married would not lead to research that could be subversive:

"we do not know, peoples intentions, some might have good intentions like you....want to improve the service but others maybe have another intention and they want to corrupt the community - do not be surprised ... this is the truth, some countries do not want to see women covered and have luxurious lives... they want us to become like them without values they want women to sleep here and there and they say to us freedom and human right....look to them they encourage sex and encourage their people to talk freely about sex...and they get AIDS and many other sexual transmitted disease...we do not want to be like them.(Amal, FD-BH43, Diary Note)

These occurrences were reflected upon a great deal in the researcher's diary about how people were shocked and surprised with the title "sexual health", about how they were curious to know about the topic and how the researcher came to be known in the setting as *"the one doing sexual research"*!

Similarly, some of the gate-keepers to the clinical areas also expressed interest, but also some concerns. The following is an extract from the researcher's reflective diary about a meeting with Professor 'Amer', a senior member of one of the hospitals:

When I meet Professor "Amer", he recognized me immediately from the title of my research; he invited me to his office to discuss the research. Once I sat in the chair he started to ask me many questions such as "what are you going to research on women sexual health? What exactly do you want to look at?" He was really interested and curious on the topic and even we discuss it in details together then he shared with me his impression that in undertaking such research "choosing this topic is very important for us at this stage of time...you are very brave women to undertake this sensitive topic" Then he said "as I know no one before you has conducted such kind of research here in Saudi Arabia whether male or female... I think because of its sensitivity...it seems to me that you will collect some very interesting data", he advised me to disseminate the research results and then wished me all the luck. (Research Diary Note, December. 2007).

The director of nursing was also surprised and curious about research topic, and a little concerned about the sensitivity of the project:

Today I met Mr. "Ahmed" the nursing director; he was very cooperative with me and welcomed me warmly. When he knew that I will be conducting my research on sexual health he looked surprised then he started to ask me more details about what I am going to ask women and staff about exactly? He expressed his concerned regarding the sensitivity of the topic and said "frankly I do not know how staff or women could

accept and deal with your questions...but you have got the permission from the committee....therefore, it is fine for me to give you the permission to start your data collection " (Research Diary: 2nd Jan. 2008).

3.12 Reflections on "A" Hospital (AH)

The hospital where the data collection started was the AH which was a good place to start the field-work. The main reason for this was the researchers' familiarity with the hospital and clinic. The following extract from field notes describes this:

I was very happy when I started my data collection in AH; this was due to many reasons the main one being that this hospital was somewhere I felt I belonged; I had studied here and my internship had been here, so I knew most of people working at the hospital and I knew all the building and units. The OPCs supervisor had been my boss when I was working as a staff nurse in urology department (ESWL). Furthermore, the gynaecology clinic head nurse was one of my friends who had graduated from the same university one year before my own graduation. I had a good relationship with both of them. They were cooperative with me and provide all the information as they could and facilitate my research during being in the setting.

It was also helpful to know the setting and be familiar with its systems and processes – all things that helped make fieldwork easier:

It was easy for me to contact anyone in the hospital because I knew the routine and the system of the hospital; I knew how the hospital was run and by whom. Due to my

relationship with the hospital, I was able to have my own desk in one of the unused consultation rooms in the paediatric clinic, near the gynaecology room. I often used it to write in my diary and to conduct some of the interviews with patients. These reasons also I felt made obtaining the ethical approval less complicated for me compared to BH. All these factors combined to make me feel I was not a total stranger. Although I had some idea and experience of how the clinic in AH had been run previously, at the beginning, I was unsure how to start because I was slightly confused about some changes to the running of the clinic, specifically the change whereby one side of the gynaecology clinic was run by consultants and the other side was run by resident doctors. The head nurse and the receptionist explained to me the routine of the clinic, which helped me during my observation. I think had I not asked them but had depended only on my own observation, I might have taken longer to understand the routine.

3.13 Reflections on “B” Hospital (BH)

Generally, it was much more difficult to get official ethical approval from BH which was frustrating taking around 5 months in total to get the final approval. However, this was achieved and on return to the hospital was referred to the OPCs manager. Meeting her was difficult at first, but once this had been arranged, she was invaluable, as the following diary extract describes:

After three visits to the OPCs manger I was able to meet her and to discuss my topic. However, she also referred me to another doctor who really helped me a lot to start

my data collection. Truly, without her support I might not have been able to start in good time. Then I met the OPCs coordinator who also informed me that nobody had informed her about my request. Actually there was no way to get the final official approval by email or by fax when I was in the UK or even when I was in Jeddah. I realized that I would have and required to go personally to complete all the processes between these departments and I would have to show each one all the necessary papers and supporting documents.

Once into the clinics people were cooperative and welcoming during field observation, but it took a few weeks before relationships had developed and the researcher became familiar with the setting and how the clinics worked. However, similar staff reactions to the research topic to those in AH were evident, as this extract from field notes illustrates:

When I got my official ethical approval, I met the OPCs clinic head nurse; she is a Saudi female, who graduated from Nursing College with a diploma degree. Her first impression about my research was a surprise in undertaken this kind of research, she asked me a barrage of questions as why I am undertaken such research and I was trying to turn the questions to her to know her view instead of telling her my view. But, eventually, she was co-operative and introduced me to doctors and staff in the clinic.

Fieldwork in BH was more difficult, but the longer it went on the more familiar the researcher became to the staff. Showing how prolonged engagement is essential in this kind

of research. The following field notes extract describes this process of gradually getting to know staff and the clinic:

Most of the people I met in the BH were new to me. I tried my best to build relations with the clinic staff and doctors. After a couple of weeks I felt that they had got used to my presence and they started to ask about me if I was not around. They even started to ask questions such as “Why did you not attend yesterday?” and “Where have you been?” and how is your data collection going on? I gained a lot of information related to my research, especially when one of the doctors asked me to meet her in the female doctors’ room in the delivery room. It was easy for me to contact many doctors and we sometimes talked as a group about my research. Group discussion was very helpful and stimulated others to share their opinions regards sexual health topic.

3.14 The recruitment process

3.14.1 Process for recruiting HCPs

With the help of the clinic head nurse a staff meeting about the study was arranged during the second day of the researcher being in the setting. The aim of this introductory meeting was to introduce the study and to ask the nurses to help in recruiting the patients. In both AH and BH the head nurse was delegated to arrange an early morning introductory meeting to all nurses who were working in the study clinics. All nurses who attended the introductory meeting were given an envelope containing invitation letters (Appendix 11) enclosed with the information sheet (Appendix 12), the reply form (Appendix 15) and an envelope.

It was not possible to arrange a meeting with doctors due to the doctors work demands and patterns and also the unavailability of a stakeholder who could make this meeting happen therefore, another approach was used. The researcher attended one of the regular gynaecology meetings and also visited the female doctor's room enabling the researcher to meet doctors working in the women's clinic and introduce the research to them. All HCPs were asked to disseminate the information if possible to their colleagues. Another way of informing HCPs was to approach them personally while in the clinic setting - asking them if they know about the study. If they expressed an interest they were handed an envelope containing the same content as the one given to their colleagues. Finally, the invitation letter and the information sheet were placed in the nurses' reception in a prominent position for all staff to read.

3.14.2 Process for recruiting women

It is difficult to recruit women in SA through postal address because there is no free governmental postal service such as that provided in the UK. People in SA have to buy or rent their own post address therefore few people have a postal address (mainly educated or business individuals) and also it was difficult to access the telephone number of postpartum and family planning cases who have appointment to the clinic.

Therefore, there was no opportunity to recruit women before they attended the clinic. Recruiting women was a complex task which was under-taken with help from clinic receptionists and nurses. Women who came for family planning or for a post partum check up

were handed an envelope containing the invitation letter (Appendix 7) and the information sheet about the study (Appendix 9) and asked to read them while they waited for their file to come from the record department and for their turn to be seen by their doctor – a period of time that could be up to one hour. Once a woman agreed to take part in the study and gave her consent, her doctor was informed. If the doctor was still happy to be observed, then the researcher attended the consultation room with her. A Summary for the recruitments process is presented in table (2).

Women who are attending for family planning or postpartum check up	They were given an envelope containing an invitation letter and information sheet by the clinic nurses or the receptionists then approached personally by the researcher when they express interest to participate or required more clarification about the study.
Doctors, nurses work in the clinic	They approached personally by the researcher A small presentation was conducted to introduce the study and the researcher
Head nurse and manager of the clinic	They were given an envelope containing an invitation letter enclosed with the information sheet, reply form and envelope. An invitation letter and an information sheet were also placed on the clinic board for all staff to read.

Table 2: Summary for the recruitments process

3.15 Reflections on the recruitment process

One of the first challenges faced in both hospitals was when some of the nurses did not want to help in recruiting female clients. When asked about this, the nurses informed me that they were busy and have something else to do, one of them saying *"it is better to recruit them by yourself particularly you know how the work is done here"* (Research Diary Note-AH). Not wishing to cause problems building trust the researcher, in the beginning, undertook the recruitment process by herself. However, eventually nurses began to help as they found out more about the study and seemed to become more accepting of the research.

Recruiting patients and HCPs was not as complicated in BH compared to AH. This was due to the way the clinic is run in the BH: it is clearer and easier to follow, postpartum patients mainly come on Wednesdays and are seen by one or two doctors, therefore it was easy to access target patients and HCPs.

In both hospitals numerous women were interested in taking part but indicated that they did not have time to be interviewed after the consultation:

"I do not have a problem with being observed but I cannot stay after the consultation because my husband is waiting outside for me". Or "I have to go because of my motherhood responsibilities" (Research Diary Note).

Sometimes women would politely end the interview when their husband came to collect them from the hospital and although this was frustrating it was possible to empathize with the women. This could be as they said above or because of the sensitivity of the topic to them or due to of the long waiting time in the clinic.

3.15.1 Resistance and refusal

During the recruitment phase there were many difficulties and challenges to recruit doctors and consultants particularly from AH due to the sensitivity of the topic. When the invitation letters in envelopes for females well known consultants at the end of gynaecology meeting (they were discussing the increase in foetal mortality in their hospital) one of them raised her and said that in her opinion *"it was waste of time doing a PhD in such a topic "sexual health. In Saudi Arabia there is a need to think about more important things and that we should not following the West in everything"*. This incident was recorded in field notes as follows:

I told her that I had heard her during the meeting comparing the hospital's mortality rate with that of other hospitals "in order to improve ourselves" and asked her why she thought it was not a good thing that we looked to improve women's sexual health care? She told me, "There is no comparison here ... because Islam gives women all the power". She advised me not to follow western propaganda about women's rights or sexual health because "they (the West) want to change us ... we are in a better situation than them". I talked to her about how our Prophet Mohammed discussed this sensitive topic, to which she replied, "That's why I told you there is no need for such a topic" then she told me she would read the paper I had given to her, and she informed

me that she did not mind sitting down to talk with me. However, I could not contact her for the interview and she did not give her reply to the receptionist.

In similar scenario a male consultant was happy and welcoming when staff informed him that I am a researcher and studying in the UK, he was smiling and took the invitation letter to read, however, once he read the research he said to me in front to his staff "*sorry I will not participate in such topic*". Interestingly, his actions actually stimulated an intense discussion about the topic among the doctors and nurses who witnesses his reaction. One of them saying: '*it is very difficult particularly for men to participate in sexual research and you have to forgive him his attitude.*' (Diary Note, AH).

3.16 Collecting data in the field

As discussed earlier, in keeping with an ethnographic approach a variety of methods were used to collect data in this study. These primarily involved observation, in-depth interviews, and documentary analysis.

3.16.1 Observation

In the current research, the researcher's role was to observe the consultation process, events, the physical elements of the setting and the behaviour of the study participants and the interaction between women and HCPs in the setting related to sexual health issues. Being a participant observer meant immersing oneself in the clinic as much as possible although also recognising the importance that the researcher's presence as an observer is made explicit to

the study participants. In AH for example some of the in charge nurses were non Arabic speakers and they used the researcher to translate things to patients such as where patients have to go for x-ray department or to inform them about their appointment etc... this helped them by just translating but was a great help in building trust and being accepted by the clinic staff. Clinics were attended and observed every day, five days per week, eighth hours per day for two months in each clinic to become more familiar with the clinic layout and structure of the setting, the working routine, daily processes and events such as staff and management meetings about the clinic, the roles of and the types of interaction between the staff and patients and staff and staff. During this time it was also possible to read clinic policy and procedure, staff job descriptions and clinic related documents such as staff assignments in the clinic and clinic cases/patients.

Detailed written field notes were recorded during these periods of observation. Field notes consist of a chronological field diary sustained for two months in each hospital and combined consultation observation cases, description of practice, service, care, events, recording personal experiences and responses, records of informal discussion with individuals and groups. In total 36 consultations were observed in AH and 38 in BH. A summary of these consultations are presented in Appendix 19 and 20.

3.16.2 Conducting Interviews in the field

Despite the sensitivity of the topic, most female clients and HCPs were interested and curious about the topic and many interviews exceed more than an hour and a half. In total, 40 interviews were conducted 21 female patients and 19 HCPs. Table 3 shows the total

conducted interviews in both hospitals. More information about the participant's characteristics is available in Appendix 19 and 20.

Conducted interview with	AH	BH	Total
Male Doctors	4	1	5
Female doctor	1	8	9
Nurses	4	1	5
Female patients	13	8	21

Table 3: Total conducted interviews in both hospitals

Due to the sensitive nature of the research, interviews always began with more generalized questions to break the ice and to try to make participants more comfortable. Female clients were asked their reasons for the visit and how many children they have for example. HCPs were encouraged to talk freely about their role and experiences in the clinic. This way of starting the interview helped to develop a rapport with them and helped not to threaten participation in the research. Not all interviews actually required this as some participants wanted to talk about sexual health right from the start – probably because they were aware of the topic from the information sheet and were interested.

Indeed in quite a few interviews many interesting views were actually expressed before starting the recorder or after stopping it. It was interesting that some participants felt more

comfortable talking about this topic without being recorded. Notes helped in these kinds of situations as they did in more informal discussions with staff. For example, group discussions happened about the project and the subject of sexual health with staff during lunch or coffee breaks or in the reception area.

3.16.3 Issues during the interviews: Interviewing about a sensitive topic

Despite the fact that interview schedule was piloted with colleagues and friends before conducting the real interviews with the study participants in order to assess the acceptability of the topics and questions. It was soon realized that did not provide a real picture of what would take place in the clinics. For example, one interview with a friend there was no problem with the question *"do you have any problem in your sexual relations?"*. However, this question was not understood by many female clients and HCPs during the interviews. Most of them asked what was meant by "sexual relation" and some asked if it meant "marital sexual relations". During the interviews participants were very specific to connect the word 'marital' with 'sexual' when they talked or answered a question. Some of them said *"I have to say that because if I will say my sentence without the "marital" word as I am doing many relations and this is not correct"*. Following this it was decided to limit the use of the word "sexual" as much as possible during the interviews. For example using questions that did not contain the word "sexual" at all such as, *"tell me about your "marital relations"* or *"what you think affects your intimate marital relations"* and so on.

Another issue was when some female patients said that they were happy to talk about everything related to their sexual health, except that related to their intimate marital sexual

life because it was "Haram" to reveal thing about it. Some of them reminded the researcher about the cultural sensitivity of the issue with 'Hadeeths' about prophets Mohammed (PUH) such as *"The evil status of people to God on the Day of Resurrection, the man who comes to his wife and she comes to him, and then one of them publish the secret of his partner."*

Women were reassured that they had the full right to decide what they want to disclose or not in interviews. However, surprisingly, it was found that these women actually did revealed details about their intimate relations during the subsequent interview, often in response to quite general questions. Most female clients also had some difficulties with sexual terminology and did not know the correct terms for such as the pubic area, clitoris, and vagina. Participants usually gave hints or used the eloquence of the Arabic language, for example the vagina was called "vagina" or "the female organ" or "Al-Annah area" or "copulation opening".

Some women and HCPs were shocked at the use of the term 'sexual'. One participant said *"I never imagine that someone can say this word easily...how could you?"* (Ghadah, Pt-AH26), one male doctor in AH related how difficult it was to hear this word coming from the researcher...he was not used to hearing it (from a woman) and was a "strange" word to him (Fahad, MD-AH6). Five female clients refused to have interviews recorded (three in AH and two in BH), stating *"I cannot allow you to record my voice"* however, they did agree to interview without recording. Only two male doctors asked why it was necessary to record the interviews, but they accepted the explanation that it would aid data analysis and recall of the interview if it was recorded. They were also assured that they could ask for recording to be stopped at any point. Following this explanation they agreed to being recorded, however, they

both asked me to stop recording during the interview. The quotation below shows when the doctors asked to stop recording.

Dr. As you know the social norms here....the community is closed....this kind of problems solved secretly....no one will talk about it....and in all the world you can find such cases...defiantly it is found her.... we can not say that the community do not have such cases her....for sure some they complain of inflammation or urinary inflammation....but I do not have any statistics to confirm how many of cases her and what is the situation is....sexual dysfunction is her but I do not have answer to explain the volume of the situation and numbers to you....people tend not to talk unless the doctor ask direct questions to them then maybe they talk

A. You said that if there are direct questions from the doctors then the patients will talk and speak...did not you feel that the doctor themselves hesitated to approach this topic with the patients

Dr. Yes this is right

A. Do you think that the community affects the doctor as well?

He asked recording to stop

(Amjad, MD-AH21)

A. I understand. So when I say sexual health, what springs to mind? What am I talking about?

Dr.nothing sprang to mind.

A.how about 2-3 days after our first conversation, what were your thoughts?

Dr.do you have to record this?

(Fahad, MD-AH6)

3.17 Data analysis

3.17.1 Translation and transcription issues

Collecting data in a language different from that in which the research findings will be represented needs extensive and careful translation work but is increasingly common in social research. Phillips (1960), Brislin (1970), Regmi et al (2010) all point out that the translation process by itself is an analytic productive procedure and a critical challenge which requires both more time and effort from the researcher. They also state that it is a process that can present various types of problems affecting the credibility of the research data and results. Therefore, much effort has to be undertaken by the researcher to minimize these problems and errors. Indeed, there is a large body of literature that discusses some of the different ways in which researchers can address the language differences in a research study such as Denzin (1989), Temple (1997), Twinn (1997), Birbili (2000), Esposito (2001), Zeilani (2008) and Regmi et al (2010). However, they are all in agreement that the first step towards producing a quality translation and minimizing translation errors is when the translating is done by a person who knows both languages *and* their cultural backgrounds.

Denzin's (1989) also argues that the quality of a translation depends upon the ability of the transcriber to maintain the meaning of the collected data. Following Denzin's point, during translation significant attempts were made to translate the interview literally and to keep the meaning as close as possible. Hence, taking each sentence in the Arabic language and translating it literally into the English language aiming not to lose the meaning of the sentences, a task that involved reading transcripts again to check if the translation made sense within an English context or not. It was found that few Arabic words that have cultural

meanings may actually lose their meaning when given a literal English translation. For example, the Arabic word "Awrah" which was sometime used by the participants has no literal meaning in English. Therefore it was necessary to search for an alternative word in English that had the closest meaning. For instance the Arabic word "Awrah" the closest meaning to it is "private". Another strategy was also used by the researcher to maintain the meaning of the collected data is providing an explanation of the word in brackets. This issue of varying cultural meanings between the words during translating is commented upon by many authors such as Denzin (1989), Twinn (1997), Esposito (2001), Zeilani (2008) and Regmi et al (2010) all stress the importance of finding as accurate and equivalent word as possible.

3.17.2 Translating and transcribing techniques

Green and Thorogood (2004) suggests that it is worth transcribing the interview immediately after conducting each interview as well writing up field notes to record the researchers' comments on the interview any important issues or observations. In the current study, transcribing and translating process started in conjunction with the field work. Initially, interviews were transcribed in Arabic. At this time, field work was a time consuming process and therefore there was not enough time to translate all the interviews immediately into English. In addition, it was not possible to find transcribers in SA who could listen to the interview then translate it to English on the researcher's behalf.

However, this early transcribing of the interviews whilst still in the field provided a great opportunity to become immersed in the data early in the data collection process. Transcribing

the interviews at early stage enabled the checking of interview technique and led to some changes in questioning style – such as not probing as strongly in some parts the interviews or sometimes asking too closed questions.

On return to the UK transcribing continued immediately to English. This was due to more time being available and because transcribing the interview into Arabic then to English was actually more time consuming. However, due to the volume of interview data, and in recognition of the workload involved it was decided to obtain help with transcribing and translating. Two assistants were located (both signed confidentiality agreements, see appendix 18) the first was a member of the University of Sheffield and was a bilingual translator fluent in both English and Arabic and had previous experience in transcribing. The second was a friend of the researcher who was studying in the UK and has a Bachelor's degree in English language. A summary table for the interviews in each hospital and showing who transcribed them is presented in Appendices 21, 22, 23 & 24.

To check and validate the accuracy of the transcription and translation the following two techniques were employed:

- (1) Each translated interview by the transcribers was reviewed again and summarized by the researcher by listening again to the original interview which was downloaded to her computer. In doing this, it was possible to do back translation ensuring that the translated interview providing the same meaning in both languages.

- (2) To assess the quality of the transcribers work they were given an interview that the researcher herself had already transcribed. This enabled a comparison to be made between both transcripts. The outcome was that they were extremely similar in context, meaning and produced the same themes with no significant issues being missed.

3.18 Data analysis framework and stages

Having used various data collection techniques involving observation and interview during fieldwork, the ethnographer faces a large amount of information that has been gathered from the research setting. Consequently the ethnographer finds themselves responsible for making decisions about how to analyze this data, and how to document this experience and most importantly how to make sense of it all?

To this end the data analysis framework proposed by Holloway and Todres (2006, p. 219) was helpful in providing a sequential structure for data analysis. These are as follows:

- (1) Bringing order to data and organizing the material
- (2) Reading, re-reading and thinking about the data
- (3) Coding the data
- (4) Summarizing and reducing the codes to larger categories
- (5) Searching for patterns and regularities in the data; sorting these and categorizing themes
- (6) Uncovering variations in the data, revealing those cases that do not fit with the rest of the data, and accounting for them
- (7) Engaging with, and integrating, the related literature. (p. 219, 220)

This framework allowed the analysis and interpretation of the data from the moment fieldwork began which helped to start developing topics and themes within field notes. These were then used as a means of exploring the data to inform additional fieldwork providing the opportunity to think about data analysis right from the beginning of being in the research setting, rather than to leaving it to be done towards the end of the study.

Holloway and Todres (2006) state that, "*Analysis and interpretation can proceed in parallel. The analytic process is not linear but iterative where researchers go back and forth between data collection, reading and thinking and data analysis. They then return to collect new data. This process continues until the collection and analysis are complete*" (p. 218-219). In terms of focused ethnography there is no set of rules or methods for data analysis and it is not necessary that all steps of any analysis sequence are followed exactly (Roper & Shapira, 2000). However, the analysis process and stages should be clear and allow the reader to understand and judge how the findings evolved out of the data that were collected, constructed and interpreted by the researcher. For the current study data analysis involved four main stages; (1) familiarization and organization stage, (2) Labeling excerpts stage (3), comparison stage and (4) Constructing a conceptual diagram for themes and sub-themes.

3.18.1 Familiarization and organization stage

Green & Thorogood (2004) emphasize the importance of the researcher becoming immersed in the data and getting a sense of the study data as a whole before breaking it into parts. Therefore, after conducting interviews and observations in the field (and prior to starting a systematic detailed list of themes from the interviews or the field notes) interviews were

listened to again, transcripts re-read and field notes re-examined in order to become totally familiar with the data and understand how respondents' accounts can be summarized. Therefore it was decided to organize the data in a format that was easily manageable for conducting the analysis - which involved arranging the different elements of the data in the following manner:

- 1) Observed consultations in KAUH / Observed consultations in MCH
- 2) Field notes in KAUH / Field note in MCH
- 3) HCPs interviews in KAUH / HCP interviews in MCH
- 4) Female patient interviews in KAUH / Female patients interviews in MCH

Thorne (2000) argues that summarizing the data is a useful step that enables the researcher to 'boil down' the complexity of the data in hand. In line with Thorne view, each transcribed interview and observation case was summarized. Transcript summaries consisted of bullets points about the main or important issues within the interview transcript or within the observed consultation or field notes. This was a good technique particularly for providing quick information about each transcript or observed consultation rather than reading the transcripts or the field diary again and again to find certain information such as reasons for visits, the number of children etc. Each transcript, its summary and its observational case (if done) was attached together in one file for each female client and HCP. This technique helped reduce transcripts and field notes to a more manageable form and ready for the next stage in the analysis.

3.18.2 Labelling excerpts stage

It is worth mentioning that in this study, data analysis took a great deal of intensive work and organization, as in all ethnographic studies, due to the great quantity of data collected from the field (Fetterman, 2009). In fact, there are numerous software packages such as the data analysis package NVivo or NUDIST designed to enable the researcher to undertake qualitative analysis (Parahoo, 2006; Hammersley & Atkinson, 2007). However, using software may actually prevent the researcher becoming extensively immersed and familiar with the data. They also require the researcher to have some experience in managing the software (Hammersley & Atkinson, 2007). Therefore, due to a lack of experience in managing such qualitative analysis software but also, importantly, to enable a greater immersion in the data, a manual rather than software assisted approach to data management and analysis was used

To commence identifying themes from the data and labeling them, the field notes, the observational cases, the transcripts and summaries were organized manually and read independently in order to make sense of the whole picture the data was presenting. While reading in each of them the researcher started writing memos in the margin of the text in the form of short phrases, ideas or interesting view or concepts arising from the texts which later help to develop themes and sub-themes. Appendix 25 provides details on how the themes and sub-themes were generated. The theme which came out repeatedly in the text or emerge as being interested or important within the data were highlighted such as “cultural issues”, then cut out and pasted together with other passages that illustrate the same theme such as “norms”, “values”, “tradition” and “customs”. Themes were then saved in a word document and ready for the next stage.

3.18.3 Comparisons stage

The comparison stage involved making connections and comparisons within and between interviews, field notes and generated themes to bring order and understanding to the data (Green & Thorogood, 2004; Hammersley & Atkinson, 2007). Sentences and paragraphs were read and analysed carefully to identify possible key concepts within the data. In this stage, the researcher also used the research aim and questions to provide a guideline to draw comparison between respondents and associations within them. For example, taking one of the observed patient transcripts and comparing it with another observed patient transcript to look at how women start the clinic, how they initiate talking in the consultation and what is the main focused in the consultation etc.

In the interview transcripts the researcher for example, looked at what were women's views on sexual health, how they define sexual health, what is their reason for their visit, how they seek sexual care and so on. This stage of analysing the data helped to make comparisons between participants and to look for similarities (common issues mentioned or done by the participants) or differences. This stage also involved frequently thinking of the generated themes, about how the themes could be related to each other and how these themes can be linked together in a more explanatory manner. For instance the themes such as "time constrains" and "shyness and embarrassment" were incorporated as sub- themes under new theme "barriers to discussing sexual health". This stage continued till no new themes emerged in the data.

3.18.4 Constructing a conceptual diagram

This final stage of analysis involved constructing a conceptual diagram for the themes and sub-themes thereby providing one diagram that allows the researcher to do more comparisons and to identify any similarities or differences or connections that can be used as a guide when discussing the findings. The thematic diagram therefore enables the researcher to present the findings in a logical manner.

3.19 Establishing the trustworthiness of the data

Both qualitative and quantitative researchers need to establish the reliability, and the internal and external validity of the data analysis within their study. Reliability is the ability to replicate the study findings in another study using the same or similar methods and tools of data collection. Internal validity means that the study is able to investigate what it is supposed to investigate (correctness), while external validity refers to whether the research result can be generalised to other populations, contexts and settings. The terms “internal validity” and “external validity” are used mainly in quantitative research. However, some researchers use the terms “credibility” and “transferability” when establishing rigour for qualitative research claiming these terms are more appropriate and applicable to naturalistic enquiry than are the terms “internal validity” and “external validity” (Ritchie & Lewis, 2003).

For instance, Guba and Lincoln (1994) suggest using the term “trustworthiness,” in qualitative research instead of using the two terms “reliability” and “validity”.

Trustworthiness is a process utilized by qualitative researchers to establish the rigour of the data in the study, which is an important way to increase the confidence that the data is accurate and reflects the participants' views (Lincoln & Guba, 1985; Lietz et al, 2006). Various methods can be used by the researcher for increasing trustworthiness in qualitative research, for example: reflexivity, audit trail, triangulation, peer debriefing, member checking and prolonged engagement. The next section will discuss how some of these methods were used to increase the trustworthiness of the current study.

3.19.1 Prolonged engagement

Holloway and Todres (2006) state that "the emic perspective is the perception of those who are members of a particular culture or group, in anthropological terms, the 'native' point of view" (P. 210). Emic perception is the insider view, where the researcher is in some degree familiar with the culture being studied. The etic perspective presents the outsider view, where the researcher may not necessarily be a member of the culture being studied (Green & Thorogood, 2004; Holloway & Todres, 2006). In these terms, the researcher is a Saudi woman who is married and has three children, two of them born in SA and one in the UK, and hence has faced much of what other women face in SA regarding living, dressing and the socio-cultural principles related to sexual health; therefore, in this sense is a native of the culture.

In addition, the researcher also works as a demonstrator in nursing school, has completed all her nursing clinical studies and work experience in Saudi hospitals and now is also a researcher who has studied in the UK since 2003 so, in this particular sense, is also an

outsider. The ability for the researcher to represent both the emic and the etic views could therefore be an advantage. The combination of the emic and etic perspectives will help in providing more description and exploration and certainly helped the researcher to understand the phenomenon being studied and provide a better description by bringing a personal and professional understanding of women in Saudi culture into the study.

3.19.2 Reflexivity

Reflexivity is a process of "*showing the audience of research studies as much as is possible of the procedures that have led to a particular set of conclusions*" (Seale, 1999. p 158). Lewis and Ritchie (2003) argue that reflexivity can be used to achieve the reliability of the study (replicability of the study). Therefore, reflexivity is an important process to be carried out by the researcher in qualitative research, especially as it gives the researcher the opportunity to give an appropriate and reasonable perspective of his or her own experiences and descriptions about the study setting and culture. Reflexivity will allow the researcher to make his or her own socio-cultural position explicit and hence that will help to the reader to look at the ways in which the researcher's position or social location might have interfered with the research process or not.

Another proposed method of engaging in reflexivity is by arranging meetings with a research group such as the researcher friends or with research supervisors. The current research is supervised by three supervisors from the UK who regularly engaged in discussion of the data analysis. As these supervisors are from a contextual background that is different from the researcher's own, their help and support during data analysis an advantage because of their

ability to raise issues and ask questions; this is an important part of the process of reflexivity, as it helped to explain or uncover hidden meanings which lead to further explanation and reflection on the study that, without doubt, enriched the findings of the study.

3.19.3 Member checking

Member checking is a technique to increase the credibility and validity of the research data. It can be done by the researcher to check whether or not the conclusion drawn from the interview or from the observation is similar to what they meant or were seen. Member checking also can be called informant feedback or respondent validation. One of the methods of achieving member checking is by taking feedback from the study participants about the study's findings and the interpretation of the data collected during the interviews and observation by, for example, sending a copy of the transcript and the interpretation made by the researcher from the study to the study participants. However, it was felt that this method was problematic, especially for female clients. This topic is very sensitive and during interviews, women may talk about very personal issues related to their sexual health, so sending the transcript to the women may raise a problem within the family. No one knows who might receive the transcript when it is sent to the participant's address. A woman may not wish to inform her husband or her relatives that she has been involved in research about sexual health, which may put them in an unsafe position and may lead to violence being used against them. Therefore, to ensure the participant's safety and privacy, this method was not used.

Another possible and plausible method to achieve member checking for the study was by talking to some of the HCPs showing them some of the emergent study findings and interpretations of the data collected. To this end the researcher gave a presentation at a Saudi conference in Jeddah on April 2009; about "women's sexual dysfunction" within which was discussed the attitudes of doctors toward sexuality and sexual health generally. Staff from both the hospitals involved in the study attended and had the opportunity to engage in dialogue during the days of the conference to discuss the topic, the findings, and the acceptance of the topic, adding their views and confirming the findings. For example the researcher was able to talk extensively with Dr "Sara" from AH; she said:

"I agree with you that we have to talk about sexual issues with our patients...but believe me this is not easy task to do when you are on the ground...you have seen by yourself how professionals people reacted on you about it today....and I am single...which make the situation more risky"

This method of validation had tremendous advantages in the study; it encouraged the collection of additional data, stimulated more data analysis, generate more reflexivity, involved more staff in the evaluation and set possible recommendations, which without doubt enhanced the depth and the breadth of the study.

3.19.4 Triangulation

Triangulation is defined by Ritchie (2003) as involving "the use of different methods and sources to check the integrity of, or extend, inferences drawn from the data" (p.43). The literature identifies two advantages to using more than one method (triangulation) in

qualitative research. The first is to enhance the validity of the study, for example, the findings drawn from one method can be supported by the other method. The other advantage is to enhance the researcher's understanding of the phenomena being studied. Many authors stress the need to give reasonable reasons for using more than one method in the same study, all of which must be related to the study aim and questions and not merely due to the researcher having been able to obtain more funding or wanting to use many methods to impress others by trying to convince them of the importance of the study (Parahoo, 2006).

Triangulation is often considered the bedrock of establishing validity (Ritchie, 2003). In the current study, the aim was to describe how women and health care professionals perceive sexual health and the services that are currently provided in SA. Furthermore, some of the objectives in the current study are to describe the role of doctors and nurses within the context of women's sexual health care and describe how sexual health care services in Jeddah, SA are designed and implemented. Therefore, observations, interviews, field notes and document analysis were used to increase understanding and add depth, enhancing the validity of the study.

3.20 Summary

The design of this study is qualitative, exploratory through a focused ethnographic approach. Two hospitals were included, KAUH and MCH in Jeddah city. Purposive sampling of nurses, doctors and female patients were employed and 74 consultations were observed (38 in BH and 36 in AH) and 40 interviews were conducted (21 female patients and 19 HCPs). Data were analysed manually using the framework proposed by Holloway and Todres (2006). The

trustworthiness of the data was established through prolonged engagement, reflexivity, member checking and triangulation. The outcome of the data analysis will now be presented in the following chapter.

Chapter 4: Findings

4.1 Introduction

This chapter will present the findings of the study which revealed many issues of relevance to women's sexual health care. This chapter will describe how women perceive and respond to their sexual health, how women and HCPs perceive the function, nature and use of sexual health services, how sexual health care services in Jeddah, are designed and implemented. The role of doctors and nurses within the context of women's sexual health care context as perceived by the women and the health care professionals will also be described. These issues will be described within the following three themes.

1) Organizations and policy issues

2) Professional's orientation and attitudes to sexual health

3) Women's orientations and attitudes to sexual health

The Figure (5) provides a thematic diagram of the themes and sub-themes identified in the final stage of data analysis outlined in the previous chapter.

Findings themes & sub-themes

Organizations and policy issues

- Protocol and Guidelines in the clinics
- General Clinic atmosphere
- Unavailability of educational materials
- Unavailability of the interpreter
- Appointment issues
- Waiting time issues

Professional's orientation and attitude to sexual health

- Reasons for not addressing sexual health

Sensitivity of the topics, Fear of the consequences, Lack of knowledge, Patient should initiate first, Time issues, not a priority, not a matter for Nurses.

- Impact of Islam on HCPs attitude to sexual health

Gender issues

HCPs attitude to sex education

- Professional's attitude within the consultation

Lack of attentions

Controlling the clinic

Women orientations and attitude to sexual health

- Barrier to meet sexual health

Culture Sensitivity, Women beliefs about sexuality and relationships, Power issues, Unavailability of female doctor, Limited source of information, Insufficient knowledge about sexual health, Delay in seeking medical advice, Lack of communication

- Impact of Islam on women's attitude to sexual health

Islam and culture: guide and source

Sexual health Education with boundaries

- Women attitude to contraception

4.2 Organizations and policy issues

This theme was concerned with the overall care, service and routines that were observed within the clinic setting. The descriptions within this theme provide an overview about the clinics and the care that is provided to the women. The clinic protocol, guidelines, administrative operations and the general clinic atmosphere will be presented and discussed.

4.2.1 Protocols and Guidelines in the clinics

As the literature review chapter highlighted there is no published Saudi government document which clearly describes a sexual health strategy. The researcher was optimistic that she could find and draw information from documents within the hospital setting that might point to a local if not a national strategy. Unfortunately this was not possible as neither of the hospitals appeared to have any written strategies or guidelines for sexual health care services.

When the clinic supervisor in hospital A was asked about this she said

"We do not have something called strategies and guidelines for sexual health care and services" (Hanan, N-AH27-Diary Note)

However, the clinic supervisor reported that she was planning to re-write the policy and procedure about the gynaecology clinic. A copy of the current policy and procedure for this clinic was examined. The content, however, focused upon medical procedures such as the sterilization technique to be used for invasive procedures and details on how medical instruments should be sent for sterilization after use. There was nothing in this policy and

procedure about care that might be offered and under what circumstances. Interestingly the clinic head nurse in hospital A claimed that she was not aware that this policy existed and it did appear that this was kept in the clinic supervisor's office.

Similarly, at the time of commencing fieldwork in hospital B the coordinator for the clinic had just finished writing the policy for the women's clinics. Policies were in place for gynaecology, obstetric and fertility clinics. When she was asked about policies for postnatal clinics her answer was:

"What shall I write for this clinic there is nothing to write?". then she added " yes it could be good if we write for the new doctors something such as the pregnancy test before intra uterine device (IUD) insertion...but this is not very urgent to do...and any one can run postnatal clinic" (Amal, FD-BH43- Diary Note).

The limited existence of written policies and guidelines for the clinics that provide sexual health related care may explain the inconsistency in the care given to women during the observed consultations in both hospitals. There appeared to be little consistency in the way that the clinics ran from day to day. Each doctor appeared to have their own way of operating in running the clinic and each doctor their own way in terms of decision making whether that be about performing and IUD insertion or prescribing the contraceptive pill. The inconsistency between the doctors was obvious in most of the observed consultations. For example, some doctors prescribed the contraceptive pill only after ordering a pregnancy test and some prescribed without any pregnancy test. Some doctors implemented an ultrasound after an IUD insertion, others requested an x-ray and others ordered no test post IUD

insertion. Some doctors agreed to fitting an IUD only after a woman has already had a child others had no such parameters. This inconsistency in approach impacted on the sexual health care that the women received. The example below demonstrates how the client was unable to access the care she wanted due to the inconsistency of approach between doctors providing care in the same clinic.

Pt: I bring the IUD with me today as the doctor advised me in the previous appointment

Dr. who told you to insert the IUD, it is not good to insert the IUD after one child, you can use another method, the pill for examples.

Pt: I already buy the IUD and the doctor told me to buy it, and I wanted it to be fixed today (patient was angry)

Dr. I am not with inserting the IUD to you, you can come again to the same doctor who wrote it for you.

Pt: why like this (patient was so angry)

Dr. I could insert it for you but if something happen to your uterus I am not responsible, your uterus still need time to retune back and to be strong to hold the IUD (Diary Note-BH-Consultation 17).

4.2.2 General Clinic atmosphere

The clinic in Hospital A usually had a large number of patients and visitors. The area tended to be very crowded with high noise levels. This was despite the efforts of clinic nurses and the female organizer to try and ensure that only those women to be seen in the clinic were

those who entered it. On many occasions it was observed that some women were able to come to the nurse's reception where patient files were located. The women would look in their files and would sometimes place their file back in a different place thus changing their order in the queue. This tended to disrupt the nurses' work and often resulted in clashes between patients and staff. The example below is one of many similar situations observed in hospital A.

"One woman Post caesarean section (CS) was inside the clinic looking for her file on the top of the clinic reception, the nurse in charge shouted at her, then the woman fought with the nurse in charge of the clinic because she had been waiting a long time but no one had called her from the waiting room. This was why she was looking herself for her file, she said to the nurse "those women who went inside the clinic many times and look for their files were able to be seen by the doctors although I came before them" (Diary Note-AH)

In addition, in hospital A there was no predetermined and fairly distributed numbers of patients to be seen by each doctor. This meant that some doctors saw more patients than others which tended to make some doctors angry whilst they were giving care to their female patients or when dealing with the clinic staff. In addition, the women would not know which doctor she was likely to see. Nor did the doctor know which patient would be next since the files were kept outside the consultation room on the top of the reception desk which accordingly sometimes delay the care given to women due to interference with the ordering of files (see example above) and thus made the women unhappy about the service and the care provided to them. The example below is a typical scenario that happened between the women patients and the nurses in hospital A.

Pt: which doctor will see me? (A 23 year old, Palestinian woman, post CS)

N: I do not know which one will see you, it depend on your file turn, the doctor who is free in your file turn is the one I will take your file to.

(Diary Note-AH).

The general clinic routine and atmosphere within Hospital B was much better compared to hospital A. The staff appeared to have a better quality relationship with the patients and each other. Overcrowding was not evident within PP clinic day and the patient files were always located inside the consultation room in advance and caseloads were equally divided between those doctors covering the clinic. However, where more than one doctor was covering the clinic each would be using the same consultation room; two patients would therefore enter the same room. Each doctor had one nurse and dealt with one appointment only. Therefore usually the two doctors and the two nurses would talk or ask each other about an investigation or diagnosis or documents in the files in front of the patients who were usually silent and listened to the professionals' talk. As one doctor interacted with their patient this disturbed the other consultation which was taking place in the same room. This situation (two doctors + two nurses + two patients) is arguably not conducive to acknowledging the confidential and sensitive nature of sexual health care.

4.2.3 Unavailability of educational materials

In both clinical settings it was striking that there were no pamphlets or small books related to women's health anywhere in these, the largest hospitals. It was also noted that there was no

reading material available to clients in the waiting room or in the corridors. Neither hospital provided information to women in the form of accessible leaflets or posters to assist the women in making informed choices about methods of contraception, sexual and reproductive health. In hospital A, for example, the wall was completely blank except for a wooden hanger used to display small religious books. This wooden hanger was distributed in almost all patients' waiting areas throughout the hospital due to the gifts of money and the efforts of religious groups in the hospital.

Some religious paintings on view throughout hospital A attracted the researchers attention. At the entrance to building "Z" (the area connecting the hospital with the male medical school) there was a big picture and on it were written two *hadeeths* from Prophet Mohammed (PUH) these *hadeeths* were all about adultery: "*Never does sexual perversion become widespread and publicly known in certain people without them being overtaken by plague and disease that never happened to their ancestors who came before them.*" It was also written, "*Whenever adultery becomes a widespread phenomenon among certain people, death will spread among them.*" The picture is located in such a way that anyone who walks through this area will be faced with these *hadeeths*.

Furthermore, there was, inside hospital A, an organisation called "friends of cancer patients". It was located in the main hospital building, which is quite far from the entrance of the OPCs and was therefore located away from patient areas. The researcher wondered why there were no pamphlets about breast examination in any of the women's waiting rooms around the hospital, and why this organization did not provide some educational pictures about breast

examination to the hospital. Was it because exposing women's breasts is *haram*? Was it because these "uncovered" pictures might provoke sexual desire, as most of the gynaecology clinic receptionists and staff indicated? However, there was one picture about breast feeding (a woman feeding her baby) in one of the female waiting areas (used only if all other waiting areas were full). When asked clinic staff remarked that some nurses who had done a presentation had put up the picture but that they might have forgotten to take it down or they might have preferred to leave it however, only a very small part from the upper breast was exposed in the picture.

In hospital B there was a TV inside the clinic, however, this TV was not used for educational purposes. It was just for entertaining the women while waiting to be seen. The only channel seen open during field work was Chanel One of the Saudi TV which provide religious talks, news and a variety of morning and afternoon shows. When HCPs were asked why their hospital did not provide written educational materials to their female patients the answer in both hospitals were similar - financial issues, the hospital aim is to give care only. When they asked why they did not try to provide it by themselves they said they cannot distribute material to the patients without hospital permission.

"Here I do not think they do...but in private yes they give pamphlets...and hand out for post natal exercise.... it is nice to have awareness program and written materials but this need financial support and most importantly approval from the all the authority her" (Maha, FD-AH17-O-I) P 12

In both hospitals there was an education department run by nurses who graduated from the university, however, none of these nurses had any educational role in either the family

planning clinic or post-partum clinic and during the consultations observed in both hospitals none of the gynaecology doctors referred any female patients to them. In contrast, the education department was very active in the paediatric clinic and paediatrics doctors referred their patients for more explanation or education session that were given by nurses.

4.2.4 Availability of an interpreter

There was a small non Arabic patient' attendance in both clinical settings but there appeared to be scant resources to effect communication and understanding. Neither of the hospitals offered information in a choice of written languages or an interpreter. In most of the observed consultations with a non Arabic or English speaker the doctors had difficulties in understanding the patients' needs and the patients had difficulties in explaining their issues. Only in one consultation in Hospital A, did the doctor ask the Pakistani nurse in attendance to explain things to the patient who was also a Pakistani. The majority of non Arabic or English speakers appeared to be very poor and had health problems. Case fourteen at Hospital B describes a consultation which illustrates how the lack an interpreter was an issue during sexual health care consultations for non Arabic and none English speaking patients.

"A Post CS, Pakistani, 40 days Post Partum and has 5 children all of them delivered through spontaneous vaginal delivery (SVD), patient look very thin, cannot speak Arabic. The sixth child died in her abdomen during her 7 months of pregnancy. Look poor and not educated. Seen by Dr "B", doctor had a hard time to speak with this patient during the consultation, patient cannot understand Arabic, and there is no interpreter service in the hospital to help the doctor in such situation". When I told the doctor that I felt that this patient had difficulties to understand what she was

explaining to her she said "I know that but what can I do more than what I did any way I wrote the pill for her and when she goes out her husband or any of her family could explain things to her".

4.2.5 Appointment issues

Despite the fact that there was a specific clinic for PP and FP cases, when data collection commenced at hospital A it was surprising how few FP or PP cases were present at these clinics. It was of some surprise that the majority of patients at these clinics were in fact pregnant or gynaecology cases. When asked why doctors gave appointments for cases other than for FP or PP most doctors felt that pregnancy or gynecology cases should be given the appointments because these patients were in more need of care than FP and PP cases. Thus, the majority of the patients attending the PP or FP clinic were patients who had CS or SVD who had medical issues. Neither of the hospitals routinely gave women a six week post delivery appointment.

"No they did not gave me any appointment after delivery (she made this appointment by herself).....they should do isn't...as I know and from my experience from my mom the hospital should give appointment after given birth for check up for the mom and for the baby but this hospital did not do this" (Ghadah, Pt-AH26) P 8

The reasons given by HCPs for not giving all SVD patients an appointment for FP consultation were similar to each other in both hospitals.

"The system can't be fitted to give appointments for all deliveries, it can never work".

(Mostafa, MD-AH24-O-I) P 2

The clinic coordinator in hospital B said that the reasons for not given an appointment for all SVD is because

".... we advise those that have had a normal delivery to go to the centers that referred them here.... And try to concentrate on those that have had a complicated delivery.... So we can give them the care that is required" (Amal, FD-BH43-I) P 5

The researcher was clearly informed by some HCPs that the hospitals at this stage were planning to reduce the numbers of postpartum women attending the hospitals and were planning instead to refer them to the PHCCs. The reason given was that the hospitals wanted to use the clinic for more serious cases. Despite referring the post partum women to the local centres, it was found that there was usually no instruction or explanation given to postpartum women on discharge which clearly alerted them to attend the centre to complete their postnatal care. No written explanation of this was available either.

4.2.6 Waiting time issues

Long waiting times were a problem facing women in clinic. The waiting time sometimes extended to four and five hours. Most women were unhappy about this and some of them decided to go home without being seen by the doctor due to other commitments, usually because they had left their infant at home.

"I left my home at 9 because my appointment is 9.45 am and now it's almost 11.00 it is not fair is it?we are six pts if just one doctor came she could see us all and we will be able to return home for our kids" (Ertwaa, Pt-BH28-O-I) P 7

In hospital B there is approximately 10 to 20 SVD every day in the hospital. However, the number of allowed booked appointments for PPC is 25, which was far less in comparison to the other day clinic and not parallel with the number of SVD conducted every day.

According to the clinic timetable four doctors were expected to be in attendance at the clinic. However, it was usually the case that only one or two doctors actually staffed the clinic and they were constantly late in arriving. This did not tend to happen in other clinics. The majority of doctors expressed their feeling that this clinic is a very easy clinic *"it is simple... just prescribing a kind of contraception method"* (Amal, FD-BH43-Diary Note) and were of the opinion that there were no complex cases or issues and so could finish their work before the clinic closing time even if they did arrive one or two hours late. One doctor in Hospital B felt that making patients wait so long before being seen was not the fault of the doctors but the fault of the appointments department which asked patients to attend far too early at 7 or 8 o'clock when doctors do not start their rounds until 10 o'clock.

"You know we cannot blame the doctor for the delay....it is not negligence from our side...we have many thing to do in the unit...we have round...we have discharge summary...and many other things....admission staff know about this... doctor will start at 9.30 or 10 that mean it is their fault why they give the appointment at 8.00am" (Randa, FD-BH40-O-I) P 14.

4.3 Professional orientations and attitudes towards sexual health

The issues of importance in this section are:

- 1) The reasons why HCPs refrain from talking and discussing sexual health issues with their patients
- 2) The impact of Islam on HCPs attitude to sexual health
- 3) HCPs attitudes within the clinic

4.3.1 Reasons for not discussing sexual health

4.3.1.1 Sensitivity of the topic

All doctors, without exception, reported that this topic is a very sensitive and private topic and therefore difficult for them to deal with. Additionally they perceived that patients found the subject to be sensitive, private and difficult also.

"As you know the social norms here...the community is closed...this kind of problem is solved secretly...no one will talk about it". (Amjad, MD-AH21-I) P 7

"Also, it is a very sensitive topic in our culture, therefore, we did not tend to talk about it as freely as anything else...we only talk about it secretly". (Wafaa, FD-BH1a)

P 1

Doctors felt that their role was to respect the cultural sensitivities of this topic and keeping silent was a way of respecting themselves and the community where they were living and working.

"Even the patients will not accept it from us...and I think whatever is...we have to take care of our patients and respect their feelings". (Amjad, MD-AH21-I) P 8

Some doctors felt that even where they believed that it was important to talk about sex and sexuality with their patients that this contradicted the wider norms and views in the community. This led to doctors choosing not to focus on these issues in order to prevent offence to the community and in addition to prevent possible isolation and ostracism from it. The result appeared to be that doctors chose to appear to be in parallel with the community by obeying the norms and traditions that they believed to be adopted by most of patients and professional colleagues.

"This is why I told you the community will direct us and not the opposite". (Layila, FD-BH2b) P 9

Because of the sensitivity of the topic, some doctors felt tremendously reticent and embarrassed about initiating questions about sexual issues in their clinic unless there were clear reasons to ask, or without first being asked directly by their patients.

"But, as you have noticed, I was quite embarrassed to talk openly and freely in this conversation, even though I am a gynaecologist. Talking about such topics will be by far much harder on others. People tend to be quite embarrassed and shy when it comes to talking about such matters in public". (Fahad, MD-AH6-O-I) P 3

One non Saudi female doctor recounted her view about other Saudi doctors who refrain from talking with their patients about sexual health:

"Because it is unusual for them...they are also embarrassed and shy...they usually hesitate to use slang terms and phrases with the patients...or to hear it from the patients...it is hard for them to handle, even for the senior doctors or for consultants...but if you ask them any gynaecological questions they immediately have the answer ready...but if you talk about sex or sexual health it is another thing and another scenario". (Maha, FD-AH17-O-I) P 1

It appeared that the extent of the sensitivity of the topic led to HCP's fearing it. This fear led HCP's to avoid dealing with sexual topics within the consultation. This is discussed in more detail below.

4.3.1.2 Fear of the consequences

As described above most of the doctors were hesitant to talk about sexual health issues with their patients. Doctors were concerned that by taking sexual details and discussing sexual issues with their patients that this might lead to their reputations being questioned and destroyed and subsequently damage future career paths. They tended to avoid the topic out of concern about offending their hospital authority, their patients, or their patients' male guardians, whether these be fathers, husbands or brothers. For instance one of the non Saudi nurses said:

"Maybe they have reservations about how the patients may act towards them...others may say, why are they asking or discussing this issue with the patients?" (Hanan, N-AH27-I) P 1

Another non Saudi doctor who shared his 20 years experience of working in Saudi Arabia and in other Arab countries said:

"We cannot tell them like this, we did not tend to tell patients to stop a pregnancy or to use something because that might provoke problems between the husband and wife... because also, if we say this, the husband might go to complain about the doctor and he might complain that the doctor did not want his wife to get pregnant...he could simply complain and say "the doctor is corrupting my wife" ...and no one will protect you...because of this doctors do not like to go through all these problems...we are very careful when advising women about these issues". (Masoud, MD-BH38-I) P 4

Without exception, all non Saudi doctors and nurses admitted that the hospitals in Saudi Arabia were very strict on things related to women and sex. The perception was that the hospital might simply end their contract if there were complaints about them with regard to talks about sex and sexuality, and that the hospital would not necessarily seek to clarify the issues with the HCP's concerned. Additionally there was concern that the hospital might place the HCP's on a "blacklist" (as most of them stated, an expression used when people break the law) and thus greatly hinder their ability to gain professional employment.

"The first thing that I was advised by the Recruitment Employment Company before coming to Saudi Arabia was to not to bring alcohol and not to talk about or perform

sex in front of Saudi people, and to have a high morality when dealing with them".

(Nora, N-AH13-Diary Note, non Saudi nurse- 2 years working experience in SA).

"Here (in Jeddah) it is acceptable for professionals to have different ideas...however, the situation is better than other areas that I was working in...but if you go to rural areas like Aseer (in the south-western area) they will kick me out immediately".

(Maha, FD-AH17-O-I) P 11

Many stories were told by doctors with regard to what they faced after giving explicit information to their patients, or having frank discussions with doctor colleagues. One none Saudi female doctor who shared her experience with me said:

"I won't say fear... but felt apprehension when I once advised a lady who was nearly approaching the menopause about contraception...she had twelve children and six of them were caesareans in a row... I told her that she might have difficulties getting pregnant again...she was very harsh and mentioned fate...another accused me of acting against Islamic morals and that I shouldn't be talking like this...because there are those that believe that destroying/wasting sperm is almost like an abortion...one day I was advising a woman about contraception and she got angry and told me that I was saying the wrong thing to her...and that contraception is "Haram" forbidden..."

(Maha, FD-AH17-O-I) P 10

Another Saudi doctor said:

"...one day I asked one patient... she said she was not using any method of contraception and I asked her what she was doing... does her husband do something,

does he withdraw?...she was upset and she said to me "Why are you asking me this question?" and she made me embarrassed...you do not know how people will act with you if you approach them". (Samera, FD-BH2a-O-I) P 5

The researcher witnessed few incidents during consultations when male doctors asked their female patients about the contraception methods they were using. The patients were harsh in their answers, particularly if the women were using natural methods such as withdrawal and a fertility schedule or a condom. When asked about their feelings with regard to women's actions during the consultation, most of them said that this is why they are reluctant to ask their patients about sexual issues and this is why sometimes they would not ask women about what type of contraception they were using. One of these doctors commented on his patient's actions by saying:

"She said she was managing her affairs, which meant please don't interfere in such matters. If she wanted to say, she would have said, and nobody would have prevented her. This is a good example of the necessity of enlightenment. This is also an example that she does not want to talk and I can't force her". (Eiad, MD-AH2-O-I) P 3

However, out of these few cases, female patients in most of the consultations observed were answering the doctors questioned and had no objection to talking to the doctor particularly with a female doctor.

4.3.1.3 Lack of knowledge

A noticeable number of HCPs admitted their limited knowledge and confidence in sexual health issues. They were also uncertain as to how they could approach patients with sexual health care issues. They therefore found themselves reluctant to address these issues in practice because they felt that their knowledge about them and ability was incomplete and insufficient. Many reported that they would like more knowledge.

"As everything...we do our best to help the patients...but frankly we are not very knowledgeable about such topics...we are as shy as them...we have difficulties when we handle such cases as dyspareunia or an unwillingness to have sex and other complaints such as a low libido...we do not have the right information in order to help them". (Layila, FD-BH2b-I) P 2

"Partially, it was because they were ashamed to discuss this subject... and partially because it was not focused on in the curriculum. I don't know what else... besides that, this problem was not as big as it is now". (Mostafa, MD-AH24-O-I) P 4

"We do not have these things here and we do not know about it...don't assume that because we are doctors we know about it...we really need it here, even though we are doctors, but even we seek this information in our personal life... I have been married for two years and I have asked ordinary people about this subject...I ask people who can provide this information and provide advice to me...my relatives are always surprised because I am a doctor and I am asking them". (Randa, FD-BH40-O-I) P1

Although more attention internationally has been placed on sexual health by the WHO, when HCPs were asked to define sexual health from their perspective, the majority of them found it

difficult to do so. Most of the participants were surprised and astonished when asked to define sexual health. Some HCPs (including consultants) admitted that they had just heard this term for the first time in their clinical practice.

"Both patients and doctors don't know what sexual health means. No one here knows what sexual health is". (Fahad, MD-AH6-O-I) P 12

It is perhaps therefore not surprising that most of the HCPs interpreted the term "sexual health" in varying ways. It was found that majority of HCPs have limited and very narrow views about what sexual health means. Their interpretations appeared to be sandwiched between notions of STI and the mechanical aspects of sexual intercourse, pregnancy and childbirth.

"Really I never thought of this subject before...but in my view it means the relationship between a woman and a man...what else could it be? I do not know? You tell me what is more than this?" (Masoud, MD-BH38-I) P2

"I can't get your point when you say sexual health more than transmitted diseases". (Mostafa, MD-AH24-O-I) P 5

"the phrase itself inspire to sex and so on..." (Samera, FD-BH2a-O-I) P 1

"The relation that's happen between the husband and wife" (Wafaa, FD-BH1a-O-I)

P1

Interestingly some junior female single doctors admitted that this topic was very difficult to handle in their clinic and claimed sexual topics were not focused on in their theoretical or clinical curricula. In addition they reported limited personal experience to draw upon, unlike their married colleagues, in order to help their patients. It was also observed that sometimes junior female single doctors tended to go out from the clinic to ask their senior expert colleagues (particularly female married doctors) who worked with them in the setting to help them with managing a case, for example, what type of contraception they should prescribe to the patient and what advice to give.

"...really we did not study sexual topics in detail...they just focused on transmitted diseases and the methods of transmission...it was important to know how to diagnose the diseases and the treatments...added to that, I am single...I am not married yet ... you know married doctors are better than us (single doctors)...they can use their personal experience when they deal with patients...sometime I cannot help the women because I do not know what she is actually experiencing..." (Mona, FD-AH-Diary Note- Doctors Room)

"Sometimes patients will ask me...I want to help them but I have no way to...I have had no experience in sex or experience in taking contraception before...how will I help them? ...and in nursing college they did not cover this subject...I always tell the patient to ask the doctor. (Fatema, N-AH12-Diary Note)

Clearly a lack of knowledge and teaching coupled with a perceived lack of experience led to junior female doctors to feel hindered in providing sexual health care.

4.3.1.4 Patient should initiate first

Most of the HCPs felt that it was a patient's responsibility to open a discussion or to ask questions with regard to sexual issues in the clinic. When asked if they usually initiated explanations about contraception or any other expected sexual health issues for women expecting their first child their answers were similar to the one below:

"I think it is better for the patient to ask about it...because as I told you this is a very embarrassing and sensitive topic...not only for the patient... even for us...and we did not tend to talk about it in the clinic unless the patient asked us a direct question...sometimes even women themselves came to the clinic and had sexual problems but could not talk directly and they go round then we get their complain".

(Wafaa, FD-BH1a-O-I) P 6

The quote above is illustrative of doctors being aware that patients usually have difficulties in raising sexual concerns and sexual health issues in the consultation. However, despite this awareness many doctors still preferred to avoid initiating the topic with their patients. In addition, the majority of doctors believed that if patients did not initiate discussions about sexual issues in the clinic that meant patients already had the information or had a preferred alternative source of information. However, during the consultation doctors did not try to assess if patients had the correct information or access to it.

"As you know during Nafas period (Nafas is a period after given birth, usually 40 days) women always talk about these issues and also the family will instruct things to the small girls who first deliver therefore we know that they defiantly get the information for this" (Badreiah, FD-BH45-O-I) P 12

"{..} By the way, most of the patients who come here have some background about these topics and they know already about it therefore no need for us to repeat things that we know they know about" (Eiad, MD-AH2-O-I) P 5

4.3.1.5 Time issues

Some gynaecology doctors stated that they rarely educated or discussed sexuality and sexual practices or problems with their female patients, due to time restrictions in the clinic. They could not "extend" (as they stated) the clinic time for sexual health matters. They felt that the education role took a long time and they didn't have enough time in their clinic to do it. Most of them felt that this role is an "extra" work they usually did not have time for.

"From my standpoint, I don't have the time to educate patients in my clinic. An independent clinic should provide such services". (Fahad, MD-AH6-O-I) P 11

"Actually, it depends on my schedule and the amount of work to be done on that day. On Thursdays and Fridays, when there is only one doctor to go around for all the 45 patients in the hospital, I would not be able to spend 10 or 15 minutes with each patient, if so I would finish checking patients after sunset, but if I had only 2 patients I would be able to check with them and even tell them how to breast-feed their babies and so on". (Mostafa, MD-AH24-O-I) P 3

"We are really busy, especially in the morning, we have about twenty patients and we can't always give extra time to anyone because of the procedures we have to go through with each patient...taking information and tests doesn't really give us time to ask about or discuss their sexual issues/problems". (Badreiah, FD-BH45-O-I) P 8

When asked why they did not educate patients and talk to them about the benefits of cervical smears and why there were no cervical smear routines in the hospital for the female patients the answers were similar in both hospitals:

"Yes it is the ideal thing to do to identify cervical cancer but we do not have enough time in the clinic to do it for the patients, and some doctors are too lazy to do it or talk about it...although I believe that the postpartum clinic is the best time that we could catch women for cervical screening and this is really a chance to do it for them".

(Reem, FD-BH-Diary Note, Consultation two).

4.3.1.6 Not a priority

Some HCPs did not feel that sexual health care is or should be a priority in SA professional education or clinical services since problems were few and far between:

"I do not think sexual health is an issue in SA...thanks god we do not have a lot of STI cases and we are not having many free relationship as in the west...this is maybe why we did not give it the attention because it is not a really problem here (Amal, FD-AH43-Diary Note)

"If we have sexual health problem yes we have to give it the right attention but as the statistics show and in the clinic as well we did not see much cases about this...in all my clinical experience I might see only one or two cases...it is very rare to find"
(Maher, MD-AH-Diary Note-Consultation 10)

It was observed that during consultations the aim of the doctors was mainly to prevent any postpartum complications and to provide "effective" methods to prevent pregnancy. They were convinced that this was their role in the clinic and that this was why women came to their clinic (looking for effective methods). In almost all field observations no other issues were dealt with.

"Yes...it isn't...what is the point and the logic of this?...if a woman came for family planning, to stop or space pregnancy, then why would I ask about sexual health?...what is the need of this?...there is no relationship...and it is not applicable".

(Amjad, MD-AH21-I) P 9

Doctors were asked why they did not directly and routinely ask their patients during the consultation about resuming sex before prescribing a contraception method. Most of the doctors felt that this question was not necessary because this was the 'usual' medical protocol undertaken by all doctors and consultants. Another reason was because they felt that all women know that pregnancy can happen if copulation occurs and that women will ask for a pregnancy test if they have had unprotected sex, therefore there was no need to ask them about it.

"... we assumed that because she asked us about contraception, or accepted the pill, that she knew....{} " (Maha, FD-AH17-O-I) P 3

Most of the HCPs felt comfortable talking about sexual health where this had a direct bearing on a patient's presenting medical condition\complaint. At this point most of the HCPs felt confident to discuss sexual issues but only with a medical orientation to them.

"{}...in my point of view there is no need to open this topic with the patients without medical reason...if the patient complains of something it is possible to open it as a medical consultation...but if there is nothing...why should we open such a topic with them?" (Masoud, MD-BH38-I) P 14

"If, while examining the patient and talking to her, we came across symptoms, or if she complained of having some symptoms, it is then that we would focus on treating the symptoms and giving the necessary sexual health advice" (Nesreen, FD-BH47-I)

P1

It is worth highlighting that one male and one female doctor adamantly opposed the position that FP and PP clinics were the right places to talk with women about sexual health issues. They criticized the researcher selection of this research topic and the two site data collection process. They felt that women in the SA community did even think of sex before completing the full forty days of the postpartum period, therefore there was no point in discussing sexual issues within the post-partum clinic. However, when asked where they thought the appropriate time and place to be they failed to specify.

4.3.1.7 Not a matter for Nurses

During observations it was clear that the role of nurses were that of organizer and assistant to doctors within the clinic. In both hospitals the nurses came in and out of the consulting room carrying files or interrupting doctors during consultations with patients. This resulted in doctors being unable to give their undivided attention and full privacy to the patients inside

the consulting room as well as reducing the time available for each patient. Additionally nurses were frequently observed avoiding providing counseling or giving information even when such was sought from the female patients. The scenario below between a patient and nurse was frequently seen in both hospitals.

Pt: how I will use this pill, I forgot to ask the doctor about it? (Patient hand in the prescription to the nurse to see it but the nurse did not take it or look at it)

N: I do not know, when the patient who is inside go out you can go in and ask her, just wait? (Diary Note-AH)

Unlike doctors, nurses felt that providing sexual health advice and information was not part of their practice. The majority of the nurses interviewed or talked to believed that this was the role of the doctor, not the nurse. When asked their opinion about being involved in providing sexual health education care very few were replied positively. Typical responses were similar to the one below:

"{...} let them work....why we have to do it for them...we do our job completely...they suggest this because they want to put more job on us we had enough of this (Renad, N-BH14-Diary Note)

Some doctors and a few nurses did feel happy with the idea of involving nurses in providing sexual health care. However they reported there to be many obstacles preventing involvement, for example, gaining permission from the clinic authorities, the support and approval from doctors as well as access to adequate training courses:

"{..} I know women like these topics and it is good idea for the nurses to involve in sexual education but I have to be prepared for this.... I am very shy person and I do

not have much idea about it plus I am single which all make it difficult at current stage ...{...}" (Fatema, N-AH12-O-I) P 23

"in the West this work load is taken away by nurses and midwives they have special advisers and councilors.... it can also be done here....but no one maybe pay attention to improve it or maybe they did not think of it as a need" (Maha, FD-AH17-O-I) P 5

"Currently that is not available in the Kingdom of Saudi Arabia (nurses involve in sexual health care)her they don't teach nurses or any health professional these role that the gynecologists does.... so I don't think it will be a good idea at the moment". (Badreiah, FD-BH45-O-I) P 6

4.4 Impact of Islam on the HCPs attitude to sexual health

4.4.1 Gender issues

It was frequently observed during the field work that some male doctors tended to leave the consulting room door open when alone with a female patient inside the clinic. When asked about their reasons for this they reported that they wanted to avoid or prevent "*Khalwah*" (an expression used when a man and woman are alone together in one closed place) and to avoid possible false allegations from female patients.

When doctors were asked about their feelings towards those female patients who refused to be seen by them in the clinic, most of them respect the patients need. Some male doctors

appeared to feel a great admiration and respect for those women who refused to talk about sexual issues or refused to reveal their body during consultations. They appeared to believe that this was indeed the 'correct' stance for a woman to take:

"{..}...I will never allow or even advice my family to go to male obstetrician....therefore as I told you I appreciate patients who shay to open or ask male doctor in such topic...{..}". (Mostafa, MD-AH24-O-I) P 10

Other male doctors felt they should be able to practice as the female doctors were able to and that patients should deal with their reluctance or shyness otherwise appropriate care may not be delivered, particularly where no female doctors are available.

"{....}....praise be to Allah. There is a system in the hospital stated that if the doctor is a male the patient has to accept being examined by him.... Some patients accept this discharge themselves from the hospital on their own responsibility; this is what we see every day, that some patients do not accept this, in which case we tell her that we have only a male doctor...{....}" (Eiad, MD-AH2-O-I) P 10

In both hospitals men had to wait outside the clinic for their female relatives. Outside the clinic in Hospital B there were red warning signs placed everywhere which stated that the area is for women only, or that men are not allowed to enter. In Hospital B men could not attend with their relative, even if they wanted to. In Hospital A however, men were permitted - it became her responsibility to call him into the clinic when her turn came to see the doctor. It was noted that it tended to be the female doctors that insisted on strict restrictions for male relatives. When asked why they did not permit husbands into consultations they remarked

that they chose to work in the female medical field because they did not want to deal with men. Also they wished to respect the Islamic ideology by avoiding "*Ekhtelat*" (an expression used to describe a mixed sex environment) and in doing so made sure their male relatives were more accepting of them choosing to be doctors.

"By working in the gynaecology field I will not treat male patients...just female patients...this will make our job in the medical field accepted to our families and husbands as you know how our community view to "Ekhtelat" area." (Amal, FD-BH43-I) P 12

In addition, some doctors believed that restricting men's access into the area was a good idea because it gave the women the freedom to talk openly with her doctor without feeling being embarrassed or frightened about the presence of her guardian. One doctor reported:

"We want women to talk freely and, as you know in our community, it is the man who will talk. We will not benefit if he attends with his wife, we want to treat the wife and not her husband". (Reem, FD-BH-Diary Note, Consultation 2)

4.4.2 HCPs attitude to sex education

HCPs tended to be divided in opinion about the need for sexual health education to be included within professional training curricula. Most of the HCPs felt strongly that there was no need for sex education to be part of the curriculum either in schools or universities. Most of them argued that suitable knowledge and guidance is available in Islamic ideology and principles - these just need to be applied and followed.

"Hope we do what Islam taught us to do....but we did not follow it as we should...."

(Layila, FD-BH2b-I) P 8

"We do not really need a separate curriculum, in my opinion we need to read our Quran and Sunnah carefully, instructed it more to our children and use it in our daily live, if we do this we definitely will have good sexual health for both men and women"

(Amal, FD- BH43-I) P 14

Two male doctors (one of which was a consultant) were of the opinion that sexual health topics should not be covered in the medical curriculum any more than currently. They also believed that before discussing or teaching sexual issues with medical students there should be clear medical reasons for this.

"No...no I am against the discussion of these things to our students... specifically the very personal things...for sure we should talk about other things which are well known medically to us such as...dysparunia and so on...these problems are related to other things...diseases and some complaints, and it is well known medically...physical issues...that's OK...it is possible to discuss such things...but other things which are related to the psychological and personal part of the patient...no, we are still not well prepared for this yet". (Amjad, MD-AH21-I) P 8

Almost all HCPs had the view that Muslims have good sexual health without the availability of sex education within a curriculum. They believed that applying the Islamic teachings which spurned adultery, marital infidelity and multiple sexual partners guaranteed good sexual health for individuals and communities.

"According to us as a Moslems....raising up is the base....we scare from Allah... and we don't walk in the forbidden...this is the great sexual health care....this is my opinion". (Mostafa, MD-AH24-O-I) P 9

"there are a lot of reasons firstly our religion plays a huge part in this (good sexual health) that we are restricted to having rules concerning sexual issues e.g. no sex before marriage....not many partners as in the west...no adultery and we are also instructed on how to wash our self after sexual intercourse etc....we have restrict also on personal hygiene as well" (Amal, FD-BH43-I) P 2

In contrast there was a smaller group of HCPs who felt strongly that sex education was an essential because men and women were much more exposed to sexual issues and problems than before. This was felt to be due to globalization, a shift in the culture of the community through greater access to TV and availability of satellite transmission and sources of information on the internet.

"that's probably true. Our communities do not need a lot of sexual education. But times have changed. More young people seem to be having sex one way or another. So if they were going to have sex anyway, then they might as well do it right in order to minimise the risk of infection and spreading diseases" (Nesreen, FD-BH47-I) P 7

Yet a Saudi doctor explained in detail why a separates sex education curriculum was necessary and how teachers who were meant to deal with available information at school did not always do so:.

"I am with the separate curriculum...I will tell you why...because we already having it in our since and in the religious curriculum....but what is happening that teacher tend not to discuss it with the student and they did not give it any proper attention therefore if it is separate curriculum teacher will forced to give it to her students and student will forced to read it as well... because now the situation vary according to the teachers teaching...some of them might even cancel it from the exam or just give it as a reading for the student and some of them they just go through it but they did not give it any attention.... as I remember we take the menstruations and the ways of ablutions but our teacher was shy to discuss it even this topic with us and she did not explain it well to us" (Randa, FD-BH40-O-I) P 11

Most of the HCPs were of the opinion that educating students about safe sex and contraception was not appropriate at school or necessary, particularly for girls. There was a sense of fear and concern from participants that if safe sex and birth control were taught at school that this would encourage "Haram" sexual activity.

"Same answer never ever (educating the girls about sexual health issues)...she should not need too" (strongly talking) (Mostafa, MD-AH24-O-I) P 11

Most HCPs were of the opinion that it was men who were most likely to engage in the sexual activities which would not be considered acceptable by Islam and the wider community. Most HCPs considered that providing more information about preventing pregnancy would only lead to men engaging in more inappropriate activity and would corrupt young girls who had previously abstained from sexual activity due to fears of becoming pregnant.

"There is some girls who fear from ALLAH and will not have adultery with men, but in the same time there is some girls who did not fear from ALLAH but fear from becoming pregnant and from losing hymen and if they know the way of protecting themselves from becoming pregnant and losing their hymen they might simply have relationships". (Amal, FD-BH43-I) P 8

Most of the HCPs who felt that sex education was essential for men argued that men were usually involved in "illegal relations" (as they stated) more frequently than girls possibly because they tended to have experienced a less strict religious background than girls. For these reasons the HCP's concerned felt that men were in more need of sex education at school, particularly in relation to safe sex.

"I think because women usually will not think of relations, unlike men, women also have no pressure to start sex before marriage while poor men yes, they mainly do it to experience or to prove their masculinity to themselves or to their friends, as I guess they thoughts that they are not men if they delayed that things till they get married". (Renad, N-AH14-O-I) P 33

It is important to state that almost all HCPs agreed that individuals who were engaged to be married should receive sex education through lectures, classes or one to one marital consultations. They tended to view this as an acceptable way for sex education to be administered in SA for men and women.

"Providing sexual health session is great idea and more acceptable because they will get married and this will help them a lot" (Samera, FD-BH2a-O-I) P 13

The majority of the doctors argued that primary health care facilities were better placed for providing holistic sexual health care, education and services than hospitals. The doctors argued that the current system in the government hospital where doctors are allocated to clinics did not offer the best circumstances under which to provide sexual health education to patients. The work load in the hospital clinics and the inability of doctors to follow up with the same patients was a repeated concern mentioned by many of them.

"The primary medical centres should play a crucial role in the matter. Medical centres are the first stop for patients before being referred to hospitals. Beside that they can see the same doctor and they have less work load compare to us It is at these centres that women should commence their education". (Nesreen, FD-BH47-I) P 6

4.5 HCPs within the consultations

4.5.1 Lack of attention

It was observed that in some consultations, some doctors did not give their full attention to the patients in their care. They did not always listen attentively to their patients or try to check whether the patient understood what was being said. Sometimes doctors talked so quickly that they made mistakes when talking to or advising women.

For instance, case eight at BH:

Doctor was quickly advising the patient to use the mini pill every day after the "lunch time". Patient seem not understand but did not ask the doctor more questions. Then the in charge nurse told the patient to take the pill in the same time not after the lunch

because the lunch may change, she advised her to take it at 9.00 every morning or 9.00 every night. Dr gave appointment after 2 months and when the patient leaved the room the doctor, the nurse and I talked together and the doctor told us "I was not aware that I told her to use it after the lunch".

When HCPs were asked why some doctors did not give their full attention to their patients most doctors replied that they thought it was because some of their colleagues did not really value the family planning and post-partum clinic as much as other clinics because most cases were normal, with no serious complications. Therefore there was no pressure on the doctors to give as much attention to the patients. For instance during one of the observed consultations the following note was made:

one doctor told me that she will not be upset if a female patient get pregnant because she did not advice her to use a contraception because this is not really threatening to her life while she will feel so guilty if a foetus died because she did not instruct and advice the pregnant women to come to the emergency room immediately if there was no foetal movement (Ameena, AH-Diary Note, Consultation 14).

Another senior doctor said:

"in post-partum clinic we prevent pregnancy and while in pregnancy clinic we help to produce a life....there is different between producing a life and preventing a life"
(Wafaa, FD, BH-Diary Note, Consultation 22).

4.5.2 Controlling the clinic

It was observed that the doctors were in control of the time, information and the content of discussions within the clinic. During the period of field observation in both hospitals doctors were encouraging and advising women to use the mini pill rather than the combined pill or IUD. The researcher did not observe any doctor encouraging the use of condoms or other natural contraception methods to women unless there were medical concerns that contraindicated these and this was very rarely the case. Some doctors believed that natural methods were not effective and therefore did not tend to tell their patients about them.

"Yes but there is no guarantee that women and the husband will do it right...and also if the women have a regular period or not....it is not effective method in my opinion"

(Badreiah, FD-BH45-I-O) P 10

In addition some did not offer any advice for condom use as they believed that the husband would not wish to use such a method. Other doctors reported feeling too embarrassed to advise their patients on this kind of contraceptive because of being required to explain to their patient how to wear the condom, the positioning of the penis and so on. Other doctors believed that their role as a doctor was to prescribe modern contraception because they thought that was exactly why the women attended the clinic. If she wanted or needed a natural method women would go to a pharmacy and/or easily get information from anyone else such as the husband, mothers or friends.

"But we know the community her... they did not prefer the natural methods and this method is difficult and it is not effective...even if they want the men her difficult to cooperate....why I will advice the patient of this method if she wants to prevent

pregnancy I have to give her very effective method (pill or IUD) from the beginning isn't it" (Wafaa, FD-BH1a-O-I) P 2

"partially of it because it is embarrassed subject...the second part is because it is over the counter... most of people know about it...this is what in my mind...as a doctor I have to provide something not over the counter.. And which I think needs a doctor" (Mostafa, MD-AH24-O-I) P 9

It was found that every doctor controlled what information to give or not to give to their patients during the consultation. They were usually influenced by personal beliefs and values when prescribing contraceptive methods for their patients.

"some doctors her even against it (IUD) because they thought its work like abortion.....one time I had a hard day and time with a doctor who said that IUD is not a contraceptive methods it is anti-ovulatory therefore it is not appropriate to advice pts about it....however, this did not prevent me or stop me of advising pts but in the same way I take care also when I speak with them (Maha, FD-AH17-O-I) P 11

Some women who had previously experienced a Caesarian Section requested that they be sterilised. However, most doctors advised the women to use any other alternative method. Doctors tended to refrain from encouraging women to be sterilised because of perceived potential consequences. The scenario below demonstrates a typical example of how doctors tended to deal with patients if they requested sterilisation.

Pt. doctor I want tying (an expression used for sterilization)

Dr. you still young and your health condition is ok, beside that there is many problems could happen to you due to of this, one of my patients done it then after one year her husband come and ask us to write a medical report stating that his wife cannot get pregnant again in order to get money from the government to marry second wife. (Wafaa, FD, BH-Diary note-Consultation 18).

4.5.3 Language used when talking about sexual issues

During the consultation the doctor and patient would use conservative words like "sleep", "contact", and "connection" when referring to sex. No participants from either side, the patient or the HCPs, used "sex" as a word voluntarily when talking during the consultation or the interview. They felt that this word was not suitable or acceptable for use in communication in any setting, particularly in a hospital setting. They felt that "sex" and "sexual" were "horrible" and "nasty" words which sounded too disgraceful and impolite.

"I think that the phrase sexual health (in English) is more used by western people not by us as Arab people, and any subject related to the word sex is only discussed between a husband and his wife. In the Arab countries it's really private, and our society is based on the culture". (Mostafa, MD-AH24-O-I) P 5

"I do not feel the word "sex" (in English) is suitable to use in our clinic...as a doctor I feel this word connects to films (sex films), and I would not feel comfortable using it...my tongue would not allow me..." (Mona, FD-AH-Diary Note- Doctors Room)

During the interviews most doctors tried not to say the word "sex" or "sexual". They tended to use the English language rather than Arabic when saying it. Most importantly they felt that these words were not congruent with Islamic principles which call for morality, shyness and decency.

"The term is very strange and we are not used to hearing it here in the first place.

Terms like "sexual" and "sexuality" (in English) are not ones that we tend to hear very often in this society" (Fahad, MD-AH6-O-I) P 1

HCPs and patients were very cautious about the words they used during consultations and phrased their sentences in a very respectful way:

"Even though I am a woman, I have to phrase my sentence when I am talking to the patients...this is for sure all the time, but I am definitely more careful when I am talking to them about private topics". (Badreiah, FD-BH-Diary Note)

"I speak very politely, and am never more daring than required". (Eiad, MD-AH2-O-I) P 3

"This does not mean I talk haphazardly. To deliver my points, I weigh my words carefully and phrase my sentences to suit the person I am talking to" (Fahad, MD-AH6-O-I) P 4

4.6 Women's attitudes and orientation to sexual health

4.6.1 Barriers to meet sexual health

4.6.1.1 Cultural Sensitivity

Similar to the HCPs feelings about sexuality and sexual health, all women participants in the study believed sexual issues to be a culturally constructed "taboo", they reported that the community believed that sexual issues should be between the husband and wife, therefore, they felt that talking about their personal life to a HCP was very difficult for them, even if they believed that this was good and the right thing to do.

"Look, it is very difficult for us as eastern and Arab countries to go to a doctor and to talk about married matters (sexual matters)... it is very difficult even if the girl feels this subject is important and she needs to talk to a doctor, no one will support her doing that...no one will agree because the culture prefers this thing to be between the husband and wife and no third person should know what happens behind doors..."

(Yasmeen, Pt-AH4-O-I) P 12

All participants in the study, without exception, stated that the community and the way they were raised were the main reasons behind them being shy and embarrassed when talking about sex or about their sexual complaints, even to their husbands. It was felt that there was a lot of cultural negativity surrounding women who talk about sex and sexuality. One of the female doctors, who was extremely candid about the topic explained why women would avoid being clear about their orientation or sexual needs:

"This is how we were raised...we thought that this was a man's issue...women should not think of this (sex)...the ones who do, people might say are hyper or sexually active...not a good characteristic for the women, but for the men this is natural in their personality...no one will look at them as having a strange attitude, but for the women they do." (Layila, FD-BH2b-I) P 3

She also added:

"In reality we were forced to keep silent...no one would say they were not sexually satisfied...this would be unusual...people would look at you as if you were abnormal...while this is your right." (Layila, FD-BH2b-I) P 7

Interestingly some women refrained from talking about their sexual lives to other people, particularly if it was going well because they were afraid of being envied. There is a high suspicion that if a women talks about her good relationship to anyone, or to many people, that the relationship and her life could be subsequently damaged. People strongly believed that personal lives, including sex, should not be known beyond the closed doors of their bedroom. For instance, women usually think that if they say that their husband withdraws, or if they say that they have got many children, something harmful will happen to their husband or themselves, either psychologically or physically. Therefore some married women tend to be reluctant to give specific answers or sometimes hide information which related to contraceptive use or their sexual lives.

"You know people here...they have strong eyes...the eye is right...we have to be careful...I learnt that it is not good to talk about my life generally...and particularly my intimate sexual life...people here will not say Mashaa Allah (good welling, touch

wood)...Wallahee (swearing)...many people died or were divorced because they talked to other people about their life". (Elham, Pt-BH-Diary Note)

There is no doubt that access to good sexual health depends to a great extent on how the culture and the community will influence the issues. In the current study the participants reported that talking or gaining sexual information is still in some ways culturally restricted to married women only. It is not yet culturally acceptable for non-married people to talk about sexual health topics freely and openly. Therefore, in general, single women tend to talk and exchange information about sexual issues secretly with each other.

No... in my family it was not acceptable to talk about it when we were single...mainly after I get married (before 3 years ago) I started to ask and search about these things....I know some before getting married...I will lay to you if I say I was not knowing anything (Bian, Pt-AH2, Diary Note)

when I was "Bent" (any women who is not married still virgin) it was difficult you can say impossible to talk openly about these things in front of people..."Aeeb" (not appropriate)...but it is ok to talk about it now after I give birth and I become "Hormah" (woman who get married-not virgin). (Atheer, Pt, AH3-Diary Note)

4.6.1.2 Women's beliefs about sexuality and relationships

Despite the fact that women felt that sexual relations were good and necessary for their lives they had difficulties in asking for or initiating sex. Some women felt too shy and embarrassed

to ask for sex while others felt that this was a role for men only, asking for sex was seen as contradicting one's feminine nature.

"I think because he is a man and I am a woman.....it is well known that men have no problem when they want to initiate intimate relation but for the women this is "Ayeeb" (in appropriate) or not nice...it is nice if the man is the one initiate the intimate relation... this is the way everywhere" (Ghadah, Pt-AH26-I) P 12

Some women felt that they could not initiate sex because this might make their husbands suspicious of them being experienced in sexual relations prior to marriage. In general most women felt that it was better for a woman to wait until she had been married some months or a few years before taking a step towards initiating sex and only where there was confidence that this would not lead to husbands doubting their wives.

"No I do not think my husband will suspect of me if I asked him to this position or that during sleeping together....As everything is on TV or in books....but I cannot dare to ask really...I feel shy and also it is nice if he is the one ask....but yes I know some women who afraid to ask because they afraid from their husband to suspect of them...it is depend on the husband personality" (Hasnah, Pt- AH16-O-I) P 8

Some women believed that a husband would not be sexually attracted to his wife if she directly asked for sex. They therefore believed that it was preferable for women to create an atmosphere for sex by wearing fancy sleeping dresses, burning incense and candles rather than verbally initiating sex.

"see it is better for the women not to ask directly for that thing (sex)...it doesn't look nice...men can ask for it directly there is no problem....but women should not be so direct....I think even men they do not like women who ask directly.... wife should use her femininity then the husband will ask her for sex...." (Khadija, Pt-AH23-O-I) P 10

"I would deliver my point in a different way... he sometimes gets upset and tells me to ask him directly and be upfront. I don't know, I don't think it would be nice to do so! So I try to put my point across in a different way for example I put my son to sleep earlier than usual then I get changed." (Rania, Pt-AH8-I) P 5

Some female participants expressed their difficulties in refusing sex with their husband particularly if there appeared to be no reasonable reason for doing so. These women felt it the role of the wife to sexually satisfy her husband at any time. However, they felt that husbands had no such restrictions in that they are free to choose to refrain from having sex with their spouse at any time without consequence.

"No I will not deny him when he approaching me... It's different when a man expresses such a need. When he asks, his wish is granted. But if a woman expresses such needs, it's up to the man whether or not he accepts her offer or denies it." (Aziza, Pt-AH15-I) P 12

When asked about why they think it is culturally acceptable for men to refuse to have sex with his wife but not the other way around, one woman remarked:

We learnt that accepting having copulation is a way for us to obey Allah...men not like women in fearing from god their personality is different they can refused their wife sexual needs...even though if something such this happen (the husband refusing his wife) the fault will be on the woman...people will always say it is must the wife fault...maybe she is not clean...may be she is wide...she cannot make him happy
(Bian, Pt- AH3-Diary Note)

4.6.1.3 Power issues

Some women stated that they were unable to attend their appointment because of transportation issues. "My husband was busy" or "my husband could not take excuse from his job" was the common reason given by women who did not arrive at their post partum clinic appointment.

"My husband didn't come with me.... just my mum and my brother...even my husband was reluctant to allow me to come today because he does not like me to take a taxi....but when I told him that my mum and my brother will go with me he allow me to come." (Hasnah, Pt-AH16-O-I) P 10

"no they did not give me this appointment for today ...The appointment was yesterday but I couldn't come because my husband was not available to take me to the hospital"
(Aidah, Pt-BH30-I) P 2

Most women reported that their husbands played an important role in their decision-making regarding contraceptive use and the timing and number of births. In general the wife's decision toward having sex, contraception use and method was strongly influenced by their husband's decision.

"For me I want to space and regulate pregnancy but my husband doesn't like me to take anything and also he wanted me to have another child soon as well....but I wish from god to leave me without pregnancy for one year....to have rest and also to breastfeed this baby" (Ghadah, Pt-AH26-I) P 7

"It was clear to me that he did not tolerate it...from his talk and his hints....I know him therefore I decided to use the IUD to make things more comfortable to both of us" (Nabela, Pt-AH11-O-I) P 4

Similarly, in both hospitals the researcher saw many women who were unable to talk and had difficulties in asking their husband to use contraceptives. During the consultation some women were asking their doctors to inform their husband about the need to space pregnancies on health grounds in order to convince and allow them to use a contraception method, for example, from a field diary entry

Dr asked the patient if she want to use contraceptive method, patient informed the doctor that her husband refuse allowing her to use contraception then she asked the doctor to speak to her husband (he was waiting outside the clinic) and to tell him that his wife need to use contraception, the patient told the doctor that she think if her husband will listen to the doctor he will accept the idea of using contraception. Dr

refused to talk to her husband and informed her that this is something between them and she should not involve and she told her "I will write pill prescription and then you discuss it with your husband if he allowed you, you can then take it". No appointment given to her. (BH-Diary Note-Consultation 9).

However, it was found that some educated women were able to influence their husband's decision:

"Even now, he suggested that I shouldn't use any contraceptives and that he'll continue practicing withdrawal prior to ejaculation. I don't want that. I am very cautious, especially right at the beginning. I want to minimise the risk of mistakes from occurring. A surgery is a serious issue." (Aziza, Pt- AH15-I) P 3

In addition to observations in consultations, many stories were heard from doctors regarding the difficulties they have faced in their clinical practice due to of the inability of women to refrain from having sex. Despite the fact that in some cases refraining from sex was very important to the health of the woman and the safety of the foetus, some women were unable to refrain from having sex with their husband, and this sometimes led to miscarriage or placed the woman in a serious, life threatening situation.

"I will give an example we find some women scared to say to their husband that sex is not allowed for some period of time....this is at threatening pregnancy....you see this is an issue her....this is for saving the pregnancy and they could not say or talk to their husband about it what about position....the situation is more difficult to them I guess" (Samera, FD-BH2a-O-I) P 10

The majority of women believed that men were usually involved in "Haram" relation (adultery) before getting married. However, these women also admitted that they had no means of protecting themselves from sexually transmitted infections which might be transferred to them from their husbands. They were not able to ask their husband to undergo any screening tests prior to marriage for fear of the consequences to their relationship including the loss of their fiancé.

"I do not know... it is difficult to ask him at that time to do it....it is very difficult....it mean I did not trust him...he might think bad about me....I might not like him after asking him this request" (Noof, Pt-BH37-I) P 16

All women felt that there should be a government policy to apply compulsory premarital tests including STI tests for all Saudis before allowing marriage. They expressed their feelings about the importance of this policy in protecting them. Without it being compulsory they would not feel able to ask their fiancés to comply:

"For me I prefer this way (compulsory premarital test) because this will protect the community from the irresponsible men who travel for adultery and bring diseases to their wives and this way will be more acceptable for the men...because no women could dare to ask her husband for this test and the husband will not listen to her but if it is compulsory from the government this will be more acceptable...{ }" (Ghadah, Pt-AH26-I) P 12

"Some men would consider that as an offence but when the test is obligatory no one will reject it...It would be better to have this test before marriage for all nationalities"

(Haneen, Pt-BH50-O-I) P 11

In two consultations women come to the clinic after having used the prescribed treatment for a sexually transmitted infection. However, the women had not asked their husbands to use the medication and this tended to upset the doctors who instructed the women again that the medication must also be taken by the husband.

"they must bear in mind that the treatment is most of the time for the couple together and not just the wife.... we should try and raise this awareness so husbands don't just send the wife and refuse to be tested." (Amal, FD-BH43-I) P 5

"{ }...Generally speaking, men rarely comply with the medication they are given. Even if the husband was prescribed medication by a doctor, he does not tend to easily accept the fact that he needs to take this medication." (Nesreen, FD-BH47-I) P 3

"She might did not tell her husband because she afraid that he could suspect on her...maybe" (Hanan, N-AH27-I) P 8

4.6.1.4 Unavailability of A female doctor

Despite the long waiting times in the clinics it was found that most observed women in both hospitals were prepared to wait even longer in order to attain the presence of a female doctor

and avoid consultations with male doctors. Many cases were documented similar to the case below:

"A 27 year old Saudi female, originally from the south provision of SA, first delivery, 43 days postpartum, came early to the hospital but there was only one male doctor available in the clinic, she refused to be seen by male doctor and asked the nurse in charge if any female doctor available today to see her. The nurse told her that Dr "N" will come but she did not know at what time she will come to the clinic. Women accept to wait more time instead of being seen immediately by a male doctor" (Diary Note- BH).

Similar scenario in Hospital A was also observed

A postpartum woman was waiting long time for her turn to come in the clinic. unfortunately all female doctor who were available left the clinic at the end of the clinic time and there was only 2 male doctors who came late in the start of the clinic who still available to see more patients in the clinic however, this woman was angry and was upset from the service because she was informed that no more female doctors left and she decided to leave the hospital instead to be seen by male doctor. In fact this woman was not looking to insert an IUD and the nurse told her that the doctor will not do any physical examination to her if she did not want (Diary Note- AH).

The case below also shows how women were very determined to be seen by a female doctor especially if private areas of the body were to be exposed:

A 22 year old Saudi woman, first delivery has inflammation in the episiotomy site, she complete 30 days postpartum and the episiotomy site not yet healed. There was only one male doctor available in the clinic and two of the female doctor team not yet in the clinic. However, despite the fact that she came early and her turn come to be seen she refused to go in to the male doctor clinic and she decided to wait for the female doctor because she knew that in her condition the doctor should reveal her perineum.

(Diary Note-BH).

However, it was also found that some women did not have a problem in talking to a male doctor providing there was to be no exposure of the lower parts of the body:

"No with the long waiting times I don't mind questions and answers about contraception with male doctor but if I was to have a coil then I would ask for a female doctor" (Khadija, Pt-AH23-O-I) P 18

Similar to female doctors, most female patients in the clinic appreciated the restrictions on men entering the clinic and felt more comfortable because of this policy. It seems also that this policy paves the way for men to have to allow females to attend these services alone and more chance for females to ask for information and advice within consultations.

"Actually I prefer this way...I feel it is not appropriate for men and women to wait in the same waiting area... men and women has their own area, we used to this way there is no problem with it...it is our religion and tradition request from us this...and I feel it is the right way" (Nadia, Pt-AH14-O-I) P 11

4.6.1.5 Limited sources of information

Despite the fact that all the female patient participants had delivered in a hospital, none of them reported having gained useful information whilst staying in the hospital and only a few of them reported that they were given leaflets to read after having given birth. In fact, all of those who were given leaflets had had deliveries in private hospitals.

"No, they did not give me anything or discuss anything...nothing at all, even no baby nappies or milk" (Ertwaa, Pt-BH28-O-I) P 9

"No, they didn't tell me anything or explain anything to me" (Khadija, Pt-AH23-O-I)
P 6

The majority of participants reported that they gained their information about sexual health topics mainly from friends or relatives in the first instance. Secondly from books (mainly religious books) or listening to religious scholars, thirdly from watching a wide range of programmes on TV and finally from gynaecology doctors.

"frankly I did not buy any books I usually ask my sisters and people around me about what is the best contraception and during postnatal gathering women always open these topics and I listen to what they said...also I usually see the TV some doctor answering women questions sometime women asking about some postnatal problems and some time they ask about contraception and I learnt from these information it help me a lot....but I know that not every women act the same way to contraceptive as every women has different body and the thing which fit you might not fit another"
(Yasmeen, Pt-AH4-O-I) P 10

"I acquire my information from the people around me...friends and neighbors"

(Rania, Pt-AH8-I) P 9

The majority of female patients stated that women's gatherings played an important role in informing them about a variety of sexual health topics. During Nafaas (the post partum gatherings), it is a known time for women to talk about their contraception experiences which helps to share knowledge about contraception methods, some of its side effects, advantages, disadvantages and common postpartum problems such as what they can do to help episiotomy healing, and the management and treatment of vaginal looseness and so on.

"I gained my information from friends and relatives....we talks when we are at women gathering particularly during Nafass gathering...we talk about different type what are the best and what is the complication that might happen..." (Nabela, Pt-AH11-O-I) P 2

"I did a lot of listening in my time! I attended many social gatherings...it help me a lot" (Aziza, Pt-AH15-I) P 6

Some participants who reported very close relationships with their mothers mentioned talking to them about sexual health topics including sex and sexuality. When asked about their mothers it transpired many of these were well educated and the majority of them were 50 years old or less.

Pt: no, my mother explained everything for me

A: what did she say?

Pt: since I was young my mother told me about sexual issues and everything, what will happen to me, she told me that I have to sleep with him!! Something like that
(Noof, Pt-BH37-I) P 6

On the other hand, a notable number of the women reported that their mothers were very strict about talking directly with their daughters about sexual topics before marriage or even after it. When the researcher asked them why they thought their mothers were so strict they reported that "keeping respect" is the main and the first reason for the mothers not talking about sexual health topics with her children. They reported that their mothers thought that talking about sex with their children could remove and break the respect between them. Other reported reasons were because mothers think that girls nowadays know about sexual health topics from school or classmates therefore no need for mothers to raise the subject or because mothers are shy in discussing this topic with her children.

"I think My mom assumed that I was fully aware about copulation and all these things because I went to school and that my friends must have told me about it therefore I think she did not bother to tell me about it" (Khadija, Pt-AH23-O-I) P 13

"When I get married no one set and teach me about what will happen and what I have to do....I think because my family thought I am a nurse I should know about all these things" (Nora, N-AH13- Diary Note)

4.6.1.6 Insufficient knowledge about sexual health

The majority of the female patients were shocked about the term 'sexual health'. Most of them felt it inappropriate to use the word "sexual". They reported that no one tended to use this particular word. As with the HCPs, female participants were not certain what 'sexual health' meant to them. They usually took considerable time during the interview to think about it. They usually reported that sexual health reflected sexual relationships. In addition, almost all of them incorporated personal hygiene into their definition.

"I don't know. Does it refer to the "appropriate" way of having intercourse? I don't know. I don't understand the concept. Cleanliness maybe? maybe the appropriate technique of having intercourse?" (Aziza, Pt-AH15-I) P 3

"I feel it means the hygiene for sexual parts ...to take care of our genital area...take care of this subject" (Aidah, Pt-BH30-I) P 4

Most women were not aware of their fertile day. They could not calculate it and they did not feel that it was necessary for them to know about it either. Only a few women, who were using or had used natural methods such as withdrawal or a calendar, were able to calculate their fertile day correctly.

Yes, I know that there is a day for fertility, but I do not know how to calculate my fertile day...no need for that as since I know myself I use Genera (CO pill)...why do I have to know about it?...it is not necessary for me. (Abeer, Pt-AH-Diary Note, consultation 5)

Some women were not able to differentiate between the combined oral contraceptive (COC) and progesterone only pill (POP). Some just knew that POP was good for breastfeeding, but they did not know how it worked, others just knew that POP is a weak contraception, and therefore did not want to use it.

She told me it was good for breastfeeding...this is why I prefer to take it... I know it is a pill suitable for breastfeeding...but I do not know how it works or what its action is.

(Atheer, Pt-Diary Note- BH3-Consultation 24)

Most women admitted that they had never had a chance to see condoms. They did not know what a condom looked like, or how to apply it to the body. Some of them were surprised to hear that a female condom existed. Most women laughed when talking about condoms.

What? A female condom? Are you kidding? (Zinab, N-BH31-Diary Note)

No one here will use a condom... even I do not know what it looks like. (Elham, FD-AH-Diary Note)

No, I have never seen a condom before. (Hasnah, Pt-BH51-Diary Note)

It was found that women depend completely on their husband on their wedding night, mostly because they have no clear idea about what they should do, or how to deal with this important night in their life. They leave everything for their husband to take care of.

"Honestly, no one sat with me and talked regarding this topic, it comes naturally".

(Ghadah, Pt-AH26-I) P 3

One woman had a bad experience on her wedding night due to insufficient knowledge about sex, leading to severe fear. Her husband was extremely angry with her because she was screaming all the time when he wanted to penetrate her. Afterwards, he asked his wife's mother to speak with her. All of the wife's family blamed her for her attitude and blamed her because she did not help her husband. She said:

“She (her mum) used to tell me that there are girls who are younger than me who got married and they never used to do like me [screaming] on their first night after their wedding...she told me this because I was resistant and screamed during my first copulation...so I said to her I did what I did because I did not know...I never knew that it was like that”. (Nora, Pt-AH13-O-I) P 8

4.6.1.7 Delays in seeking medical advice

Despite the fact that many women stated that they wanted to discuss their personal sexual problems with a HCP, only a few of them reported going directly to consult with HCP when they had a sexual health issue. For the women, sexual health issues include pain during intercourse, vaginal dryness, vaginal inflammation, pain or inflammation from episiotomy, a reduced\low desire to have sex and wideness of the vagina. The majority of participants tended to consult a HCP only after consulting a friend who had been unable to provide a satisfactory solution. Additionally women tended to go to see a doctor only if the situation was very serious in affecting their health and most importantly their marital life. This finding confirms what doctors have reported - that women do not usually come directly to them to consult about sexual health issues.

"Not serious thing just regular inflammation that happen to any women and i am fine now there is nothing to worry about....frankly I did not go to hospital to treat it I just treat it at home I used hot water and salt and after sometime thank god I did not complain of anything" (Ghadah, Pt-AH26-I) P 3

"maybe because it was a normal pain after any delivery..."all of them told me to wait and to be patient...this pain is expected and will go with time...the area need healing tile retune to normal" (Noof, Pt-BH37-I) P 11

Some women who experienced sexual health issues such as inflammations, vaginal pain and a low desire to have sex reported negative impacts on their sexual relationships. Most multiparous women reported that they had experienced a decrease in the frequency of sexual intercourse or experienced pain. However, they did not tend to seek a HCPs advice because they feel that this is an expected issue after having children.

A.did it affect on your intimate marital life?

Pt. yes...but I tried not to show him that I suffer from anything...I usually make him happy

A.you were acting?

Pt. in away yes....but actually I have pain, but it was not a killer... it is possible to afford...and I heard this is normal to happen anyway (Noof, Pt-BH37-I) P 12

Almost all primiparas who had SVD were more likely than multiparas to report seeking medical care when severe perineal pain and serious sexual health problems occurred such as bleeding or unusual discharge. Most of them felt that they knew little even though they had asked their friends, mothers and relatives. Women who delivered for the first time reported

feeling fear and not yet certain about using a particular method of contraception. These feelings tended to be the main reasons for coming to the hospital.

"this is the first time for me to give birth I do not know what I have to do and what type of contraception is good for me therefore I came today to see the doctor"
(Hasnah, Pt- AH16-O-I) P 8

"it's because I had an cesarean section. So I decided that it would be best to go see the doctor after 40 days of my surgery. I figured it wouldn't be good to get pregnant immediately after surgery. The baby was my 1st child and I did not have much experience. I wanted to know if I can start using the pill." (Aziza, Pt-AH15-I) P 1

"there are those that say that they get pregnant even when they have it, and some say it came out....everyone will say something therefore it is better to ask a doctor who knows better than them....I do not want to be confused that's why I have come for the doctor's advice". (Ertwaa, Pt-BH28-O-I) P 4

A few of the study participants reported seeking private hospital treatment. The primary and most repeated reason given for this was for better care and advice. They did not feel satisfied with the governmental services in the clinic as these were experienced as too crowded, lack of continuity with doctors, difficulty in obtaining appointments and a lack of attention from doctors due to the pressure of work load.

{..but I usually go to private for follow up to make sure that I had the right advice and care because the doctor her did not talk to you as you want and need....}
 (Yasmeen, Pt-AH4-O-I) P 10

The suggested preferred place for most of the female participants for seeking sexual health care, gaining full details about sexual health information and education was the hospital through talking to a specialist or by having lectures. Some of the women who had transport difficulties suggested better use of reading materials such as pamphlets and leaflets.

"It is not necessary to be after delivery...lecturs should be at certain days and for every one...everyone who wants to attend the hospital....}" (Bashaeir, Pt-AH9-O-I) P 17

"Even if lectures were to be organised, not everyone will be able to attend them. I think distributing pamphlets would be more useful." (Aziza, Pt-AH15-I) P 14

"I prefer to read, that way I don't forget...and I prefer the booklet more than attending the lectures because the transport issues and children responsibilities as I told you" (Khadija, Pt-AH23-O-I) P 17

4.6.1.8 Lack of communication

During the consultation the doctors did not routinely ask about resuming sex or frequency of sex and the patients did not inform the doctor about personal details such as the availability of

their husband and his job. It was noticed during observations that due to the lack of communication, women would sometimes return to the clinic and ask the nurses to explain the contraception to them, or ask them to allow them to see the doctor again to clarify things. Lack of good communication in the consultation between the patients and the doctor was affecting the patient, the clinic and the doctor.

A. Returning to the educational part...during my observation with you I found a woman whose husband was working in a military job, she lived at her home in Jeddah near to her family and her husband was working in the west provision...he came to her just two days per month...is it OK to prescribe the mini-pill to her? ...

Dr. Yes, how will I know if her husband is away or not? She should tell me about that...let me think a while of another similar incident...one day I prescribed pills for a woman, then after a few days her husband called and asked me whether his wife should take the pill every day or just take it on the days he came to her...because I remember he was travelling a lot for his work and also marrying more than one woman...he came to her just 4 days per month or maybe less...depending on his work...I cannot remember. (Wafaa, FD-BH1a-O-1) P 4

Some notable numbers of women from those observed and interviewed had the same thoughts as their doctor about the aims of the clinic "the aim of the clinic is for preventing any postpartum complications and prescribing a contraceptive method". Most participating women did not know if it was appropriate for them to take "extra time" (as they stated) in the clinic after getting their contraceptives, in order to talk about their sexual issues. They did not tend to ask the doctor about their sexual complaints during the consultation. Some women

thought that they had to get another appointment for their sexual complaints. This may explain why during consultations only a few women asked and initiated talk about sexual issues other than contraception.

"I did not know if I could ask the doctor about this (she had no desire to have sex)...I think I have to make another appointment for this... isn't that so? (Bashaeir, Pt-BH9-Diary Note-Consultation 12)

Most of the women reported that they took the appointment from the nurses or the doctors in the postnatal department without an explanation being given to them about the reasons for their visit or what kind of questions they could ask or raise with the doctor. Some of them were not totally certain about their visit when they were asked about their reasons for coming to the clinic or why they were given the appointment.

"No, I don't know exactly why I'm here today. Is it because they want to check on me after my caesarean section? I don't know. But the important thing is that I have showed up for it." (Aziza, Pt-AH15-I) P 1

"I do not know but I guess they want to make sure that the operation site is OK." (Yasmeen, Pt-AH4-O-I) P 1

Most women complained about the care received in the service and they felt that the time limit in the consultation which was controlled by the doctors was not enough for them to explain their sexual health as they needed and wanted

"They only answer questions directly.... They are so busy they want to finish...but it is not fair for us as well...we leave our home and children and my husband has to get excused from his job...then I did not receive the full

details...sometime I will forget to ask some question due to the way they run the clinic" (Khadija, Pt-AH23-O- I) P 17.

Women were usually unhappy and not satisfied after the consultation they had received due to it being rushed.

"Yeah I felt that she was in a rush and wanted to finish quickly, that's why I wasn't happy". (Rana, Pt-BH51-O-I) P 10

Another woman said:

"in general some doctors welcome to answer you while others don't...and because I am Yemeni the situation is more difficult for me...I feel as they have more power to not to treat us in this hospital because the priority is for Saudi....sorry this is my feeling " (Haneen, Pt-BH50-O-I) P 15

Women reported that the doctors' workload was a possible reason for the doctors to limit the patient time in the clinic.

"Possibly because of their heavy workload. They have see so many patients that by the time it's my turn, they're fed up" (Rania, Pt-AH8-I) P 13

Female patients even suggested the need for a permanent expert doctor to fulfil women's needs and who would be able to give women enough time in the consultation clinic to talk about and explain their sexual health issues freely and in detail

"I think if there is another doctor for us....just to talk with us and not the one should see all this pts and not the one responsible to insert the IUD.... we need someone free to talk with us and give us time to talk and discuss things with her....because by this current way we are not able to talk and the doctor want also to finish her patients and go home" (Yasmeen, Pt-AH4-O-I) P 6

Most women found it very difficult to build trust and rapport with the doctor because every time they visited the clinic they were seen by a different person. They felt that one doctor should look after a certain number of cases and this would make the situation easier for them to talk about their sexual issues and to open up during the consultation.

This is why I don't like this hospital...every time you come you see another doctor...you have to tell them all your history again and you will forget why you are here...I want to see the previous doctor...she knows everything about me...I prefer to talk to her...but they told me she is not available. (Afaf, Pt-AH-Diary Note-Consultation 23)

Women were also concerned about doctors' judgmental attitudes of them if they talked about their sexual complaints. When women were asked why they did not talk about their sexual complaints to their doctors, most of them replied *"What will the doctor say about me? That I am not nice."* Conversely, HCPs admitted to me that it was not usual for them to see women in their clinic complaining about sexual issues, therefore if a woman came for sexual issues most of the doctors would talk about her and about her complaint, and this was simply because they were not used to it.

Actually we do not have many patients complaining of sexual issues in our clinic...women will not come to us for this...yes truthfully we find it strange for us to see a women asking about sexuality or sexual complaints....and sometimes we talk about her when we are gathering in the doctors room and sometimes we disagree about whether she should bring her sexual complaint to a clinic. (Nesreen, FD-BH47-Diary Note)

Opposite to the doctors' perceptions that women will be offended if they asked about sexual issues during the consultation, the majority of female patients reported that they would not mind if doctors asked about such issues during the consultation. They also felt that the doctor should be the one encouraging them to communicate with regard to their problems. They stated that the HCPs who ran the clinic could make the initial conversation easier for them. There was an agreement from the participating women that it was less embarrassing if the professional took the lead, asking questions and giving advice, rather than sitting back and responding to their requests. However, they also strongly felt that it was better if it was a female doctor who talked to them, because they could not talk freely about their sexual issues in front of a male doctor.

"If the doctor asked me about it (frequency of sex) I think I would talk to her about it...but it is difficult to tell her by myself. I feel embarrassed to talk." (Tamah, Pt-BH4-Diary Note)

4.7 Impact of Islam and culture on women's views

4.7.1 Islam and culture: a guide and a source

All of the participants reported that they learnt from Quran and Sunnah and used them to understand and to explain what is right and wrong in relation to sexual health. The majority of the study participants believed that if the Islamic principles and instructions were applied correctly by people that would be enough to ensure good sexual health.

"The way how we raised up is the main reasons....we raised in a way that keep our dignity....we have honor...our religion learn it to us..." (Bashaeir, Pt-AH9-O-I) P 16

None of the participants approved of homosexual or premarital sex. However, they reported that because homosexual and premarital sex is not condoned by Islamic principals or socially, it does occur in the community but is underreported. All participants stated that they believed that pre-marital sex and homosexuality were sins whatever the reasons behind such behaviour:

"I am not with sex before married at all...the women who do that will lose everything...herself, her religion, her family and los her reputation..She is the loser at the end" (Haneen, Pt-AH14-O-I) P 7

However, It was found that the non-religious cultural norms were more influential than religious beliefs in relation to sex and sexuality. When the researcher asked participants about having sex during *Melkah* time (the time when the couple is officially married but still in

their family's house) they reported that according to Islam this is not a sin and it is Halal however, it is not culturally acceptable:

"No...the good women did not have sex with her husband during Melkah...what people will say about her if something goes wrong...she might lose her virginity and the husband might be dog...saying I am not the one do" that because he wants her family to forgive him from paying the dowry or any particular married expenses...she might become pregnant and her husband died before the wedding party...what she will do at that time" (Khadija, Pt-AH23-O-I) P 13

"Yah I now it is Halal but according to our customs and tradition this is not...we should follow the common tradition her, this what all people do" (Randa, FD-BH40-O-I) P 9

Generally, female participants felt that talking, searching and obtaining information about STI and contraception had become slightly more culturally acceptable compared to doing the same in relation to sex and sexuality.

"I can give reasons for girls gaining information about contraception and STI but for sex and these talks I do not think it is the same...there is no similarity her" (Ertwaa, Pt-BH28-O-I) P 12

They stated that this was because when talking about sex and sexuality people believed that this can lead to prohibited sexual relationships and also because it is still considered too forward *"Gelat Hayaa"* and less demure *"Gelat Adab"* to do - particularly for non married

women; and most importantly because Islamic principles discourage people from talking about personal sexual issues casually or without reasonable reasons therefore "respectful people" (as they stated) refrain talking about sex and sexuality matters.

"{..}...all sexual relation should be between the husband and the wife this is so private and our prophet advice us not to talk about it in public without reason. (Haneen, Pt-BH50-O-I) P 9

4.7.2 Sexual health Education with boundaries

Most of female participants stated that sexual health education should be accessible to all people particularly for men and that it should be provided in an age appropriate, culturally sensitive manner and most importantly to be in parallel with and derives from the Quran and the Sunnah.

"The matter of education and spreading awareness is very important.... more importantly for the man" (Rania, Pt-AH8-I) P 14

"if it is provided in respectful way and based from our Shariah it is ok I do not mind it" (Haneen, Pt-BH50-O-I) P 21

"I think there will be no problem talking about sexual education.... people today have changed...however; this should also respect the Saudi community by providing respectful information guided by ALLAH words and his prophets Muhammad" (Khadija, Pt-AH23-O-I) P 18

Many participants mentioned that it was easy to look after girls and to guarantee that girls would not be exposed to sexual relations or poor sexual health because they spend most of their time at home and accompanied by their mothers. This was not the case with boys and this is why majority of the participants believed that boys and men were in need of sexual health education at schools and universities while, it was not seen as a necessary for women and girls.

"{...} my mom scare more about him (her brother)...especially he is the only boy she got....she is scare that something might happen to him...therefore if he went to the street and did not retune early...she will take her abaia (black dress to cover all body) and she will look around for him...{...}" (Bashaeir, Pt-AH9-O-I) P 11

"I think it is obvious that there is a problem in the society now....I can supervise my daughter more than my sons...my daughter always at home with me therefore I can watch her more...so when my sons go out I am always worried about them" (Khadija, Pt-AH23-O-I) P 12

Some of the study participants said they would approve of sexual health education in schools for providing students with information on a "wide" range of sexual health topics including puberty, abstinence, healthy relationships, STI/AIDS prevention, sexual orientation, and ways of preventing sexual abuse or coercion.

"There is no problem to educate them about menstruation...how they clean their body.... about avoiding sex until married to know that rectal copulation is

haram...having sex with many people is inappropriate and led to AIDS and so on"
(Haneen, Pt-AH14-O-I) P 7

"For me I would like it...because I know the need for this kind of things especially for the retarded children....nowadays there is many raps accident we cannot hide this truth and if there is such curriculum this will help a lot in spreading awareness between children both girls and boys....this will help them to understand the consequences of sexual abuse" (Ghadah, Pt-AH26-I) P 11

None of the participating women were comfortable about having information at school about safer sex and birth control.

"Menstruations yes it is possible to discuss it ... to teach her how to use the pad and how to do ablution and so on but other things like marital relation or contraception and these thing of curse no" (Ertwaa, Pt-BH28-O-I) P 12

Only three women participants acknowledged that their teachers had discussed fully the topics that related to sexual health that were part of the designated curriculum.

"for me the explanation was clear, I was in good school and the teacher were excellent, they explain everything was in the books about the period and how to clean yourself and ablutions they even give instruction about the wrong relations such as lewat (lewat: an expression used to refer to sex relation between men) or Sehaq (Sehaq: an expression used to refer to sex relation between women), they warn us

about the illegal relation with men...they always advice us and some time they make sudden check to our bag to see if there is any inappropriate thing such as make up, picture love letter and so on the school play a good role in my life" (Haneen, Pt-BH50-O-I) P 5

4.8 Women's attitudes towards contraception

All women participants reported that they use or had used contraception to delay having children (spacing). However, most of them usually did not use contraception immediately after marriage and they had to think about it and used it only after having one child.

"Yes I had one period before my married wedding then I get pregnant no period came to me after that....I conceived immediately" (Ghadah, Pt-AH26-I) P 2

"I get pregnant after three months since my marriage". (Hasnah, Pt- AH16-O-I) P 6

There were many reasons given for not using contraception immediately after marriage. The most frequently reported reasons were; wanting to have children, fear of infertility problems, difficulties or inappropriateness of asking husband to use a condom or withdrawal methods:

"it's the dream of every married women to have children immediately....and if she did not she will be worried and trying to get a baby...therefore it is better to have a baby then she can space" (Haneen, Pt-BH50-O-I) P 23

"{}I heard that using contraception before married is not good for pregnancy later on... therefore I was not interesting to take anything before having baby...I do not want to have problems with conceiving therefore I did not use any contraceptive immediately after a get married" (Yasmeen, Pt-AH4-O-I) P 5

Most women felt that having children proved that they loved their husbands and vice versa.

They felt that having a child immediately after marriage was good for their marital life.

"{}but for me I prefer having children first then to space....this way is better for married relation...it helps for reaching stability" (Haneen, Pt-BH50-O-I) P 23

Notable numbers of participants reported resuming sex before completing the 40 days of their postpartum period and before consulting their doctor about contraception. Most of them relied on withdrawal methods or breastfeeding (lactating) method, despite the fact that some of them knew that this did not guarantee that they would not become pregnant:

"I am not very strict like my mum in completing all the forty days...but my mum was so strict and she advised me and advised all my sisters to do this...but me and my youngest sister did not tend to do this...once we are clean we sleep with our husbands". (Haneen, Pt-AH14-O-I) P 6

However, in spite of the fact that the withdrawal method was used as a method to prevent pregnancy, some women found it difficult to admit that their husbands were using a method and they always said "I am not using anything". It was noted also during conducting the interviews that women's understanding of the phrase "contraceptive use" was limited to any

mechanical or chemical substance, for example, when women were asked about the type of contraceptive used and natural methods were being used then answers were:

"I didn't use any contraception for all my children {...} (Ertwaa, Pt-BH28-O-I) P 2

A. During your engagement, did not you talk to your husband about postponing having children until after you graduated

Pt. Yes we did. That was the plan... we weren't using anything. We "sort of" followed the calendar charting for 8 months and then I got pregnant. (Rania, Pt-AH8-I) P 8

It was found that women who have no fear of becoming pregnant within two years after giving birth tend to use natural methods. Some of them reported that there was no time to waste because they married late (30 years and more) or because they had problems in conceiving, or because they trusted their husband's commitment to using male methods. These women had no intentions of using any modern contraception such as IUD or COs.

"My husband very committed to this method (withdrawal), I trust him on this, I am using this method for 5 years now and thanks god he is able to continue and he did not complain of using it". (Khawlah, Pt-BH33-O-I) P 12

Women felt that when they talked about condoms it was associated with illegal relationships "outside marriage" and with HIV or other transmitted diseases. In addition to doctors not encouraging condom use, linking condoms with prohibited relations could be a reason for couples not using this particular method, as some doctors explained:

"It is rare to find couples using a condom here...even if they use it no one will know about them...they usually hide it between themselves...and here there is a strong belief that condoms are usually used if there is disease, or if the man is having a Haram [forbidden] relationship". (Amal, FD-BH43-Diary Note)

Not surprisingly very few women reported using condoms as a method of contraception. Of the few that did use condoms they explained that this method was used because they were encouraged to use it by either their doctors or husbands for just a short period of time. This result was not surprising given that all participant doctors admitted that they were not interested in encouraging condom use:

"Now no I am not using any kind of contraception, but in the past I used condoms because my husband had hepatitis B and the doctor said it can be transmitted through sex plus I had to wait two years breastfeeding my daughter due to my religion (Quran encourage women to breast feed for two years). I also took three vaccinations against hepatitis B in "T" hospital (private hospital) after that we never used condoms. Then the next months from stopping using the condom the period didn't come to me so I was worried" (Nora, Pt-AH13-O-I) P 2

Most of women who used modern contraceptives such as the pill or IUD complained of side effects which they believed to be associated with the contraceptive methods. However, most of them continued to use these methods because they believed them to be effective at preventing pregnancy. The repeated insistence of doctors in to prescribing the contraceptive

pill or IUDs in the clinic may have influenced women's choices and attitudes when selecting a method to prevent pregnancy.

"Yes I was in a mood most of the time! Even trivial things would set me off! The atmosphere at home was always tense. I shouldn't be putting my husband and my son through that. Everyone says that "Yasemine" (type of pill) has minimal side effects, which is not what I thought. So when I went to see my doctor, I asked her. She said that this doesn't mean that it should suit all women". (Rania, Pt-AH8-I) P 2

"It was fine with me but the first time I put it I had bleeding...and I have heavy period and it was hard when they inserted but the second was ok and there was no problem with me" (Nabela, Pt-AH11-O-I) P1

4.9 Summary

The results of this study show that sexual health topics are a very difficult topic for HCPs and female patients to deal with. It also provides evidence that the services provided and participant's attitudes and orientation to sexual health is complex with multiple layers of reasons and influences. Many reasons and justifications were given by HCPs and female patients as to why they perceive sexual health issues in the way that they do and why discussion of sexual health issues are avoided in consultations and in general. However, the sensitivity of the topic and the influence and impact of both Islam and Saudi culture was extremely notable across all the data. The next chapter will discuss the findings by identifying an appropriate theoretical framework to explain and explore the findings and also place the findings in the context of the literature.

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Chapter 5: Discussion

5.1 Introduction

The overall aim of this study was to explore how HCPs and women perceived sexual health within women's reproductive health clinics in SA, and how the clinics and staff within them work. This chapter discusses the findings of the study from within a theoretical framework drawn from the concept of 'social norms' and using the Theory of Reasoned Action (TRA) (Ajzen & Fishbein, 1980). It will argue that this theoretical approach provides the best framework to explore the significant cultural, gender and professional issues related to sexual health described in the previous chapter, and also highlighted as key issues within the literature review in Chapter 2. This chapter is divided into the following sections: 1) re-visiting the data; 2) justifying the theoretical framework for the discussion; and 3) using this to discuss the study findings and place these in the context of the related literature.

5.2 Re-visiting the data

As discussed in the methodology chapter, naturalistic inquiry depends on an inductive approach requiring frequent and constant comparative analysis to develop insightful ways of understanding social or human phenomena. When analysing qualitative data, the researcher firstly reflects on the complexity of the phenomena studied, and then presents the underlying structures and patterns that make sense of the whole complex phenomena (Green & Thorogood, 2004). In other words, data that is drawn from qualitative research, particularly that exploring a complex topic, needs a more holistic description to bring it all together by identifying connections and links within and between the themes and sub-themes, in order to

produce a broader contextual picture of the social phenomena being studied (Baptiste, 2001; Green & Thorogood, 2004).

Hence, this process saw the findings reviewed and re-read extensively. In doing so, it became clear that a dominant aspect shared across the data and the themes were the issues of 'culture', 'religion' 'traditions', 'customs' and 'values' (both professional and personal) related to sexual health that concerned both professionals and women. It is argued that these elements, and the way in which they influence the behaviours and structures of the clinics and the consultations, are central to explaining the findings of this study. For example, HCPs and women frequently mentioned in interviews and discussions that topics related to sexual health were strongly influenced by the social norms and cultural beliefs about sex within Saudi culture.

The findings of this study also revealed that female clients often received direct or indirect encouragement to avoid discussing sexual topics from their social networks, such as family, friends and relatives, and that this played a strong part in their feelings towards sexual health and raising issues within consultations. In the same vein, the HCPs reported similar concerns: staff from SA demonstrated an awareness of the social values surrounding sex that influenced their practice, and non-Saudi professionals also indicated that they did not tend to initiate or discuss sexual health topics due to an awareness of Saudi cultural values relating to sex. The findings were also clear in that they identified the role that religion played within Saudi culture, and how this affected both HCPs and female clients' behaviour; especially as regards the issues of gender, power and relationships (both professional and personal).

It is therefore argued that a participant's behaviour in relation to sexual health is always strongly influenced in favour of the predominant perceived norm within the community in which they are working, regardless of factors such as education, age, gender, nationality or professional career. Figure 6 shows this overlap, found in the research findings, and describes how the perceived social norms influence women's sexual health care in the current study.

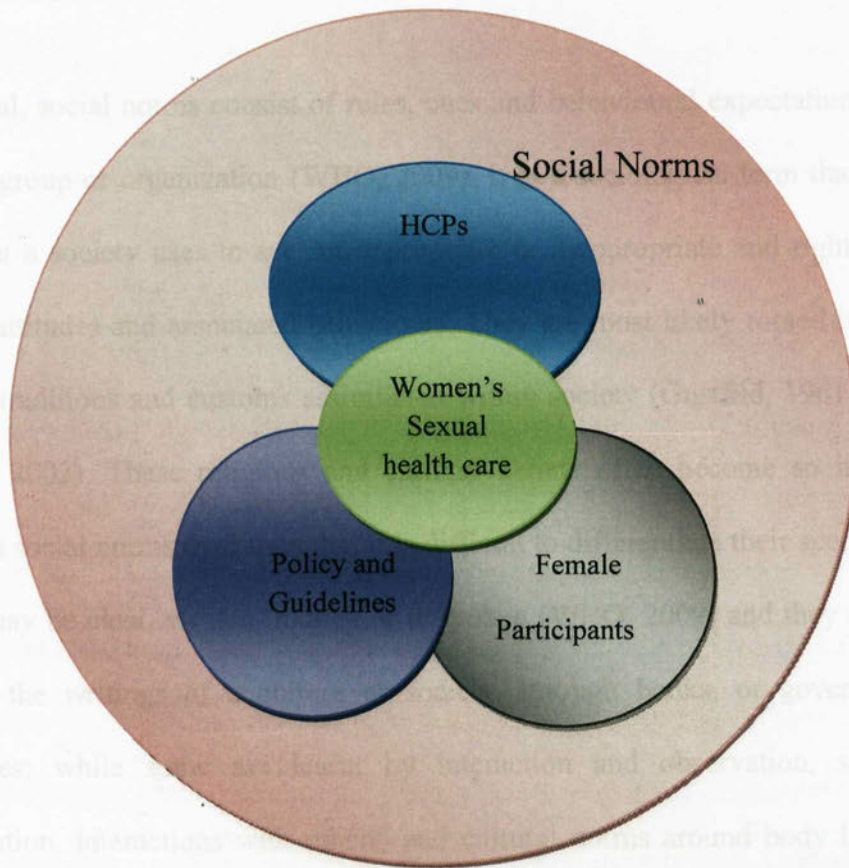


Figure 6: Social norms influencing women's sexual health care

The next section aims to discuss how social norms are generally defined in the literature; to identify the components that formulate social norms; to examine how social norms impact upon women and sexual health; and finally to identify a possible framework incorporating social norms that could be used to provide a theoretical framework within which to explore and explain the findings of this study.

5.3 Social norms

In general, social norms consist of rules, cues and behavioural expectations, prescribed by a society, group or organization (WHO, 2009). It is a sociological term that refers to a set of rules that a society uses to set out appropriate or inappropriate and right or wrong values, beliefs, attitudes and associated behaviours. They are most likely rooted in religious beliefs, cultural traditions and customs assimilated within society (Gustfild, 1961; Durkheim, 1951, Perkins, 2002). These religious and cultural beliefs often become so integrated within a society's social norms over time that it is difficult to differentiate their specific origins. Social norms may be clear, written, hidden or unspoken (WHO, 2009) and they can be represented through the writings of a culture or society, through books, or government policy and guidelines; while some are learnt by interaction and observation, such as childhood socialization, interactions with others, and cultural norms around body language and dress codes. Young (2007) argues that social norms are:

"A function to coordinate people's expectations in interactions that possess multiple equilibria. Norms govern a wide range of phenomena, including property rights, contracts, bargains, forms of communication, and concepts of justice" (P.1).

The concept of 'norms' has a long history and, in fact, dates back to Hume's work in 1739 (Young, 2007). He emphasized the power of norms by referring to the '*normative order*' by which the rules and regulations of society and the moral boundaries within these societies operate. Workman & Freeburg's (2000) definition provides a useful explanation of 'normative order':

"The normative order consists of shared standards or rules which specify what human beings should or should not think, say, or do, and how human beings should or should not look under given circumstances". (P.46)

Within the literature on this topic, it is clear that the terms 'normative order', 'normative beliefs', and 'social norms' are sometimes used interchangeably (Ajzine & Fishbein, 1980, Ajzine, 1988; Ajzine, 1991). This can be extremely confusing as it is not clear if these terms are synonyms of each other or different. Indeed, within some of the literature there are detailed explanations as to the different types of norms in order to differentiate between them, particularly in the psychological research that aims to measure them. For instance, a *descriptive norm* refers to what is typically done in a given setting. *Injunctive norms* refer to what is typically approved in a society and *perceived* or *subjective norms* both refer to perceived social pressure on individual behaviour towards a particular phenomenon.

Nevertheless, it is clear that, whatever term is used, all these different terms have common defining features in that norms are cultural and social products that society values greatly. Cultures are then governed by these norms, which consequently affect the way individuals behave, and influence most of the decisions that they have to take. For instance, work by Fishbein et al (1993), in St. Lucia, to assess participants' knowledge, attitudes, beliefs and practices about AIDS, found that the strongest influence on condom use was the perceived normative pressure from friends and partners. If people believed that the norm was not talking about sex, not having one sole partner, and not using a condom - then that is what the

norm became; thus, people usually believe in or conform to it, or at least acquiesce enough not to challenge or question it.

It is also important to mention that social norms are not constant and can vary between countries and even between different social groups within these countries (Young, 2007; WHO, 2009). What is regarded as abnormal in one country or culture, for example, might be regarded as normal in another. Stephenson (2009) examined the role of community-level factors, reporting risky sexual behaviour among young people aged 15 to 24 years in three African countries with varying HIV prevalence rates, and pointed out that community-level influences on sexual behaviour varied by country. However, social norms may change over time, and possibly lose their original context as the particular society changes and develops. This change often depends on the extent to which these norms are rigorously held within a society, and individuals' motivations to conform, or not, to these norms (WHO, 2009).

Within the framework of 'social norms', or the 'normative order', it is suggested that individuals living in a particular culture are strongly influenced by the social rules that exist within that culture (Heinrichs et al, 2006; Varela & Maloney, 2009). Conforming to what is perceived to be socially acceptable behaviour plays a large part in encouraging individuals to make certain behaviour choices, and express beliefs and attitudes that are in line with these norms in order to avoid social sanctions when doing something in conflict with the normative order (Heinrichs et al, 2006).

Perhaps the most famous example of the significant role of the normative order, particularly that related to religious influence upon norms, is the work of the functionalist Emil Durkheim on suicide (1915). Durkheim analysed suicide data cross-culturally and came to the conclusion that the more ardently Catholic a country was, the fewer people committed suicide. He reasoned this was because of the power of the normative order, that suicide, inextricably linked to sin and hell as it is in Catholic doctrine, was against Catholic norms and morals. The sanctions of hell and the stigma attached to family members prevented more Catholics from committing suicide.

5.4 Social norms and women's health

The role that social norms within a culture play in women's health is well documented (Bankole et al, 1998; Coleman & Nelson, 1999; Lee et al, 2004; AbouMehri & Sills, 2010). The WHO (2009) identify many social norms that support sexual violence and pressure against women, reinforce male power around sex, stigmatize female sexuality, and make it difficult for women to be open about sex and sexual health. Women are often culturally and socially oppressed, especially in relation to sex, and are forced to feel shame, guilt and sadness about sexually related matters. For example, a woman's decision to seek abortion for an unwanted pregnancy is neither simple nor easy (Lee et al, 2004). Most literature argues that women feel strong emotions derived from religious or cultural norms and values that depict abortion as a disgraceful practice, and that the women who do this are depicted in a negative light (Bankole et al, 1998; Coleman & Nelson, 1999; Lee et al, 2004). These cultural values then act upon women's decisions to express feelings or take action about sexual health and, when referring to abortion again, Bankole et al (1998) emphasize that community values

that oppose abortion are the most significant social barriers that impact on women's decisions to seek safe abortion. Social barriers can also impact on sexual health services from culturally diverse backgrounds (Burman et al, 2004). Women, for example, may avoid seeking sexual health services for fear of stigma and a loss of social status. For instance, a Vietnamese study (Rawson & Liamputtong, 2009) discussed the impact of traditional Vietnamese culture on young Vietnamese Australian women's uptake of mainstream health services for sexual health matters. It found that the young women perceived that a Vietnamese doctor would have the same traditional views of sex held by their parents' generation, therefore, they tended not to seek services run by Vietnamese doctors. In addition, social norms also have an effect on the sexual health services that are available to women. Some countries, for instance, are apprehensive about funding research and supporting sexual services such as abortion clinics for unwanted pregnancies, and tend to deny unmarried women and lesbians access to sexual health services for fear that this might cause anger in their communities (Wood & Aggleton, 2004).

Broadly, women's social situations are more difficult in developing countries because these cultures often have strict social norms that relate to the female gender. Women are often classified as having a lower social status than men and often not given full autonomy. Abou-Mehri and Sills (2010) provide an excellent example of this when they explore the consequences of Arab social norms for women. They discussed the issue of the hymen in Arab culture and traditions, and emphasized how it is still a sign of female chastity and a matter of life and death, even among Arab residents in modern and liberal countries such as France. It is a required social norm for women to ensure that blood is spilled on her sheets on her wedding night (indicating her virginity), therefore, some women who had had sex outside

marriage sought medical help to re-fashion the tissue of the hymen to save their lives. Social norms are, therefore, a reason for crimes against women, particularly those committed in the name of honour. Most of the perpetrators of honour crimes are male relatives, such as brothers, sons, fathers, uncles, nephews and husbands; however, these men are often unpunished for their crimes, receive reduced sentences or are exempted from prosecution, due to the cultural justification of honour killing (Stewart, 1994; Gill, 2006).

Referring again to the power of social norms within cultures, Saleem & Bobak (2005) argue that women in Pakistan had lower fertility control, and lower rates of contraceptive use, than most other Muslim countries because they lacked autonomy regarding sexual health decision-making. Pakistani women are culturally required to obtain permission to use contraception from both their husband and mother-in-law, a cultural norm so socially ingrained in some Pakistani communities that it seriously affects women's ability to choose and use contraception. Degni et al (2008) explored the roles played by gender, power and male sexual norms within male affected women, in a study of Somali men residing in Finland in relation to condom use. They found that, for religious reasons, most Somali men who participated in the study avoided using condoms and disapproved of the use of contraception by women. It seems that they were influenced by a particular Muslim scholar's interpretation of the verses of Quran and Hadeeth encouraging procreation and, therefore, had developed a negative image of contraceptives (Kridli & Newton, 2005). This study actually indicates two important variables that impact on a woman's decision to use birth control: religion and the significance of gender power in the acceptance of contraceptive practices. Indeed, similar power issues have been seen in other research in developing countries (Sahin et al 2003; Saleem & Bobak, 2005), indicating that men seldom cooperate in such contraceptive or safer sex practices, and

that women are highly vulnerable as a result. The literature explored here, and in the literature review chapter, shows how social norms have a great impact on sexual and reproductive health decisions and behaviours that could provide real challenges to women's health generally, and sexual health particularly. It can be concluded that the components that structure and influence social norms around sex, sexuality, and sexual health, such as religion, culture, and gender, in any particular community need to be carefully studied in order to foster change, to reduce or prevent poor sexual and reproductive health outcomes, and to identify behavioural attitudes that can adversely affect women's health care. It is therefore argued that the more understanding we can gain about social norms and their influence on the attitudes and behaviours evident within the data from this study, the more accurately interventions can be designed to influence these norms in a desirable and sensible direction.

5.5 Social Norms and related theoretical frameworks

There are many theories that are built around the influence of social pressure on attitude and behaviour, such as the Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 1975; Ajzen & Fishbein 1980), the Theory of Planned Behaviour (TPB) (Conner & Norman, 2005), and Social Norm Theory (Berkowitz, 2004). All of these offer some potential as explanatory frameworks for the findings of this study. However, Social Norm Theory seems limited, as it merely focuses on the misperceived norms that are overestimated or underestimated by individuals and how these misperceived norms influence how we act. Individuals, for example, tend to exaggerate the negative health behaviour or underestimate the positive health behaviour of their peers, which in turn influences their behaviour. The BACCHUS and

GAMMA Peer Education Network (2003) explains that social norm theory is all about “*assuming that individuals action in relation to others and that what we think about individual norms is often incorrect*” (P. 4).

In addition, there is no model, framework, or process identified to help in explaining the influential factors on attitude and behaviour. It was mainly used as preventive approach to gather and identify the misperceived data from a particular group, and then strategies were used to correct it (Berkowitz, 2004). The other possible theory is the TPB, which is actually a variation of the TRA; both theories are similar to each other but TPB has a third determinant called the perceived behavioural control. It reflects the extent of the resources which the individual perceives him or herself have, such as knowledge, time, resources, etc. that influence their behaviour. It could be argued that this was not a significant variable in relation to the current study, as it was noted that all HCPs and the majority of the female patients are well-educated, most of them have access to the internet, and have had reasonable opportunities to raise wide sexual health issues in clinics but still did not discuss sexual issues there. However, it is also possible to discuss this variable under the *personal factors* which influence attitudes as a feature of the TRA.

It was therefore decided that the TRA is eminently suited to understanding the data in this study. The literature review in this study offered insight to the lack of knowledge about women’s sexual health in SA, and discussed the challenges that SA may face within the coming years in respect to sexual health care. The TRA provides a clear framework that enables an explanation as to the influences, effects, or pressures of social norms and

behavioural beliefs on attitudes, intentions and behaviours, in relation to both professionals and female clients in this study (Fishbein & Ajzen, 1975; Natan et al, 2009). It is a very powerful, clear and succinct theory for explaining human behaviour, and has been used by many researchers in various domains but particularly by researchers interested in sexual health. For instance, TRA was used to investigate the provision of sexual health by Wilson & Williams (1988) and by Gamel et al (1995); sexual health education by Mullan & Westwood (2010); quality of care of hospitalized drug users by Natan et al, (2009); and to understand sexual health behaviour in numerous studies such as Armitage et al (1999), Gillmore et al (2002), Schaalm et al (1993), Selvan et al (2001), and Wong and Tang (2001).

To date, most of the research about sexual health using the TRA has focused on measuring broad medical health issues, such as condom use, safe sex, or HIV transmission, and not given much attention to the social influences on sex, such as the religious or cultural values that can act as normative forces upon individual attitudes and behaviours. The current study revealed that social norms function as strong elements affecting and influencing the way that participants perceive and deal with sexual health. Therefore, this theory provides a helpful theoretical framework within which to discuss the impact of the cultural and religious influences on how sexual health is addressed and thought about by the study participants.

Moreover, the TRA can also help to provide an explanation of the reasons why an attitude may not result in expected or particular behaviour. This includes issues that seem important in this study, for example, why HCPs will not routinely discuss sexual health issues with their patients despite it being part of their professional duty, and why female patients did not

discuss intimate issues or problems despite feeling they needed to. It can also be used to explore why male, and single female, doctors have more difficulties in dealing with sexual health topics in a health setting than their married or female counterparts, and why many HCPs struggle with the concept of sexual health generally.

5.6 The Theory of Reasoned Action

The Theory of Reasoned Action (TRA) was proposed and formulated by Ajzen and Fishbein in 1975, based upon work they actually started in the 1950s on social attitudes and behaviour (Ajzen & Fishbein, 1980). They were able to formulate this theory after working for several years to find strong correlations between attitude, measures and performance of '*volitional behaviours*' (Ajzen & Fishbein, 1980). Volitional behaviour refers to whether an individual has control over performing certain behaviours or not.

Ajzen & Fishbein (1980) stated:

"We do not subscribe to the view that human social behaviour is controlled by unconscious motives or overpowering desires, nor do we believe that it can be characterized as capricious or thoughtless". (P.5)

The concept of social behaviour, as stated by Ajzen & Fishbein, actually parallels the concepts of sexuality and sexual health discussed in Chapter 2. It was revealed that individuals and cultures perceive sexuality and sexual health differently because of the influencing factors that are involved in their social construction, such as biological, cultural

and religious affiliations, and, as a consequence, individuals and cultures may see the topics of sexuality and sexual health in diverse ways. It can be argued, therefore, that Ajzen & Fishbein's statements about social behaviour are in harmony with the concept of sexuality and sexual health, as both are considered to be socially constructed and greatly shaped and affected by social influences.

Although the TRA is now used extensively across the social sciences and many other health related fields, the origins of this theory actually belong in the field of social psychology. The original intention of the TRA was to describe the links and relationships between beliefs, attitudes, norms, intentions and behaviour (Conner & Norman, 2005). Hence, it provides a framework or 'tool' to predict and understand people's intentions and behaviour, and how they are influenced by numerous internal and external factors. According to Ajzen and Fishbein (1980), the major assumption in this theory is that individuals always evaluate the implications and the consequences of their actions before they agree to engage or not to engage in a given behaviour, or express a belief or display an attitude; in other words is the outcome "is it good or bad to them" (Natan et al, 2009).

Ajzen & Fishbein (1980) go on to explain that beliefs, attitudes and behaviour must be conceptualized in terms of the way in which 'subjective norms' interact with personal beliefs towards a particular subject. Subsequently, in their work on the TRA, they established two essential determinants that influence individuals when they are planning to engage in behaviour: these two determinants are *person attitude* and his/her *subjective norms* towards

the behaviour taken, together with any external variables, such as religion, cultural, knowledge, or gender, that could influence behaviour.

The first determinant is the attitude towards the behaviour actually held by the individual, which is the 'personal factor', 'normative belief' or 'personal belief'. It refers to an individual's positive or negative evaluation of performing the behaviour. In other words, is the individual in favour of, or against, performing the behaviour. To apply this determinant to the current study when participants are asked about their perceptions of sexual health they evaluate their attitude in the following manner:

My attitude towards sexual health is

Favourable-----Unfavourable

The second determinant is the subjective norm, which really refers to the 'social pressures' or 'social influences' upon the individual that play a part in influencing their actions. It refers to the individual's perception of the social norms that exist from their wider social and cultural environment, for example, what are the expectations within any given society in relation to the phenomenon in question? To apply this within the current research, study participants evaluate the situation thus:

Social/cultural norms related to sex

Support -----Do not support

Talking about certain sexual issues

The following quotation is a very helpful and clear summary of how the TRA works:

“If a person perceives that the outcome from performing a behaviour is positive, she/he will have a positive attitude forward performing that behaviour. The opposite can also be stated if the behaviour is thought to be negative. If relevant others see performing the behaviour as positive and the individual is motivated to meet the expectations of relevant others, then a positive subjective norm is expected. If relevant others see the behaviour as negative and the individual wants to meet the expectations of these "others", then the experience is likely to be a negative subjective norm for the individual”. (Ajzen & Fishbein, 2000, P. 3)

The adapted theoretical model of TRA in figure 7 shows the process of how determinants influence individual's behaviour toward sexual health.

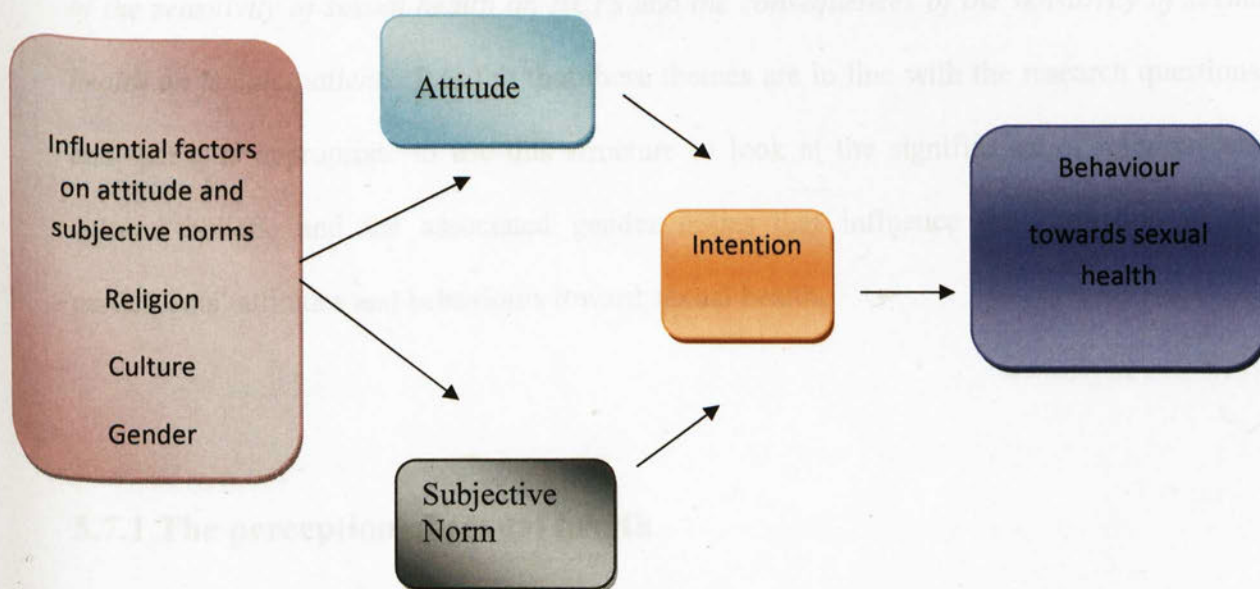


Figure 7: Theoretical model of TRA (Ajzen & Fishbein, 1980, P.84)

(Arrows indicate the direction of influence)

5.7 The Theory of Reasoned Action: explaining the findings from the ethnography

There are five distinct questions which this research seeks to resolve. Firstly, to describe how women and health care professionals perceive sexual health and the services that are currently provided. Secondly, to explore how women perceive their own sexual health. Thirdly, to explore how women and health care professionals perceive the function, nature, and use of sexual health services. Fourthly, to describe how sexual health care services in Jeddah, SA, are designed and implemented. And finally, to describe the role of doctors and nurses within the context of women's sexual health care.

The findings will be discussed within the following themes: *the perception of sexual health; maintaining good sexual health; adapting to the concept of sexual health; the consequences of the sensitivity of sexual health on HCPs and the consequences of the sensitivity of sexual health on female patients*. It is felt that these themes are in line with the research questions, and that it is appropriate to use this structure to look at the significance of religious and cultural beliefs, and the associated gender issues that influence the formation of the participants' attitudes and behaviours toward sexual health.

5.7.1 The perception of sexual health

The findings indicate that most HCPs and most female patients consider sexual health to be an important element of being a human being. However, even though the participants often recognized how important sexual health is for the individual, it seems that this was not

implemented in their daily practice as an HCP, or discussed as a patient. Participants reported that sex and sexual health were considered to be a private matter that should only be discussed between a husband and wife, and that they are subjects surrounded by significant cultural and religious taboos within the Saudi community. The findings also show how participants' beliefs and behaviours are shaped and constrained by discourses around sexuality and sexual health, and how conflicts between their beliefs, attitudes, and behaviour (such as wishing to discuss sexual issues, to be brave when asking for sex) are due to the fact that the SA community is a religious and conservative society whose norms and identity are closely bound to its religious and cultural core. Participants' thinking about sexual health and relationships are based on and rooted in their interpretation of the Quranic verses and their understanding of the social order around them.

Cultural and religious impact upon sexual health is widely recognised (Pryce, 2006; Sinha et al, 2008). In 2007, the UK Royal College of General Practitioners emphasized that sexual health is associated with various cultural and religious taboos that can lead to the stigmatisation of individuals, either patients or health care providers, which then results in a continuous challenge for health promotion initiatives. Indeed, a notable number of researchers describe how more religious and conservative communities tend to have more conservative attitudes and behaviour towards sex, sexuality and sexual health than do liberal societies (Coleman & Testa, 2008; Mohtasham et al, 2009). Studies identify a relationship between religious affiliation and the way individuals understand and perceive sex, sexuality, sexual health and sexual behaviour. For example, Werner-Wilson (1998) found that religious influences on participation was the most important predictor of the sexual attitudes of public high school students: the more religious the individual, the fewer partners they had had.

Kouta & Raftopoulos (2010), in a survey of 697 third grade students in public general secondary schools, reported that almost half of their sample, 50% (N=346), considered contraception to be a sin. They found that factors that affected adolescents' emergent sexuality were church power (29%), family (79%), knowledge of sexuality issues (81%), and media power (43%). Furthermore, they found that, in 97% of their sample, religion played a central role in their daily life. Likewise, Sinha et al's (2008) study also demonstrated that culture, gender and religion appeared to impact and combine with relationships and sexual activities in a very dramatic and multifaceted way. For instance, in many cultures and societies it is socially acceptable for males to desire sex at any time and to have more partners, while females are encouraged to be shy, chaste, to delay starting to have sex, or to stay a virgin until married. How a society and its religious leaders transfer their social norms and religious roles to its people, and how people deal with and interpret these issues will certainly influence the timing of initiation of sexual activity, use of contraception, and number of partners.

In a cross-sectional survey, Coleman & Testa (2008) reported young people's variations in sexual health knowledge, attitudes and behaviour by religious affiliation, in a sample of 3007 students in school years 11-13 (ages 15-18). The sample were 36.3% (n=957) Christian, 25.8% (n=679) Muslim, and 22.1% Hindu (n=582). They found that among those reporting that they were having sexual intercourse, risk behaviours among all religious and non-religious students were really evident. Over one-third of Muslim females who had sexual intercourse did not use contraception on their first occasion, compared to 10% of those with no religious affiliation, 12% of Christians and 20% of Hindus. Christian and Muslim females reported the highest prevalence of never using contraception at 55%, and non-use of

contraception with two or more sexual partners was 14%. They concluded that, in general, religious students reported poorer sexual health knowledge, and were more conservative in their attitudes to sex compared to those reporting no religious affiliation. These studies show how culture and religion greatly affect sexual health and attitudes towards sexuality.

In this study, sexual health is typically considered by many HCPs, and several of the female patients, to be incompatible with health care in Islamic countries because they felt it contradicts some of the values and beliefs of Islam. For example, the concepts of 'safe sex' and 'sexual health education' were not seen as a relevant topics to be fully discussed with women; reflecting very clearly the wider societal beliefs that being a Muslim means it is not expected that one would engage in risky sexual practices or behaviour. This could explain why HCPs did not discuss such behaviour with female patients, not even those complaining of frequent vaginal discharge. This reluctance has also been seen in other settings, for example, Rankin et al (2009) examined the impact of two mitigating social institutions, religious organizations and the state, on Malawian women's vulnerability to contracting HIV. Religious leaders stated that agreeing with, or encouraging, condom use would widely promote infidelity in the Malawi communities and would certainly undermine the message of abstinence that was ordered by their holy books. They also emphasized their concern that such messages about condoms encourage extra-marital sex.

In fact, many countries, including some in the West, have issues with the influence of social norms and the influence of religious leaders. For example, when an abstinence programme was prioritised over condom use by church religious leaders in the USA, the National Secular

Society website called for a society in which religion and the State should distinctly separated, and asked for human rights to take clear precedence over religious demands. Similarly Abioje (no date provided) provides a detailed study concerning the issue of how churches, with particular reference to the Catholic Church, relate to academic freedom vis-à-vis the subject of human sexuality in Nigeria. The conclusion was that the principle of *Roma locuta causa finita* is still powerful and very much in vogue and trend in the Catholic Church, and that the Church still commands and enforces, albeit in a subtle manner, absolute obedience, compliance and docility. In turn, this influences individual's sexual health decision-making as regards practising safe sex and promoting sex education, and may consequently put an individual at possible high risk. It is, therefore, clear that the perception of sexual health is still an issue within all societies; and it is understandable why it is still unclear and not fully acknowledged in SA, due to the conservative leaders' power and the strict social norm that exist around sex and sexuality.

5.7.2 Maintaining good sexual health

Many of the participants in the current study felt strongly that if individuals were living correctly, and adhering to Islamic principles, then good sexual health would be assured. They did not really recognize that female patients may be at risk of sexually transmitted infections. Many researchers discuss the fact that Islam encourages healthy sexual behaviour through abstinence instead of safe sex, and use this as evidence to provide an explanation for the low incidence of HIV infection in Islamic populations (Lenton, 1997; Gray, 2004; Madani et al, 2004), arguing that Islamic values are a significant factor in the prevention of HIV (Madani et al, 2004). There is some basis for this, with studies showing that pre-marital sex remains low

among Muslims compared to young adults in other monotheistic religions (Coleman & Testa, 2008). It could be argued that this literature, which appears to demonstrate an association between being Muslim and practicing healthy sexual behaviour, may be a factor that leads Islamic countries to argue that Islamic values are actually a cost-effective solution to tackling sexual health issues without the need for setting up sexual health programmes or services. However, it can be argued that relying on Islamic principles and teachings alone is not enough to protect Islamic countries against the dramatic spread of HIV, STIs and the risk of high fertility rates, which have been discussed in detail in Chapter Two.

In fact, Maulana et al (2009) explains that Islamic values portraying sex outside marriage as a sinful practice are often believed to contribute to sexual ill-health, as they reject the idea of safe sex practices. This explanation is similar to other researchers who blame religious ideology for blocking effective sexual health promotion (Goldin, 1994; Rankin, 2005; Smith, 2003; Spira et al, 2000).

Religious beliefs can also affect the way clients may report sexual risks to HCPs, for instance, Trinitapoli (2009) found that participants who accepted the legitimacy of condom use are significantly more likely to report having used them, compared to those who oppose condom use. In addition, other studies have reported that religious individuals who are sexually active are less likely to report having protected sex or using safe sex practices (Trinitapoli, 2009). In fact, some studies indicate that religious individuals can often engage in risky behaviour, contradicting their religious beliefs (Hasnain et al, 2005), therefore, it is much better to teach them about safe sex in case such behaviour happens.

A study assessing the intention to remain sexually inactive among male adolescents in Iran found that 23% rejected the notion of remaining abstinent, and 20% were uncertain (Mohtasham et al, 2009). Furthermore, a recent study conducted by Kamarulzaman & Saifuddeen (2010) found evidence of how illegal intravenous drug use has become widespread in many Islamic countries, despite the fact it is prohibited in Islamic law. The fact is that even though religious advice may be strong, individuals, particularly the young, often ignore it or find it hard to apply this advice to themselves.

It is worth mentioning that some societies such as the UK and Tunisia that have experienced strict social norms in relation to sex and sexuality have been going through changes recently: their sexual norms have changed or become relaxed compared to before. 100 years ago, for example, pre-marital sex by a man with an unmarried woman was prohibited while today, in some societies, it is considered to be a lead-up to the marital relationship. Marriage used to be an entirely family arrangement but nowadays couples tend to know each other or live with each other for a period of time before marriage. Today it is easy to know what other cultures believe, to see their attitudes and practices through the internet, movies and TV series, and to be influenced by them. Hence, there is a high possibility that these norms might transfer to other cultures due to globalization (sometimes called Americanization), which refers to "*the acceleration and intensification of interaction and integration among the people, companies, and governments of different nations*" (Rothenberg, 2003, P.2).

However, because globalization sometimes changes and affects humans' well-being, cultural ideas, religion, norms, political systems, health, personal safety, and their environment, it is

often faced with some amount of tension, worry, and opposition (Rothenberg, 2003). Nevertheless, researchers have emphasized the influences that globalization has on cultural norm changes (Chinnammai, 2005; Gray & Kittilson, 2006), and SA is not an exception. Saudi community values are expected to face possible changes due to many reasons, for example, the wide spread of satellite, the availability of the internet, the ability to travel abroad, education, and tourism (particularly in neighbouring Gulf countries, such as Dubai and Bahrain). Hence, it can be concluded from what has been discussed here that religious affiliation might sometimes be difficult to adhere to by an individual all the time, and may not be at the same high level of strength and expectation in all cases. As a result, it cannot simply be solely relied upon in relation to maintaining good sexual health, particularly with the possibility of external change factors such as the influence of globalization. This clarification strongly supports the recommendation that HCPs should provide all possible information, and encourage more services, that women and individuals could use in order to make more informed choices to maintain good sexual health.

5.7.3 Adapting the concept of sexual health

Sexual health care is a vital part of clinical health practice. Nevertheless, due to social norm pressures, this study demonstrates that sexual health care and services in SA are limited; they lack integration with sexual health education, and centre on reproductive health through the provision of obstetrics and gynaecology care and contraception. As demonstrated in Chapter Four, the reproductive life course was the sole framework available within the clinics. There were no specific services to address sexual assault or sexual relationship difficulties. For instance, sexual health relating to issues such as sexual relationships, sexual pleasure, or

sexual problems and pain, were not addressed. Therefore, it is possible to argue that the sexual health services currently provided cannot deliver helpful sexual care, and are not designed to fully and efficiently meet women's sexual health needs. This may be as a result of a number of connected reasons that are explored in the current study: 1) SA cultural norm pressures upon sex and sexuality; 2) the attitudes of HCPs to sexual health; 3) the way the clinics are designed and their purpose; 4) the lack of a holistic definition of sexual health within the clinics; and 5) the lack of guidance and policy on sexual health for professionals.

The Royal College of General Practitioners (2007) in the UK stresses that sexual health must be viewed as an important and central dimension of health care practice in the same way as mental health, reproductive health and physical health. They also point out that unfortunately sexual health is neglected, and that most of the time it is rarely prioritized in health practices for both known and unknown reasons (Timm, 2009). In actual fact, the concept of sexual health has only recently become an important public health issue in the West, and that is mainly due to the continued increase in STIs, and the high rates of teenage pregnancies (Adler et al, 2002).

It was only ten years ago, in January 2000, that the National Assembly for Wales published the consultation document "*A Strategic Framework for Promoting Sexual Health in Wales*", and the first ever national strategy for sexual health and HIV in England was not published until July 2001 (Adler et al, 2002). According to the Royal College of General Practitioners (2007), in 2005 Scotland clearly called to improve the sexual health of its population due to the efforts of Andy Kerr, the Minister for Health and Community Care in Scotland, who

launched the Scottish Parliament's strategy for improving sexual health: "*Respect and Responsibility: strategy and action plan for improving sexual health*". However, despite these efforts, to date sexual health services, strategies and promotion in the UK are still struggling to achieve their strategies and goals. Part of the reason is due to the negative influence of the cultural and social factors that impact upon sexual health in the UK, while in turn it can be argued that adopting the concept of holistic sexual health explicitly in SA would be expected to be even more difficult and problematic.

Mehryar et al (2007) argue that the concept of sexual health provided at the International Conference on Population and Development (ICPD), held in Cairo in September in 1994, raises a challenge for Islamic countries as to how they adopt this within their health care systems, because it touches on highly sensitive issues such as sex, sexual rights, sex education and also has close links to women's rights and gender mainstreaming. The wide range of issues around reproductive and sexual health that were discussed and recommended in the Cairo conference is summarised in table 4.

1) Family planning: the action plan stresses the importance of the free choice of couples to decide the number and spacing of their children. Couples have to be informed about family-planning programmes and about the use of modern contraceptives which represent an important opportunity for individual choice. Governments have to engage in ensuring everyone the right of voluntary choice in family planning.

- 2) *Sexually transmitted diseases and HIV prevention: reproductive health programmes have to increase their efforts to prevent, detect and treat sexually transmitted diseases. The important role of education, information and counseling is acknowledged. The distribution of high-quality condoms should be a component in all reproductive health programs.*
- 3) *Human sexuality and gender relations: gender relations affect the ability of both men and women to achieve their sexual health and to manage their reproductive life. Sexual education should be supported as well as educational programmes aiming at protect women and children from any abuse.*
- 4) *Adolescents: information and services should be provided in order to make adolescents more aware of their sexuality. Education should play an important role in making men respectful of women's right to self determination and willing in sharing responsibilities with women in matters of sexuality and reproduction*
- 5) *Early child-bearing is recognized as an impediment to improvements in social, economic and educational status of women. Reproductive sexual education has to reduce the number of adolescent pregnancies.*

Table 4: Cairo conference recommendation

Source: International Human Rights References to Sexual and Reproductive Health and Rights (2007).

Obare et al (2010) state in their study that a major challenge facing many developing countries is the inability to fully implement the recommendations due to: (1) lack of funds;

(2) bureaucratic delays; and (3) limited awareness among various stakeholders. The outcome of this conference clearly recommended that by 2015 governments had to work to improve sexual and reproductive health by reducing infant, child and maternal mortality, and provide a full range of appropriate health services, including contraception for sexually active individuals, and sexual health education. To date, based on the literature review chapter, it seems that much has been done in SA towards lowering infant, child and maternal mortality, though few of the recommendation in regards to sexual health services have been achieved, and none regarding education. What is clear is that this conference and its recommendations created significant debate in the Arabic media with some famous speakers, including Muslim scholars, arguing that the conference focussed on encouraging "bad deeds" and that adopting the conference's suggestions on sexual health would encourage adultery and pornography. Some Arabic media channels (some Government, some private) have stressed that the Cairo conference recommendations have dangerous consequences for morality in Islamic countries, to the extent that they have even accused individuals and governmental bodies employing these recommendations of participating in a "Western conspiracy" to destroy Islamic values.

This type of media perception clearly represents a resistance to the development of holistic sexual health care and services, in keeping with the WHO definition and the Cairo conference; this feeling is very strong in SA, and seems to be increasing. One possible explanation is likely to be the growing opposition in the media towards the development of more 'Western' style sexual health services following the Cairo conference of 1994. However, there may also be other political reasons for the continued negative attitudes towards sexual health in SA. For example, on November 7th 2003 George Bush, the President of the United States, made a famous speech calling for the implementation of

democratic systems in Middle East countries, under the title of "the new Middle East" (Ottaway et al, 2008), which also seemed to argue for a liberalization within those countries. The social and political pressures around sex and sexuality in SA help one to understand the essential reasons why the current study found no clear written sexual health policy guidelines, why limited sexual health care and services were found, and why the structure and routine of services that provide sexual health services for women were prioritized for gynaecological diseases or postpartum complications. Indeed, it is perhaps unrealistic to expect female patients and HCPs to discuss wider sexual health issues in consultations when such care is not really acknowledged within SA health care services and the notion of holistic sexual health care appears to be limited.

The next section will discuss the consequences of social norms and political pressures on sexual health for HCPs and female patients that were explored above, and how these strong social pressures made sexual discussions difficult and taboo.

5.8 Consequences of the sensitivity of sexual health on HCPs

5.8.1 Difficulties in discussing sexual health

This study revealed that, despite the fact that SA has entered another period of social and economic change with advanced health care, HCPs, who represent the first point of contact for female patients, do not discuss a range of sexually-related issues in consultations. They perceive that doing so would be highly problematic because of one or more of the following: (1) the cultural sensitivities around sex, sexuality, and sexual activity in SA; (2) they felt that

providing sexual health care was not their role; and (3) they did not have a conception of what sexual health precisely is.

However, these findings are not restricted to Saudi society as many Western studies have reported sex and sexual topics to be a very difficult to discuss with patients (Humphrey & Nazareth, 2001; Gott & Hinchliff, 2003; Gott et al, 2004; Hinchliff et al, 2004; Hinchliff et al, 2005; Hinchliff & Gott, 2008). A study conducted by Vassiliadou et al (2008) that aimed to investigate Greek nurses' knowledge and their practical application of sexual counselling among post-infarction patients found that only 20.7% of patients said that nurses undertook any sexual counselling. A UK study, conducted in Sheffield by Hinchliff et al (2004), identified many barriers that prevent GPs from discussing sexual matters in consultations, which impinge upon potential treatment and also have an indirect effect on the patient's life, health and intimate relationships. The findings of the current study concur with those in other cultures too. For example, a Japanese study (Takahashi et al, 2006) which investigated doctors' practices and attitudes, and the correlation to sexuality-related consultations in their clinical encounters, concluded that talking about sex-related topics is still repressed in patient-doctor encounters in Japan; findings that were also reflected in other Islamic countries (Amado, 2003; DeJong et al, 2005; Mohammadi et al, 2006).

It could be argued that discussion and communication between HCPs and patients about sexual health issues is particularly difficult in Islamic countries. As Islam is not just a religion but a way of life, it is very strict regarding personal behaviour, which is policed by restrictions and penalties that are well known in Sharia law, and which are adopted in SA.

This clearly puts pressure on both the HCPs and female patients to be very careful and conservative about their professional and personal behaviour in clinical practice, particularly in relation to sexuality and sexual health. This also could explain why some male HCPs tended to leave the door open while providing care to women, even though this led to a disturbed consultation because of noise coming from the clinic, and why female patients refused to see, or reported more difficulties when treated by, a male doctor.

Another possible explanation could be the impact of the term 'conservative'. SA is repeatedly described as an extremely conservative country in the media, which seems to mean not talking about sexual issues. This probably results in sending out the wide message that talking about such things is prohibited in all circumstances, including the health sectors. As parts of society, HCPs and female patients may simply be negatively affected by the media. As a consequence, this conservative social norm may impact upon their ability to integrate and to initiate discussing sexual issues in clinical practice. The social pressure provided by media stereotypes can, therefore, act as a barrier to encouraging discussing sexual health issues.

Anxiety about personal behaviour in clinics could explain why the majority of HCPs avoid discussing sexual health topics when providing care to their patients, and why they discussed such topics quickly and carefully only if there was a medical need, as they feared a breakdown of the doctor/patient relationship as a result of offence. In fact, in the current study, HCPs tend to control the conversation in consultations if there was a need to discuss sexual health related issues. It was observed in consultations that HCPs were using tactics

and strategies, such as short and closed questions, and direct conservative words. They also made statements and gave instructions that focused only on disease-related issues to overcome the sensitivity of the topic, such as “Is your wound okay?”, or “Do you need contraception?”

It is worth mentioning that most of the HCPs in this study stated that, from their medical point of view, they did not have to focus on sexual well-being in the broader sense; they believed that their female patients were sexually healthy as long as there were no gynaecological issues or STIs to identify. Focussing on medical issues alone is in line with Meystre et al (2006) who argue that, when discussing sexual related issues, physicians usually decide to focus on patients who are considered to be at higher risk, such as drug users or men who have sex with men, and focus less on healthy adults and new patients; the same is true of patients in more ‘neutral’ or ‘healthy’ situations, such as routine check-ups.

5.8.2 Lack of knowledge and communication tools

Many authors argue that consultations provide an effective opportunity to identify and address sexual health issues (Nusbaum et al, 2002; Gott et al, 2004; Ferreira et al, 2010). However, most of the HCPs in the current study admitted that they did not know how to approach the subject of sexual health with their patients. Being raised in a conservative family and not being given adequate knowledge or communication tools at school, or even at medical school, with respect to sexual topics was a repeated reason given. It can be concluded that, without proper knowledge and communication in consultations, female

patients miss out on the opportunities to get the guidance they need to maintain good sexual health. The results were similar to Gianotten et al (2006), who reported that only 12% of the professional staff in their study considered themselves sufficiently trained to broach sexual problems with their patients. Indeed, a lack of knowledge and communication skills has been reported to be one of the main barriers for addressing sexuality, and sexual health, within clinical consultations (Humphrey & Nazareth, 2001; Gott & Hinchliff, 2003; Gott et al, 2004).

Communication in this study is hindered by a number of barriers as explored above; however, the most reported one is a busy work environment. This study sheds light on several cases where doctors made quick decisions, apparently with little or no concentration, which resulted in incorrect information or instructions being given to their patients in relation to very important topics, such as contraceptive use. However, this issue is not limited to SA; for example, in a US study women reported missed opportunities when they attempted to discuss sexual concerns with their physicians, who frequently appeared unconcerned and failed to follow up on concerns raised (Nusbaum et al, 2002). Time may also be an excuse used by HCPs in the current study. HCPs possibly used time issues to avoid talking about sexual issues, or rationalized that they did not have time to address sexual health in order to justify not addressing this important issue to themselves or to the researcher. A confident and proactive approach to sexual topics, using adequate knowledge and communication skills, would definitely help HCPs to overcome time issues and give them tools to communicate effectively with patients.

During fieldwork in SA, it was clear that many female patients did not raise sexual issues in the clinic, although they talked about them with the researcher during the subsequent interviews when they were assured that they could talk privately about any issue they wanted to raise. They often said that they preferred the HCPs to initiate and raise sexual issues in the consultation rather than to do so themselves. It seems that once assurance and rapport is established between the patient and the care provider, particularly those of the same gender, they can talk frankly about their sexual difficulties, especially when they feel that the person they are talking to is open about the topic and trustworthy.

Effective communication helps to transmit meaning in an attempt to create shared understanding (MacPhail et al, 2009). The Quality Assurance (QA) Project, funded by the US in 1990, provided a useful facilitation tool for improving interpersonal communication between HCPs and patients. It pointed out that communication is a shared responsibility between the health provider and the patient, which needs a process of strategies including awareness, education, training, and then behaviour change. This process requires a vast repertoire of skills, most importantly the interpersonal processing, which involves listening to someone, making eye contact, speaking clearly, questioning the problem, analyzing the situation, and evaluating the solutions and the outcome. In addition, the PLISSIT model, that was developed by the psychologist Jack Annon in 1976 (Annon, 1976; Alteneder & Hartzell, 1997), could be an appropriate tool to be used in SA by HCPs during consultations. It is a simple counselling model or tool that allows an HCP to introduce sexual topics into a consultation in a practical way (Alteneder & Hartzell, 1997; Murtagh, 2010). The table 5 shows what the PLISSIT model means and how it can be used in clinical practice:

P	Permission	Be proactive to initiate the topic, allowing the patients to talk about sex, to ask questions.
LI	Limited Information	Involve the service with basic information on the topic of sex and sexuality
SS	Specific suggestion	Make direct suggestions that may include directing the patients to a recommended self-help book.
IT	Intensive therapy	Use the usual point of referral when appropriate

Table 5: PLISSIT model developed by the psychologist Dr Jack Annon

The PLISSIT model is a framework that can be used by a HCP to develop and implement an intervention to assist their clients in maintaining their sexual problems, issues or sexual relationship (Annon, 1976). However, Taylor & Davis (2006) argue that the PLISSIT model tends to ask for sequential application of fixed stages which can be viewed as a limitation. Despite the fact that the researcher agrees with Taylor & Davis (2006) about the sequential application of the PLISSIT it could be, in fact, this sequential application makes it more easily understood and used in clinical practice by HCPs. However, there is no guarantee that the sequential stages in PLISSIT model can be achieved by HCPs without proper knowledge and preparation about sexual health topics in the first place. In addition, there is a need for HCPs awareness about process of referral, when should a referral to be done and to where for example. Besides that, the ability of the HCPs to establish good communication and rapport with the patients when using the model is a key issue in its applicability.

The clinics in both hospitals included in this study also found there to be problems in establishing a rapport to encourage effective communication with patients. It is important to mention that this study discovered that in both hospitals the doctors providing the care to female patients frequently changed, particularly in FPC or PPC. Therefore, doctors might only see a patient once, even if the patient visits the hospital many times and attends the same clinic. As a result, it could be argued that, even if the doctors had a positive attitude and skills in relation to sexual health, there is a limited chance for them to establish a good rapport with the female patients and achieve effective communication. This is an important issue that has to be considered when assigning doctors or nurses in services that provide sexual health care.

Gott et al (2004) stressed that HCPs have a professional role to fulfil and must take the responsibility to initiate and welcome discussions of sexual topics with patients in their clinics. Within SA, the health providers who are more likely to have the most opportunity to initiate discussions of sexual health issues with women are the gynaecology and obstetrics practitioners. Gynaecology and obstetrics doctors are the first point of contact for many female patients with variety of sexual health concerns, and would be a particularly appropriate source of help for women who attend the hospital frequently for health care, such as for pregnancy or postpartum check-ups and contraceptive advice.

The current study indicates that nurses have less opportunity and a smaller role to play in the current services in SA, but it can be argued that enhancing nursing practice in this important area of women's health care is necessary and possible. Hayter's (2008) study, in the UK, shows how nurses are able to play a key role in the promotion of women's reproductive and

sexual health care. In SA, for instance, the majority of staff in educational departments in hospitals are nurses who hold university certificates, therefore, it is possible to routinely refer patients to them for sexual health education to make sure that patients have the full information to facilitate better informed choices for their sexual health. It can be argued that referring patients to nurses for educational classes, or one to one sessions, during premarital tests, antenatal and postnatal visits, is a sensible start and probably will be more socially accepted in SA.

5.9 Consequences of sexual health sensitivity on female patients

5.9.1 Difficulties in talking about sex

Sex and sexuality is an important aspect of being human, particularly for women who are often affected physically, psychologically and socially, due to their reproductive role and function and gender power imbalances. Nusbaum et al (2000) describe how sexual health concerns are prevalent for women seeking routine gynaecological care, with a total of 98.8% women who were surveyed in their study reporting one or more sexual concerns. Female participants in the current study also reported experiencing sexual health issues, such as vaginal discharge or pain during intercourse, and said that they would like to discuss sexual health issues with a health professional, however, they often felt unable to do this because of a lack of openness within society or their families about female sexuality. Cultural beliefs and social norms within a society about how active a woman should be in sexual relationships can control, impact and influence how a woman feels about and acts towards her body, sex and sexuality (Gillespie, 2005).

Fostering modesty and chastity, particularly for unmarried women, is extremely prevalent in Saudi culture, and in this study it was certainly an aspect that made women hesitant and reluctant to talk about sex and sexuality, even within a health care setting. Female patients appeared embarrassed and felt that an interest in sex may be considered to be inappropriate behaviour; this is why they refrained from asking even their husbands about sex, and for the same reason they were concerned about their HCPs' reactions if they raised sexual issues in the consultation. These findings are similar to those of Gillespie (2005) who describes Jamaican women's sexual health knowledge and behaviour as being deeply affected by cultural and social factors, and who said that the women expressed difficulties in talking about sex and related issues because it was still viewed as taboo within their community. Sarkadi & Rosenqvist (2001) also describe the difficulties women face in a Swedish study exploring the effects of type 2 diabetes on 'womanhood and intimacy' and found that women felt uncomfortable raising sexual problems with their GP. It seems that many women find it very hard to talk about their private sexual life, issues and problems within a health care consultation.

In general, it seems that many patients can experience difficulties in initiating and talking about sexual issues, even if it is related to diseases that could affect their health and well-being. This is the case in SA, even with male patients. For instance, a cross-sectional Saudi study by Al-Turki (2009), aiming to determine the cardiovascular risk factors among men with erectile dysfunction (ED) at a hospital-based primary care clinic in Riyadh, found that the estimated prevalence of ED was 18.9% of the total of 264 men, and that only 28% of them had consulted their physician regarding their problem. They stress the importance of enabling patients to talk with their treating physicians about sensitive issues during

consultations, concluding that this will help patients to seek proper and safe medical advice. Based on Al-Turki's (2009) study, it can be argued that if Saudi male patients find it hard to raise sexual issues, female patients clearly experience more social normative pressures than their counterparts, making it even harder for them to raise a sexual health concern in the consultation; an issue that HCPs have to consider when giving health advice to female patients.

Women in Arab countries are raised in a restricted way and the concepts of chastity and honour are deeply entrenched in Arab social norms. This social pressure teaches them to ignore their body, relationships with men, sexual pleasure, not to talk about sex, and to preserve the hymen until married; any suspicions that they have not followed these social orders could have serious consequences. Following the social norms, particularly those related to sex and sexuality, is very important for women in many ways: it will increase their chance of getting married, guarantee their family trust and satisfaction towards them and, most importantly, save their lives. This may explain why single female doctors in the current study find it hard to talk about sexual issues in consultations.

An interesting and detailed Jordanian study, conducted by Faqir (2001), deals with the issue of honour killings: the most extreme type of violence against women in Jordan, where women are killed for suspected deviation from the sexual norms imposed by Arab societies. It is a particular type of intra-family femicide in defence of honour in Jordan and most Arab countries too. In her study, she discussed the legal, social, religious, nationalist, and tribal dimensions and arguments surrounding such killings, and concluded with the argument which

the researcher of the current study herself also believes: that violence against women will continue in the name of social sexual norms unless the prevailing discriminatory culture changes and starts to implement a comprehensive programme of socio-legal and political reform. Social change can start by increasing awareness and education about the topic, however, to date only three governments in Arabic and Islamic countries, Iran, Morocco and Tunisia, have clearly started to support and enhance sexual and reproductive health education and awareness programmes, and shown efforts to increase women's status and rights (Hessini, 2007).

5.9.2 Insufficient knowledge

This study revealed how and when female patients acquired knowledge of sexual issues, and the impact that traditional Saudi culture has on the acquisition of this knowledge. Culturally, there are many social norms surrounding sex and sexuality within Saudi society that have been explored in the current study, examples include the beliefs that: unmarried women should not talk, seek and or search out sexual topics until married because it is seen as inappropriate; women should be chaste, modest and shy, particularly with issues related to sex and sexuality; and services that provide sexual health care are for married women only. These norms may explain why the female participants in the current study tended to seek knowledge and talk about sexual health issues privately with their close friends, which is considered the most important source of information for them. However, this seems to lead to poor levels of knowledge, and many studies emphasize that insufficient knowledge about sexual health issues, at an appropriate time, is the biggest barrier that affects women's health

and an important reason for their unmet needs globally (Ferreira et al, 2010; United Nations Population Fund, 2010; WHO, 2010).

In the current study, female participants wished to have knowledge and written information in advance of marriage about sexual health topics, and before and after giving birth, but unfortunately these were not provided by their current hospital services. During field work, it was observed that some of the female patients received prescriptions for a particular contraceptive method but were not informed about other available methods, nor common side effects, warning symptoms, or even advantages and disadvantages of using that method. Ferreira et al (2010) explain that lack of knowledge about contraception is a major cause of unwanted pregnancy, which usually leads to negative sexual health for women. Indeed, limited knowledge and lack of sources of information certainly will not help women to make their own informed choices and to overcome the harmful consequences for their sexual health (United Nations Population Fund, 2010; WHO, 2010).

Lack of knowledge is actually a product of culture and how women perceive sex and sexuality. Hence, some countries in the West, such as the UK, noted the importance of enhancing knowledge by education in health care sectors, through counselling sessions and distributing educational material to their patients. A study conducted by Hayter (2008) explores unique empirical data into how nurses conduct one-to-one consultations with women. This study provide a novel insight into how contraceptive information is explained in clinical situations in the UK, to make sure women are given clear impartial advice about contraceptive methods and their effective use.

Similarly, a cross-sectional Brazilian study, conducted by Ferreira et al (2010), was carried out from July to October 2008, involving 150 low income women receiving post-abortion care at a family planning clinic in a public hospital. The participants, who had undergone an abortion, were invited to take part in the study before receiving hospital leave from five different public maternities. Each woman received information on contraceptive methods, side effects and fertility. Counselling was individualized and addressed their feelings, expectations and motivations regarding contraception, as well as their pregnancy intentions. Of all the women enrolled in this study 97.4% accepted at least one contraceptive method. Distributing leaflets or pamphlets to increase awareness and knowledge has been found to be efficient and useful in health sectors (Little et al, 1998). Indeed, it can be concluded that providing services that include a structured range of sexual health topics, counselling, and discussing possible health risks with free, sensible and easy access to sexual health services and education is vital.

The literature indicates that school-based sexual and reproductive health education is one of the ways to help individuals improve their awareness of their reproductive and sexual health (Kirby, 1992; Kirby, 2002; Kirby et al, 2006). However, because of the social and political opposition to sex education at school in the current study, it is would be difficult to suggest introducing an explicit and separate sex education curriculum in schools at this time to elevate awareness about sexual health topics. Changes should be gradual, and made with sensible strategies for SA culture, as it is believed by the researcher that it is not an easy or quick process to produce and promote culturally appropriate materials for sexual education, particularly for girls' schools. It needs active engagement, support and acknowledgment from

government authorities, religious leaders, and HCPs; collaborations which have not been started yet. In the meantime, it is possible to encourage less controversial sexual health topic material via the solid foundations of science and the religious curriculum (focusing on biology, personal hygiene, puberty, menstruation, sexual disease and abstinence). Another possible acceptable way is a structured curriculum or programme for couples who are about to get married, in order to help them to start and enjoy their married life healthy and happy together.

5.9.3 Gender and power inequality

The literature review chapter shows how social and cultural norms define gender norms that have greatly shaped and influenced female and male behavior, particularly in the realm of sex, sexuality and sexual health. It is often not socially acceptable for women to have sex or pre-marital partners in the same way it is accepted for men, and it is considered appropriate for men to have more active sexual roles than women in relationships (Njovana and Watts, 1996; Blanc, 2001). Therefore, women are less likely able to negotiate safe sexual encounters (DuGuerny et al, 1993; Amaro et al, 2001) due to unequal social power between men and women within cultures; gender norms that have possibly grave consequences for women's reproductive and sexual health.

In the current study, gender is an area identified as a potential barrier to sexual health, and the influence of the woman's husband is very strong. Many female patients reported that having sex is an obligation and that the wife is duty bound to satisfy her husband. They reported that a woman should not refuse sex with her husband unless she has a legitimate reason, such as

sickness or tiredness, which is compatible with religious advice. Many verses of the Quran and Sunnah were quoted by female patients in the current study when they discussed this aspect. Islam is the state law that regulates every aspect of life in SA, and there are many verses in the Quran and Sunnah that encourage women to obey their husband to guarantee their entry to heaven, such as this verse from the Sunnah; “*The woman who died and her husband was satisfy from her, she enter the heaven*”. Yet many well-known Muslim religious leaders issued different *Fatawa* (interpretations given by Muslims scholars when verses and text of the Quran and Sunnah are not direct or clear) that instruct women to obey their husbands in everything, except things that provoke anger from Allah, such as drinking alcohol or any other prohibited acts in Islamic law. It can be argued that, in accord with women’s religious and social beliefs, their husband is the way to heaven and it is, therefore, understandable why women tend to accept the gender social norms that promote their husband’s satisfaction and needs over their own.

Earlier in this thesis it was also argued that gender norms and gender power in relationships can jeopardize the sexual health of women; this is confirmed by the current study. Almost all female patients reported that their husband’s opinion of using contraception was important, and they were discouraged from using certain types of contraception if they felt that type would not satisfy their husbands, such as condoms. In addition, they felt shy about asking their husband to seek testing for STIs or HIV even if they suspected him of sexual infidelity. Female patients were concerned that they had to conform to Saudi social norms and values so, for example, asking their husband for sex was not considered to be appropriate “from a feminine characteristics point of view” and might give the husband a reason to suspect that

his wife was having a pre- or extra-marital affair. Reasons given for satisfying their husbands were to obey Allah and to avoid their husband to looking for another wife or being unfaithful.

Much of the literature previously discussed concurs with the current study in the role that husbands play in influencing and controlling women's reproductive and sexual health (Fullilove et al, 1990; Wingood et al, 1998; Gollub, 2000; Raj et al, 2004; Saleem & Bobak, 2005; Degni et al, 2008). Numerous studies, such as Zierler et al (1991) Irwin et al (1995), Raj et al (2000), Saleem & Bobak (2005), and the researcher in the current study, believe that women who are not empowered are less likely to have control over their reproductive and sexual health decision-making. As explored in the introductory chapter and the literature review, by law and the prevailing social norms, women in SA have little power: male guardians, husbands, fathers, brothers and even sons, have more control over their lives, which means less chance of controlling sexual and reproductive decision-making, particularly in a relationship that lacks harmony and understanding.

Husbands dominate most sexual decisions: when to have sex; the choice of contraceptive method; satisfaction with the method chosen; and continued use of female methods are often influenced by or for the husband's wishes. Nonetheless, despite the fact that a husband's involvement in his wife's life is essential in Saudi communities, they are not allowed to take part in family planning consultations. In Hospital B, male entry is totally prohibited, while in Hospital A it depended on the female patient's choice. It was noted during the observations that some women asked the doctors to talk to their husbands in order to convince them of the necessity of using contraception after giving birth, however, the doctors refused because they

felt it was problematic to be “involved in a personal issue” and failed to refer these couples for counselling.

A study in Addis Ababa (FHI, 1998a) suggests that involving husbands in family planning education significantly influences a couple's decision about whether to begin using contraceptives. In their study, more than 500 married women who were not using any modern method agreed to home visits by a two-member family planning educational team. About half of the women received this counselling alone, while the education for the others was given to both husband and wife. After one year, contraceptive use was nearly double among the couples who received the husband-wife counselling (33%), compared with use among the couples where women were counselled alone (17%).

Similarly, a Bangladeshi study (Akhter et al, 1993) suggests that involving husbands in Norplant counselling sessions can improve continuation rates for the contraceptive implant. They provide counselling, including information about insertion and removal procedures, side effects, and how men can help when their partners experience side effects. After three years, continuation rates were substantially higher among women whose husbands were counselled (42% continued using Norplant), compared with women whose husbands did not receive counselling (32% continued use). It can be concluded that HCPs should recognize the important role husbands play in improving women's reproductive and sexual health; therefore, better ways to involve them with reproductive and sexual health services and education are needed.

5.9.4 Delay in seeking sexual health

This study shows how social norms related to sex and sexuality in SA affect women's ability to speak openly with HCP about their sexual health concerns, which in turn has an influence on their health care seeking behaviour. Female patients reported that shyness, embarrassment, and a lack of communication regarding sexual health issues was critical to their inability to speak openly with their providers to seek sexual advice and treatment. Similarly to HCPs, they only approached the topic when a health complication or serious issue arose, such as unusual and obvious heavy bleeding or an unusual vaginal discharge. The HCPs in the current study reported that female patients have difficulties discussing their sexual concerns, and that they themselves only understand the issues by identifying the symptoms and asking questions of the patients.

This result is similar to US research conducted by Shifren et al (2009), that described the healthcare and information-seeking behaviour of women with self-reported sexual problems and accompanying sexually-related personal distress, identified from a large population-based U.S. survey. They reported that only 6% of participating women who sought medical advice scheduled a visit specifically for a sexual problem. Barriers to seeking sexual care were poor self-perceived health, and embarrassment about discussing sexual topics with a physician; while factors related to help-seeking were having a current partner, and interacting with the health care system. Another study conducted in the UK by Gott and Hinchliff (2003) also emphasized that only a small minority of people experiencing sexual problems seek treatment, and they identified several barriers as inhibiting seeking help. These included the demographic characteristics of the GP, the GP's attitudes towards later life sexuality, the

attribution of sexual problems to “normal ageing”, shame/embarrassment and fear, perceiving sexual problems as “not serious”, and lack of knowledge about appropriate services. A recent study conducted by Webber & Spitzer (2010) identified that challenges in accessing reproductive health care services because of the barriers of cost, shyness, and the stigmatizing attitudes of health care providers, were common problems for many of the women participating in their study.

The majority of the women in this study implicitly linked giving birth with difficulties in their intimate marital relationships. However, they often accepted sexual difficulties, pain, or problems during intercourse post-partum as a reality of their reproductive life; most of them stated that “It is natural”. This is the second most common reason cited by women for not seeking immediate medical help or consulting a doctor about a sexual problem. A study by Olsson et al (2005) found that discordance of sexual desire with their partner was a problem reported but that most of the women participating in their study expressed confidence that their sexual desire would return shortly. It is important to mention that the majority of female participants reported that they had to ask permission from their husbands to seek medical care to take them to the hospital. Some of the female patients reported that they could not attend because their husbands were busy in work at the appointment time given to them. It could be argued that it is unrealistic at the current time to recommend that women in SA do not to get permission from their husbands or depend on them for transportation to attend appointments, as this practice is deeply embedded in Saudi culture. However, providing more socially accepted services would be helpful and reasonable, such as providing a hotline service, counselling before discharge, operating weekend opening hours, and instructing women to

visit the nearest PHCC if they miss their appointment because it is easier for them to be seen there quickly than making another hospital appointment.

Another possible reason for not seeking immediate advice from HCPs by female patients in the current study could be the fact that Muslim women ask Muslim scholars about almost everything related to their life, including their views on conception use, abortion, and sexual matters, such as whether it is accepted to practise oral sex. This could act as a barrier to considering the HCP as their first contact for advice as they have to ask a scholar even if they have consulted an HCP, to make sure that what they have been advised does not contradict their religious practices.

The other likely reason could be the information and advice given by family, friends and relatives. As reported by female patients, the information and advice given to them during female gatherings helps them to solve their sexual matters and problems to some extent. Important reasons may also be access to the services, which appears to be a persistent problem for the participating patients. Waiting times are very long, with difficulties in obtaining appointments and a low quality of care being provided, which kept some female patients from attending or delayed their postpartum visit for up to two months after giving birth, which in turn could lead to an unwanted pregnancy. It seems that multifaceted interventions and programmes are necessary to improve the quality of services that provide sexual health care in order to make sure that female patients are encouraged to seek and attend these services at the appropriate time.

5.10 Summary:

At the beginning of this chapter the researcher re-visited the data and identified that Saudi social norms influenced the study participants. It was clear that social norms through Islam, gender, and culture, have an impact on how participants perceived sexual health. The findings were discussed by using the Theory of Reasoned Action and the discussion looked at five themes: the perception of sexual health; maintaining good sexual health; adapting to the concept of sexual health; the consequences of the sensitivity of sexual health on HCPs; and the consequences of the sensitivity of sexual health on female patients.

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Chapter 6: Conclusion

6.0 Introduction

At present, the worldwide health authority, in the form of the WHO, has drawn great attention to the importance of improving women's sexual health globally. It is increasingly concerned about women's sexual health and permanently works to shed light on the innovative approaches that are needed to raise women's awareness of risky behaviour, and to help them access the advice and treatment they need to avoid negative health outcomes that would impact on their future lives. The contribution of this study is unique, as it is the first ethnographic study conducted about women's sexual health care in SA. It offers an understanding of Saudi culture's attitude towards sexual health by investigating how women and HCPs perceive sexual health and the care that is currently provided. It helps to explore the impact of the current local and socio-political norms and values regarding sex, sexuality and sexual health. Hence, these findings are useful as a guide for those interested in sex, sexuality and sexual health, such as health authorities, health educators and health professionals, both globally and within SA.

6.1 The resume of the study

This study revealed that attitudes, beliefs, values and behaviours towards sexuality, sex and sexual health are significantly socially modified and constructed in SA; they are deeply embedded in Saudi culture through Islam, gender and customs that all have enormous power and influence on Saudi societal social norms and values. The study identified that the

perceptions, attitudes, beliefs and behaviour of the study participants about sexuality, sex and sexual health reflect traditional collective values. Sexual issues are considered to be taboo; a private matter between a husband and wife. Participants' views are always consistent with the social norm within the Saudi community, regardless of their age, gender and educational level.

The study findings also show that some of the study participants perceived certain sexual health practices, such as safe sex, as incompatible with Islamic values. Good sexual health was seen as easy to maintain by adhering to Islamic values, such as marriage, and by prohibiting pre-marital and extra-marital relationships. Heterosexuality was the accepted form of sexual relationship, and sex should be within marriage. Contraceptives were used to space pregnancies though female patient used sterilization as a form of contraceptive method because of medical indication.

These findings are in parallel with the known Islamic position in SA, which were discussed in Chapters One and Two. A possible explanation for these findings is that, even today, Islam plays a significant role in everyday life in the Saudi culture. The effect of Islamic guidance on Saudi culture and in participants' lives was very strong and clear. During the interviews and fieldwork many citations and stories from the Quran and Sunnah were quoted by the participants. This study confirms that religion has a great impact on people's sexual perception and behaviour one way or another. In fact, the influence and power of religion on perception, attitudes, beliefs and behaviour is not exclusive to SA, as the impact of religion

on individuals was reported in numerous literature that has been explored in the Discussion Chapter.

The Introductory chapter highlighted how Islamic leaders and representatives hold important key positions in different political and social organizations in SA; they have great power, with which to influence individuals' decision-making and perceptions. This study revealed that notable numbers of the participating female patients gained their information about sexual matters through Islamic books or from listening to Islamic scholars. Therefore, it is argued that their support, presence and involvement in enhancing and promoting sexual health in the Saudi community would be greatly valued and welcomed. However, it is the researcher's view that it may be necessary for steps to be taken by Islamic leaders in order to understand the contemporary challenges of the Saudi community's needs, particularly in relation to women's sexual health and, more importantly, for them to start taking positive action with regards to it. In fact, there is currently no research that investigates Saudi Muslim scholars' views and position towards sexual health care and education, which is a worthy area for future research.

This study indicated that it is not socially acceptable for women; particularly those who are single and young, to freely talk or ask questions about sex and sexuality, or to desire sex. Pre-marital intercourse is prohibited in Islam for both genders, though in general it was seen as justifiable for men but not for women. The Saudi culture looks upon women with great respect when the sexual social order in the Saudi community is adhered to, i.e. they should not talk about sex and stay virgins until they are married. A woman is considered to bring

dishonour to herself, her family and her community if Saudi sexual norms are not followed. When women are taught about sexuality by their mothers it is often done in a negative way, including “intimidation”. It was argued that all these social norm pressures that are embedded in Saudi culture have influenced women’s attitudes and behaviour towards women’s sexual health care.

For instance, female participants reported experiencing more difficulties in talking about sexual matters generally, and specifically to those that related to sex. They were embarrassed to initiate sexual encounters with their husbands, and found discussing sexual issues in health consultations very difficult. They were concerned about their reputations and how their husbands, relatives, HCPs or other health care members might judge them was frequently mentioned; in turn, they are denied their right to talk about sexual matters. It was argued that the ability to talk and communicate properly about sexual issues or problems is an important need because it allows women to share their feelings and worries, and to tackle problems and find solutions. Missing the opportunity to talk about sexual issues in general, and in consultations in particular, put women at the possible risk of poor sexual health.

This study revealed that female patients tend to delay seeking sexual health care as a result of the influence of Saudi social norms around women’s sexuality. They tend only to seek out sexual information or treatments when they get married or after giving birth. Even after marriage, some of them had delayed seeking medical advice or treatment because they were shy or too embarrassed to raise these topics in the hospital, or because they perceived it as natural, or they had sought advice from family or friends; therefore, they only approached a

health care establishment when a complication appeared or a serious associated health issue occurred. A further possible reason for delaying treatment was the quality of care provided in these clinics, as female patients repeatedly complained of appointment issues and long waiting times. Yet, the other most commonly identified barrier to women accessing sexual health care or advice was that they were dependent upon their husbands for transportation to attend an appointment. It was argued that providing other possible services, offering advice and treatment in places that could be accessed more conveniently, would be a helpful strategy to ensure that women would be more likely to seek medical advice or treatment in relation to sexual health problems from health providers. These services could be hotline services, counseling at postpartum discharge, visiting a local PHCC, or weekend opening hours.

This study revealed the issues of gender influence and power in SA. For instance, female patients perceived their husbands' permission and satisfaction to be important and necessary. It was revealed that husbands have great influence on the decision to use contraceptives and the method to be used. Female patients tended not to refuse sex for the sake of their husband, unless there was a reasonable reason such as tiredness or sickness, and it was difficult for them to ask for HIV/STI tests even if they suspected their husband of infidelity. It was argued that their limited negotiating powers due to shyness and embarrassment exposed them to greater sexual and reproductive health risks. It was also argued that empowering women is necessary to strengthen their ability to build their capabilities, and to strengthen their personalities to be able to control their destinies in various matters, including sexual health. In addition, it was argued that involving husbands in sexual and reproductive health services would be a useful way of influencing men's decisions regarding sexual health matters.

It is important to mention that this study indicated that HCPs were aware of the social norm pressures surrounding sexual health in SA, particularly those that related to female sexual norms. Therefore, they tended to avoid initiating discussions about sexual matters in their clinical practices, to respect the cultural norms and avoid offending the patient. This may be explained because SA is a conservative and Islamic country so there is a high degree of concern about sexual behaviour, which is taken into account by individuals. However, many other barriers to talking about sexual topics in the clinic were also reported by the HCPs in the current study, such as: lack of training and knowledge; time constraints; such discussions not being a priority or not being part of their role; feeling patients should initiate such discussions first; and lack of communication skills. It was also revealed in the fieldwork that there are no policies or guidelines in hospitals that could help to inform HCPs about sexual health care in clinical practice.

Lack of skills in effectively communicating about sexual matters was a significant issue revealed by the current study. The majority of HCPs admitted that they did not know how to communicate effectively with their patients about sexual issues. It was argued that, to facilitate effective communication with patients about sexual issues, HCPs have to be more proactive and to have adequate communication skills and knowledge about the topic. It was suggested that the PLISSIT model would be a useful tool for HCPs in SA to facilitate communication in consultations.

However, it is important to mention that this tool cannot be applied fully in SA, as one of the PLISSIT tools is to refer patients to a specialist when necessary, such as a sexologist. To the

researcher's knowledge there are no sexologist doctors in either hospital, and there is no list of private services that could provide such care in order for the HCPs to use it as a guide to refer their patients to. Nevertheless, a further possible suggestion is that of taking a structured history. This could be taken either by the HCP during the consultation, or by giving the history form to the patient to fill in and hand back to the HCPs in order to facilitate communication within the consultation. Conducting research to investigate the possibility and effectiveness of applying the PLISSIT model and taking of structured histories to facilitate sexual health communication in SA is an interesting area that needs to be examined and explored.

This study revealed that the sources of sexual information and care provided by the Saudi Government to women through hospitals and PHCCs are limited. The services that provide sexual health care, such as FPCs or PPCs, are run within the gynaecology and obstetrics clinics for one day and for limited hours. These services focus on providing care through prescribing contraceptive methods and eliminating postpartum complications; they have no support systems for sexual health education, such as antenatal or postnatal classes, premarital counseling, nor referral to the patient education department. No leaflets or written materials were distributed or even displayed on hospital walls or in the women's waiting areas. Gynaecology and obstetrics doctors were in charge of providing care and advice in these services, while the nurses' role was mainly giving assistance and performing organizational tasks. Therefore, it was suggested that nurses could become involved in women's sexual health, for instance, making referrals to patient education departments or operating nurse-led clinics that provide educational information. Involving nurses in such important health

practices is anticipated to improve the quality of care, reduce pressure on doctors and reduce waiting times.

It was argued that, due to SA religious leaders' power, political pressure and the country's conservatism in SA, the difficulties of explicitly applying the concept of holistic sexual health care in Saudi health care system are understandable. However, it is the researcher's view that health authorities in SA should not use social norms as a justification for failing to develop women's sexual health care, as the findings of this study revealed that changes and development are possible and necessary in order to improve these services and quality of care. Sexual health promotion should become a priority within SA, and should occur both within and outside of the health care system. Gradual developments and creating sensible services and programmes that are compatible with Saudi social norms are possible; of course this requires positive attitudes towards sexual health promotion and improvements.

Sex education is not included as a component of the school health education programme or school curriculum in SA. However, the current study participants reported the need for education in sexual health matters. They reported that sex education should be introduced in a sensible way, that was age appropriate and that adhered to Islamic values. Sex education is a very sensitive and controversial topic in SA and many other countries, therefore, in order for it to be accepted and taught correctly for the benefit of the Saudi culture, it must be studied carefully, scientifically and very thoroughly. Designing a sex education curriculum in SA at the current time would be difficult but not impossible, though it is a long process that has not yet begun. It is argued that the combination of religious teachings and sexual health education

would contribute to a successful sex education curriculum that would be strongly accepted in SA. Saudi society and the Saudi Government adopt Islamic positions, hence, policymakers could benefit from the influence of religion within Saudi society to legitimately introduce sex education by encouraging an environment in which modest religious leaders, institutions and organizations, could play a significant role in promoting the importance of sexual health.

This study revealed that participants were concerned that providing information about sex and sexuality through sex education would arouse curiosity that might lead to sexual experimentation and, in turn, encourage 'Zena' (illegal) relationships. This apprehension towards sex education is understandable, as sex outside marriage is prohibited in Islamic law and is punishable by execution by stoning for married culprits. However, adopting sex education that focused on a solid foundation that discussed the risks associated with sexual activity, body biology, responsible behavior, abstinence, puberty, menstruation, personal hygiene, and sexual disease, is anticipated to be more socially acceptable. Initially this information could possibly be integrated into the religious and science curricula, then developed into a separate curriculum to ensure that the information is delivered and not ignored. Furthermore, it was argued that providing pre-marital consultations for those attending pre-marital tests is necessary, and would be widely welcomed and appreciated within the Saudi community.

6.2 Strengths of the study

- 1) This study provides a unique contribution to knowledge by being the first ethnographically based study exploring women's sexual health care in SA. The results

of this research provides rich data that helps to develop our knowledge of, and feed into, current debates on the impact and the influence of culture, religion, norms, and values on sexual attitudes and behaviour among women and HCPs, which have a direct effect on sexual health care in SA.

- 2) As revealed in the literature review chapter, surveys remain the extensive source of routinely collected data in most previous research conducted in SA in relation to sexual health topics, therefore, being in the field and selecting a qualitative method is a two-fold strength as, without doubt, this adds to our knowledge at a methodological level in an area that has never been researched before. This approach, including observing events, reading materials, interviewing participants to clarifying ambiguities, and further questioning according to the participants' responses, enabled the researcher to use a variety of approaches to make sure that the data collected represents reality in the field.

- 3) The study is unique in that it is the first to collect qualitative data within the SA health care system from interviewing participants about such sensitive topics. In using individual's narratives one may claim that this may possibly introduce some form of bias as participants may mis- or under-report sexual perceptions, activities, statistical cases and attitudes, or simply voice opinion that they thought would be consistent with common policy and social norms. Notwithstanding, it is possible to argue that the potential for misreporting or under-reporting the attitudes and behaviour of participants in the current study was overcome, as the findings were produced through

observation, reading materials, and an in-depth exploratory approach that is rigorous and rich because more than one method was undertaken. Therefore, the information gained through the present analysis is believed to far outweigh this possible bias.

- 4) One of the gaps identified in the Saudi sexually related literature is that research is overwhelmingly drawn from samples of men. This study significantly addresses this gap by recruiting women. Therefore, a further strength of this study has been the fact that women's voices were represented when they were previously ignored in sex related research.

6.3 Limitations of the study

- 1) The findings of this study are difficult to generalize in terms of the wider population because the criteria for selecting female patients were limited to postpartum and family planning cases in two governmental hospitals in Jeddah. However, it should be noted that it was not the intention of the current study to generalize the findings to a wider population, as the main aim was basically to understand and to explore women's and HCPs' perceptions of sexual health and sexual health care provided. Therefore, theoretically, it is possible to argue that the results of the current study are applicable to be obtaining from the same or similar characteristic to the participants included in the study.

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- 2) It was noted that, during some of the observed consultations, that doctors did not ask for a patient's demographic characteristics, such as number of children or previous contraceptive use, and this information is either not available or not fully completed or updated in the patients' files. It would have been useful for the researcher to take this information before observing the consultation as this information would provide a wider picture of participants' situations. A demographic sheet could be handed to patients prior to the consultation requesting the following information: age, nationality, number of pregnancies, number of live children, number of miscarriages, years married, age at marriage, how long after giving birth did they wait to resume sex, contraceptive method used after giving birth, and previous contraceptive method used.

 - 3) The researcher did not investigate women's satisfaction with the care they were given in all the observed cases because some of the female patients were not able to participate in interviews after the consultation. However, it is the researcher's view, after conducting the study, that a structured follow-up sheet could be handed to women to fill in after the consultation; this would be useful in investigating women's satisfaction with the care given, the way doctors run the clinic, waiting times, and the treatments or the contraceptives given.

6.4 Recommendations for improving women's sexual health in SA

The following recommendations are based on the findings and discussions in previous chapters of this thesis. They recommend ways of improving women's sexual health care in SA. The improvements should be made by influencing social norms in the Saudi community, empowering women, enhancing HCPs' function and role, and conducting further research on sexual health. These recommendations will help towards more positive outcomes for women's sexual health care and practice in SA. In relation to the four recommendations, the following elements should be all considered:

6.4.1 Influencing social norms in the Saudi community

1. Encourage modest Muslim scholars to take part in local mosque, community and media campaigns, in order to promote sensible sexual health education to both men and women, utilizing the Quran's and the Hadeeth's instructions.
2. Hold educational programmes, campaigns and symposia for Muslim scholars, HCPs, parents, and the young, regarding the importance of sexual health care and methods for preventing issues related to poor sexual health, to enhance their tolerance, role, support and knowledge of these topics.
3. Encourage the media, either print or audio and visual, to encourage communication; stressing the importance of visiting HCPs for counseling before marriage, during pregnancy, after giving birth, and at any other necessary stages.

4. Collaboration between Muslim scholars, health authorities and HCPs to work towards integrating sexual health information with the Islamic and science curricula, then developing a separate curriculum that is sensitive to Saudi society's needs.

6.4.2 Empowering women

1. Ensure that all women receive the full information they need to protect their sexual health at any necessary stage, particularly before getting married and after giving birth.
2. Provide women with more accessible formal information on sexual health, by enhancing efforts to expand access to sexual health information. This should include sexual health education sessions in schools and universities, special TV programmes, and distributing small leaflets and books as routine in all schools, governmental hospitals and PHCCs, particularly those providing gynaecological care services.
3. Make sexual health education and counseling available to all pregnant, newly delivered, and engaged women, as an essential component of pre-marital, pre-natal and post-natal care.
4. Distribute small books, pamphlets and leaflets that have clear and simple explanations regarding sexual health issues as routine to women after clinic visits, and during pregnancy follow-ups and the postpartum period.

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5. Ensure that services that provide women's sexual health care are equipped with the proper number of expert and educated staff, particularly female staff.
 6. Provide women with more accessible services that provide sexual health care and information, such as hotline services, nurse-led clinics, weekend opening hours, and walk-in services.
 7. Assure women that they can raise and discuss any sexual health issue during visits to their HCPs.
 8. Integrate pre-marital courses with the pre-marital test to ensure that full information is given, particularly regarding sexual concerns, problems and contraception.
 9. Involve husbands in sexual health or family planning education and counseling, particularly in cases where partners refuse contraception or if there are STIs that need both partners to be treated.

6.4.3 Enhancing HCPs' role and function

1. Provide a national policy and guidelines describing and explaining a standard sexual health care framework, to ensure that consistent care is applied by all HCPs within all services that provide sexual health care in order to ensure equitable service provision.

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2. Encourage and assist all women to make better informed choices about available methods of contraception or treatments of sexual and reproductive health matters during gynaecological visits, pre-natal appointments, and throughout pregnancy and after giving birth, with onward referral to the appropriate educational services if necessary.
 3. Ensure that sexual health services are arranged appropriately to enable women to access sexual health care without delays in getting appointments or excessive waiting times, and by providing opening hours during weekends.
 4. Ensure sexual health education and care services are provided separately, or as integrated parts of all women's clinics.
 5. Provide interpreters for those who cannot speak Arabic or English.
 6. Inform patients verbally or in writing about service locations and opening hours, as well as the types of care treatment and counseling provided in clinics.
 7. Attend regular educational courses, programmes and symposia to enhance communication skills and enhance ability to approach patients with regards to sexual issues.

8. Develop nurse-led clinics to provide educational sessions and information to help to ensure that women are well-informed, to minimize the working load of doctors, and enhance quality of care.

9. Encourage recognition of the importance of routine discussion and communication, and the effective counseling of women regarding their sexual health, when providing women's care.

10. Play a more active role in approaching, initiating, discussing and educating patients about sexual health matters.

11. Encourage HCPs to specialize in sexology and sexual health counseling.

12. Introduce training and skills development related to sexual health in medical and nursing schools, and encourage use of the term 'sexual health' in discussions and communications.

6.4.4 Sexual health research in SA: the future agenda

1. Increase the financial support to researchers to conduct studies on women's sexual health issues, problems, and care.
2. Initiate studies that pay more attention to sexual health problems, particularly those related to decision making, sexual violence, abortion, rape, unmet needs, risky behaviour, and knowledge and attitudes towards various sexual health issues such as HIV and STIs.
3. Conduct further exploratory research to investigate medical and nursing school roles in supporting and encouraging the implementation of sexual health care in their curricula and practice.
4. Conduct large scale research using large homogeneous samples of nurses, doctors, women, and Muslim scholars, to assess their perceptions, knowledge, beliefs and attitudes towards sexual health.
5. Conduct research to investigate the possibility and the effectiveness of establishing nurse-led clinics, using PLISSIT and by taking structured histories, to improving the quality of care provided in women's sexual health services.

6.5 Summary and concluding remarks

This thesis provides a unique contribution to our knowledge about women's sexual health care in SA. It offers an understanding about Saudi culture, attitudes and behaviours towards sexual health and it discussed the challenges and recommends ways to improve women's sexual health care in SA. In addition, it highlights the possible interventions, future research and ways of developing and improving HCPs roles and functions in order to achieve positive improvements to sexual health care in SA. It can also be argued that this study actually starts to sets out the key principles for further work assessing and evaluating the sexual health care provided in SA. Finally, although the data was collected in SA, most of the research process was undertaken in the UK which provided an opportunity for the researcher to be more aware about the sexual health care developments and services within the UK. This was a unique opportunity to facilitate future links and collaborations in relation to sexual health research and service development between the UK and SA in the future, a collaboration journey that this study provides a foundation for.