



Title: Health Communication and Islam: A critique of Saudi Arabia's efforts to prevent substance abuse

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Abstract

Health communication has gained worldwide recognition as one of the most effective methods for tackling global health challenges; a conclusion that is supported by a range of studies showing generally positive results. Literature in the field has tended to focus on one of two perspectives: either individual behaviour change or a cultural/critical approach. This dissertation, which falls into the latter category, extends previous work on health communication and culture into a new context, namely Saudi Arabia.

The thesis is motivated by two main research questions. First, how has culture influenced health communication in Saudi Arabia specifically in initiatives against illicit drug use and alcohol abuse? Second, how has this communication developed? At the heart of this study is the role of Saudi culture in health communication in an increasingly interdependent and connected world.

The dissertation makes use of mixed qualitative data collection methods. Principally, it utilised semi-structured interviews with key officials and focus groups with young Saudis and health promoters in Saudi Arabia as well as attendance at and observation of health-communication events and permanent exhibitions as a subordinate method.

The study reveals promising findings supporting the growing scholarly interest in the cultural dimension of health communication. It concludes that the key influence of the Saudi culture on health communication against substance abuse is Islamic beliefs about health, in particular those about substance abuse. These beliefs created a rejection of illicit drug abuse in Saudi society, thereby shaping a supportive environment for promotion activities against risky health behaviour. In addition, Islamic influence inspired the related regulations and laws in the kingdom.

Islamic and local influences exert a powerful influence on the practical side of health communication in Saudi Arabia, including the content of messages, the appeal used to attract the specific audience, and the communication channels used to promote the campaigns. The study engages

with four concepts constituting the Islamic model of health and illicit drug abuse: prohibition (haram), promotion (Da'wah), repentance and inclusiveness (Tawbah), and treatment and rehabilitation (Elaj). The study also examines controversial issues about health communication in the country, such as the predominance of top-down communication, the absence of participatory communication and cultural diversity. In short, a lack of innovation and creativity in delivering health communication messages.

The study illustrates the major role the Saudi government has played in communicating health and substance abuse since the 1980s, when officials realised the need to modernise the means of communicating health and drug issues from mosque-based only to include modern methods such as televised campaigns, school-based programmes and hospital-based health education. Since then, government-led health communication initiatives have been well established in the kingdom.

The dissertation is able to demonstrate a critical understanding of the reality of health communication against substance abuse in Saudi Arabia and make a range of recommendations to improve the efficacy of current policies and suggest new avenues for future research.

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Chapter One: Introduction

1.1 Introduction

This chapter aims to equip readers with an introduction to the scope of the research, the research questions, the methodology and the significance of the study. At the end of this chapter, the reader should have a good understanding of the topic, the mechanism used to approach it, and the document (thesis) structure. It is beyond this chapter's scope to engage with the literature or to provide in-depth details about the methodology. Subsequent chapters will deal with all that in an expanded manner.

In a sequential manner, the first section is an overview of the thesis focus, the research questions and the motivations behind the study's objectives. In addition, the overview section will highlight the disciplines framed within this thesis. Some information about the methodological approach used will be included. The overview section will conclude by highlighting the major outcomes/findings of this study. This is then followed by a summary of the thesis structure with introductory details to each chapter.

Overview:

Health is a word that can be understood in many ways depending on the context and on the situation, but in this thesis it refers to the status of an individual's physical, mental and spiritual circumstances as well as the extent of the well-being experienced by his community or society (WHO, 2015a). Undoubtedly, the issue of health has been challenged through known history either by infections, diseases, catastrophes, epidemics, famine or wars. At the present time, the world is facing numerous environmental and health challenges. Both communicable and non-communicable diseases have been imposing challenges to public health. Communicable diseases such as sexually transmitted diseases (STDs), hepatitis, influenza, and the non-communicable diseases such as obesity, alcoholism and blood pressure are prevalent. Most importantly, non-communicable diseases have been responsible for most of the deaths in recent decades. Recent international figures show that 75% of all the deaths in the world are caused by non-communicable diseases (NCDs) (CDC,

2014b; WHO, 2015b). In fact, about 17.5 million deaths were caused by cardiovascular diseases (WHO, 2015b). Equally, infectious diseases have imposed significant challenges to human health.

Unlike infectious diseases – which mostly occur as a result of interaction between agents (humans) – non-communicable diseases are behaviourally-oriented¹. Non-communicable diseases evolve over a long period of time, and in most cases, cause premature death (CDC, 2014b; WHO, 2015b). The risk factors leading to NCDs can be divided into two groups; modifiable behaviour and physiological risk factors (WHO, 2015b). Smoking cigarettes, excessive drinking of alcohol and drug use/abuse are examples of these behaviours, which lead to non-communicable diseases. Indeed, this risky behaviour can not only cause premature death, it is also likely to have negative consequences or impacts on society (Bassiony, 2009; Bassiony, 2013; Bean, 2008; Garrusi & Nakhaee, 2012; Gifford, Friedman, & Majerus, 2009; NIDA, 2005; Rassool, 2011; Rassool, 2014c; Schumacher & Milby, 1999; Wilson & Kolander, 2003).

In 2012, an estimated 183,000 people died worldwide as a result of drug use/abuse or related issues (UNODC, 2014e). Between 162 million and 324 million people aged between 15 and 64 years old consumed illegal drugs in the same year (Ibid). The prevalence of this problem is clear. Between 16 million and 39 million people worldwide are reported to be dependent on illicit drugs (Ibid). Similarly, over 3.3 million deaths worldwide are attributed to the harmful use of alcohol (WHO, 2014; WHO, 2015b). The world response to such chronic diseases stretches beyond the biological (medical) model. The international community has developed multi-layer models in recent years in an attempt to deal with the harmful use of alcohol and illicit drugs.

Initially, a global system to regulate and control licit and illicit drugs was established in 1961² (UN treaties, 2015; UNODC, 2008). Then international bodies were created to enhance collaboration and the exchange of experiences such as the United Nations Office on Drugs and Crime (UNODC)³

¹ Many causes of these behaviours are generated from the lifestyle changes driven by modernity and economic improvements.

² The year 1961 marks the beginning of the modern international system of drug control.

³ Besides this international body there are other related bodies. Firstly, the Commission on Narcotic Drugs which functions as a governing body of the (UNODC). Look at <http://www.unodc.org/unodc/en/commissions/CND/index.html?ref=menutop> . Secondly, the

(Pietschmann, 2007). Academics studying these new lifestyle-oriented diseases started to look beyond simple medical interventions. For many states, however, the primary defence was the implementation of new laws aimed at preventing or criminalising the illicit use or production of drugs. Alcohol presented a different problem and different strategies were required to combat its abuse compared to illicit drugs (Jernigan, 2009; Wilkinson, 2013).

Most international measures treated alcohol as simply a common item for trade and normal consumption. Each country devised its own policy for the selling, distribution, location of selling and drinking of alcohol and the demographic characteristics of consumers (Ibid)⁴. As this study will illustrate, in some parts of the world there is less acceptance, even zero tolerance, toward the sale or consumption of either alcohol or illicit drugs.

In the 1960s, epidemiologists, primary care specialists' and public health experts acknowledged the necessity of non-medical and lawful means to minimise the hazards of behaviours such as substance abuse. In particular, preventing such behaviours from occurring or worsening, and promoting healthy choices were the primary approaches recommended to prevent such risky behaviour (Abadinsky, 2010; Bukoski, 1991a; Bukoski, 1991b; Fields, 1995; Schumacher & Milby, 1999; Simons-Morton, Donohew, & Crump, 1997; Wilson & Kolander, 2003). In the 1970s insightful developments within communication studies in the context of health care emerged (Korsch, Gozzi, & Francis, 1968). The attention and focus were directed to the potential roles communication could play in minimising negative health outcomes, health inequalities, health illiteracies, workers' incompetence, health disparities and risk behaviours (DuPré, 2014; Kreps, 2010; Thompson, Dorsey, Miller, & Parrott, 2003; Thompson, Parrott, & Nussbaum, 2011; Wright, Sparks, & Dan O'Hair, 2012).

Embraced by medical specialists and physicians since then, health communication has developed into a respected academic scholarly field offering theoretical foundations for solutions to many of the concerns previously mentioned in health care (Ibid). Health communication has evolved through a

International Narcotics Control Board (INCB) is an international quasi-judicial body supervise the application of the international treaties. Look at <http://www.incb.org/incb/index.html?ref=menutop>

⁴ Recently, different measures to minimise the harms of drug abuse in society were introduced, famously, legalising drug sales; namely the so-called liberalisation or decriminalisation or re-legalisation of drugs (Bean, 2008; Wilson & Kolander, 2003).

dynamic journey of development, implementation, review, monitoring and evaluation, and improvement. However, the key focus of health communication remains the effective use of communication strategies, tools and methods to spread knowledge and information related to health issues. Furthermore, the main purpose continues to be focused on enabling the receivers of health communications to maintain or change their health behaviour or make informed decisions on their options (N. Corcoran, 2010a; Dutta, 2008; Dutta & Basu, 2011; Harrington, 2014; Lewis & Lewis, 2015; Northouse & Northouse, 1998; Schiavo, 2014; Sparks & Villagran, 2010; Wright et al., 2012). In general, the definitive objective of health communication will always be to improve or maintain the health of individuals, communities and societies (Ibid).

Coupled with these high expectations, the mechanism of researching health communication has developed in parallel with epistemological advances (Britten, 2011; Du Pré & Crandall, 2011; Harrington, 2014; Kreps, Bonaguro, & Query, 1998; Kreps, 2008; Kreps, 2011; Neumann, Kreps, & Visser, 2011; Thompson, Cusella, & Southwell, 2014; Whaley, 2014). The nature of researching health communication can now be said to hang between three mechanisms, namely; multi-disciplinary, inter-disciplinary, and trans-disciplinary (Ibid). These mechanisms have framed research aimed at predicting changes to an individual's health behaviour from a social-psychological perspective (positivism, and post-positivism views) (Dutta, 2007; Dutta, 2008; Dutta & Zoller, 2008; Dutta & Basu, 2011; Harrington, 2014; Kar, Alcalay, & Alex, 2001c; Kreps, 2014; Sparks & Villagran, 2010; Wright et al., 2012). However, driven by the imperatives of multi-culturalism and in the light of the growth of scholarship from *developing countries*, an interpretive perspective has found a place within health communication studies (Ibid).

The study of the cultural dimension has now become a fundamental dimension of health communication developed in recent years to overcome the demographic challenges and to fulfil the cultural competence needs of the health care system (Airhihenbuwa, 1995; Dutta, 2008; Kreps & Kunimoto, 1994; Lupton, 1994; Tseng & Streltzer, 2008). Recently, critical and post-colonial theorists have challenged the dominant perspective in studying the role of culture in health communication - the *cultural sensitivity (cultural barriers)* pathway.

Instead, a new importance has been assigned to other processes such as where health overlaps with culture, power, identity, control and social consciousness (DuPré, 2014; Dutta, 2007; Dutta, 2008; Dutta & Zoller, 2008; Dutta, 2010; Dutta & Basu, 2011; Harrington, 2014; Wright et al., 2012). As a result, new frameworks have been introduced into the field such as the *culture-centred* approach (Ibid). Indeed, the acknowledgement of culture as the centre of health communication has arguably brought marginalised communities together and given them an opportunity to have their voice heard (Dutta, 2007; Dutta, 2008; Dutta & Zoller, 2008; Dutta & Basu, 2011). Culture, in other words, is evidently a domain which contributes far more than just values to our understanding of health communication. It is also the place where meaning is given to health issues and where important decisions are made affecting individuals and communities alike (Ibid). It is beyond this chapter's scope to deliver a full account of the history of health communication. However, it is critical to acknowledge these significant developments in the field as they have particular relevance to this thesis - most notably the emerging cultural/critical perspective of studying health communication (Airhihenbuwa, Makinwa, & Obregon, 2000; Airhihenbuwa & Obregon, 2000; Airhihenbuwa, 1995; DuPré, 2014; Dutta, 2007; Dutta, 2008; Dutta & Zoller, 2008; Dutta & Souza, 2008; Dutta, 2010; Dutta & Basu, 2011; Lupton, 1994).

The primary question of this study is to explore the influences of Saudi culture on health communication. In particular, the focus will be on health communication relating to the prevention of drug abuse and the consumption of alcohol. This study will engage with health communications originating from specialised organisations⁵ in Saudi Arabia, but excludes interpersonal health communication. This study's second research question will address how health communication against substance abuse in Saudi Arabia has developed. Driven by the objectives of this study and by the nature and dynamics of health communication research, this study also cuts across different disciplines, providing an inter-disciplinary perspective.

⁵ These organisations include the Saudi Ministry of Interior; Departments, Ministry of Education, Ministry of Health, activists, NGOs and religious Imams.

The two, major overlapping fields in this study are therefore health communication and culture. These are sub-divided into three extracted sub-fields: communication strategies and techniques in delivering health messages; the cultural perspective of health communication; and the role of culture in communicating health and substance abuse issues. It is hoped the interest in culture within this study will also shed light on the role culture plays in the formation of a drug culture⁶ and in the development of such problems. In addition, it will examine the role culture plays in forming a stance (perspective)⁷ toward such risky behaviour. It is worth noting that the concept of prevention will be examined within the discussions in this study.

The inspiration behind this study comes from a number of sources including a discipline-oriented fascination with the importance of context in health communication and an interest in the global nature of non-communicable diseases. Saudi Arabia, as my main focus, is also an important subject as I and other academics ponder its rapid evolution from a primitive economy in the 1950s, to a modern one bolstered by the petro-chemical industry. The rapidity of the change undergone in Saudi Arabia has had a range of attendant but major implications (see Chapter Three; the Saudi background). Changes to the demography meant a significant rise in the number of young people which, in turn, sparked an increase in the problem of drug abuse⁸ from several hundred cases in the 1960s to almost thirty thousand by 2011 (MOI, 2011). Furthermore, the economic boom brought about an influx of multi-cultural guest workers (such as expatriates, migrant labourers and businessmen), who also imposed pressures on the health system as well as on the socio-cultural aspects of local people's lives.

The domestic changes in Saudi Arabia took place in parallel to the global trend in the phenomena of drug abuse and the drinking of alcohol, vis-à-vis how the illicit drug trade market can be divided into producing countries, trafficking countries and distribution countries (Bean, 2008). In addition, a powerful factor

⁶ Refers to the culture of drug use among the communities in term of recreational or traditions or healing purposes (Abbott & Chase, 2008; Hanson, 2013; Heath, 2001; Room, 2013a).

⁷ Refers to the society judgement of the drug users and alcohol abusers.

⁸ For the links between the social and economic improvements in Saudi Arabia and the growth of substance abuse phenomenon in the kingdom, look at (Al-Humidan, 2008; Al-Qashaan & Al-Kenderi, 2002; A. ALshareef, 2008; Hafeiz, 1995).

has been the expansion of advertising and the concentration of the alcohol industry worldwide into a handful of multi-national companies (Jernigan, 2009).

The increasing number of drug users and dependents poses a significant challenge to public health worldwide. Moreover, technological and communication advances have eased and accelerated international movement and trade between countries. World authorities have warned that non-communicable diseases and in particular illicit drug abuse and alcohol consumption have shown no signs of decreasing as one of the major threats to world health (CDC, 2014b; UNODC, 2014e; WHO, 2014).

The dynamics of the Saudi context and the challenges posed by drug abuse and alcohol consumption have led to the exploration of the role of culture in health communication, in accordance with the growing cultural perspective in health communication led by Dutta and others (Airhihenbuwa et al., 2000; Airhihenbuwa & Obregon, 2000; Airhihenbuwa, 1995; DuPré, 2014; Dutta, 2008; Dutta & Basu, 2011; Kar, Alcalay, & Alex, 2001b; Kreps & Kunimoto, 1994; Wright et al., 2012). As is highlighted in the literature review, issues such as the demographic changes in the West, the growth of multi-culturalism, the ageing of populations, the array of critical challenges to the world health system, the growth of consumerism in health care and the emergence of alternative medicine have all contributed to emphasising the importance of context and culture when it comes to understanding why and how people make decisions and choices concerning their health.

In studying this context and culture, rather than focusing only on the social psychological and behavioural perspectives of health communication, I concur that an individual's decision-making is the cornerstone of health communication (Airhihenbuwa & Iwelunmor, 2012; N. Corcoran, 2010b; Dutta, 2008; Dutta, 2014). Furthermore, technological advancements, in general, add another justification to the emergence of the cultural perspective in health communication. As the internet and mobile devices ease the manner of communication, they also ease the movements of people, goods and messages across borders (Harrington & Head, 2014; Kreps & Neuhauser, 2010; Noar & Harrington, 2012).

Saudi Arabia is the birthplace of Islam, the holiest place in Islam, the cradle of Islam and is long rooted in Arabic history (AIRasheed, 2010; Long,

2005a; Metz, 1993). This context makes the investigation all the more significant personal but also extends health communication scholarship into a new and unique context.

This study is, then, motivated by a combination of reasons. At root is the intention to explore and examine the role of Saudi culture in health communication against substance abuse. Further discussions about the rationales and motivations of the study will come in section 4.2 in Chapter Four (Methodology). In order to answer the study's main concern/questions, I have adopted a qualitative methodology. To be precise I have used mixed qualitative methods; namely semi-structured interviews, focus groups and field observations. In addition the qualitative analysis of recent anti-drug announcements was also conducted. The principal reason behind the use of such an approach is to delve into the lived experiences of the social world. Practically, the collected transcriptions were analysed in a thematic way (more details in section 4.5 Chapter Four).

Before approaching the next section of this chapter, I should bind together the highlights of the major findings of this study. First, Saudi culture is a central element in the understanding of the concepts of health, illness, disease, healing and recovery (see Chapter Five). Secondly, the main argument of this dissertation has emerged from research participants' comments inspired by an Islamic perspective on health, illness, intoxicant use and drug abuse. Thirdly, I describe how the dominant Islamic/Arabic culture in Saudi Arabia contains a holistic approach to dealing with drug abuse and alcohol consumption. In fact, this approach conceptualises prohibition (protective) and is positive in encouraging treatment and healing and promotes awareness of the danger of drug abuse and alcoholism (see Chapter Five). To Muslims, the first communication about the dangers and hazards of using drugs and drinking alcohol came fourteen centuries ago, when the revelations to the Prophet Mohammed about intoxicants were received (J. Thomas, 2013). Islamic and local officials emerged as the primary players in Saudi culture, and subsequently have been major influences in health communications about drug abuse and the drinking of alcohol (see Chapter Five).

The second group of findings brings a practical and narrative lens to the study. For the first time, this study translates the narrative of official health

communication against drug abuse and the drinking of alcohol and combines this with unstructured views and stories from participants to form a well-structured argument. The most prominent feature of the narrative from the early days of health communication in Saudi Arabia has been the Government taking the lead and sponsoring and managing health efforts (see Chapter Six), unlike in other places where academics more often guide practices and interventions (Kar et al., 2001c).

1.2 Thesis structure

This thesis consists of seven chapters, the first of which is this introductory chapter. The next chapter will critically review the literature on health communication, especially the cultural perspective of studying health communication. The third chapter will focus on Saudi Arabia. It will convey introductory information about the context of the study, after which, the methodological pathway and the research methods this study adopted will be discussed extensively. The fifth chapter will present the first set of findings of the study; i.e. the Islamic perspective and role in health communication about substance abuse. The second set of findings in Chapter Six will bring together the narrative of health communication against substance abuse in Saudi Arabia. The final chapter will comprise the conclusion, recommendations, limitations and suggestions for future research. These chapters overlap and are interdependent of each other. Collectively, they present the story of this study.

1.3 Conclusion

To sum up, this chapter has assembled introductory insights into the thesis's main focus, the motivations behind my intention to conduct this study and the methodological pathway that I have adopted to answer the research questions. Furthermore, a brief highlight of the study outcomes was included. At this stage the reader will have a clear understanding of what this research is all about, and where it falls in the academic spectrum. Generally, this chapter functions as a map for the reader.

Chapter Two: Health communication and culture; Literature review

2.1 Introduction

The aim of this chapter is to review key research and resources on the topic of health communication and culture, the central field of this dissertation. The chapter will provide an overview of the available research and of relevant studies and will in particular review the academic literature underpinning the main research question, Saudi cultural influences in health communication on drug abuse and the consumption of alcohol.

The literature presented is interdisciplinary, owing to the increasingly complex body of work in the evolving field of health communication. The application of a cultural perspective as an additional framework to health communication adds a further layer of work that needs to be reflected upon. There are, furthermore, a number of aspects in the consideration of the development of health communication and its approaches, which will also be included.

This chapter comprises three overlapping sections. First, I will discuss the circumstances and the history of health communication and within that the dynamic of the theoretical approaches and perspectives. Extensive details about the dominant paradigm in health communication will be discussed. Second, I am going to present the procedures and strategies of various communication campaigns that demonstrate aspects of health communication. Third, I will outline the theoretical framework of the study, which functions as a guide to understanding the role of culture in health communication.

It is beyond this chapter's scope to cover every theory and approach within the diverse field of health communication, but the chapter will convey a balance of relevant health communication theories, with an obvious focus on the cultural perspective. At the end of this chapter, the research questions will be outlined.

2.2 Health communication; the story of a field

The dynamism of health communication is one of its most distinguishing features and will be evident throughout this discussion of the field. Since it

emerged as a field in the 1960s, health communication has generated a wide range of theories and perspectives on research. The key term, health communication, can be defined as the use of different communication channels, techniques and strategies at different communication levels, whether interpersonal, group, organisational or public, to convince the receivers, either public or individual, about particularly beneficial health behaviours (Harrington, 2014; Kreps, 1989; Peters, Mueller, Garces, & Cristancho, 2009; Ratzan, Payne, & Schulte, 2004; Wolff, 2007; Wright et al., 2012). Fundamentally, health communication seeks to create a health communication message which can guide the public's health actions and health professionals' practices (Kreps, 1989; Lewis & Lewis, 2015; Lupton, 1994; Ratzan et al., 2004; Wright et al., 2012). Indeed, the term is defined precisely by Schiavo as follows:

Health communication is a multifaceted and multidisciplinary field of research theory and practice. It is concerned with reaching different populations and groups to exchange health-related information, ideas, and methods in order to influence, engage, empower, and support individuals, communities, health care professionals, patients, policymakers, organisations, special groups and the public, so that they will champion, introduce, adopt, or sustain a health or social behaviour, practice, or policy that will ultimately improve individual, community and public health outcomes (2014, p.9).

Health is the main domain and focus of the health communication theory and practice (Basil, 2014a; Dutta, 2008; Leshner, 2014). Therefore, the primary role health communication plays is to provide information and knowledge through various means, including health services and products (Ibid). In the case of health interventions, various services and products are available both in terms of communication and health services support (Ibid). Health communication and interventions always seek to facilitate the adoption of healthy behaviour, the maintenance of healthy choices and lifestyles, the changing of risky-health behaviour and the prevention of illness and disease (Robinson et al., 2014).

There is a robust justification for the use of communication scholarship and its theoretical basis in addressing global health problems and dilemmas. The effectiveness of communication combined with health structure support and facilities are widely considered to be critical by both scholars and health

authorities for the attainment and improvement of good health in a variety of contexts (Backer, Rogers, & Sopory, 1992; Basil, 2014a; Basil, 2014b; Beato & Telfer, 2010; Freimuth & Quinn, 2004). Equally, this effectiveness is the main motivation for the use of health communication campaigns for drug prevention and the avoidance of harmful alcohol consumption and its attendant behaviour.

From the second half of the Twentieth Century, mass media campaigns have been implemented in order to predict or change people's behaviour (Abroms & Maibach, 2008a; Noar, Harrington, & Helme, 2010; Puska, 2002; Wakefield, Loken, & Hornik, 2010a). These campaigns have varied from cancer screening, tobacco use and drug use to alcohol abuse (Ibid). The effectiveness of campaigning, however, goes beyond the misuse of substances and has included other health issues such as eating behaviour (Elder et al., 2004; Haug, 2004; Noar, 2006; Robinson et al., 2014; Salmon & Murray-Johnson, 2001; Snyder, 2007). Accumulated evidence about the success of using mass media health communication campaigns combined with health, education or community intervention is compelling (Helme, Savage, & Record, 2015; Wilkinson, 2013).

Since health communication is concerned principally with the use of communication strategies to modify health behaviours for the better or to sustain current healthy behaviours, attitudes, and knowledge, both health promotion and health education are concepts that will be referred to in this study and both therefore require definition.

Health promotion was defined in the Ottawa Declaration in 1986 as a mechanism for providing people with enough information and sources to enable them to exert control of their health choices and behaviours (Catford & Nutbeam, 1984; Hoving, Visser, Mullen, & van den Borne, 2010; Leshner, 2014; Tones & Tilford, 2001a; WHO, 1998). Health promotion aims to encourage receivers to opt for the right health choices (Ibid). Health education, on the other hand, concentrates on the use of different means to educate the public about health and health risks with the aim of enhancing awareness (Catford & Nutbeam, 1984; Wilson & Kolander, 2003). In practice, health education uses schools and mass media either together or separately (Ibid).

2.2.1 Health communication emergence and development

To detail the story of health communication we need to outline the two mainstreams of inquiry guiding research and application in the field. The predominant consensus among health communication scholars is that the field is located at the meeting point between health care and mass communication (Basil, 2014a; P. Crawford & Brown, 2011; DuPré, 2014; Dutta & Basu, 2011; R. Thomas, 2006; Wright et al., 2012). Nowadays, communication in health care tends to be delivered on a number of fronts including by health care deliverers to consumers, by health professionals, health teams, during patients' decision-making processes or in the form of therapeutic communication¹(Ibid). The public communication of health focuses on the use of communication strategies to promote healthy lifestyles and choices and prevent risks (Basil, 2014a; P. Crawford & Brown, 2011; DuPré, 2014; Dutta & Basu, 2011; Leshner, 2014; R. Thomas, 2006; Wright et al., 2012). Both of the inquiries are interdependent and function in a parallel manner in order to achieve health objectives.

The dominant research paradigm in the field embraces two steps to conduct health communication research and intervention; audience-based and message-based (Dutta & Zoller, 2008; Dutta, 2008; Leshner, 2014). In audience-based research, appropriate target groups are identified and effective ways to reach them are drawn up (Ibid). In message-based research, the focus is on the use of strategies to design effective health messages. This approach also encompasses the continuous development of the design of the campaign and also of the evaluation process to accomplish the aims of the campaign or intervention (Ibid).

The dynamism and rapid development of the field have generated a wide diversity of field studies. This has taken place in two stages. At first, as the practice of health communication developed scholarly interest was piqued and an association established. In the second phase, a range of theories and approaches have emerged. As a consequence, the development of health

¹ This term refers to the communication aspects of the therapy delivery. As Tamparo and Lindh argued "therapeutic professional communication takes place between a person who has specific need and a person who is skilled in techniques that can alleviate or diminish that problem" (2008, p.6).

communication is inseparable from the development of public health and epidemiology and both need to be considered in tandem.

The issue of maintaining health is rooted deeply in the history of humankind, and health behaviours such as sex, diet, and seeking cures have been significant since ancient times (Basil, 2014a). Through history, behaviour-oriented health risks have run in parallel with the most risky aspect of health, the infectious disease (Basil, 2014a; CDC, 2014b; Kar, Alcalay, & Alex, 2001a; Kar et al., 2001b; Roberto, 2014; WHO, 2015b). In fact, viral disease is largely responsible for the emergence of both epidemiology and for notions of public health (Ibid). In the past, primitive health systems were not able to cope with infectious diseases. That led to millions of deaths such as in the “Black Death” of 14th Century Europe and the cholera epidemic of the 1800s (Basil, 2014a; Bukoski, 1991a; Bukoski, 1991b; R. Eckersley, 2006; Schumacher & Milby, 1999). A glimmer of hope emerged in 1854 when John Snow successfully identified the source of cholera and isolated it (Ibid). A few decades later, the germ theory was developed by Louis Pasteur and public health scholarship and epidemiology had begun (Ibid).

The 19th and 20th centuries witnessed the advance of the modern health paradigm (western paradigm) which set out to contain many of the deadliest infectious diseases in the developed and developing worlds, and partially in the Third World (Basil, 2014a; Kar et al., 2001b; Roberto, 2014). Undoubtedly, communication contributed to this success through educating the public about public health measures such as drinking clean water and support for vaccination programmes (Ibid). Just as technology advancement was an implicit part of the 20th Century, so mass communication offered a new set of means to accomplish success (Ibid). This stage in public health scholarship is known as the infectious disease (communicable disease) phase (Ibid).

In the latter half of the 20th Century, public health faced a new range of disease challenges, namely behaviour-oriented, non-communicable diseases. These diseases are driven by two causes; modifiable behaviours and physiological features. Non-communicable diseases cause, nowadays, more death than infectious disease (Basil, 2014a; Kar et al., 2001b; Roberto, 2014; WHO, 2015b). Poor diet, lack of physical activity, smoking cigarettes and using drugs are major contributors to premature death (Ibid). It is true that the

developed world has largely succeeded in tackling communicable diseases, but the change in the lifestyles, driven by prosperity, in the West has put new pressure on health care (Ibid). On the other hand, the Third World still is facing infectious disease challenges due to health system incapacity and the rising threat of non-communicable disease (Ibid). It is this combination of elements that has led to the current stage in public health.

This stage is marked by a combination of chronic and acute diseases either transmissible or non-transmissible in nature (Kar et al., 2001b; Roberto, 2014). The prevalence of disease is determined by different variables but the extent of economic development and the availability of public health services are both key factors (Ibid). Communication theories and practice have played a central role in efforts to confront public health epidemics and other challenges. So where and when did health communication begin? In fact, communication about healing, diseases, and protection cannot be limited to modernity nor even to the known communication literature. Since prehistory, people have painted or carved signs in caves containing messages about threats to life, including health (Basil, 2014a). However, this chapter will engage with only the known story of health communication in the literature

The first appearance of health communication was in the 1960s when doctors found the purely-scientific medical approach inadequate (Basil, 2014a; Dutta, 2008; Harrington, 2014; Kreps, 2014; Northouse & Northouse, 1998; R. Thomas, 2006). Although the bio-medical paradigm had achieved advancements in treatment and diagnosis, the healthcare deliver-receiver relationship had not advanced to a similar level (Ibid). In the 1960s, the receiver of health services was seen as a passive player in the health care context while the doctor was considered the authority (Hoving et al., 2010). In practice, the one-sided (top-down) relationship has continued to be popular among health professionals (Ibid). However, scholars were working on finding a solution to what was often a blockage in the delivery of health care. Health communication as a practice and a discipline was born.

At the time, sociologists and psychologists were simultaneously testing the communication variable in the health context. Their work and findings started to filter through to medical and communication professionals, who were also pondering the importance of communication in health care (Kreps, 2014;

Thompson, 2003; Wolff, 2007). New insights into the study of therapeutic communication were discerned by psychologists who examined the role of interpersonal communications especially within the family. Watzlawick's influential work, *The Pragmatics of Human Communication* (1967), brought yet more attention on to communication roles in the health setting (Ibid).

One of the early studies about the communication interaction between the physician and the patient was conducted by paediatricians trying to understand the influence of verbal communications on patient welfare and follow-up care (Korsch et al., 1968). The study concluded that communication was an important way to limit the lack of warmth in the doctor-patient relationship and was a positive factor in patients' accepting medical advice (Ibid). Social, economic and cultural backgrounds were also considered by Barbara Korsch to be influential in the interaction between the physician and patient (Ibid). By contrast, since the 1960s and 70s, there have not been any significant shifts in perceptions about the patient's passive role (Hoving et al., 2010).

Furthermore, health communication has expanded to include other areas. Since the 1970s, health institutions have faced difficulties in covering the cost of services provided to patients, leading to a change in the way hospitals work (DuPré, 2014; R. Thomas, 2006). In particular, the rise of consumerism in the health sector has seen a shift in patient identity from a beneficiary of government services to a consumer with the right to choose (Hoving et al., 2010). As a result, the need to communicate with consumers to assure customer satisfaction has added greater emphasis to communications in the health sector (Ibid). The rise of consumerism has also been arguably responsible for the growth of marketing in the health care sector, especially in the United States (Andreasen, 1994; Hastings & Domegan, 2013; Kotler & Roberto, 1989). In recent decades, the evolution of marketing has offered new possibilities for health promotion, such as through social marketing² (Ibid).

In the same manner, the emergence of prevention as a strategy to minimise the risks imposed to public health have drawn the attention of communication scholars and practitioners. Communication is now considered

² More discussion about social marketing and communication strategies will appear in the following section.

essential to the prevention of diseases, both infectious and chronic (Bukoski, 1991a; Bukoski, 1991b; Fields, 1995; Freimuth, 2014; Roberto, 2014; Schumacher & Milby, 1999; Wilson & Kolander, 2003). It was soon recognised that there were communication needs at all levels of prevention; primary, secondary and tertiary (Ibid). In primary care, doctors focus on educating patients' about how to take care of themselves and prevent potential risks (Ibid). Similarly, health professionals at the other two levels use communication such as a therapeutic tool at the tertiary level to achieve the same objective (Ibid).

Public health specialists acknowledge, therefore, that communication is an important way of achieving their goals (Abroms & Maibach, 2008a; Alcalay, 1983; Beato & Telfer, 2010; Hornik, 2002; Noar et al., 2010; Simons-Morton et al., 1997). In fact, public health interests in communication have led to the emergence of more roles for the mass media and for mass communication in promoting health to maximise the achievements of public health programmes (Ibid). Communication's capacity to reach a wider audience through mass media and through technological channels has fuelled the growth of mass media campaigns in health communication (Atkin & Rice, 2013; Atkin & Rice, 2014; Salmon & Atkin, 2003; Silk, Atkin, & Salmon, 2011).

The study of communication in health care has progressed rapidly in the years following the first study. In addition to the research, there have been contextual and structural changes that have backed up the need for more research about communication in health. Most significant, health systems and institutions struggling with costs has led to a change not only in understanding the patient is a consumer, but also on an organisational level through the merging of hospitals and medical facilities into larger, holding entities (DuPré, 2014; Schiavo, 2014). Such a development, especially in the US, introduced a new set of challenges such as the communication between management and shareholders as well as between consumers and healthcare deliverers (Ibid).

Moreover, the 1980s-90s witnessed considerable shifts in the position of the patient in the context of healthcare. For example, in the 1980s, under pressure from self-care and self-help groups, several countries introduced regulations regarding patients' right to be informed about their condition and the potential treatments (Hoving et al., 2010; R. Thomas, 2006). Consequently, communication with patients shifted from being a matter that was the personal

preference of the professionals to a more regulated exchange (Ibid). Patients advanced from a passive to an active role in the healthcare process. In the following years the situation has developed further still and patient-health education and patient involvement in making healthy choices are common positions (Ibid).

Above all, health communication has not been immunised from changes in the surrounding context. Cultural diversity and technological advancements have raised more concerns and questions about health and communication (Dutta, 2008; Schiavo, 2014; Wright et al., 2012). Technological improvements in the late 20th Century have certainly been perceived as a great opportunity to improve health, especially as the notion of e-health³ has evolved (DuPré, 2014; Kreps & Neuhauser, 2010; Lupton, 2015; Neuhauser & Kreps, 2003; Noar & Harrington, 2012; Sundar et al., 2011; Wright et al., 2012). However, the dilemma of multiculturalism in healthcare delivery systems has emerged as an imperative challenge to the dominance of culture in health and healing (Dutta, 2007; Dutta, 2008; Kar et al., 2001a; Kar et al., 2001c). The cultural shifts caused by demographic changes in the West have encouraged scholars to investigate communication's role in understanding diversity, inequality and discrimination in healthcare delivery (Ibid). Multiculturalism, cultural diversity and demography are, indeed, largely responsible for the growth of the critical/cultural perspective in the study and application of culture in health communication⁴.

Having said that health communication was born and developed within the environment of healthcare, some scholars argue that the emergence of the mass media has been a critical factor. Studies investigating the role of the mass media in health interventions and campaigns began in earnest at the beginning of the 20th Century (Dutta & Souza, 2008; Wakefield, Loken, & Hornik, 2010b; Wartella & Stout, 2002). At the core of most of these studies was the attempt to both predict and change behaviour around health.

³ E-health refers to the use of communication technologies such as the internet, wireless, e-applications, satellite positioning in the delivery of health care and health promotion to the public (DuPré, 2014; Kreps & Neuhauser, 2010; Noar & Harrington, 2012; Sundar, Rice, Kim, & Sciamanna, 2011; Wright et al., 2012).

⁴ The third section of the chapter is dedicated to this issue, which is the framework of this thesis.

One of the earliest health campaigns was conducted by Lashley and Watson in 1922. It was a film campaign about sexual diseases. The results of the study concluded that the film had an effect on the audience's knowledge about sexual diseases, but not on their attitudes (Wartella & Stout, 2002).

Another study in 1933, by Peterson and Thurstone, focused on the use of mass media to change the attitudes of children and adolescents (Ibid). Children and adolescents were exposed to pictures and films on various topics. The attitudes of the participants were then measured by means of a paper-pencil test in the classrooms (Ibid). The findings supported the greater effect of mass media campaigns on younger people compared to adults, especially if the children had not received any information about the potential topics prior to exposure (Ibid).

Further, after these initial beginnings in communicating health, the momentum in researching and applying communication in health-related issues has reached new levels in terms of communication levels and practice. Beyond the doctor-patient interaction, health communication has achieved more progress in other areas (Ratzan et al., 2004). Public health communication, in other words, has gone through three different eras (Ibid).

First was the, "pre-television era" when health communicators mainly used radio and newspapers, but the achievements were not effective at all (Ibid). The second era was marked by the use of television and was hailed as an era of "success" due to television's demonstrably powerful impact (Ibid). During this era, scholars tested the use of extensive mass communication in order to promote health but didn't include community support or personal counselling (Abroms & Maibach, 2008a; Alcalay, 1983; Basil, 2014b; Beato & Telfer, 2010). Some examples of health communication campaigns using mass media tools that were considered successful: the Stanford Three Community project and the Stanford Five-city Project in 1970s-80s (Basil, 2014a; Basil, 2014b; Leshner, 2014), Minnesota's Heart Health programme in 1980 (University of Minnesota, 2012), Rhode Island's Pawtucket Heart Health project in 1980 (Carleton, Lasater, Assaf, Feldman, & McKinlay, 1995; Eaton et al., 1999; Hunt et al., 1990), Missouri Bootheel Heart Health in 1989-90 (C. Brownson, Dean, Dabney, & Brownson, 1998; R. Brownson et al., 1996), and

the famous, long-running North Karelia project in Finland started in 1972 (Puska, 2002).

All the community-based programmes above focused on cardiovascular diseases, as non-communicable diseases had begun to attract physicians' attention from the late 1970s. Generally, all the above programmes have demonstrated that the use of integrative interventions can bring positive results in reducing risky-health practices (Abroms & Maibach, 2008a; Basil, 2014b; Puska, 2002). Integrative interventions refer to the use of more than one approach or mix of approaches including education-based, community-based and mass media-based approaches to the implementation of health communication programmes (Helme et al., 2015; Wilkinson, 2013). In fact, combining approaches has become a popular tactic in the implementation of health communication programmes (Ibid).

Finally, the 21st Century has become known as the “communication age era” (Ratzan et al., 2004). This era is more alternative from the earlier eras in terms of reaching the public due to the huge technological development such as the internet, the prevalence of wireless, increase in the use of mobile phones, smartphone applications, websites and software's (Kreps & Neuhauser, 2010; Neuhauser & Kreps, 2003; Noar & Harrington, 2012; Wright et al., 2012), in addition to various achievements and effects relating to changes in health behaviours (Ratzan et al., 2004). Nowadays, the key challenges facing health communicators are health disparities, inequality and a range of socioeconomic factors.

Since the early studies of the 1960s, health communication as a field has achieved academic recognition and academic scholarly organisations have multiplied (Kreps, 2014; Wright et al., 2012). The first academic body to create a division with a specific focus on health communication was the International Communication Association (ICA) in 1975 (Kreps, 2014; Thompson, 2003; Wolff, 2007). In 1985, this was followed by the National Communication Association of the USA while the American Public Health Association officially recognised health communication in 1997 (Ibid). Across the Atlantic, the field has also been acknowledged by the European Communication Research and Education Association (ECREA) and the European Association for Communication in Healthcare (Schulz & Hartung, 2010).

The first dedicated academic journal in the field, *Health Communication*, was launched in 1989 and started to cover various issues of communication in health settings (Kreps, 2014; Thompson, 2003; Wolff, 2007). The second journal, the *Journal of Health Communication*, was launched in 1996 with the intention of focusing more internationally and practically on health communication (Ibid). Both journals are based in the United States. The *Communication and Medicine Journal* currently publishes in the UK, while the *Patient, Education & Counselling* journal is based in Europe (Schulz & Hartung, 2010)⁵.

Unfortunately, academic research into health communication in the Arab world, and in Saudi Arabia in particular, has not reached anything like the level seen in the United States or in Europe. The reasons for this imbalance will be discussed below in further chapters. I will now turn to the theoretical section of the health communication development story.

2.2.2 Health communication; perspectives and nature of research

In line with the thriving and dynamic features of health communication practice in the mid-20th Century, research in the field has also developed rapidly. I will locate the nature of health communication research first, and then present health communication research perspectives, both scientific and interpretive.

The discipline of health communication is “multifaceted and multidisciplinary” (Ratzan et al., 2004, p.485). It is multifaceted because it describes the nature of health communication practice as a combination of different elements and steps⁶ (Ratzan et al., 2004). Its multidisciplinary character has been commented on by scholar Nancy Harrington who claims health communication research is “multidisciplinary, interdisciplinary, and transdisciplinary” (2014, p.10). This disciplinary complexity is the natural result of the circumstances that led to emergence of health communication. Initially, efforts to study the role of communication were conducted by health professionals with medical backgrounds such as physicians and nurses (Korsch

⁵ For more details about literature, professional organisations and conferences, see (Kreps, 2014; Paek, Lee, Jeong, Wang, & Dutta, 2010; Schulz & Hartung, 2010).

⁶ It is compatible with the nature of the old days before health communication practice emerged when pragmatic advice in how to deal with patients was received from a diverse group’ (Morse, 2012).

et al., 1968; Morse, 2012; Morse & Field, 1998). Early contributions from psychology and medical sociology ensured a multidisciplinary aspect in the field (Kreps et al., 1998; Kreps, 2014; Kreps, 2009; Ratzan et al., 2004; Wolff, 2007). As a result, multidisciplinary has been cultivated in the theories of health communication as well as in the practice.

From the beginning, health communication scholars from different disciplines approached the subject from multiple directions (Harrington, 2014; Kreps, 2014; Parrott & Kreuter, 2011). Some intra-disciplinary studies examined health issues while others focused on the communication dimension. The multidisciplinary of the early research led in time to more integrated, interdisciplinary research practice (Ibid).

Interdisciplinary research offered a collaborative platform for researchers from different disciplines to come together and address health issues or communication aspects in health (Harrington, 2014; Kreps, 2014; Parrott & Kreuter, 2011). Furthermore, the collaborative nature of interdisciplinary research adds advantages to health communication; improves the validity of outcomes, extends the research schema, and reinforces health enhancement programmes (Ibid).

Recently, transdisciplinarity as a mechanism of conducting research has emerged. Basically, it means integrating insights and knowledge from different fields to form new theories and approaches generated from different disciplines (Harrington, 2014; Kreps & Maibach, 2008; Parrott & Kreuter, 2011). It aims to melt the barriers preventing intellectual integration. It is also an opportunity for research to merge expertise together and bring in new, integrative efforts (Ibid). Overall, researching communication on health topics has become a flexible field welcoming diverse disciplines to contribute to the inquiry.

In light of the nature of the dynamic field, theories and approaches to health communication have expanded rapidly since the early endeavours of interested physicians and the first studies of mass media's impact on health. Moreover, there have been methodological advances within many of the research paradigms which have contributed to a rich ecology of perspectives in the field (Kreps, 2011; Neumann et al., 2011; Thompson et al., 2011; Thompson et al., 2014; Whaley, 2014). Health communication scholarship is now effectively housed in one of two major research perspectives, scientific and

interpretive (Dutta & Zoller, 2008; Dutta & Souza, 2008; Dutta, 2008; Dutta & Basu, 2011; Harrington, 2014).

Early approaches to health communication, as I have mentioned, largely concerned doctor-patient communication (DuPré, 2014; Dutta & Zoller, 2008; Dutta, 2008; Dutta & Basu, 2011; Kar et al., 2001c; Lupton, 1994; Sparks & Villagran, 2010; Thompson, 2003). Most aimed to identify global features of the communication between physicians and patients while using observation methods over communication interactions in healthcare to create a prediction system (Dutta & Zoller, 2008). Observation is one of the key research methods of the scientific paradigm. This paradigm constitutes, as Dutta argues, the dominant research paradigm in the field (Dutta, 2008; Dutta, 2010; Dutta & Basu, 2011).

Inspired by positivism, the scientific paradigm is founded on the principle of objectivity and adheres to the belief that the real world can be measured by the researcher without bias and without necessarily referring to context or to personal differences or preferences (Dutta, 2007; Dutta, 2008; Dutta & Souza, 2008; Dutta & Zoller, 2008; Harrington, 2014).

The post-positivism paradigm was a critical response to the positivism of the dominant framework. Methods were less empirical and more deductive. Study outcomes could potentially approve or disapprove the hypothesis of the study (Ibid). However, the scientific paradigm did not necessarily mean the absence of qualitative methods in early health communication studies. In fact, several nursing scholars conducted ethnographic studies that constituted the first step in the emergence of transcultural nursing⁷ (Morse, 2012).

Consequently, the scientific group welcomed the growing stream of behavioural and social science theorising. Attributable to the field's multidisciplinary nature, behaviour-oriented studies adopted the scientific method of researching for answers. Two levels (themes) of communication were addressed in this approach, interpersonal communication and health communication campaigns (Dutta & Zoller, 2008). Also, quantitative methodologies have been common in this approach (Ibid).

⁷ For further details see; *Two Worlds to Blend* (1970) by Leininger, Brink edited volume, *Transcultural Nursing* (1976), and *Transcultural Nursing* (1979) by Leininger (Morse, 2012).

Burgoon has critiqued the use of quantitative methodologies when it comes to communication in a health setting, arguing he felt it did not make sense if the fundamental measure was “Dead or Not” (Burgoon, 1995, p.3 cited in Dutta & Zoller, 2008). In other words, studying individuals with no consideration of the context is meaningless. Feedback from the public was essential, he suggested, in understanding how public opinion and campaigns worked (Ibid).

Others saw health communication campaigns as heaping more responsibility onto the shoulders of campaigners to inform the public about potential health risks and how these could be avoided to stay in good health (Scherer & Juanillo, 1992). This approach, too, was not without its critics.

Overall, post-positivistic health communication approaches tend to focus on the roles of social psychological factors in the prediction and change of behaviour (Dutta & Zoller, 2008). According to Dutta & Zoller: “This line of research has typically been concerned with the identification of constructs, operationalization, measurement, and prediction of health-related communication constructs” (Ibid, p.5). In health campaigns, this approach is concerned with spotting variables such as perceived outcomes in order to maximise the effectiveness of the campaign (Dutta & Souza, 2008; Harrington, 2014; Helme et al., 2015; Wilkinson, 2013). In other words, this approach seeks to provide practical solutions to overcome barriers or problems which could minimise the effectiveness of health interventions at the individual level (Ibid).

I am going to examine further the dominant (scientific) paradigm of researching health communication by bundling together the prominent social cognitive theories in health communication. Furthermore, these models provide useful ways to study the personal, contextual factors and events influencing behaviour changes, especially when it comes to predicting or understanding these changes, along with the strategies and bases on which to conduct successful health interventions (N. Corcoran & Corcoran, 2010; R. J. Donovan & Henley, 2003; Fishbein & Cappella, 2006). However, the cultural variable in these theories is excluded. Since the 1970s, social cognitive theories and models have grown fast and become more recognisable in the disciplines of behavioural science, social science and social psychology, and then in health

communication and other related health-related disciplines (Rutter & Quine, 2002).

Researchers have developed a wide range of instruments within the broad ambit of social cognitive theory such as the Health Belief model (Becker, 1974; M. Rosenstock, 1974; M. Rosenstock, Strecher, & Becker, 1994), social learning/ cognitive theories (Bandura, 1994; Bandura, 1977; Bandura, 1986), the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein, 1975), the theory of planned behaviour (Ajzen, 1991) the trans-theoretical model of behaviour change (Prochaska & DiClemente, 1983; Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 1992), the theory of subjective culture and interpersonal relations (Fishbein et al., 2002; Fishbein & Cappella, 2006; Triandis, 1977), and the integrative model (Fishbein et al., 2002; Fishbein & Cappella, 2006). I will now examine each of these below.

The Health Belief model was developed by Becker in 1974, based on Rosenstock's 1966 paper 'Why people use health services' (N. Corcoran, 2010b; Dutta, 2008; Schiavo, 2014). The main idea of this model is that an individual will change behaviour depending on the effects of two factors.

Firstly, the negative impacts of behaviour on the person, meaning she/he should understand the threats of behaviour to them, in other words, how vulnerable they are from carrying on with this behaviour (i.e. lung cancer for smokers). In addition, how strong the negative impacts of this behaviour are on the individual in terms of severity (Airhihenbuwa et al., 2000; N. Corcoran, 2010b; R. J. Donovan & Henley, 2003; DuPré, 2014; Dutta, 2008; Fishbein et al., 2002; I. M. Rosenstock, Strecher, & Becker, 1988; Rutter & Quine, 2002).

Secondly, the benefits and barriers of changing behaviours, meaning the individual must perceive that the benefits from changing behaviour are an improvement on the current situation, either in terms of money, time, emotion, or social contact. For example, the benefits of quitting smoking would be a lower likelihood of contracting cancer as well as the prospect of saving money while losses might include missed opportunities to socialise with other smokers (Ibid). In addition, there were three more elements added to this model; modifying factors, cues to action (i.e. education, media information and symptoms), and self-efficacy (N. Corcoran, 2010b; R. J. Donovan & Henley,

2003; Dutta, 2008; Fishbein et al., 2002; I. M. Rosenstock et al., 1988; Rutter & Quine, 2002; Schiavo, 2014).

Social learning theory: This theory was developed by Bandura in 1977 and is based on the main assumption that an individual learns new behaviour from the surrounding social world as well as from observing members of society who have adopted the potential behaviour. This process depends on two determinants; expectancies and incentives (Airhihenbuwa & Obregon, 2000; R. J. Donovan & Henley, 2003; I. M. Rosenstock et al., 1988). In other words, an individual learns behaviour in part depending on social incentives (outcomes) from a social context and in part due to the incentives received by witnessing others adopting that potential behaviour (Ibid). In addition, social learning theory distinguishes itself by putting more attention on environmental roles (R. J. Donovan & Henley, 2003). This theory subsequently developed in two directions; Digital or (New) social learning theory and social cognitive theory (Catford, 2011; R. J. Donovan & Henley, 2003; I. M. Rosenstock et al., 1988; Schiavo, 2014).

New social learning theory refers to the combination of social learning theory and new social media, and the idea that to create a new theory for health communication and health promotion depends on opportunities that are provided by social media (Catford, 2011). According to Catford, new social learning can reframe social media from a marketing dimension to a strategy that encourages knowledge transfer and enables learning with, from, and about each other. According to this theory, individuals anywhere and at any time can learn to change themselves or the world around them (Ibid). The importance of this theory comes from the notion that new social media demolishes the time and distance between communicators. In addition, the low cost of the new technology is likely to lead to better accessibility and more effective health messages (Ibid). Therefore, new social learning theory provides a framework by which communicators can reach marginalised or isolated people through online discussions while providing a path to shrink social inequality (Ibid).

Social cognitive theory was developed by Bandura in 1986, It considers self-efficacy as an essential determinant for predicting behaviour along with expectancies and incentives (Airhihenbuwa & Obregon, 2000; R. J. Donovan & Henley, 2003; DuPré, 2014; Dutta, 2008; Fishbein et al., 2002; I. M. Rosenstock

et al., 1988; Rutter & Quine, 2002; Schiavo, 2014). Self-efficacy is an individual's self-assessment about her/his ability to perform a particular behaviour. So if a person has high self-efficacy towards performing an initial behaviour, he/she is more able to adopt the behaviour, whereas if a person has low self-efficacy, the opposite will be the case (Ibid).

The Theory of Reasoned Action (TRA) suggests that an individual tends to behave in a particular way depending on their intention (Airhihenbuwa & Obregon, 2000; R. J. Donovan & Henley, 2003; DuPré, 2014; Dutta, 2008; Fishbein et al., 2002; Rutter & Quine, 2002; Schiavo, 2014). Intention is defined as a 'subjective likelihood' that one will perform (or try to perform) the behaviour in question (Ibid). From this theory, intention depends on two determinants - attitudes and subjective norms (Ibid). The theory of planned behaviour can be described as a modified version of the Theory of Reasoned Action. It shares the same variables with an additional determinant, which is perceived behavioural control (N. Corcoran, 2010b; Rutter & Quine, 2002). It was developed by Ajzen (1985) to provide people with an appraisal system to measure their ability to adopt an initial behaviour (Ibid).

The integrative model was developed by Martin Fishbein in 2000 (Fishbein et al., 2002; Fishbein & Cappella, 2006). It is based on a set of four theories and models; the Health Belief model, social learning/cognitive theories, the Theory of Reasoned Action and the theory of planned behaviour (Ibid). The integrative model aims to establish frames to identify elements and determinants for behaviour prediction, understanding and intervention. This is recognised as the first stage in conducting an appropriate health campaign (Ibid). After reviewing the existing theory, Fishbein came to the conclusion that specific variables are essential to understanding behaviour, namely; susceptibility to threats, attitudes, beliefs and self-efficacy (Ibid). Unlike other classic health communication models, the integrative model considers individual differences as well as being sensitive toward culture (Ibid).

Together all these behavioural and social science theories of health communication share the joint aim of determining the influential aspects in an individual's behaviour with no consideration of the surrounding context (Airhihenbuwa, 1995; Airhihenbuwa, Ford, & Iwelunmor, 2014; Dutta, 2007; Dutta, 2008). Therefore, the Health Belief model and social cognitive models

tended to be culturally ignorant and individual-focused in their self-assessment and decision-making processes (Ibid).The achievements of the scientific paradigm cannot be ignored, of course, but the lack of cultural aspects was a distinct weakness of the framework.

While the scientific paradigm remains dominant in health communication, various commentators and scholars have raised concerns about its limitations and weaknesses (Airhihenbuwa & Obregon, 2000; Airhihenbuwa, 1995; Dutta, 2007; Dutta, 2008; Lupton, 1994). This criticism gave rise to an alternative (non-objectivist, non-scientific) paradigm which relies on interpretive, critical and cultural perspectives. Following the cultural diversification of the 1980s and 1990s and the growth of health literacy imperatives, scholars looked for alternative ways to incorporate subjective meanings and the surrounding context (Airhihenbuwa, 1995; DuPré, 2014; Dutta, 2008; Kar et al., 2001a; Kar et al., 2001b).

Since the scientific paradigm is focused on the individual, it does not engage with the natural environment nor does it reflect structural changes within the health sector. Key relationships such as those between patients and experts in the sector are not reflected. Neither were patients assigned any agency in the modification of behaviour or in changes of attitude or belief. Indeed, the manipulation of the health intervention process (the paternalistic feature of the paradigm) led to a search for other means to engage receivers (Dutta, 2008; Dutta & Zoller, 2008).

Moreover, the growing interest in finding alternative perspectives has been accompanied by methodological debates among scholars aimed at solving the dilemma of excluding subjectivity and researcher roles from scientific methods (Brikci & Green, 2007; J. Creswell, Plano Clark, Gutmann, & Hanson, 2003; Hammersley, 2011; Mason, 2011). In fact, the emergence of alternative approaches to the study of health communication has been paralleled with the development of a range of qualitative and mixed methodologies (Kreps, 2011; Neumann et al., 2011; Thompson et al., 2014).

Besides the motivation to find an alternative approach to study health communication, the interpretive perspective has a number of favourable aspects. It emphasises, for instance, how meanings related to health issues are socially constructed (DuPré, 2014; Dutta, 2007; Dutta, 2008; Dutta & Zoller,

2008). Interpretive scholars recognise that there is more than one truth within the reality that is the social world, and researchers have a role to investigate these truths. Interpretive scholars acknowledge that a degree of bias may exist in the research outcomes (Ibid), but argue that the qualitative methodology provides measures to minimise the bias. In general, interpretive scholars tend to prefer qualitative methodologies (Kreps, 2011; Neumann et al., 2011; Thompson et al., 2014). Traditional methodologies such as phenomenology, ethnomethodology, ethnography, semiotics and rhetoric, are popular, and research methods such as interviews, focus groups and participant observation are common (Ibid).

Within the interpretive school, the critical perspective considers the role of health communication in building dominant power relationships as well as in marginalising some groups in a society with shared characteristics (Dutta & Zoller, 2008, p.6). It argues a number of questions, for instance, “How do communication practices in health settings serve the status quo? How are the interests of the underprivileged sectors of social systems represented in the discursive space of health communication theories and applications?” (Ibid, p.6-7). This perspective aims to empower the marginalised groups to change (social change).

Lastly, the cultural approach to health communication has been introduced as an alternative to fill the gaps in the dominant (scientific) paradigm. Here, the concentration on individuals is replaced in the cultural perspective by context (culture) and community (Airhihenbuwa, 1995; Airhihenbuwa et al., 2014; Dutta, 2007; Dutta, 2008; Dutta, 2009; Dutta & Basu, 2011; Kreps & Kunimoto, 1994). This perspective prioritises culture in the assessment and intervention in public health communication, education, and promotion (Ibid). Indeed, this perspective resists the paternalistic focus on the relationship between the researcher (promoter) and the receiver(s) and the ignorance of potential change through community-based programmes (Dutta, 2008). In fact, the cultural perspective embraces the centralisation of culture in health communication theorisation and practice (Dutta, 2014).

The cultural approach argues that the meanings behind health communication messages are socially constructed in particular cultures by powerful actors in this culture (Dutta, 2008; Dutta & Basu, 2011). The approach

is influenced by the interpretive research paradigm in that it considers how health meanings are formed in local environments and how this affects meaning. Also, the critical approach seeks to explain the role that power plays in a local context in shaping social meaning for both messages as well as discourse (Airhihenbuwa et al., 2000; Airhihenbuwa & Obregon, 2000; Dutta, 2008).

In the following section, I will address strategies regarding the implementation of health communication programmes before considering how best to apply culture to health communication.

2.3 Health communication campaigns and strategies

Health communication has now moved away from focusing mainly on the interaction between doctors and patients to incorporate various topics such as e-health education, mass health communication and tele-medicine (DuPré, 2014; Dutta, 2008; Harrington, 2014; Wright et al., 2012). Since the emergence of the notion of using communication strategies bundled into interdisciplinary models, the field has witnessed progress in transferring theory to practice and in engaging with those in need of health information (Ibid). At the outset, scholars' efforts were directed at personal communications in health care settings (Kreps et al., 1998; Kreps, 2014). Since then, the focus has shifted to public health challenges, the growth of behaviour-oriented health risks (*non-communicable diseases*) as well as alternative solutions to the use of public communication campaigns and communication interventions (R. Ahmed & Bates, 2013; Dutta & Souza, 2008; EMCDDA, 2014). First, let us consider the practical side of combatting risky health behaviour through health communication campaigns and interventions.

Campaigns are a long-standing practice aimed at communicating with wider audiences (Atkin & Rice, 2014; Kopfman & Ruth-McSwain, 2012; Salmon & Atkin, 2003). Historically, the use of campaigns has not been specific to health. The known history of campaigning identified war and politics as the initial topics (R. J. Donovan & Henley, 2003; Kotler & Roberto, 1989). Indeed, *John Muri* was recognised as the first to have campaigned to save the environment in America, particularly the forests (Rose, 2005). The first and second World Wars are considered by many as the starting point for the use of

campaigns and communication to manipulate the public and win hearts and minds (L'Etang, 2008; Paisley, 2001). The early forms of public relations and diplomacy emerged under these circumstances (Ibid). There has been very little work done on the development of campaigns and communications worldwide as most studies have tended to focus on a specific region or country. Here, therefore, I will present two examples of work which I will use as the basis for my own interpretation. In the United States, the use of campaigns to influence public knowledge, attitudes and behaviour was linked to the days of reform in the country prior to 1800 (Paisley, 2001). These campaigns varied from individual initiatives to group efforts in support of such issues as temperance, women's rights and support for freed slaves.

The spread of free market principles and consumerism popularised the use of campaigns in business (Ibid). Indeed, the emergence of marketing, advertising and public relations as practices and as scholarly disciplines has enhanced the popularity of campaigning even further (DuPré, 2014; Schiavo, 2014; R. Thomas, 2006). Successes in politics and in driving economic products added impetus to campaign use, a tendency which itself was nurtured by the growing tide of consumerism following the Second World War (L'Etang, 2008).

In the Arab world, the story was very different. The region witnessed economic and political shifts in the late 20th Century but the campaign was introduced mainly as a communication method to achieve political goals such as liberation from colonial powers and traditional monarchies (Mellor, 2011; W. Rugh, 2007; Yushi, 2012). The Egyptian regime's use of radio (the Voice of the Arab) in the 1950s-60s was the first form of campaigning that attempted to communicate directly with the Arab masses. Since illiteracy was high at this time, radio communication proved to be effective (Ibid). At the same time, the rapid development of the oil industry in the region contributed directly to the growth of consumerism and to the expansion of the media industry, marketing and advertising and, therefore, to the emergence of campaigns and communications (Long, 2005a; Wheeler, 2003).

The development of communication with the masses has been different from one country to the next while the milieu in which this takes place also plays a crucial role. In authoritarian states, the relationship between the state and

campaigners is quite different compared to a liberal context, while differences in levels of economic prosperity or in the economic system (whether market-based or socialist) are also important (Paisley, 2001). This key point has often been overlooked by scholars, though it is crucial.

Since the mid-20th Century, technological advancements in communications have been reflected in the applied side of campaigning. These advances have, in turn, also encouraged the expansion of the methods to other sectors beyond the political landscape⁸ in different areas (Wright et al., 2012).

As discussed in the previous section, the use of mass media campaigns in tackling health problems has moved beyond the physician in the health care setting. The modern form of campaigning has linked health problems with specific objectives such as reducing smoking in public, eating fast food and encouraging exercise (R. Ahmed & Bates, 2013; Dutta & Souza, 2008; Logan, 2008; Salmon & Atkin, 2003). Various scholars have expressed optimistic views about the potential of the mass media and of campaigns to achieve beneficial health outcomes (Ibid). Since the 1960s, public communication campaigns have been used to raise awareness about the negative consequences of drinking and driving. In the UK, the first televised advertisement to highlight the dangers of drink-driving was aired in 1964. Since then, the Department of Transport has continued broadcasting advertisements, mostly every Christmas season, to contain the problem. The campaign, together with new laws and regulations, have succeeded in reducing drink-driving deaths from 1,640 in 1979 to 230 in 2012 (Westcott, 2014).

A second example of campaigning was the anti-drug “Just say no” campaign of the 1980s, the first American attempt to combat the problem of drugs by using communication initiatives (Atkin & Rice, 2013; Forman & Lachter, 2011; Lachter & Forman, 2011). As a result of the campaign the number of cocaine users dropped (Ibid). Since then, the US government and NGOs have devoted considerable effort and funds to prevent illicit drug taking. Between 1998 and 2004, the US government spent almost \$1 billion on the battle against illicit drugs through the White House Office of National Drug Control Policy (Atkin & Rice, 2013).

⁸ See Encyclopaedia of Presidential Campaigns, Slogans, Issues, and Platforms by (R. N. Roberts & Hammond, 2004).

The use of public communication campaigns to confront health challenges has expanded substantially to include not just alcohol and drug abuse, but also issues of nutrition, physical activity, cardiovascular disease, HIV/AIDS, cancer, anti-smoking, road safety and youth violence (Wakefield et al., 2010a). So how do we define a public communication campaign, how does it function?

A campaign refers to a set of planned processes and tactics conducted by a responsible body or state to accomplish identified (pre-set) goals in an identified timeframe (Barnard & Parker, 2012). It could be a war campaign or a blood donation campaign. In the health communication context, especially with regard to the topic of drug abuse and drinking alcohol, a campaign is the process of using communication (mass communication and non-mass communication) to reach wider groups or a specific group within a timescale to change health behaviour, attitudes or knowledge (Atkin & Rice, 2013; E. Crawford & Okigbo, 2014; Helme et al., 2015; Kopfman & Ruth-McSwain, 2012; Silk et al., 2011).

According to Atkin and Rice (2014), “campaign designers perform a situational analysis and set objectives leading to the development of a coherent set of strategies and implement the campaign by creating informational and persuasive messages that are disseminated via traditional mass media, new technologies and interpersonal networks” (, p.3).

Before going further, it is important to clarify the difference between health communication interventions and campaigns. Basically, an intervention according to Haas is:

Communication interventions usually have more specific objectives, a narrowly defined audience, and programs or tools tailored to inform and persuade that audience. Although mass media are sometimes included, Communication interventions tend to use direct, interactive communication methods to encourage individual empowerment. Also, because interventions often are implemented in more controlled environments, it can be easier to assess if the intervention had an impact on behaviour (2014, p.214).

When it comes to health behaviour, campaigns aim to change behaviour, attitudes and understanding or to prevent risky behaviour. Nowadays, health campaigns take on different features whether conducted on a personal level or

public level. Accordingly, Wakefield and others (2010) observe that “mass media campaigns are widely used to expose high proportions of large populations to messages through routine use of existing media, such as television, radio, and newspapers” (, p.1261). However, campaigning for health behaviour differs from other kinds of campaigns such as advertising or politics. Health behaviour campaigns tend to focus on something different such as attempting to persuade people to stop doing something they enjoy, such as smoking or engaging in risky sexual behaviour, to obtain long-term health benefits (Haug, 2004).

Campaigns have become an increasingly important weapon in the battle against communicable and non-communicable diseases for a number of reasons. First, campaigns have a record of achieving good results. In the health sector, positive results have been recorded in a number of areas such as skincare, cardiovascular disease and the environment and campaigns have been effective at changing behaviour and attitudes (Beato & Telfer, 2010; Breitbart, Greinert, & Volkmer, 2006; Noar et al., 2010; Puska, 2002). Additionally, improvements in campaign design and management have popularised their use in both the private and public sectors, including NGOs (Silk et al., 2011). Furthermore, the developments of new communication technologies such as the internet, smartphone, and social media applications have promoted new opportunities for campaigners in general and in the health sector (Kreps & Neuhauser, 2010; Neuhauser & Kreps, 2003; Noar & Harrington, 2012). Finally, the emergence of democracy, transparency and accountability in the public service has popularised the use of campaigns, especially in the first world and democratic countries (Volkmer & Römmele, 2002).

Campaigning in health communication, like campaigning in other areas, is characterised by two key features; objectives and methods (Haas, 2014; Paisley, 2001). The aim of a campaign determines the targeted audience and the content of the delivered messages (Ibid). Based on its objectives, health communication campaigns divide into two types; informative (awareness) or campaigns aimed at changing health behaviour, and campaigns aimed at policy change (Coffman, 2002; Moffitt, 2004; Silk et al., 2011; Yeomans, 2006). Whether campaigns are informative or policy-oriented depends on the method

and procedures used. In other words, a communication campaign is a process-based practice (Ibid). In their efforts to promote advocacy and awareness, communication campaigns have shifted from a linear-model of communication to an interactive one (Yeomans, 2006).

Since the emergence of the campaign in efforts to achieve social benefits, the management of the campaign process has matured considerably. The consensus among public communication scholars is that communication campaigns consist of three phases; pre-campaign preparation, the period during the campaign and the phase after the campaign has been completed (Atkin & Rice, 2013; Atkin & Rice, 2014; E. Crawford & Okigbo, 2014; Haas, 2014; Moffitt, 2004; Silk et al., 2011; Silk, 2014). These phases are naturally integrated, a pattern shared by communication interventions as well (Silk, 2014).

The pre-implementation phase of the campaign is known as the period of formative research. It is the time in particular for audience analysis and for the design of the campaign (Atkin & Freimuth, 2001; Coombs, 2004). The campaign objective determines the targeted groups and the pathway to implement the campaign (Ibid). Most campaigns take one of two routes; promoting a healthy lifestyle or behaviour, or preventing dangerous behaviour (Atkin & Rice, 2013; Atkin & Rice, 2014; Silk et al., 2011; Wright et al., 2012). The designer then looks at the available literatures and data to identify the traits of the targeted groups and prevailing knowledge and perceptions about their health behaviours. In order to achieve the campaign's goals, the designer uses qualitative and quantitative data collection methods to develop suitable message content and appropriate communication channels (Ibid).

It is in the stage of preparing the campaign that both paradigms of researching health communication (the scientific and the interpretive⁹) can be used to guide the development of the campaign and in the selection of the preparatory steps (Ibid). The second phase involves implementation as campaigners convert the plan into reality and make use of various channels to achieve their aims. Alternative qualitative and quantitative tools are used to assess the progress of the campaign to measure, for instance, whether the right

⁹ The following section will address the interpretive theories, especially the cultural perspective approaches.

message is reaching the intended audience and also to keep track of progress (Atkin & Rice, 2013; Atkin & Rice, 2014).

Scholars in this area recommend the use of informative or awareness-oriented messages to encourage healthy choices while the preventive approach tends to embrace messages about avoiding or changing risky health behaviour (E. Crawford & Okigbo, 2014; Logan, 2008). The style of the message could take different forms, i.e. fear appeal, informative or persuasive appeal (Atkin & Rice, 2013; Atkin & Rice, 2014; Salmon & Atkin, 2003; Silk et al., 2011). Furthermore, there are means of maximising the effectiveness of the messages. For instance, message content should be credible, engaged, relevant, understandable and motivational (Ibid). A number of quantitative tools have proven useful for evaluating the distribution of the messages. According to Atkin and Rice, the “five major aspects of strategic message dissemination are the total volume of messages, the amount of repetition, the prominence of placement, the scheduling of message presentation, and the temporal length of the campaign” (2014, p.12).

The third phase is the evaluation of the campaign. The evaluation can be in terms of campaign outcomes or can be summative. This process helps the campaign's management team analyse the results of the campaign on the targeted group's behaviour, attitudes and understanding (Atkin & Rice, 2013; Atkin & Rice, 2014; Silk et al., 2011; Wright et al., 2012). Survey or focus groups are often appropriate vehicles for this process. The evaluation step is crucial to assess the efficiency of the communication and the required changes (Ibid). An effective evaluation process requires skilful communicators and sufficient funds, elements often lacking in organisations responsible for health communication campaigns. Evaluation is, therefore, one of the critical aspects of health communication.

All three of the above steps are applicable to communication interventions, with the only exception being that communication interventions might also include services or health products (Haas, 2014). Both a campaign and a communication intervention can be conducted at a mass media level or at an interpersonal level, depending on the aims. Indeed, the responsible organisations such as governmental agency or NGO are influential in the three steps (Ibid).

Health communication scholars have utilised a range of different strategies to direct their efforts, particularly around campaigns and interventions. These strategies have evolved under different circumstances and include, for example, the three levels of prevention, a communication-persuasion matrix, an ecological approach as well as education-based or community-based strategies and social marketing. The diversity of health communication strategies reflects the dynamism of the field. I will outline these in more detail below.

As I have mentioned, the evolution of infectious and chronic diseases and the growth of epidemiology has stimulated groups of public health and communication scholars to work on developing solutions to these challenges. The three levels of prevention model sets out primary, secondary and tertiary stages to health provision (Bukoski, 1991a; Bukoski, 1991b; Fields, 1995; Freimuth, 2014; Roberto, 2014; Schumacher & Milby, 1999; Wilson & Kolander, 2003). As each level is affiliated with specific groups and conditions, this strategy offers the opportunity to integrate service or health products to maximise the outcomes. It is applicable to both communication interventions and campaigns (Haas, 2014).

In the 1970s, social psychologist William McGuire developed a model of communications based on persuasion (N. Corcoran, 2010b; McGuire, 2001; Schiavo, 2014). At first, the communication-persuasion matrix was used extensively in the advertising industry, but the idea of extending this theory - which seeks to explain how the receivers of messages process the information - to health communication campaigns soon followed (Ibid). McGuire proposed a matrix as a progressive process in a sequential manner. He argued that in the communication from sender to receiver, there are identifiable external and internal factors that might influence the outcome, factors he referred to as the information-persuasion model (Ibid). In addition, McGuire emphasised inter-reliant steps to achieve the initial aims (Ibid).

The model was subject to a range of criticism, including its dependence on the use of mass communication tools, its embracing of a rational (cognitive) model as the dominant paradigm of health communication, and its failure to consider the dynamics and changing characteristics of the targeted groups (N. Corcoran, 2010b; McGuire, 2001; Schiavo, 2014). However, the model's clear

steps and its inclusion of evaluation are considered strong features of McGuire's matrix (Ibid).

The ecological perspective, which concentrates on factors which influence a person's health, developed as an alternative to the individual focus approach to health communications (Bernhardt, 2004; Haas, 2014; Kar et al., 2001c; Lewis & Lewis, 2015; Ohs, 2014). This paradigm assumes the individual's environment, or ecology, determines the various levels of influential factors on health. It shifts the focus from individuals to communities and emphasises, therefore, a partnership with communities as an important tool in combatting health challenges (Ibid). The approach argues that multiple factors at various levels are interdependent and influence each other. Therefore, this approach draws attention to social health determinants and focuses on bringing about change through communities or groups rather than individuals (Ibid).

The concept of education has been a fundamental element of health communications (Helme et al., 2015; Logan, 2008; Wilkinson, 2013). Informing and educating the masses about health behaviour hazards are generally a priority of health communication campaigns (Ibid). The rise in the number of marijuana abusers at US schools, for instance, and the theoretical debates among drug prevention and education scholars has led to the popularity of a school-based approach in conducting health communication programmes (Wilson & Kolander, 2003). Because the school population is captive by nature within certain ages and the education environment already set up, school pupils as subjects are attractive to health communication practitioners (DuPré, 2014; Helme et al., 2015; Wilson & Kolander, 2003).

Nowadays, school-based programmes are generally supplemented with internet-based applications (Ibid). In addition, this approach embraces the use of different methods to reach receivers such as class lectures and inserting health information into the existing curricula (Ibid).

Since most health communication interventions and campaigns aim to change health related behaviour, attitudes or knowledge among targeted groups, the community-based approach provides a set of appropriate tools for these objectives. It concentrates on reaching smaller groups to engage with them directly, thereby providing beneficial outcomes for the whole community (Helme et al., 2015; Wilkinson, 2013). Unlike, the mass media campaign or

intervention, this approach sends information and, in some cases, services and products to the targeted groups to maximise outcomes (Ibid). Indeed, this approach promotes the participation of the community in the health communication process (Ibid). Undoubtedly, technological advancement and the growth of the internet are an important part of this approach's efficiency (Ibid).

Social marketing is a branch of the marketing discipline and was developed in the 1970s by Kotler and Zaltman (R. J. Donovan & Henley, 2003). However, the concept of social marketing was not new. Its first appearance can be traced back to a question which was raised by Wiebe in 1952, who asked "Why can't you sell brotherhood like you can sell soap?" (Solomon, 1989, p.87). He conducted four social campaigns and discovered good signs in terms of positive results from using marketing elements (Ibid). The first official definition of social marketing came from Kotler and Zaltman in 1971, who described it as "the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication and market research" (Kotler & Zaltman, 1971, p.5). Kotler, among others, discussed the voluntary change of behaviour after the receivers were exposed to messages, which were conducted and designed by using commercial techniques and tools (Andreasen, 1994; N. Corcoran, 2010b; Daniel, Bernhardt, & Eroglu, 2009; Kotler, Roberto, & Lee, 2002).

Social marketing falls under the umbrella of marketing, but they differ in aim. Commercial marketing mostly seeks to persuade a targeted group to buy a product or service, whereas social marketing hunts for social change in societies or public groups in terms of improving for example public health, individual health, or well-being. To achieve this, social marketing adopts techniques from commercial marketing (Dutta, 2008; Hastings, 2007; Hastings & Domegan, 2013; Peters et al., 2009; Simons-Morton, Crump, & Donohew, 1997). According to Wartella and Stout, "Public health campaigns today are more likely to use an integrated strategy for planning, development, and delivery of intervention by employing a social marketing approach. Indeed, social marketing is the current buzzword in developing targeted advertising strategy" (2002, p.27).

Social marketing's involvement in health communication campaigns which seek to predict or change health behaviours depends mostly on the nature of social marketing's influence. Indeed, social marketing can be used to influence not only personal decisions about health behaviour, but also public decisions. For example, it can result in the changing of related policy, the imposing of new policies or the establishment of new governmental programmes (S. Corcoran, 2010; Schiavo, 2014). The influence of social marketing as well as the positive results of social marketing campaigns across different subjects has led to the integration of the social marketing approach into the health communication campaign process (Ibid). In practice, health communication practitioners use marketing's four Ps in the design, implementation and evaluation of campaigns and communication interventions. The four Ps are the marketing mix consisting of product (behaviour, service or knowledge), place, price (cost of performing behaviours), and promotion (N. Corcoran, 2010b; Daniel et al., 2009; Schiavo, 2014; Simons-Morton et al., 1997; Solomon, 1989).

Although it is evident that social marketing is useful, there are those who have raised criticisms. Most importantly, social marketing's focus on individuals (customers) with less interest in customer or marketer context is perceived as a disadvantage (R. J. Donovan & Henley, 2003; Edgar, Volkman, & Logan, 2011; L'Etang, 2008). Indeed, social marketing's top-down approach does not encourage participation from receivers (Schiavo, 2014). Others have also critiqued the use of manipulation techniques or tools to persuade customers, a tendency that has raised ethical concerns (Ibid). On the contrary, social marketers counter this criticism with the usefulness of social marketing's audience-based research tools as well as its cost-effectiveness (Ibid).

The variations of strategies and approaches signal the valuable debate in the field among scholars and the dynamism of the problems health communication sets out to eliminate (Basil, 2014b; Beato & Telfer, 2010; Noar et al., 2010; Puska, 2002). It is common among interventionists to use single or dual strategies in designing and implementing campaigns or communication interventions. However, insights from the evolving field point to the use of more than one approach to maximise the intervention or campaign efficiency (Ibid). For example, North Karelia project managers recommended the use of

education-based, mass media, personal communication, counselling, and the participation of the community (Puska, 2002). Likewise, other successful projects have reached the same conclusion (Basil, 2014b). Therefore, the combination of approaches is a growing trend in conducting health communication campaigns or interventions. Indeed, more attention is also now given to the integration of policy and law enforcement in facing health challenges (Ibid).

Worth mentioning are the implications of the digital revolution in information technology on how interventions or campaigns are conducted. As a result of this process, we have witnessed the emergence of a number of sub-fields such as e-health communication, telemedicine, health informatics, interactive behaviour change technology and various applications (Cassell, Jackson, & Cheuvront, 1998; Harrington & Head, 2014; Kreps & Neuhauser, 2010; Lupton, 2015; Neuhauser & Kreps, 2003; Noar & Harrington, 2012). The digital revolution has influenced the ways of disseminating information, seeking information and even sharing information (Ibid). Nowadays, all strategies tend to be digital-inclusive.

Since the first political campaigns, predicting behaviour has been an important part of marketing. Therefore, the strong presence of top-down, cognitive models in the early attempts was understandable (Abroms & Maibach, 2008b; Alcalay, 1983; Hyman & Sheatsley, 1947; Katz & Lazarsfeld, 1955; Mendelsohn, 1973; Salmon & Murray-Johnson, 2001). Recently, many critical theorists and post-colonial scholars have started to question this approach. In campaigns around health and Aids particularly in deprived areas of the world, scholars rejected the lack of consideration of the context of the receivers. Scholars such as Dutta and others challenged this top-down, expert as subject paradigm (Dutta, 2008; Dutta & Basnyat, 2010). So, interpretive, critical and cultural perspectives in studying the role of culture in health communication developed. In the next section, I will set out these cultural perspective approaches, which in fact underpin this study theoretically.

2.4 Theoretical framework

The dominant paradigm¹⁰ of health communication centres on individuals and makes use of a linear model of theorising based on rationality. And while this paradigm was successful in particular societies for specific diseases (Airhihenbuwa, 1989; Airhihenbuwa, 1995; Kreps, 2006; Thompson, 2003; Thornton & Kreps, 1992), in recent decades many scholars (such as Basu & Dutta, 2009; Dutta, 2008; Dutta & Zoller, 2008; Jamil & Dutta, 2011) have argued the paradigm has significant limitations in addressing health issues in different contexts, mostly non-western. Therefore, the necessity to insert culture and context into the design, implementation and evaluation of campaigns has become imperative (Airhihenbuwa et al., 2014; Dutta, 2014). This is the case not only for communicating the HIV/AIDS issue in African communities, but also expands to other issues. This section will provide additional elements concerning the theoretical framework of this study.

Cultural involvement in health communication was the result of academic discussions, debates and research during the 1980s and 1990s. The inclusion of culture was part of the general critique of the dominant paradigm and its importance soon gained support among scholars in the field (Dutta, 2014). Lupton, for instance, argued in her 1994 paper 'Toward the development of critical health communication', that health communication had become too paternalistic in its top-down features, either between physicians and patients or between professionals and patients. Lupton critiqued health communication patterns and power relations and pointed out the importance of the interchangeable relationship between health promotion and health communication. Because health promotion enabled people to take control of their health choices (Leshner, 2014; Tones & Tilford, 2001b).

Lupton (1994) proposed a framework to include culture in health communication through employing discourse in medical settings. It was critical, she argued, to "focus attention on discourse and the ways that the use of language in the medical setting acts to perpetuate the interests of some groups over others" (p.60). Likewise, McKnight, in 1989, raised the necessity of *disenfranchising* medical communication as a principal key in improving and

¹⁰ In some literatures, the scholars refer to it as the universal or the traditional paradigm.

protecting health issues (Dutta & Zoller, 2008). In response to the growing complaints from patients about the use of medical or scientific language by physicians, attention to the language of interaction and communication between patients and providers has grown (Northouse & Northouse, 1998).

As most of the behavioural-social models of the dominant paradigm were developed in Western contexts, but were applied in different contexts, local culture has not generally been incorporated into the model's structures (Airhihenbuwa & Obregon, 2000; Dutta, 2008). To meet this challenge, scholars and practitioners have called for culture to be embedded in the study of health communication, and not for it to be considered as a barrier to be overcome (Ibid). Early attempts to study the role of culture considered culture as an obstacle (Kreps & Kunimoto, 1994; Northouse & Northouse, 1998). Out of insightful and theoretical debates, health communication scholars have started to highlight the importance of centralising culture in the design, implementation, and evaluation of communication programmes (Airhihenbuwa et al., 2014; Dutta, 2008; Dutta, 2009; Freimuth & Quinn, 2004). The paradigm has been widened, in other words, from the individualistic to the context-oriented (Ibid).

These early academic efforts paved the way for other scholars to study the role of culture further and to reflect on the effectiveness of health communication. Dutta emphasised that "the field of health communication has recently seen a growing interest in the concept of culture; with the idea that culturally based theories of health communication should guide effective health communication applications" (2009, p.274). Besides academic efforts, other aspects shed light on the necessity to import culture into health communication.

A combination of factors encouraged scholars and practitioners to make use of culture-based theories including demographic changes such as aging populations (mostly in the US and Eurocentric countries), growing cultural diversity among populations in many parts of the world, positive outcomes of integrating culture in health communication interventions and, especially, in changing cultural landscapes such as the family and the household, both of which have been shrinking (Airhihenbuwa, 2010; Airhihenbuwa et al., 2014; Dutta, 2007; Dutta, 2008; R. Thomas, 2006).

Scholars have been working to develop health communication culture-based theories either by integrating culture in existing theories or by developing

new ones. A decade after Airhihenbuwa's path breaking 1995 book, *Health and culture; beyond the western paradigm*, health communication as a discipline has witnessed a growing number of models and approaches. Since the recognition of the need to study culture in health communication, scholars and practitioners have developed various approaches and models (DuPré, 2014; Dutta, 2008; Dutta, 2009).

In order to group all these under one umbrella, Dutta among others developed a guiding framework to incorporate all efforts to conceptualize and theorise culture in health communication. Enlightened by Craig's work in theorising communication theory (1999); Dutta and others identified four approaches based on two dialectical tensions; social change/status quo and the theorizing of culture as a static/dynamic (Dutta, 2008; Dutta & Zoller, 2008; Dutta & Basu, 2011; Dutta, 2014). The categorisation of health communication approaches was based on the way scholars' perceived culture in these approaches, static or dynamic, also the communication means to achieve objectives (Dutta, 2008).

The dialectic of social change and status quo emphasises that health communications or interventions have different roles based on the goal (Dutta, 2008; Dutta & Basu, 2011). In the case of the status quo, communicators try to work with the available social configurations without touching or changing the social structure. Programmes that do seek to bring about social change aim to alter social configurations in order to contain the targeted health problem (Ibid). Furthermore, the way of conceptualising culture differs depending on the objective. The status quo paradigm treats culture as static, suggesting culture is a cluster of values, ethics, beliefs and morals shared among a group of people through the generations in identified space. In contrast, the social change paradigm understands culture as "transformative and contextually situated" (Dutta & Basu, 2011, p.321).

Consequently, the intersection of the two dialectic tensions produces four approaches to study culture in health communication; the cultural sensitivity approach (Airhihenbuwa et al., 2000; Pasick et al., 2009; Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000), the structure-centred approach, the ethnographic (cultural understanding) approach and the culture-centred

approach (Dutta, 2008; Dutta, 2009; Dutta & Basu, 2011). More details about these approaches will follow.

The structure-centred approach seeks to achieve social change in targeted groups, and culture in this approach is treated as static (Dutta, 2008; Dutta & Basu, 2011). This approach puts health problems as outcomes of the structure, so it aims to change the system to solve health problems in communities (Ibid). In this context, the structure refers to the system that organises the social structure, while other sources are defined as health services, available technology and services (Ibid). Health communication scholars with this approach look at the role of the structure, particularly the social structure, in situating health in the realm of accessing health service and solutions (Ibid).

Two levels of the structure are discussed in the literature; economic and social. From an economic view, the structure refers to the health services that are available or unavailable to members (DuPré, 2014; R. Thomas, 2006). In contrast, the social (community) structure refers to the social networks, ties and strength of relationships within communities (Goldsmith & Albrecht, 2011). Therefore, health communication scholars argue that communication with individuals depends on their position in the structure.

Unlike, the dominant paradigm's concentration on the individual, this approach tends to provide solutions to health problems beyond the micro level (Dutta, 2008; Dutta & Basu, 2011). This approach addresses issues such as health disparities, inequality and the role of communication in overcoming such challenges. Studies in this approach discuss the positive reflections of the high level of social capital in a society with the spread of health information, whereas the opposite is the case with low social capital communities (Kawachi & Kennedy, 1999). Indeed, variables such as income and equality are thought to be influential in widening or shrinking health disparities. Low levels of income and equality tend to lead to low levels of social capital (Kreps, 2006; Ndiaye, Krieger, Warren, & Hecht, 2011).

Health communication scholars draw attention to the variety of communication channels used depending on the socioeconomic context. Less access to communication channels used by a health campaign is common among those with low income (Dutta, 2008; Dutta & Basu, 2011). As a result,

many scholars reached the conclusion that more communication and technological infrastructures are needed in such communities to enhance health literacy as well as health communication or intervention effectiveness (Kreps, 2006; Zoller, 2005).

This approach has many implications for the practice of communicating health from putting health disparities under the spotlight to promoting justice and equality for all in the policy making system (ibid). Indeed, the role of communication in structure-based programmes is directed toward changing the structure and providing services¹¹. Culture is measured here as a variable and the predominant research methodology in this approach is quantitative.

The second, ethnographic (cultural understanding) approach aims to explain and explore culture as a construct for the meanings of health (Dutta, 2008; Dutta & Basu, 2011). This approach does not seek social change. Instead, it treats “culture as dynamic, such an approach emphasizes the meanings of health, and the ways in which cultural members come to understand meanings of health through communicative practices” (Ibid, p.321). This approach should not be seen as applicable only to low income countries or the underdeveloped world as the anthropologists suggest, but it is applicable to any culture, even if it’s a specific sub-group shared characteristic.

The third approach regarding cultural sensitivity in health communication is also the most popular one. The reason for “the increasing popularity of cultural sensitivity has primarily been a result of the large-scale immigration patterns in the United States, the growing number of critiques of the dominant paradigm and its inability to meet the needs of cultural communities, and the gaps in access to health care services and prevention measures that vary by culture” (Dutta, 2007, p.207). Basically, the cultural sensitivity programme stands on the incorporating of cultural variables in health communication theories and practice (DuPré, 2014; Dutta, 2008; Dutta & Basu, 2011; Northouse & Northouse, 1998). It is believed that segmenting audiences and receivers of health communication messages and inserting such cultural characteristics in programmes will lead to effective and relevant messages (Ibid).

¹¹ Advocacy and campaigning for rights and policy change are examples of efforts in this approach.

In accordance with the guiding framework, culture is a static entity that contains a mixture of beliefs and values. So the communicator uses culturally appropriate materials for targeted groups, but with no intention of changing the status quo (Dutta, 2008; Dutta & Basu, 2011). Instead, the idea is to change the undesirable behaviours of targeted groups or the undesirable characteristic of the culture associated with the targeted health behaviours. Therefore, cultural differences between populations and within populations should be considered during the planning and conducting of health communication programmes to increase the cultural acceptability of the intervention among targeted groups (Ibid).

The incorporation of culture in this approach takes two dimensions; surface and deep dimensions. The surface dimension means matching health communication materials with the culture of the receivers, including such issues as language, ethnicities and beliefs (Freimuth & Quinn, 2004; Resnicow et al., 2000). In order to achieve this, formative research needs to be conducted to identify the surface features. In contrast, the deep dimension of this approach refers to the process of considering cultural complexity in the process of designing, implementing and evaluating health communication interventions (Ibid). In terms of its communication role, the cultural sensitivity approach is seen by scholars as a transmission process of culturally appropriate health information to the targeted audience and is used to maximise the possibility of changing health behaviour (Dutta, 2008).

Critiques of this approach focus on the consideration of culture as a barrier that needs to be overcome by the health service provider or adopt a top-down communication model (Ibid). Many of the early implementations of this approach were in medical settings between the physicians and patients and were aimed at overcoming challenges in interactions with patients from different cultural backgrounds (Kreps & Kunitomo, 1994; Northouse & Northouse, 1998).

The simplicity of the approach has been accompanied by diverse and confusing terms of cultural sensitivity, for instance, “cultural competence, culturally syntonic, culturally relevant, culturally appropriate, culturally consistent, multicultural, culturally legitimate, ethnically sensitive, cultural diversity, cultural pluralism, cultural tailoring and cultural targeting” (Resnicow et

al., 2000, p.272). Alternative frameworks were developed within this approach, and I am going to include two of them here.

Firstly, the Person Extended Family (PEN3) Model developed by Airhihenbuwa in 1989. It is one of the most famous cultural sensitivity models. Before proposing his PEN-3 model, Airhihenbuwa had already argued that self-empowerment was an influential and effective method (Airhihenbuwa, 1995). In his work, he compared self-empowerment with preventive-medical and radical-political methods (Ibid). Airhihenbuwa defined self-empowerment as an approach that “facilitates choices for individuals and communities within the context of the sociocultural and political environment. This is accomplished through the supplementation of health knowledge acquisition with values clarification and practicing skills in decision-making through non-traditional teaching methods” (Ibid, p.27).

Later on, he developed the self-empowerment concept into the notion of cultural empowerment (Ibid). He believed the word ‘*self*’ minimised the perspective of his approach and focused too much on individuals while highlighting a preventive-medical framework (Ibid). It was not only the semantics of the word *self that he problematized*, but also the old ways and approaches of tackling health problems. Prior to the growth of cultural dimensions in health communication, scholars tended to see others’ traits and underdevelopment, such as in African communities, as the reason behind the failure to change behaviour (Airhihenbuwa, 1989; Airhihenbuwa, 2010; Airhihenbuwa, 1995). So Airhihenbuwa introduced the idea of focusing on the context of health behaviour rather than on the individual, as the dominant paradigm proposed.

The PEN-3 model put culture at the centre of health communication. It functions by identifying positive and negative values and beliefs in relation to health behaviour. In other words, the model embraces the search for values that support or that undermines healthy behaviour (Airhihenbuwa et al., 2014). This model was first used in addressing HIV/AIDS among African American communities in the US in the 1980s (Airhihenbuwa, 1989).

Enlightened by scholars’ efforts to modify existing models to incorporate the culture element in them, this model emphasised two features; the need for a dialogue process to assert that messages are culturally appropriate for the

targeted groups, and addressing health and cultural issues at the micro (individual, family, and community/ grassroots) and macro (national and international power and politics) levels (Airhihenbuwa, 1995).

In response to Eurocentrists' claims about silently ignoring other peoples and culture, Airhihenbuwa said that "the process of culturalising health knowledge, attitudes, and practices does not assume that people are powerless or ignorant. The process affirms diversity in the way people construct their individual and collective realities within the possibilities of their locations. What is positive or negative cannot be based on a universal notion promoted in economic development" (Airhihenbuwa, 1995, p.35).

The PEN-3 model consists of three intersecting domains; cultural identity, cultural empowerment and relationships and expectations. Cultural identity is understood to focus on the person, extended family or neighbourhood (Ibid). Indeed, cultural empowerment contains positive, existential and negative aspects. The positive aspects refer to morals and relationships that favour the health behaviour of interest while the negative aspects include the beliefs and values in the culture that are risky to health and wellbeing, and the existential issues observe the qualities of the health behaviour that make it desired (Iwelunmor, Idris, Adelokun, & Airhihenbuwa, 2010). Thirdly, relationships and expectations involve aspects such as perceptions as well as the role of enablers and nurturers (Ibid).

In practice, the mechanism of how this model functions is described as follows:

During the assessment phase the Relationships and Expectations and Cultural Empowerment domains are crossed in a 3 x 3 table to produce 9 cells. During the intervention phase, the qualitative data are checked with the community members, who, together with the researchers, determine the intervention entry point(s) or the Cultural identity (i.e., the person, extended family, and/or neighbourhood) (Airhihenbuwa et al., 2014, p.78).

Since its development in the 1980s, the PEN-3 model has been used in many studies worldwide. According to Airhihenbuwa the model has been used in more than 100 studies (Airhihenbuwa & Iwelunmor, 2012) including areas such as HIV/AIDS in Africa and beyond (Airhihenbuwa et al., 2000; Airhihenbuwa & Obregon, 2000), child malaria treatment (Iwelunmor et al.,

2010) and in Diabetes type 2 self-management (Barbara & Krass, 2013; Cowdery, Parker, & Thompson, 2010). The evidence from these studies highlight the existence of positive aspects in every culture in relation to health behaviours and promotion, and the positive role community and family could play in this matter (Airhihenbuwa, 2010; Airhihenbuwa et al., 2014; Iwelunmor, Newsome, & Airhihenbuwa, 2014).

Another model in relation to integrating culture in the process of health communication to be more culturally appropriate was conceptualised by Matthew Kreuter and Stephanie McClure (2004). They added the element of culture to the widely used persuasion-communication model, originally developed by William McGuire. They found the effectiveness of health communication programmes was much better when the culture of the segmented audience was incorporated in the source, message and channel of the communication (Ibid).

Last, in response to scholars' criticisms of the dominant paradigm and the needs to incorporate culture into health communication interventions (Airhihenbuwa et al., 2000; Airhihenbuwa, 1989; Airhihenbuwa, 1995; Kreuter & McClure, 2004; Lupton, 1994), Dutta developed the Culture-centred approach to put culture at the forefront of health communication intervention. Unlike, previous approaches, this approach embraced the use of dialogue to reach and change marginalised groups' health behaviours (Basu & Dutta, 2009; DuPré, 2014; Dutta, 2007; Dutta, 2008; Dutta, 2010; Dutta & Basu, 2011; Jamil & Dutta, 2011). Two factors are fundamental to this approach; community and dialogue. First, the community in this approach plays a role in defining the problem and the solution (Ibid). Second, dialogue refers to the process of engagement with marginalised communities to understand health problems, how they are perceived and to develop solutions together (Ibid).

The theoretical roots of this approach come from critical theory, cultural studies, postcolonial theory and subaltern studies (Dutta, 2008; Dutta, 2009; Dutta & Basu, 2011). This explains the trend of this approach toward its critique of Eurocentrism and the dominant paradigm. According to Dutta, "the culture centred approach is an emerging approach to health communication which questions the constructions of culture in traditional health communication theories and applications, examine how the latter have systematically erased

the cultural voices of marginalised communities in their constructions of health, and build dialogical spaces for engaging with these voices” (Dutta, 2008, p.4).

Dutta’s approach treats culture as a dynamic concept that emphasises the local context, a context where cultural members’ negotiate their meanings of health, illness and recovery (Dutta, 2007; Dutta, 2008; Dutta & Basu, 2011). Therefore, this approach gives cultural members the opportunity to re-negotiate and co-construct the meanings of health in a participatory mode of communication. Because it is participatory, this approach also promotes social change (Ibid).

To achieve the goal of social change, Dutta developed three intertwined elements; structure, culture and agency (Dutta, 2008; Dutta & Basu, 2011; Dutta, 2014). The intersection between these factors represents the process of how communication works in the culture-centred approach (Ibid). Structure is defined as the organisation, in context (community) that provides health services and promotes healthy choices (Ibid). Agency refers to the ability of cultural members to participate in the process of health communication by presenting their problems and suggesting solutions (Ibid). Culture in this approach is defined by Dutta as “dynamic and embodied in the locally situated contexts within which cultural members negotiate their meanings of health” (Dutta, 2009, p.375).

The intersection between structure, agency and culture creates a space in which cultural members can be listened to and in which marginalised communities can participate both in the airing of problems and in their solution (Dutta, 2007; Dutta & Basu, 2011). This approach was responsible for a new emphasis on participation in health communication and culture.

Finally, this approach differs from other cultural theories of health communication by incorporating the five characteristics of hegemony, marginalisation, context, stories and resistance. According to Dutta,

- (a) power, ideology, hegemony and control (which) demonstrate how health communication theories and research projects and applications serve the interests of the dominant social actors;
- (b) marginalisation which reflects upon how conditions of subjugation are created and supported by the dominant practices of health communication;
- (c) contexts within which health experiences are realized and enacted;
- (d) the stories shared by cultural members

about their health experiences, as being constituted in the realm of the structures as well as being about the possibilities challenging these structures, within which health is constituted; and (e) resistance which reflects the ability of individuals, groups, and communities to challenge the dominant structures within which health is constituted, and offers opportunities for creating new discursive and material possibilities (Dutta, 2008, p.12-13).

The transformative nature of the approach to change the social structure and alter undesirable health behaviour through culture has led to many consequences in the practice of health communication, including health activism, mobilization, advocacy and citizen participation in health decision-making (Dutta, 2009). The framework promotes the benefits of bottom-up communication with underdeveloped groups (Ibid). Since the culture-centred perspective emerged, many scholars have conducted practical studies enlightened by the approach (Basu & Dutta, 2009; Dutta & Basnyat, 2010; Jamil & Dutta, 2011). All these studies have agreed the need to put culture and context at the centre of health communication, and to eschew the negative impacts of top-down (experts-receiver) programmes. They have also noted the positive outcomes of creating space for the marginalised (affected) groups to speak out about the health problems and their possible solutions. From sex workers groups and traditional healers to development and health campaigns¹², the authors agree that the incorporation of culture in health communication is imperative (Ibid).

The study and application of culture in health communication is a notion that has become increasingly influential due to its positive impact on efficiency and the growing importance of multiculturalism and diversity. These four approaches function as the theoretical basis of this study.

2.5 Conclusion

Dynamism and progression are the best words to describe the journey of health communication since it made its first appearance in the 1960s. It has developed out of the focus on physician-patient interactions and now

¹² In the study about the Johns Hopkins University communication programme in Nepal, Dutta and other draw attention to the hegemonic nature of such projects from the first world to the third on the basis of how these projects perceived the receivers' as uninformed and the need to change, also the influence of the political economy of these health communication studies (Dutta & Basnyat, 2010).

encompasses online and e-health communication forms. The field has absorbed the various changes and challenges in health by finding new routes to research communication in health. Of particular relevance was the growth of cultural diversity and the fundamental demographic shifts underway in many societies (Dutta, 2008; Kar et al., 2001a; Kar et al., 2001c). Undoubtedly, health communication and prevention face a rising challenge from non-communicable diseases, in particular.

As highlighted above, the underlying imperative of current research and practice around health communication is the importance of culture. This has particular resonance when it comes to combating risky health behaviour concerning drugs and alcohol since culture is a major player in the spread of such phenomena among the affected groups (Abbott & Chase, 2008; Heath, 2001; Room, 2013b). This review has highlighted a number of studies in which culture has been emphasised in successful campaigns directed against such high risk behaviour.

However, this is not the case in Saudi Arabia. Here, studies on substance abuse and communication tend to focus on socioeconomic factors, the prevalence of the problem, the negative impacts on society and on the replication of models or studies already conducted using a local, Saudi sample (Algamdi, 2007; Al-Ghaferi, Osman, Matheson, Wanigaratne, & Bond, 2013; Alibrahim, Elawad, Misau, Shaikh, & Allam, 2012; Alsanosy, Elsayi Khalafalla, Gaffar, & Mahfouz, 2013; Al-Sanosy, 2009; Alsanosy, Mahfouz, & Gaffar, 2013; Alsanosy & El-Setouhy, 2013; A. ALshareef, 2008; Hafeiz, 1995; Iqbal, 2000; Mahfouz, Alsanosy, & Gaffar, 2013; Qureshi & Al-Habeeb, 2000; J. Thomas, 2013). Indeed, public communication campaigns in the Kingdom in general are also lagging significantly behind current scholarship. As Aloffie (2012) has observed, health promotion campaigns are not founded on a scientific basis and neither are they subject to a clear design plan (2012). Also, irregularity and a lack of strategic vision are common features of these campaigns.

There seems to be no evidence that work has been conducted on the cultural aspects of health communication concerning substance abuse in Saudi Arabia, making this the first inquiry along these lines. Because this study is the first in Saudi and there is an absence of a well-structured narrative about how health communication on substance abuse started in Saudi Arabia, a secondary

question will be addressed. This question asks how health communication against substance abuse emerged in Saudi Arabia?

The aforesaid ethnographic (cultural understanding) approach is at the forefront of this inquiry, though it is supplemented by the other three cultural approaches as well. Since the study is keen on exploring Saudi cultural influences, more insight into the context of the study will be presented in following chapter. Indeed, further explanations will be provided for the reasons and motivations behind conducting this study and concerning how culture has been included in the study's methodology¹³.

¹³ For further details look at section 4.2 in Chapter Four.

Chapter Three: Saudi Arabian society, transition, Islam and the media

3.1 Introduction

As this thesis focuses on exploring Saudi cultural influences on health communication aimed at drug and alcohol problems, it is important to explain the context of this study. This chapter presents key features of Saudi Arabia, the nation, and its people. It aims to illustrate the context underpinning the study and to present some of the issues emanating from this context. This chapter provides a comprehensive and explanatory overview of the long-established relationship between the religion of Islam and modern-day Saudi Arabia, the impact of the discovery of oil, the trajectory of social change and human development. It will also describe the country's media environment, another important dimension to communications generally and to health communication in particular. This chapter narrates the problem of substance abuse in Saudi Arabia and considers the consequences of this phenomenon. All of these issues are relevant to communications in the Kingdom and have had a direct influence on the creation and efficacy of communication programmes aiming to combat substance abuse.

The discovery of oil, for instance, was a critical factor in the transformation of the Saudi Arabian economy, sparking change within and reflection upon virtually every aspect of Saudi society. The rapid economic development that inevitably followed the discovery of oil is linked by many to an emerging trend of drug and alcohol abuse (Algamdi, 2007; Al-Humidan, 2008; Al-Qashaan & Al-Kenderi, 2002; A. ALshareef, 2008).

This chapter will be divided into three sections which all overlap to a certain extent. At the outset, the chapter will present factual information about Saudi Arabia, a country that has not occupied the mainstream of scholarship and so requires a degree of explanation. The chapter will then deal with issues such as the demographic shifts within Saudi Arabia, the social and health improvements and the importance of oil to the country's economic development. Finally, this chapter will draw attention to the long-standing relationship between

Islam and Saudi Arabia. I will finish the chapter with an introductory summary of the Saudi media environment¹.

On the whole the focus of the first phase of this chapter is to present the dramatic level of transformation that has taken place within Saudi Arabia within the last generation. The country is not isolated, however. It forms part of the Arabian Peninsula and this has had a direct impact not only on religious and cultural development, but also on the Kingdom's susceptibility to the drug trade. Saudi Arabia has a key location in the unsettled world map of drug trading. This, combined with rapid population growth sparked by the oil boom, accelerated urbanisation and the high proportion of young people, has contributed to Saudi's current predicament (AlRasheed, 2010; Vitalis, 2007).

By the end of this chapter you should have a clear understanding of the context of the study and of its significant elements, all of which are important in the consideration of the research questions.

3.2 Saudi context; transition experience

The Saudi Arabian economy has transformed radically since the 1930s when it was dependent on taxation, pilgrim trips to the Muslim holy land and was dominated by Bedouins (nomads). In the 21st Century, Saudi Arabia is a largely urbanised country with a sophisticated economy based on the lucrative petrochemical industry (Al-Khateeb, 2007; Duke Anthony, 1982; El Mallakh & El Mallakh, 1982; Farsy, 1990; Metz, 1993; Sultan, Metcalfe, & Weir, 2011; Yamani, 2009). This transformation has touched many aspects of the lives of the people of Saudi Arabia as well as the region (Ibid). Some scholars argue the shift is an outcome of political and economic desire in the Saudi system (Karake-Shalhoub, Weir, & Sultan, 2011). Saudi Arabia's transformation and the extent of the resulting social change have been reflected across much of the Arab World since the Second World War (Nydell, 2006). While this chapter will present many of the important dynamics of change, including Saudi Arabia's geographical location, topography, climate, urbanisation, demography, education and economy, I will be making frequent links with the phenomenon of substance abuse.

¹ Part of which is about the emergence of the Saudi media.

The Kingdom of Saudi Arabia, (the official name - Saudi Arabia for short) is an Arab country located in the far west of Asia in a region known as the Middle East (AlRasheed, 2010; Long, 2005a; Twal, 2010). It was established on the 23rd September 1932, after a 30 years long battle waged by the founder of the kingdom King Abudl-Aziz Ibn Saud and his supporters aimed at consolidating the peoples of the Arabian Peninsula under one united Arabic government (Ibid). Saudi Arabia occupies 2,149,690 km (or 20% of the area of the United States) with only 1.67% arable land and 0.09% of land bearing permanent crops (Farsy, 1990; Lindsey, 2006; Nyrop, 1984; Twal, 2010). It has thirteen provinces according to the 1992 Saudi Provinces Act, which divided Saudi Arabia into regions with a capital city for each region and a regional government structure headed by an appointed governor (in local terms, an Emir) (Twal, 2010).

Riyadh is the capital city of Saudi Arabia. It is located in the middle of the country. Jeddah is to the west on the coast of the Red Sea, and is both the centre of trade and the economy and the second largest city in the country (Farsy, 1990; Nyrop, 1984; Twal, 2010). Far to the east is Dammam, the centre of the province from which most of the oil is extracted. The Holy city of Mecca (*Makkah* in Arabic) is close to Jeddah on the west of Saudi Arabia and is a holy city for Muslims, where the Grand Mosque (*Al-haram Alshrief* المسجد الحرام) is located (Ibid). About 400 km north of Mecca (Makkah) is the second holy city of Medina (*Almadina Almonorah* in Arabic) where the Prophet Mohammed's mosque and grave are located (Ibid).

Geographically, Saudi Arabia is located between the Asian and African mainlands and is near both the Suez Canal and the Mediterranean Sea (L. Carter, 1984; Lindsey, 2006; Long, 2005a; Metz, 1993). As can be seen in map (3:1) below, Saudi Arabia shares borders with Jordan and Iraq in the north and with Yemen and Oman in the south. The Red Sea forms the long west coast of Saudi Arabia. The Arabian Gulf is to the east, along with the countries known as the Gulf States, namely; Kuwait, Qatar, Bahrain, the United Arab Emirates and Oman.



Map (3.1): Saudi Arabia (source: <http://www.globalsecurity.org/military/world/gulf/sa-maps.htm> accessed date 01/12/2013).

On the world map of drug producers and traffickers, Saudi Arabia is located to the west of the famous Golden Crescent² and Golden Triangle³, but far away from South America's cartels, which tend to concentrate on the cocaine and heroin business, especially in the Andean region (Bean, 2008). Saudi Arabia's close proximity in particular to the Golden Crescent (which includes Pakistan, Iran and Afghanistan) draws it into the ambit of the major drug grown and trafficked in this area, the opium trade. Indeed, a neighbouring country, Lebanon, under internal local circumstances, has developed into a hub for cannabis cultivation in the region (J. Marshall, 2012). By 2012, Afghanistan was categorised as the top producer and cultivator of illicit opium in the world responsible for 72% of world production (UNODC, 2014e).

All of the countries that form part of the Golden Crescent are Muslim states, giving their citizens strong religious reasons to visit Saudi Arabia and establishing a major flow of people in and out of the country. Such movements are conducive to the expansion of trade in drugs. However, the geographical location is not the only determinant of drugs trade and production. The topography and weather are also key, natural factors along with the policy, cultural and religious issues that will be discussed in later chapters.

David Long (2005) evocatively describes Saudi Arabia as:

² Reference to the area covers Iran, Pakistan and Afghanistan (Bean, 2008).

³ Reference to the area covers Burma, Laos and Thailand (Bean, 2008)

A rough, elongated triangle on a northwest by southeast axis with its top lopped off. About 100 kilometres (60 miles) east of the Red sea coast, the arid coastal plain called Tihama gives way abruptly to an escarpment range called the Hijaz Mountains in the north and the Asir Mountains in the south. The entire range rises from about 700 meters in the north to around 3,000 meters in the south. To the east, the country descends gently in elevation to the Gulf coast (, p.2).

Long adds that Saudi Arabia's notable deserts stretch

Along the Kingdom's entire southern frontier... [to] the Rub al-Khali (accurately Empty Quarter in Arabic). It is a huge pink sand dune which can get as high as 250 meters and stretches in parallel lines up to 40 kilometres in length. Covering over 550,000 square kilometres, the Rub al-Khali is the world's largest quartz sand desert and was largely unexplored by Westerners until the twentieth century (Ibid).

Importantly, there are other deserts and uninhabited areas across the country, including "a smaller quartz desert, the Great Nafud, which is about 55,000 square kilometres in size" in the North (Ibid). "Stretching from the Great Nafud to the Rub al-Khali in the east is a narrow strip of sand desert, the Dahna" (Ibid). The topography of Saudi Arabia results in harsh weather, dry and extreme heat in the summer with the exception of the Hijaz Mountains and the southern-west mountains where the weather is pleasant. In contrast, the Saudi weather in winter turns cold and can reach 5°C and much lower in the mountains (Farsy, 1990; Lindsey, 2006; Nyrop, 1984; Twal, 2010).

Due to the harsh topography of Saudi Arabia and the hot climate, the cultivation of drugs would seem to be impossible (Algamdi, 2007). Exceptionally, in some parts of the southwestern mountains are areas where the plant of Khat (Qat القات) (*Catha edulis*) grows naturally and an illegal, local cultivation business has developed (Alsanosy et al., 2013; Al-Sanosy, 2009; Alsanosy et al., 2013; Alsanusy & El-Setouhy, 2013; Mahfouz et al., 2013; Manghi et al., 2009; K. A. Sheikh, El-setouhy, Yagoub, Alsanosy, & Ahmed, 2014). Consequently, Khat chewing has become common in these areas and is an important element of social tradition and custom not only here but also in Yemen, Somalia, Ethiopia, Eritrea and other parts of East Africa (Ibid). Aside from the Khat that grows naturally in the southwestern mountains, there has been no evidence or published research to date claiming the existence of other

types of drug cultivation or naturally growing drugs in the country including small-scale cannabis (marijuana) production.

Given Saudi's natural environmental conditions, it is clear this is not an environment favourable for commercial drug cultivation. This is certainly the case compared to other parts of the world such as South America (where cocoa leaves grow naturally and are converted into cocaine) (Bean, 2008) or even within the region of the Middle East where opium is cultivated in Iran and Afghanistan, Khat is produced in Yemen, Somalia and Eritrea (Al-Sanosy, 2009; Alsanusy & El-Setouhy, 2013; Mahfouz et al., 2013; Manghi et al., 2009; K. A. Sheikh et al., 2014) or in Lebanon where cannabis growing is well-organised (J. Marshall, 2012).

The production, wholesale, distribution or retail of alcohol is illegal in Saudi Arabia, for reasons to be explained later on in this thesis. However, this illegality has undeniably spawned a black market for alcohol in the Kingdom (Hawwari, 2001). Alcohol is not only smuggled into Saudi Arabia in the form of branded drinks, it is also produced by local, secretive home brewers⁴ (Ibid). The hidden, illegal production network is the result of a combination of aspects, to which I will return in the discussion chapters where I examine how they were experienced by the study's participants.

Local alcoholic beverages and illicit drugs are used in specific physical or social spaces in Saudi Arabia (Galea & Vlahov, 2005). The physical locations tend to be residential areas or places where alcohol or drugs are consumed. These spaces can be urban or rural, though there have been significant shifts in this aspect of Saudi life in recent years.

Nowadays, most of Saudi Arabia's population lives in urban areas, according to the Saudi census of 2010, with more than eight million people inhabiting the three major cities (CDSI, 2010). Around 83% of the population live in three regions - the western, eastern and central regions - out of the thirteen regions in the country (Ibid). This matches the global estimation of Saudi Arabia's urban population which was 82.1% in 2010, leaving the rural segment at around 17.9% (GEOHIVE, 2009).

⁴ It is important to note that the quality of these brewers' products is often very low. They have been known to have health impacts that are more harmful than branded products.

Saudi Arabia underwent a rapid urbanisation process. While 30% of the population was urbanised pre-1970, this had risen to 49% by the end of the 1970s and jumped to almost 83% by the 1980s (Lindsey, 2006; Nydell, 2006). Correspondingly, the nomadic population in Saudi Arabia decreased dramatically (Farsy, 1990). Saudi Arabia's experience of urbanisation was far from unique. Global urbanisation rose from 30% in 1950 to 54% by 2014, according to United Nations figures (UN, 2014). Regionally, the Arab world has changed into one of the planet's most urbanised societies, with urbanisation percentages in the region rising from around 50% in the 1970s to over 85% in countries such as Saudi Arabia, the UAE and Libya⁵ (Nydell, 2006).

The demographic shift toward urban areas in Saudi Arabia draws attention to the level of social change experienced within ordinary Saudi's lives over the last few decades. This change has extended into many different aspects of life, including the shift from a traditional to a more modern lifestyle (Ibid). For Farsy (1990), Saudi's massive urbanisation and "the development of the Kingdom's infrastructure and, in particular, its industrialisation program, has had a predictable effect on old patterns of life" (, p.202). Other scholars believe the oil-led development during the first oil price boom in 1970s was the major driver of the urbanisation expansion (Sultan et al., 2011).

Social and public health scientists have been examining the negative health outcomes of the rapid urbanisation process, and its impact on future, anticipated health threats. Some conclude the relationship between rapid urbanisation development and drug abuse is quite strong (Galea & Vlahov, 2005; Yoo, 2012) with substance abuse labelled as a common characteristic for newly urbanised areas (Ibid). There have been conflicting views, however, and others suggest that identifying urbanisation as a cause of drug misuse has not been proven and requires further investigation (Schifano, 2008).

Urbanisation together with industrialisation has fuelled the growth of drug and alcohol demand for years and will do so for years to come, argues Yoo (2012). In the light of this, the Saudi demographic shift toward urbanisation is expected to continue, but at a lower rate in comparison with previous decades. In fact, Saudi population projections expect the percentage of urbanised people

⁵ It is important to note that all these countries are oil-producer countries, drawing attention to the Oil boom of 1970s and its connection with urbanisation projects.

to reach 88.4% by 2050 (UN, 2014). Global projections of urbanised populations expect 2.5 billion inhabitants to move to urban areas by this time, most of these in Asia and Africa (Schifano, 2008; UN, 2014). Therefore, the problem of substance abuse is expected to rise significantly on the basis of these anticipated demographic changes in Saudi Arabia based on the hypothetical relationship between the two elements. Since I have mentioned the demographic shifts in Saudi Arabia, let us now move on directly to this area, in particular the growth and structure of the country's population.

3.2.1 Demographic information

The demography of Saudi Arabia has been through dramatic changes in terms of its figures, structure, features and even in the methods of gathering demographic data (Alribdi, 2010a; MOI, 2014). The data used here were retrieved from international data sources and official Saudi reports. My approach to the analysis of these figures is principally descriptive, though I will synthesize the data to identify changes and predict challenges.

Methods for collecting national demographic information and the introduction of a census in Saudi Arabia emerged four decades after the consolidation of the Kingdom in 1932 (Alribdi, 2010a). Early planners were naturally keen on building Saudi statehood and understood that data gathering was necessary in order to fulfil the needs of Saudi citizens (AlRasheed, 2010; Al-Sadhan, 1980; Farsy, 1990). But immaturity and a lack of experience to conduct a national census were features of the Saudi government apparatus pre-1960, before a Saudi revolution to develop a bureaucratic administrative system took place (Ibid).

But it was the discovery of oil and its commercial exploitation that was the turning point in Saudi lives and in the country's administrative system (Farsy, 1990; Jungers, 2013; Sultan et al., 2011; Vitalis, 2007). Government development has been an inevitable consequence of managing the growing income and ministering to internal public needs (AlRasheed, 2010; Al-Sadhan, 1980). Under these circumstances and coupled with a lack of skilled workers to run the oil and petrochemical facilities, waves of foreign workers started to arrive in the 1930s to help the Saudis with the challenging tasks of building a

state and running the world's largest national oil industry (AlRasheed, 2010; Farsy, 1990; Jungers, 2013; Karl, 2004; Vitalis, 2007).

In fact, oil-led development sparked demographic and social challenges for years to come, reflecting both social and economic improvements on the one hand along with the influx of guest workers and attendant questions of multiculturalism on the other (AlRasheed, 2010; Al-Sadhan, 1980; Farsy, 1990; Vitalis, 2007). The Saudi labour shortage and the beginning of the Saudi oil industry caused a dramatic shift in the Saudi's demographic size, structure, characteristics and even in its methods of demographic data collection (Farsy, 1990; Tabutin & Schoumaker, 2012).

In 1961, the Saudi government issued a new law to regulate the process of collecting statistical data about the economy in general and a national census in particular (Farsy, 1990). The government also established the Central Department of Statistics and Information (CDSI) under the supervision of the Ministry of Finance to be responsible for collecting and analysing the national census as well as collecting other types of data, such as economic trends and material prices (Ibid). The CDSI publishes figures that are intended to be helpful for academic researchers and business managers as well as for the development planners in the country (Ibid).

In 1974, the first national census was taken by CDSI. The results of the 1974 census were not released until 1976 when an official gave a brief report claiming that the population of Saudi Arabia was 7,009,466 million (see table 3.1 below). The national census of 1974 has been used by Saudis as a baseline for the national demographic. It's impossible to ignore the demographic trends in the Arab world during the same periods, which were peaking rapidly (Tabutin & Schoumaker, 2012). Between 1960 and 2005 the total population of the Arab world tripled (Ibid).

As the 1974 census was the first, it is difficult to synthesize the data, but from the available figures there are two important trends that need to be acknowledged. First, the international flow of labour to Saudi Arabia for economic reasons was shared among the Arab world, but particularly within the GCC⁶ countries (Ibid). Second, the ratio of men to women was skewed by the

⁶ Gulf Cooperation Council.

labour migration with many more men than women soon occupying the working age cohort. This inevitably raised concerns over the cultural and social challenges involved in hosting such a diverse workforce and its likely impact on the dominant culture.

It took almost 18 years to conduct the second national census⁷, which concluded that the country's population had reached 16,948,388 million by 1992. As table (3.1) below shows, the number of Saudi citizens jumped to over 12,3 million, and the non-Saudi residents to over 4,6 million. The skewed gender ratio remained evident. By contrast, the gender structure of non-Saudis changed in favour of women, 42% of whom were from the non-Saudi population in 1992. The increase in women 'expats' (foreign workers, or 'expatriates') was a consequence, in part, of the empowerment programmes sponsored by the Saudi government. The total Saudi population in 1992 matched the UN's prediction in 1990, which was believed to be 16,2 million (2012).

The third Saudi national census was conducted 12 years after the second one and, again, there was no official explanation for the irregular delay (Alribdi, 2010b). By 2004, the Saudi population had jumped to an estimated 22,678,262 million. Saudi Arabia's population growth figures once more matched the UN's predictions (United Nations, 2012). In 2004, the ratio of Saudi to non-Saudi was steady at the same level as in 1992 (72% Saudis and 28% non-Saudis). However, the number of non-Saudi males overtook females by 69% to 31%. The consequence was a significant bulge in the adult male population segment (see table 3.1 below).

In 2010, the figures of the first joint Gulf Cooperation Council (GCC) census indicate the Saudi population had dramatically increased by 19% to 27,136,977 million. However, the growth of the Saudi population fell by 13%, to a total of 18,707,576 million. In contrast, the non-Saudi population grew from 6,150,922 in 2004 to 8,429,401 million by 2010 (CDSI, 2010), an increase of 37% over six years. Table 3.1 below shows an historical comparison of all Saudi national censuses according to the CDSI.

⁷ There is no official justification for Saudi irregularity in collecting the national census (Alribdi, 2010b).

Years	Saudi			Non-Saudi			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
2010	9527173	9180403	18707576	5932974	2496427	8429401	15460147	11676830	27136977
2004	8287370	8239970	16527340	4269870	1881052	6150922	12557240	10121022	22678262
1992	6215793	6094260	12310053	3264180	1374155	4638335	9479973	7468415	16948388
1974	3193544	3024817	6218361	528671	262434	791105	3722215	3287251	7009466

Table (3.1) comparison between Saudi national censuses (CDSI, 2010).

The descriptive illustration above draws attention to the rapid population growth experienced in Saudi Arabia over a short period of time and its correlation with social, health and economic improvements. It is worth engaging with the characteristics of the demographic transition. These indicators will include population growth rate, gender and age structure, migration, fertility and mortality. Caldwell (2009) proposes a demographic transition model which seeks to trace the transition from a traditional model with high death and birth rates to a more classical model with low rates of death and a natural growth rate (Tabutin & Schoumaker, 2012). It is a model that depends on many contextual factors which impact on the length of this transition process.

3.2.2 Population growth rate

Saudi Arabia's population has more than quadrupled in the last five decades, from over seven million in 1974 to 29.9 million by 2014 (CDSI, 2010; CDSI, 2014; Tabutin & Schoumaker, 2012). A combination of elements led to this rapid growth, including a decline in mortality and an increase in fertility as a consequence of improvements in social, health, sanitary and economic sectors (Tabutin & Schoumaker, 2012). The annual population growth rate in the country, in general, has been increasing, especially during the period of economic growth and oil industry development, because of the influx of expatriate workers (Farsy, 1990). The average annual population growth rate for Saudi Arabia between 1980 and 1985 was 5.98%, above the world and Arab average rate (United Nations, 2012). This rate is confirmed by World Bank data for this period (World Bank, 2014). This high population growth rate matches the first oil-boom of the 1970s (Farsy, 1990; Jungers, 2013; Sultan et al., 2011),

when thousands of guest workers arrived in Saudi Arabia as part of the third Saudi development plan⁸.

The Saudi population growth rate dropped from 5.98% to as low as 1.63% for the period between 1995 and 2000 (United Nations, 2012). The rate then rose to 4.07% for the period between 2000 and 2005 (United Nations, 2012; World Bank, 2014). Since 2005, the population growth rate has been decreasing (Ibid). Currently, the Saudi population is around 29.9 million (CDSI, 2014), though alternative local figures suggest the number is well over 30 million (Arab News, 2014). Of these, an estimated 10 million are guest workers (Expatriates) from multi-national backgrounds, according to the Saudi Ministry of Labour (2014).

3.2.3 Migration, population gender and age structure

The migration story in Saudi Arabia is about two key pathways: local (internal) and international. Both have been driven by the economic opportunities and the projects of urbanisation. As a result, the table 3.2 below shows the movement of Saudis into the urbanised areas during the previous four decades. Almost two thirds of the population (65.9%) inhabited urban areas in 1980, rising dramatically to 82.1% by 2010.

Year	Urban (Thousands)	Rural (Thousands)	Total (Thousands)	Percentage Urban (%)	Percentage Rural (%)
1980	6,455	3,346	9,801	65.9	34.1
2010	22,530	4,918	27,448	82.1	17.9

Table (3.2) internal migration in Saudi Arabia, comparison between 1980 and 2010 source:(UN, 2014).

Similarly, the international movement of guest workers to Saudi Arabia has grown since the nation- and economy-building process started in the last Century. Nowadays, non-Saudis residents represent nearly 30% of the total Saudi population. The gender and age structure of the Saudi population has

⁸ This refers to the economic strategic approach adopted by the Saudi government in the 1960s. Basically, it's the process of planning the country's needs and the mechanism to fulfil these needs in a limited time, mostly over a period of five years (Farsy, 1990; Looney, 1982).

also shifted considerably in recent years. Table 3.3 below covers the distribution of the Saudi Arabian population based on gender and nationality in 2013, according to official Saudi statistics.

Year	Male (1000)	Female (1000)	Total <i>Saudi</i> (1000)	Male (1000)	Female (1000)	Total <i>Non- Saudi</i> (1000)	Male Total (1000)	Female Total (1000)	Total (1000)
2013	10,181	10,090	20,271	6,643	3,079	9,723	16,824	13,169	29,994
(%)	50.2%	49.8%	100%	68%	32%	100%	56%	44%	100%

Table (3.3) The Saudi Arabia, population gender and nationality structure source: (CDSI, 2014).

The age structure and the percentage of youth among Saudis are critical demographic features that need to be discussed. In fact, the Arab world is categorised by many demographics scholars as a region with young populations (Tabutin & Schoumaker, 2012). At present, some fifty percent of Saudi nationals are under 25 years old (Arab News, 2014), and 32% of Saudis are under 15 years old (UNESCWA, 2014). Saudi Arabia is, then, a nation populated by young people with the expectation that this will only increase in the future (Tabutin & Schoumaker, 2012). By 2025, there will also be growth in the 60 years and over age group, which in turn will pose new challenges to the country's health system (Ibid). However, at present, Saudi's health problems are mainly related to youth and drug and alcohol abuse. See Afifi et al. (2012) for more details about the health of young people in the Arab world.

Figure 3.1 gives a detailed representation of the age-gender structure in the country. It is important to note that there is an equal balance between male and female for those between 0 and 19 years old, because most of this group are Saudis. This matches the male to female ratio for Saudi nationals (101 men opposite 100 women). In contrast, the situation is different for the age groups between 20 and 55 years old, where there are many more males than females with a significant margin for those between 20 and 39 years old. The general

gender structure is visualised in figure 3.1, in which there are 120 males to 100 females (UNESCWA, 2014). These figures include both Saudi and non-Saudi.

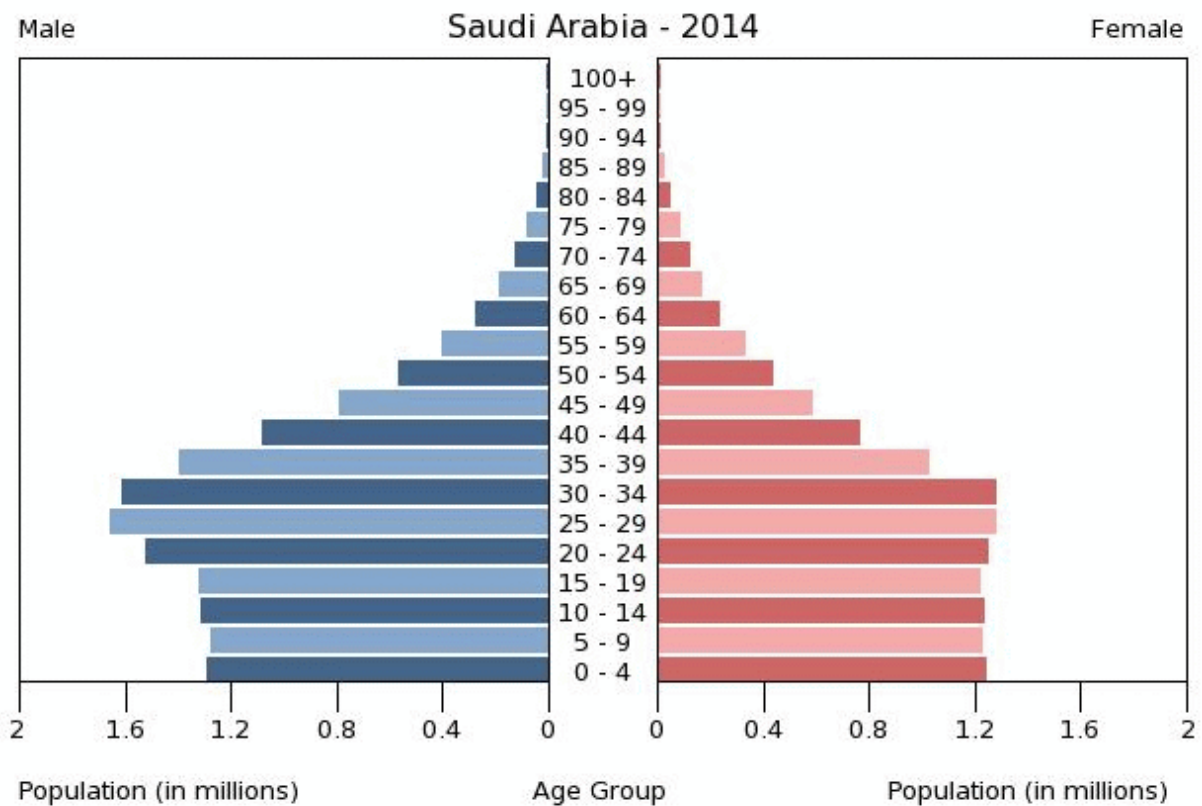


Figure (3.1) the Saudi Population gender-age structure in 2014 adopted from (Indexmundi, 2014).

The phenomenon of labour migration is rooted at the beginning of Saudi Arabia’s state-building project when the government was forced to choose either to postpone development and infrastructure projects for lack of labour or hire foreign workers (Farsy, 1990; Looney, 1982; Smyth, 1994; Sultan et al., 2011; Yamani, 2000). The decision was taken to permit the recruitment of workers from abroad paralleled with a structured programme to educate and train Saudis with the needed skills to fill these jobs in the future (Ibid). Since then, education and knowledge development have been considered permanent elements in Saudi five year development plans.

The most challenging dimensions to the hiring of guest workers are the social and cultural impacts on the host culture. As Farsy⁹ explains: “Saudi Arabia was indeed confronted with a critical dilemma: whether to strive for this

⁹ He worked as a minister in the Saudi cabinet.

crucially needed foreign manpower in order to carry out development projects essential to future prosperity, or to curtail the inflow of foreign labourers in order to safeguard a social system based on 'orthodox' Islam" (1990, p.210). He argued the Saudi government remained confident in the Saudi ethos and in the social structure to absorb the flow of foreign workers (Ibid).

In fact, the cultural challenges of the 1970s had transformed Saudi Arabia into a multicultural society by 2014. It is true that all Saudi citizens are Muslims and Arabic speakers with a minority of non-Arab ethnicities who immigrated to Saudi Arabia during the 20th Century and obtained citizenship (Ibid). The homogeneity of the Saudis cannot hide the fact that there are over 10 million people in Saudi Arabia from more than 100 countries and from very different backgrounds. This diversity of foreign manpower imposes challenges on the social system and the structure of the country. Although, the Saudi government still emphasises a Saudi *Arabian-Islamic* identity (Metz, 1993).

3.3 Health, education and economic indicators in Saudi Arabia

The health sector in Saudi Arabia emerged from almost nothing in 1926 to a modern healthcare provider (Ministry of Health, 2015a; Mufti, 2000). Two sets of indicators illustrate the shift in the Saudi health spectrum. First, the increased establishment of health facilities and the growth of the number of health professionals signal the extent of the structural change. Next, the outcomes of such structural projects are reflected in the health indicators (Ibid). So let us take a closer look at this huge shift in Saudi health standards.

In 1926, the Saudi government established two primary care centres in the cities of *Mecca* and *Taif* in the west, and in 1950 the Ministry of Health was established with responsibility for health care and research (Albugami, 2011; Farsy, 1990; Mufti, 2000). Nowadays, the health sector in the Kingdom is considered to be one of the most sophisticated in the region (Ibid). From a handful of hospital beds in the 1920s, Saudi is now host to more than 415 hospitals and around 2,094 primary care centres (Ministry of Health, 2013a). Along with the growing health sector, the number of health specialists has increased dramatically (Ibid). Undoubtedly, this medical development is inseparable from the oil-led development sweeping the country as a whole.

Prior to Saudi development ventures, high levels of fertility, mortality and morbidity were common features. In fact, the region exhibited the poorest overall health indicators of the first half of the 20th Century (Tabutin & Schoumaker, 2012). These figures have certainly changed, as health indicators suggest. The mortality rate in Saudi has fallen from 241 per thousand (female) in 1980 to 97.3 in 2009 (Arab Human Development Reports, 2012), whereas male mortality has dropped from 283 per thousand in 1980 to 130 in 2009. By 2013, the number of deaths had reached 91.9 per thousand (WHO, 2012).

Likewise, infant mortality dropped from 65.8 per thousand in 1980 to 15 in 2010 and the child death rate (under five years old) also decreased from 90.3 per thousand in 1980 to 17.5 in 2010 (Arab Human Development Reports, 2012). Similarly, the maternal mortality ratio (per 100 000 live births) was down from the high figures of the 1980s to 16 by 2013 (WHO, 2012). Since health measures have improved, life expectancy also jumped from 62.3 at birth in 1980 to 76 in 2012 (Arab Human Development Reports, 2012; WHO, 2012). Collectively, the immunisation efforts, the increase of free medicine and the establishment of primary care centres in remote areas have all made significant contributions to these improving statistics.

In accordance with health improvements in the Kingdom, the fertility rate has declined from over 7 children per women in the 1960s to 2.6 in 2013 (WHO, 2012). Driven by the drive for socioeconomic improvement, the size of the family in Saudi Arabia has shifted¹⁰. There are a number of reasons for this, including the changing of women's social roles in the country and the timing of marriage (Tabutin & Schoumaker, 2012). Still, the desire for children and the value of family are highly prized in Saudi Arabia and in the Arab world more broadly (Ibid).

Although it is true that Saudi oil-led development has generated positive impacts in the health sector, and Saudi basic law (articles 27 and 31, 1992), guarantees the provision of health services to all citizens, there are a range of modern health challenges in Saudi Arabia. Most of them are reflections or extensions of global issues. These include the shifting of the disease burden due to economic prosperity and demographic transformation, the increased cost

¹⁰ It is compatible with the shifts in Arab family size due to social and cultural changes (Tabutin & Schoumaker, 2012).

of health services and the pressure on the quality of healthcare provision (Albugami, 2011).

Nowadays, communicable diseases have been contained at relatively low levels. But it is the non-communicable diseases that are imposing additional risk through, for instance, traffic accidents, cardiovascular diseases, high or low blood pressure and smoking. Communicable disease is now considered to run parallel with non-communicable disease worldwide (CDC, 2014b; WHO, 2015b). Recently, Saudi's health authority has embarked on new communication and promotion strategies in order to face up to such problems and, in particular, has embraced e-health for its potential contribution.

The education sector in Saudi Arabia has received great attention and care since the consolidation of the Kingdom with Islam endorsing the acquisition of knowledge in principle (AbdulJawad, 2004). Opening schools and universities has been a top priority of the Saudi authorities since the 1930s (Farsy, 1990). However, the Saudi education system went through enormous change from mosque-based schools in the 1920s-30s to modern educational facilities in the 21st Century. In 1932, there were three to four schools (primary-elementary) in the region of Hejaz, and they were funded by philanthropists' (AlRasheed, 2010; Teitelbaum, 2001). They were the legacy of the Ottoman Empire in the region. Additionally, the two holy mosque-based schools have been great sources of Islamic, jurisprudence and of Arabic and Sunna studies for centuries (Ibid).

Endorsing the Ottoman educational legacy, the Saudi government began the expansion and development of education in the 1930s with the opening of schools and with the formation, in 1950, of the Ministry of Education. The Saudi government took another route in developing the country's education by sending students abroad for higher education (Farsy, 1990; Metz, 1993; Twal, 2010). In 1957, the first public university was opened in Riyadh, followed by the Petroleum College in the eastern region and the King Abdulaziz University in Jeddah in the 1960s (Ibid). Unquestionably, the country's rapid economic development embraced and prioritised the educational system and structure (AlRasheed, 2010; Al-Sadhan, 1980).

Away from this tangible growth, Islamic values continue to powerfully influence the education system and curricula in Saudi Arabia. Not only have regulatory aspects been adopted that ensure the adoption of Islamic teachings,

but Saudi basic law (articles 29 and 3) commits the government to provide public education, encourage scientific research and combat illiteracy (Saudi Basic Law, 1992).

The total number of pupils in all Saudi schools in 1969 amounted to 478 (Farsy, 1990). By 2013, this number had reached 4.6 million pupils in 26,606 schools (Ministry of Education, 2014). In 2015, the number of pupils jumped to over five million (Al-arabiya, 2014). Similarly, higher education in Saudi Arabia comprises 30 public universities, ten private universities' and 37 colleges (Ministry of Education, 2015b). In 2013, the total number of students in higher education was 1.35 million and over 50% of them were female (Ministry of Education, 2015a). They are divided mainly between humanities, social science, medicine, engineering and vocational courses (Ibid).

Aside from the growth in the quantity of the education sector, projects have also been adopted aimed at enhancing the quality of education in Saudi Arabia. These have included sending students abroad to top universities and opening high quality collaborative research centres with excellent research institutions (Weir, Sultan, Metcalfe, & Abuznaid, 2011). In 2013, the number of Saudi students' abroad amounted to 228,000, 77.43% of them enrolled in West European or American universities (Ministry of Education, 2014). In addition, Saudi authorities have established three unique projects; in the 1970s the establishment of the King Fahad University of Petroleum and Minerals¹¹, the King Abdulaziz City for Science¹² and Technology, and in 2009 the King Abdullah University for Technology and Science¹³. Collectively, these projects aim to cultivate high quality education within the Kingdom.

The story of education in Saudi Arabia illustrates the government's prioritising of education and scientific development. Nonetheless, Islamic teachings are a constant parallel force in this dynamic (Ministry of Education, 1995). Saudi Arabia has clearly passed the materialistic phase of development and entered a period of knowledge building (Weir et al., 2011). This is

¹¹ This university was established in the eastern region, the oil-rich region, to build a national skillful workforce in this industry.

¹² The city was built to promote, develop and support applied research in the country, for further information see the link <http://www.kacst.edu.sa/en/research/Pages/landingpage.aspx>

¹³ Likewise, this university was created to be a hub for advanced research and several Nobel Prize winners' are members of staff in this university, and many international students' enrolled in it <http://www.kaust.edu.sa/>

compatible with the shift in the economy to be knowledge-based (Ibid). The Saudi government continues to provide free education to the level of doctorate, pays out monthly sums¹⁴ to university students, funds adult literacy programmes and provides support to students in remote villages and Qurannic schools (Farsy, 1990). Unsurprisingly, the literacy rate for both genders has climbed from 79.4% in 2000 to 98% in 2011 (UNICEF, 2014). Improvements in education and health wouldn't have been possible in Saudi Arabia without the economic development or without the government's emphasis on both sectors.

The Saudi Arabian economy has been through remarkable change in recent years from a dependence on Islamic taxation (Zakat; alms-giving) and the Muslim pilgrim hospitality industry to become the biggest economy in the Middle East and North Africa (Metz, 1993; Sultan et al., 2011; Twal, 2010). Many commentators attribute this huge economic shift to the discovery of oil (AlRasheed, 2010; Jungers, 2013; Vitalis, 2007). It is true that before the first Oil-concession in the 1930s and then the commercialisation of oil-production in the 1940s-50s, the Saudi Budget was around one million pounds sterling in 1936(AlRasheed, 2010).The most recent national Budget for 2015/16 amounted to more than £145 billion. It is this enormous pool of wealth that has given Saudi authorities the wherewithal to construct a modern state.

Saudi Arabia is the second biggest producer of crude-oil in the world. In addition, it has the second biggest crude oil reserves amounting to some 265.8 million barrels (OPEC, 2013; US Energy Information Administration, 2014). Moreover, oil industry production has gradually expanded as new facilities have been installed on the back of a growing global demand for oil (Ibid). In fact, Saudi Arabia's daily crude-oil production has risen from 1.3 million barrels in the 1960s to 11 million barrels per day in 2014. As a result, the GDP per capita went from \$ 6306.54 in 1975 to \$25,961 in 2013 (Al-Sadiq, 2014; World Bank, 2015). Some argue the 2004 oil-price increase has not yet reflected in the real GDP per capita figures nor or on the real living standards of Saudis in comparison with developed economies¹⁵ (Al-Sadiq, 2014). The hydrocarbon

¹⁴ These sums vary depending on the degree and subjects; for undergraduate science students' \$300 and humanities \$250, and over \$500 for postgraduates.

¹⁵ The slow growth of the real GDP per capita and economic disparities results of the less economic diversification policy and the dependence on hydrocarbon sector revenues. Indeed, the restrictions on the foreign direct investments, which made the Saudi economy depends on the oil-revenues. The

sector revenues are the biggest contributor to the Saudi Budget, responsible at present for a third of Saudi's GDP and 89% of its exports (Ibid).

Oil-price volatility, notably the sudden slump in the 1980s-90s, encouraged the government to introduce new policies to stimulate economic growth and sustainability (Al-Sadiq, 2014; Sultan et al., 2011). Moreover, the government, in 1980, entered into an economic block with other Arab Gulf states (the Gulf Cooperation Council, GCC) in order to enhance trade and bolster stability (Al-Kazi, 2008). However, these policy efforts proved to be a failure in some aspects and needed further modifications (Al-Sadiq, 2014). Undeniably, the Saudi government diverted its oil-wealth to invest in infrastructure, build health and social services, acquire assets abroad, improve human development and turn around the country's socioeconomic figures (Alsharekh, 2007; Farsy, 1990; Metz, 1993; Twal, 2010).

Human development and health services are currently a priority for the Saudi government. Accordingly, during the first oil-price boom of the 1970s, the government invested heavily in these two sectors and in the boom since 2004, the same strategy has been adopted (Al-Kazi, 2008; Nydell, 2006). With a rapidly increasing proportion of youth, such an investment may prove to be a wise choice. In the subsequent chapters of this thesis, I will consider further the significance of the youth and the factors evident in government's decisions around health communication about substance abuse (see chapters five and six for further details). Table 3.4 below contains comparative details about the Saudi Budgets for the years between 2000 and 2010. In the table, the significant support afforded to the health and education sectors from the Saudi Ministry of Finance is clear.

In all the development and throughout the improvement projects and plans, the Saudi government has held fast on its commitment to and preservation of Islamic teachings. This was one of the late King Faisal's principles: to embrace development without reversing Islam (Farsy, 1990). I will now deal more specifically with this issue, with the status of Islam in Saudi Arabia.

fluctuation of prices in the oil-market is one of the reasons why the dependence on oil only worsens the economic disparities.

Table (3.4) Saudi public budget figures from 2000-10 (in millions Saudi riyals)

sector	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Human resources development (education)	49284	53010	47037	49609	55832	69899	87164	96483	104600	121942	137440
Telecom and transportation	5534	5732	5464	5634	6352	8629	9804	11329	12143	14642	16442
Economic development	5955	5629	4969	6927	7020	10516	12454	13902	16317	21692	29288
Health and social development	16381	18089	18970	16767	17971	23057	26798	31010	34426	40426	46600
Infrastructure	2067	2532	2693	2544	2620	3292	4555	5188	6384	7762	8438
Municipality services	5710	7224	7965	5393	6192	8976	11588	13576	14954	16509	18748
Defence and security	74866	78850	69382	70303	78414	95146	110779	132922	143336	154752	169667
Managing public facilities	19277	37372	39316	44848	49936	51665	62814	61756	63031	79148	92017
Governmental loans special institutions	436	411	373	375	387	502	575	1026	479	524	596
Local banking help	5490	6151	5831	6600	5276	8318	8469	12808	14329	17602	20764
Spending	185000	215000	202000	209000	230000	280000	335000	380000	410000	475000	540000
Revenues	157000	215000	157000	170000	200000	280000	390000	400000	450000	410000	470000

(Source: <http://www.mof.gov.sa/english/downloadscenter/pages/budget.aspx>)

3.4 Islam and Saudi Arabia

Islam in Saudi Arabia has not only informed the emergence of the education system but has had a profound influence on the structure of the Saudi economy, the country's development philosophy, the healthcare delivery system as well as the culture itself. Islam has been an important element in the region of the Middle East and beyond for centuries (Brown, 2009; Nydell, 2006). It is best described as an overarching system of beliefs, values, ethics and lifestyle codes (Hallaq, 2009; Weeramantry & Hidayatullah, 1988). Since the

Seventh Century, when Islam emerged in the Arabian Peninsula, it has influenced life in multiple ways within this limited geographical space, which is called now Saudi Arabia (L. Carter, 1984; Farsy, 1990; Twal, 2010).

This longstanding relationship between the geographical space of Saudi Arabia and Islam's history and principles make its inclusion in this dissertation critical. However, I will not attempt to provide a complete review of the religion and its ritual codes here. Rather, I will explain the relationship between the Saudi Arabian system and its people and attempt to convey the degree of influence that the religion imposes on the country's legal and social system. In order to do this, I will briefly relate the story of Islam before explaining how Islam and its five pillars integrate into contemporary Saudi Arabia.

Researchers often fail to take note of the importance of the pre-Islamic era in the region, a key phase in terms of Muslim identity and unity¹⁶. Before Islam, the Arabian Peninsula in the late Sixth and early Seventh centuries was immersed in enmity between Arabians and there was great diversity in religious beliefs and in ritual practices (Brown, 2009; L. Carter, 1984; Kluck, 1984; Qutb, 2007). This period is known as the **Jahiliyyah** in Arabic, which means the era of ignorance (Ibid).

The Jahiliyyah is not a religion or a phenomenon associated with Arabs or religious rituals, but a combination of elements. It represents, in other words, the worldview of the inhabitants of the Arabian Peninsula at that time. Religion in the Jahiliyyah period was a form of polytheistic paganism (Brown, 2009; Kluck, 1984). There were idols and goddesses across the land and each Arab clan or tribe affiliated itself with one idol or a group of idols. The worshipping of idols was the common religious practice before Islam, supplemented by a minority of monotheists (Christians) in the south of Arabia (Ibid). It's worth referring to Qutb's description: "Jahiliyyah is not an abstract theory; in fact; under certain circumstances it has no theory at all" (2007, p.25).

Jahiliyyah's diversity of idols and goddesses did not act as a source of unity or identity for the Arabs. In fact, Arab identity has been based historically on tribe lineage and kinship as well as on the spoken language (Abudabbeh,

¹⁶ Since Islam, as a religion, reflects on the identity of the Muslims, and put a set of morals, ethics, values and expectations from the member of this religion (Ahsan, 1992; Al-Azami, 1994).

2005; Al-Rasheed M, 1991; Duke Anthony, 1982; El Mallakh & El Mallakh, 1982). However, inequality and injustice toward some tribes, non-tribal groups and women was evident, exacerbated by tribal hierarchies and variations in wealth and power (Brown, 2009; L. Carter, 1984). According to Daniel Brown, the period before Islam was one characterised by misery and injustice: “These were people desperately in need of a prophet to destroy their idols and to drag them out of ignorance” (2009, p.26).

At the beginning of the Seventh Century, a glimmer of hope arose when Islam appeared in 610 A.D through Prophet Mohammed¹⁷ (Brown, 2009; Farsy, 1990; Kluck, 1984; Metz, 1993; Teti & Mura, 2008; Twal, 2010). According to Muslim belief, the Prophet Mohammed received the first revelation from God (in Arabic, Allah) through the Angel Gabriel in the Hera Cave¹⁸ (in Arabic Gaher Hera'a) to the east of Mecca (Ibid). The Prophet Mohammed then preached the message of Islam for two decades until his death (Ibid).

The early days of Islam were nurtured in the Meccan community, which had been going through the Jahiliyyah period with all its injustices and ritual practices. Early adherents were, therefore, inhabitants of Mecca as well as the Prophet's relatives and friends (Brown, 2009; L. Carter, 1984; Metz, 1993; Twal, 2010). The call of Islam was, of course, not limited to the Meccans¹⁹, but was universal. After Islam emerged in Mecca, Muslim preachers spread across the Peninsula and beyond even the Prophet Mohammed emigrated from Mecca to Medina (now it's called Al-madina Almonawrah 400 kms in the north of Mecca) (Ibid).

This emigration, known in the literature as Hegira (in Arabic Hijrah), was a result of the Mecca community's resistance to the new religion, which threatened the elite and their system at that time (Brown, 2009; L. Carter, 1984; Farsy, 1990; Kluck, 1984; Teti & Mura, 2008; Twal, 2010). Two years before the

¹⁷ Mohammed ibn Abdullah bin Hashim from Quraysh (Arabian tribe). He is the messenger of God (Allah) and the informer of the last Abrahamic religion (Islam). He was born in Mecca (Makkah), and he spent much of his adulthood working as a merchant in the Arabian Peninsula before he had received revelations (L. Carter, 1984; Farsy, 1990; Twal, 2010). Prior to prophetic time, Prophet Mohammed had been known for his good character, and he was called as the honest and trustworthy man (Ibid).

¹⁸ It is a cave in the mountain of lights (in Arabic Jabal Alnoor), which located in the east of Mecca (L. Carter, 1984; Twal, 2010). Prophet Mohammed used to go to this cave and spend times thinking about surrounded context and unfair system and ethics dominants Meccans at that's time (Ibid).

¹⁹ It is the plural for the city of Mecca inhabitants.

Prophet's death in 630 A.D, he and the fellow Muslims who emigrated to Medina, returned to what became known as the Holy City of Mecca (Makkah). By the time of Prophet Mohammed's death in 632 A.D, Islam had spread throughout the Arabian Peninsula and has been the prevailing religion there ever since (L. Carter, 1984; Twal, 2010).

Let us pause here and define Islam and its core components. In linguistic terms, the word Islam means peace, submission and a total commitment to the will of God (Allah) (Brown, 2009; Long, 2005b; Nydell, 2006; Voll, 2003). Unlike the Jahiliyyah, the doctrine of Islam is monotheistic (*Tawhid*) with Allah as the one God and Mohammed as his messenger²⁰. This is the essence of the Islamic faith (Encyclopaedia Britannica, 2014; Gimaret, 2014; Kluck, 1984; Qutb, 2007; Teti & Mura, 2008; Voll, 2003). "For the Muslim, it is believing and affirming what is stated by the first article of the Muslims' profession of faith: there is no other god but God (la ilaha illa Allah)" (Gimaret, 2014, p.224). So Islam means dedicating oneself to a belief in one God (Allah) and worshipping this God (Allah) without a mediator. This, therefore, is key to the history and identity of Islam and of its adherents (Sunitan, 2008).

As a religion, Islam has two fundamental sources, the Quran and Prophet Mohammed Sunna (*Prophetic traditions*) (Brown, 2009; Kluck, 1984; Teti & Mura, 2008; Weeramantry & Hidayatullah, 1988; Younos, 2013). These are believed by Muslims to contain revelations from God (Allah) to his last Prophet Mohammed (Ibid). The **Qur'an** teaches togetherness, unity and forgiveness (acceptance of repentance from bad deeds) (Weeramantry & Hidayatullah, 1988; Younos, 2013). It's seen as a source of guidance and instruction to Muslims and to all of humankind on all the important aspects of life such as rearing children, marriage, justice, the economy, politics, social solidarity, hygiene and health. These aspects divide into four categories of Quranic texts; oracular utterance, polemical, narrative and religious.

In terms of structure, the Quran contains 114 chapters, which are called *Surah* in Arabic, and each chapter contains verses, called *Ayah in Arabic*. The

²⁰ Islam did not only bring a monotheist religion to Arabia, it was a turning point for the whole of Arabian society (Brown, 2009), from one divided on a tribal basis to a society based on piety and religiousness; from a society where idols and goddesses were sanctified to a society believing in the oneness of God (Allah); from a society where the vulnerable were treated unequally and unfairly to one in which women were given full economic status, fair treatment and the right to inherit (ibid).

whole Quran was revealed in Arabic and its texts were translated to other languages.

Additionally, the Quran was not only seen as a sacred book, but as a source of blessing, wellness and happiness. In Saudi Arabia and the Islamic world, the Quran is recited in prayers, in mosques between prayers, at weddings, funerals and at social and official gatherings such as school assemblies (Long, 2005b; Younos, 2013). Those able to memorise the entire Quran hold considerable social status in Saudi society such as *Hafiz Kitab Allah*, as well as in other Islamic and Arabic countries.

Sunna is the second source of Islam (Brown, 2009; Kluck, 1984; Long, 2005b; Michalak & Trocki, 2006; Nydell, 2006; Teti & Mura, 2008). This refers to the group of Prophet Mohammed acts and sayings (Ibid). It is intended as a guide to clear up misinterpretations of the meanings of the Qur'an and to address issues not in the Quran (Ibid), making it a living set of documents. The spoken part of the Sunna is called the Hadiths, referring to Prophet Mohammed's sayings, remarks and talks. These were documented by Prophet Mohammed's companions²¹ and are divided into books with chapters, with each chapter containing groups of hadiths under a theme, for instance, a prayer book, a marriage book and a five pillars book (Kluck, 1984; Long, 2005b; Michalak & Trocki, 2006). This process was carried out in a careful manner to maintain reliability, as the hadiths were narrated from Prophet Mohammed through his companions and ancestors (Ibid).

Due to bad memory or false or un-realistic narrators, the reliability and trustworthiness of Hadiths are considered by scholars to be an element of central importance. Hadith scholars have established a system for tracking Hadith authenticity, called the *Isnad system* (Awliya'i, 2015; Islamic Awareness, 2012). This is based on interrogating the reliability of those who have transmitted the Hadiths. The Hadiths categorised as reliable are called *sahih* (Ibid). Others, perhaps because of gaps, false names or fictional people, were categorised as doubtful or weak (Ibid).

²¹ Refers to those who accompanied Prophet Mohammed in his life either in Medina (*Almadinah*) or Mecca (*Makkah*), also it includes those who lived with him such as Prophet Mohammed's wives. In Islamic and Arabic literature, the phrase *Alsahaba* plural means accompanies, and the single *Alsahabie*, which means the companion.

For Hadith scholars²², there are eight great books or, as they call them in Arabic, *Sahih* (which means correct). These books are the ones that have been authenticated as trustworthy. These eight *Sahihs* are; *Sahih Al-Bukhari*, *Sahih Muslim*, *Sunan an-Nasa'i*, *Sunan Abi Dawud*, *Jami at-Tirmidhi*, *Sunan Ibn Majah*, *Muwatta Malik* and the *forty hadiths Nawawi*.

So what do Muslims do to obey and fulfil the message of Islam? Principally, Islam has five central foundations, which are called the five pillars; *Shahada* (confession of faith), *Salah* (prayer), *Soum* (fasting during the month of Ramadan), *Zakat* (alms-giving) and *Hajj* (Pilgrimage to Mecca) (Brown, 2009; Farsy, 1990; Kluck, 1984; Long, 2005b; Nydell, 2006; Teti & Mura, 2008; Twal, 2010). These five pillars are Muslims' duties of faith.

Firstly, the testimony of *Shahada* is to recite and believe that 'there is no God except God (Allah) and Mohammed is his messenger', in Arabic '*Ashhadu anna la ilaha illa Allah wa Ashhadu anna Mohammed Rasul Allah*'²³ (J. Al-Omari, 2008; Brown, 2009; Farsy, 1990; Kluck, 1984; Long, 2005b; Teti & Mura, 2008; Twal, 2010; Weeramantry & Hidayatullah, 1988). Secondly, by *Salah* (prayer) Muslims are obliged to pray five times daily facing Mecca, the Holy city for Islam²⁴. *Salah* is a spiritual connection with God (Allah) through which Muslims seeks rewards, happiness and forgiveness (Brown, 2009). The *Salah* must be performed in groups with other Muslims in mosques²⁵ (in Arabic, *Masjid*²⁶).

The third pillar is *Soum*, the month of fasting during Ramadan²⁷, when Muslims are obliged to abstain from drink, food, sexual intercourse and

²² In Islamic and Arabic literature, the hadiths scholars called *Muhaddithun* and *Muhaddith* for the singular (Brown, 2009).

²³ This is the first thing non-Muslims do to convert to Islam and be a Muslim (J. Al-Omari, 2008), and it should be expressed verbally in front of a number of Muslims with no specific requirements on location, but it is preferably in a mosque. These words are the first words whispered to Muslim babies after birth (Brown, 2009). Moreover, the *Shahada* encompasses the call for prayers *Athan* (ibid).

²⁴ This is called *Qiblah* in Arabic, which means the direction for prayer.

²⁵ Under certain conditions, Muslims can perform prayer at home or in any other clean place.

²⁶ *Masjid* in Arabic is a mosque, and the plural is *Masajid*. Mosques vary in size and capabilities for prayer. *Large* mosque known as *Jammi'a*, and the different between the two is in *Jammi'a* Friday prayer take place where the case for mosques is not.

²⁷ Ramadan is the ninth month of the lunar Islamic calendar. The Islamic Calendar started on the date of Prophet Mohammed's emigration from Mecca to Medina in 622 A.D, and because they are lunar calendar months, they are always 29 or 30 days, but never 31. Ramadan is also called *the month of the Quran*, because the first revelation came to Prophet Mohammed in Ramadan and Muslims recite the Quran during Ramadan and have a special prayer for Ramadan called *Tarawih* (Weeramantry & Hidayatullah, 1988).

smoking. Fasting starts from sunrise and lasts until sunset, so the length of fasting varies from one area to another depending on the length of the days (J. Al-Omari, 2008; Farsy, 1990; Kluck, 1984; Long, 2005b; Teti & Mura, 2008; Weeramantry & Hidayatullah, 1988). The idea behind fasting during Ramadan is to teach Muslims to be patient, to feel the feelings of poor people and to be self-disciplined. It is a time for contemplation (Ibid).

Next, Zakat (alms-giving) obliges Muslims to pay a certain percentage from their annual profits, savings, incomes and assets (Farsy, 1990; Kluck, 1984; Long, 2005b; Teti & Mura, 2008). This obligation is applied on one condition, which is the completion of a full financial year without losses. So only those who can afford to pay Zakat, do so, usually through distributing it to poor people or to people in need (Ibid). The idea behind Zakat is to promote social collaboration between members of society in order to help those in need (Weeramantry & Hidayatullah, 1988; Younos, 2013). Also, it emphasises the value of collectivism among Muslims. In contemporary Saudi Arabia, almsgiving is well recognised by the government and a governmental department was established in the early days for the Saudi government to collect and distribute Zakat²⁸ (Farsy, 1990; Kluck, 1984; Twal, 2010).

Finally, Muslims are obliged to perform the Hajj pilgrimage to Mecca in Saudi Arabia at least once in a lifetime if they have adequate health and wealth²⁹ (J. Al-Omari, 2008; Farsy, 1990; Kluck, 1984; Twal, 2010; Weeramantry & Hidayatullah, 1988; Younos, 2013). Muslims gathering together wearing only white garments with no colours or adornments to show their status or income represent Islam's equality and purity (Ibid). Since the holy places and cities of Islam are based in Saudi Arabia, the Saudi government is responsible for pilgrim's safety, health and comfort³⁰. Nowadays, more than 3 million people visit Mecca in the Hajj season alone³¹. According to the Central Department of

²⁸ Since present day Saudi Arabia was formed on the basis of implementing Sharia law, the collection and distribution of the Zakat was one of the first things the Saudi authorities implemented after the consolidation in the 1930s (AlRasheed, 2010).

²⁹ Usually Muslims perform Hajj in the twelfth month of the Islamic calendar—*Dul alhijah*-(meaning the month of Hajj in Arabic) for the days between the eighth and thirteenth (Long, 2005).

³⁰ Each year the Saudi government transfers its headquarters from the capital city of Riyadh to Mecca (Makkah) (Farsy, 1990).

³¹ Because there is Ummrah visitors' and their number is not included above. Recent projections indicate the number is soon expected to reach five million pilgrims a year.

Statistics and Information in Saudi Arabia, 1.8 million Muslims visited Mecca in the Hajj season in 1995, compared to 3.16 million in 2012 (CDSI, 2014).

The five pillars and Islamic teaching emphasise the values of caring, collectivism and equality and these are reflected both within Saudi society and among Muslims worldwide. Islam emerged in Arabia and has been a powerfully transformative factor in the region's political and intellectual history. Islam is more than a religion or a set of ritual practices. It is a way, or a system, of life (AlRasheed, 2010; Long, 2005b; Younos, 2013). Islam is deeply embedded in Saudi Arabia ancient and historical roots. Even beyond Arabian shores, Islam, as a system of governing, has been adopted by many Empires and Kingdoms worldwide. From Córdoba to Istanbul, Islam has been a key determinant of public lives and systems (Aarts & Nonneman, 2006; Brown, 2009). Prior to Saudi Arabia's emergence on the world political map, this area was governed by Islamic Empires and Sultanates (Ibid). So when the Saudi authorities adopted Islam, this was not a new issue in the area.

The story of modern-Saudi Arabia and its affiliation with Islam was the result of a series of conquests and military campaigns across the Arabian Peninsula led by the founder of the modern Kingdom of Saudi Arabia, *King Abdul-Aziz bin³² Abdulrahman Al-Saud, Ibn Saud* (AlRasheed, 2010; Farsy, 1990; J. Habib, 1978; Long, 2005; Twal, 2010). The motivation behind this political movement was the implementation of Islamic precepts in the Arabian Peninsula (Al-Atawneh, 2009; Bligh, 1985; Doumato, 1992; Nevo, 1998; Steinberg, 2006). At that time, the Al-Saud family was not new to the Arabian Peninsula or to central Arabia due to its connection with the Eighteenth Century Islamic reform movement in central Arabia known as the *Unitarians³³*, or in Arabic, *Muwahhidon* (AlRasheed, 2010; Brown, 2009; Farsy, 1990; Smyth, 1994).

This movement called for the purification of Islam and its return to the core focus of the faith on the oneness of God (Allah) and on the direct submission to God (Allah) without intermediaries (Ibid). To support this movement, a political and religious alliance was formed in an Arabian oasis between *Mohammed bin Saud and Mohammed bin Abdulwahhab* (AlRasheed,

³² Means the (son of) in Arabic.

³³ In some western literatures it is known as Wahhabism as well.

2010; Bligh, 1985; Doumato, 1992; Nevo, 1998). The basis of this alliance was to divide responsibilities between the two sides; Ibn Saud would be responsible for political and governmental issues, whereas Bin Abdulwahhab and religious figures would maintain the religion in the Arabian Peninsula (Ibid).

According to Al-Atawneh:

Shaykh Muhammed Ibn 'Abd al-Wahhab (d.1792), eponymous founder of Wahhabism, divided the hegemony of the state between the 'ulama' (religious officials; 'divines'), who were the authorities in matters of jurisprudence, and the umara' (political rulers), who ruled and presumably consulted the 'ulama'. Accordingly, the sharia needs the ruler's commitment and enforcement, while the state needs the sharia for its legitimacy. However, Ibn Abd al-Wahhab neither provided a precise model of cooperation between the 'ulama' and the rulers, nor delineated the structure and functions of the Wahhabi state (2009, p.727).

Consequently, loyalty to the Saudi system was not based on the hereditary monarchy but on the sustainability of Islam in the country. In order, to pay obedience and allegiance to the King (*the Muslim society leader*), he was required to preserve the faith and implement Sharia Law. Scholars believe this bond between religion and law is a key element in the long-term sustainability of the political-religious alliance (Rudolph, 1984).

The combination of faith and law led to what can be described as a *theo-monarchy in Saudi Arabia*³⁴. Figure 3.2 below shows the structure of the authorities in Saudi Arabia and how this political-religious alliance is implicitly integrated into the system. The king is the top power (authority) and all authorities intersect and fall under his supervision and responsibility. These three authorities are the cabinet and the consultative council (*Majlis Al-shura*) and provincial authorities (Emirates). In contrast, the relationship between the king and the *Ulama (Islamic clerics)* is not a hierarchical relationship, but a two-way relationship based on the consultation (*Shura*) concept in Islam, which encourage the ruler to take decisions based on consultation with those who will be affected by that.

³⁴ Al-Atawneh believed that "The Saudi Monarchy, I would suggest, is a genuine monarchy that accommodates Islam. It is best described as a '*theo-monarchy*' shaped by religion and long-standing religio-cultural norms. It is based on an ongoing compromise between the two major authorities, the existing religious institutions and the Saudi monarchy" (2009, p.733).

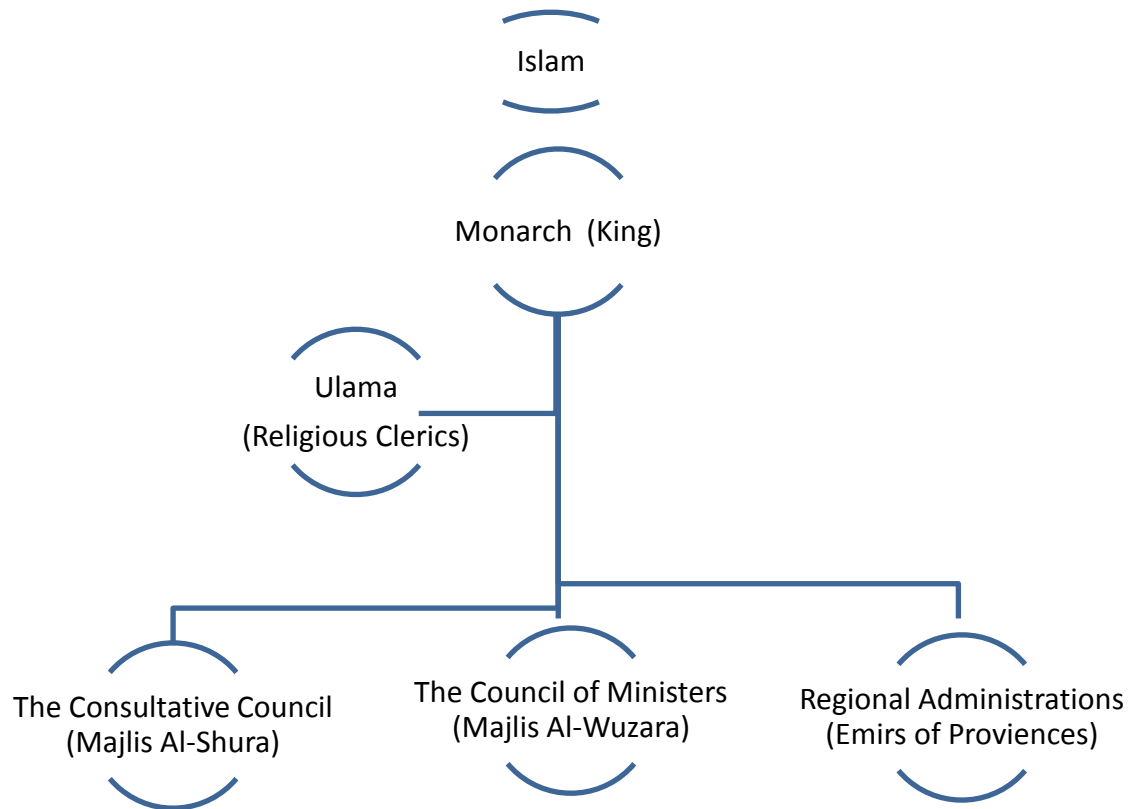


Figure (3.2) the Saudi system structure.

As the figure above shows, Islam is situated on top of all authorities and constitutes a vital principle. Therefore, no authority will violate the rules of Islam (Farsy, 1990; Looney, 1982). Under Islam come the authority of the King (the leader of the Muslim society), and beneath him, the authorities run the daily business of the country. It is stated in the Saudi Basic Law (article eight) that the government of the Kingdom stands on the Islamic principle that “governing in Saudi Arabia stands for justice, Shura (consensus and consultation), and equality according to Islam” (Saudi Basic Law, 1992).

The council of ministers is the executive authority in the kingdom. Since it first met in 1953, the council has been responsible for the country’s economy, security, military readiness and for all strategic issues (AlRasheed, 2010; Farsy, 1990). Since its creation, the council has witnessed the development and restructure of various new ministries. It was this council that managed the wave of development and construction in the 1970s and 1980s, as well as current

infrastructure projects (Ibid). Legislation and policy making are also the consultative council's responsibility.

The Consultative Council (*Majlis Al-Shura*³⁵) is an extension of Islamic influence on the Saudi official system rooted in the notion of consultation (AlRasheed, 1996; Hrair Dekmejian, 1998; Twal, 2010). In this model, the King holds the final power to sanction proposed laws or policies³⁶ (Al-Atawneh, 2009). Therefore, as Figure 3.2 above shows, the legislative relationship between the cabinet and the Consultative council is a joint one. The council proposes laws, reviews regulations, gives opinions on governmental matters and reviews government's performance. If there is disagreement between the cabinet and the consultative council, the King has the final say.

The Saudi government felt the need to have structured regional authorities in the 1990s and a law was promulgated in 1992 dividing the Kingdom into 13 regions (Twal, 2010). Each region has a regional council headed by the regional Emir which identifies strategic plans and needs (Ibid). Both Saudi provincial law and the Shura council form part of the 1992 constitutional reforms³⁷.

The last component of the Saudi current system is the *Ulama* (*religious clerics*). It is an Arabic plural word for the singular word *Alim*, which refers to the religious individual who specialises in one or more of the Islamic studies such as Islamic jurisprudence (Fiqh), Quranic studies, the Prophet Mohammed's Sunna studies, theology or the study of Islamic rituals. This group acquired its position in the Saudi official structure through a theological basis (Al-Atawneh, 2009; AlRasheed, 2010; Bligh, 1985; Doumato, 1992; Nevo, 1998; Rudolph, 1984). The Ulama are responsible for religious affairs, while the King and his ministers and councillors deal with political matters (Ibid). Between 1932 and 1970, the Ulama had various roles and recognised duties. As religion and state are indivisible, the Ulama have been a significant player in various areas such

³⁵ The concept of *Shura* mentioned in the Quran in a whole chapter, number 42, called (*Surt Ash Shura*), and in verse 38 the concept of consultation explicitly was acknowledged "(38) And those who have responded to their lord and established prayer and whose affair is [determined by] consultation among themselves, and from what We have provided them, they spend" (Quran, 42:38).

³⁶ It is rare, because the policy making process goes in parallel with informing the king.

³⁷ In 1992, King Fahad issued three constitutional reforms; the Basic law, Consultative council law and provinces law, for further details see (AlRasheed, 1996; Hrair Dekmejian, 1998; Twal, 2010).

as the judicial system³⁸, education, media, public places, commerce and religious establishments (Ibid).

In the 1970s, as a result of a consultation with the Ulama, the government established a council for the Ulama, which consisted of fifteen Alims³⁹, headed by the Grand Mufti⁴⁰ (Bligh, 1985; Farsy, 1990; Twal, 2010). The council's responsibilities were to; maintain the implementation of Sharia law, manage juridical courts, supervise education establishments' performance and curricula⁴¹, and supervise mosques and the Muslim holy places (Ibid).

This section has highlighted, above all, the deep relationship between the place, the people, the religion and the political establishment of Saudi Arabia. For the Saudis, Islam is not only a faith, but a system of life. This will be important when I come to discuss the importance of Islam on health communication in Saudi Arabia. Now I turn to another key area, the development of the media environment in Saudi Arabia.

3.5 The media environment in Saudi Arabia

Nowadays, it is common to find articles about the increasing use of information and communication technology, such as social media, among the Saudis (Askool, 2013; The Economist, 2014). Creating an information-based society has been declared a specific objective of the Saudi authorities (Farsy, 1990; Twal, 2010). This section of the dissertation presents the media environment in Saudi Arabia with a brief summary of media history in the country.

The media in Saudi Arabia is rooted back before the Saudi consolidation in 1932. While book publishing in the region has existed for many centuries, a media was established during the period of the Ottoman Empire (Ezat, 2008). In fact, not all the Arabian Peninsula was affected by the media movement during

³⁸ Before 1970 the Saudi juridical system consisted of courts across the nation and the decisions of these courts could be appealed to two higher courts; in Mecca and Medina. All the courts used to be under the supervision of Chief Judge (Qadi) based in Mecca, who administratively fell under the Grand Mufti's supervision (Bligh, 1985).

³⁹ The plural word of *Alim*. It means a person with religious knowledge and qualifications.

⁴⁰ The Grand Mufti is the scholar with highest knowledge in Islam among his peers in the council, and he and other Ulama issue fatwas (verdicts) in public matters and on private issues as well.

⁴¹ At the early stages of the Saudi Educational system traditional schools were based at religious figures' houses or at mosques. Though these schools have developed and expanded their curricula, they remain under the supervision of the Ulama.

this time, only the western region (Hejaz) (Ibid). In 1882, the first printing house was opened in Hejaz and an annual book about the region was issued by the Ottoman authorities (Ibid). However, after Ottoman reforms in the 1900s, six governmental and semi-governmental newspapers were established. They were published in Arabic and Turkish and they played a major role in the politics of the Hejaz, including the first Arab revolution in the 20th Century⁴² (Ibid).

After the end of the Ottoman period in the region, the local ruler (the Hashemite King), encouraged newspapers and publishing and four newspapers and the first technical magazine⁴³ were published. All these newspapers were in Arabic and were concerned with internal and regional issues, poems, the Arabic language and the arts (Ibid). This was from 1916 to 1924, at which time the Hashemite Kingdom of Hejaz came under the rule of Saudi Arabia. Consequently, 1924 marked the emergence of the first Saudi official newspapers⁴⁴ (Ezat, 2008; Farsy, 1990; R. Habib, 2004).

The early days of Saudi journalism were, therefore, in the Hejaz region due to existing infrastructure such as printing facilities and to the presence of intellectual debate and an educated readership (Ezat, 2008; Long, 2005a). Media scholars generally agree that Saudi journalism has had three different eras in term of ownership and structure (Ezat, 2008; R. Habib, 2004; Yamani, 2008).

The first, individual journalism phase was between 1928 and 1959, during which period any individual could open a magazine or a newspaper with only economic requirements to meet (Ibid). As a result, the diversity of the content and the types of journalism increased as well as the readership⁴⁵ (Ibid). Then, in 1959, the number of newspapers reached saturation point and the government decided to merge them together into larger entities to ensure the continuity of the different types of journalism and quality (Ibid). Some argue this move was an act of government intervention with the objective of imposing censorship through regulation (Long, 2005a; Wheeler, 2003). In 1964, a new press law was promulgated which gave the right to open a newspaper or magazine to private organisations only (Ezat, 2008; R. Habib, 2004; Wheeler,

⁴² This revolution was against the Turkish movement taking control of the Ottoman authority in Istanbul.

⁴³ It was a periodical for an agricultural school in Mecca (Ezat, 2008).

⁴⁴ Between 1908 and 1924 there were three official newspapers for three different regimes’.

⁴⁵ There were over 40 newspapers in 1959 from one in 1924.

2003; Yamani, 2008). In 2002, the law was updated, new procedures for setting up newspapers were introduced and the first Saudi Journalists' Association⁴⁶ was established (Ibid).

The development of the journalism industry in the Kingdom has been pulled by both internal and external factors. First, social and economic improvements led to an increase in commercial activities as well as the literacy rate (Ezat, 2008; Farsy, 1990; Long, 2005a). Second, Saudi authorities recognised the importance of journalism in keeping the population informed about foreign policy and government performance (Ibid). Both these factors led to increasing demands for newspapers.

In general, the journalism industry remains privately owned with only one newspaper owned by the authorities, the official newspaper *Umma Al-Qura* (Ibid). Under the Press Law of 2002, 10 private concerns⁴⁷ own the 16 national daily newspapers; two in English, two specialising in sport, one dedicated to the economy, two dedicated to Pan-Arabism and the rest are national newspapers in Arabic (BBC, 2006; BBC, 2015; Wheeler, 2003). At the beginning of the new millennium, many of these newspapers went online (Ibid). Also, there are hundreds of online-newspapers and news websites such as Elaph.com and Sabq.com.

As in other parts of the world, Saudi newspaper circulations have fallen as a result of the increase in information and communication technology penetration and the growth of 24 hours Arabic News Channels. For instance, *Okaz* newspaper in Jeddah sold 147,000 copies in 2003 but, by 2006, this had dropped to 110,000 (BBC, 2006; Wheeler, 2003). Likewise, the *Al-Riyadh* newspaper's circulation fell from 170,000 in 2003 to 150,000 in 2006 (Ibid)⁴⁸.

The electronic media in Saudi Arabia developed under Saudi rule and not before. In 1932, the first radio station was established in Jeddah to keep the monarch connected with the Saudi regional governors and to inform the power elite about what was happening in the world and the Kingdom (Boyd, 1970; Boyd, 1999; Ezat, 2008; Long, 2005a; Marghalani, Palmgreen, & Boyd, 1998;

⁴⁶ Some commentators argue the weakness of this body in protecting the journalist from the authorities.

⁴⁷ For example, the Saudi Research and Publishing co, Al-Yamama Press Establishment, Okaz Organization for Press and Publication and Al-Jazirah Press, see for details http://news.bbc.co.uk/1/hi/world/middle_east/6176791.stm

⁴⁸ For more details about circulation and industry see (Tuncalp, 1994).

Ministry of Culture and Information, 2012; Wheeler, 2003). Later, in 1948, the first public radio station was launched, also in Jeddah (Ibid). In 1954, the government passed a law regulating the work of radio stations, and a directorate of Saudi radio was established. In 1962, the station Call of Islam began broadcasting from Mecca and, in 1965, a radio station opened in Riyadh (Ibid). From then, these radio stations expanded and more public stations were opened such as *Quran* Radio and *Saudia* Radio in English (Ibid).

The 1954 Law of Radio insisted the main purpose of this medium was to spread the call and teachings of Islam internally and externally, and also to counter illiteracy (Long, 2005a). Programming across all these stations during the 1960s was diverse and included, for instance, news and information (22%), education (27.5%), religious and cultural (38.8%) and entertainment (11.7%) (Wheeler, 2003).

In the same period, the Saudi government in collaboration with the US network of NBC established two television stations in Riyadh and Jeddah (Boyd, 1970; Boyd, 1999; Ezat, 2008; Marghalani et al., 1998; Wheeler, 2003). The first broadcast was aired in 1965 and, four years later, a nationwide network was completed (Ibid). The introduction of television faced criticism in particular from religious figures, but after explanations and clarifications from the authorities on the social benefits of such a medium, resistance to television eased. In 1962, the Saudi authorities created a Ministry for Information⁴⁹ to supervise the country's media industry (Ministry of Culture and Information, 2012).

Today, Saudi television now has nine channels with a wide range of interests including Public Channel 1, English 2, News, Economy, Culture, Kids (Ajial means generations), Sports channels, the Quran Channel and the Sunna Channel. Together, they fall under the supervision of the Saudi Broadcasting Corporation (SBC)⁵⁰. Most of these channels have websites and/or the channel's contents are available online, for instance on YouTube.

The motivations behind the Saudi government's introduction of radio and television go beyond Saudi radio law's official objective, which is to inform and educate the public. The political and economic scene in the region during the

⁴⁹ In 2003, the government changed the name to be Ministry of Culture and Information.

⁵⁰ <http://www.sbc.sa/> الرئيسية

1950s-60s was dominated by the Pan-Arabism Republicans, who were in principle against monarchies and colonial powers in the regions (Yamani, 2008; Yushi, 2012). Supported by the massive Egyptian media machine at that time, the Saudi King Faisal realised the necessity of a media that would resist Arabism and embrace Islamic principles. Furthermore, the presence of American companies and personnel led to the establishment of a first TV channel in 1955 at the US air force base at Dhahran, and two years later the Oil Company; Aramco⁵¹ opened Aramco TV, later known as Channel 3⁵² (AlRasheed, 2010; Boyd, 1970; Vitalis, 2007).

Internally, the Saudi government found the electronic media a good platform to connect with the masses, especially the uneducated, as well as a useful medium to express the national identity and enhance national pride among citizens. The electronic media were also valued for their role in improving education. In addition, the government used television and radio to promote the country's five-year development plans.

So, state-owned broadcasting and private newspapers characterised the Saudi media ecology until the 1990s. At this time, rapid change impacted on Saudi's media. This was when direct satellite broadcasting⁵³ started and also the internet went public. After the first Gulf war in 1991, the first private satellite Arabic channel (Middle East Broadcasting Channel MBC1) went on air, owned by two Saudi businessmen (Cochrane, 2007; Hammond, 2007; Long, 2005a; Yamani, 2008; Yushi, 2012). Later, two TV cable networks emerged (Arab Radio and Television Network ART) and Orbit (Ibid). The number of the channels increased dramatically between 2000 and 2010, not only in Saudi and the Gulf but across the Arab World (Ibid). Nowadays, the prominent private Arabic media channels and networks are owned by Saudis, extending Saudi influence far beyond its own territory, as we will see later.

Use of the internet in Saudi Arabia has jumped from 112,000 users in 1999 to over 17 million by 2014 (Internetlivestate, 2014; Wheeler, 2003). According to a study conducted by the Saudi Communication and Information Technology Commission (CITC), 53% of Saudis owned computers in 2009

⁵¹ Arabian American Oil Company.

⁵² It was discontinued in 1998 as a result of the competition from satellite channels and new media, so the company found it rational to close the channel.

⁵³ It was through two Satellites; Arabsat and Nilesat.

compared to 43% in 2007 (CITC, 2009). Also, internet penetration rate had reached 40% of the population by 2009 (Ibid). Improvements have also been experienced in the provision of broadband infrastructure and in the diffusion of internet usage among different age groups and across different sectors such as business, health and education (Ibid). But it is the arrival and popularity of Web 2.0 technology that represents the most recognisable shift in Saudis' relationship with the internet⁵⁴.

A recent study on Saudi use of social media⁵⁵ revealed interesting findings and figures (Muhammad, 2013). Three million users from both genders were found to access Twitter with the age groups between 18-24 years and 25-34 year the biggest groups (Ibid). Indeed, 12% of the Saudi population were registered Twitter users and 26% of the online population (Ibid). Saudi YouTube viewers became the first in the world to reach 90 million views per day (Ibid). The Social Networking Website Facebook has also proved very popular with 6 million users from the age groups above, 30% of them female (Ibid).

Furthermore, figures also show that by July 2014, 31% of the Saudi population logged into their social media accounts at least once a month (Statista, 2015a; Statista, 2015b). This compares to the global average of 27%. The most popular social networking sites were WhatsApp with 22%, Facebook 21%, and Twitter 19% of the population (Ibid).

The transformation of the Saudi media into a dynamic, modern ecology has been driven by local and national governmental efforts to embrace new technology along with regional and global changes. In the 1960s and 1970s, the Saudi authorities would review media content before publishing or broadcasting. Nowadays, due to media convergence, high usage of the internet, and direct satellite broadcasting, the Saudi authorities have been unable to regulate to the same degree. Scholars and commentators have observed an increasing degree

⁵⁴ Recent events in the Arab world such as the movement by young people to topple the authoritarian systems in the region are a great example.

⁵⁵ "What attract individuals to use social media are the ease of connection, communication, participation and collaboration, as well as avoidance of restriction for meeting people who are in different places. They also provide people with new and different ways to interact over the internet; using their PCs or mobile devices" (Askool, 2013, p.201).

of freedom of expression⁵⁶ and heightened tolerance of criticism, particularly in the printed media (Long, 2005a; Wheeler, 2003).

While the massive expansion in technology and communication opportunities have led to the easing of restrictions on discussing sensitive topics in the mass media, the true change has been the eruption of discussion and debate in social networking websites and microblogging applications (Arab Social Media Report, 2012; Askool, 2013). However, the government still retains some control over the social media in terms of monitoring suspicious accounts or those accounts believed to promote public disorder or terrorism, but to a lesser degree than the days of old media. The media system in the country is based on a loyalist system. According to William Rugh:⁵⁷

The countries in the loyalist media group also have political systems in which there are no political parties or competitive elections, and the political environment also does not encourage dissent to be expressed against the government. But the regime adopts a more passive attitude toward the media than is the case in the mobilization systems and does not seek aggressively to exploit the media to mobilize the public for specific political purposes as the mobilisation system does (2007, p.6).

In such a system, critiquing the head of the system or Islam or the king is unlawful. The authorities in Saudi Arabia are still able to censor media content and have a strong influence on the industry (Cochrane, 2007; Hammond, 2007; Wheeler, 2003; Yamani, 2008; Yushi, 2012). But the social media gives youths and users in general the opportunity to debate and criticise. The large number of young people living outside the country suggests this use of social media will continue to increase in the future.

The Saudi media system's influence extends far beyond Saudi shores and impacts on the entire Arab World. Since the 1970s, Saudi businessmen and princes have invested in Pan-Arab newspapers and TV networks. Nowadays, most of the influential private Arab media are owned by Saudis or by investors from the Gulf States⁵⁸(Cochrane, 2007; Hammond, 2007).

⁵⁶ For more details about the freedom of expression in the region look at the "The Freedom of Press in the Middle East and North Africa" by Joel Campagna, 2003.

⁵⁷ In his study, he outlined three categories of media system in the Arab world; mobilisation, loyalist and diverse (W. Rugh, 2007; W. A. Rugh, 2004).

⁵⁸ Qatar, Kuwait, Bahrain, Oman and UAE.

Networks such as MBC, Alarabiya Channel, Rotana networks, some Lebanese stations and others are owned by Saudis. Indeed, many of the influential Islamic channels are owned and operated from Saudi Arabia and some operate abroad, but still comply with the Saudi view.

The private popular media and biggest media groups are owned by Saudis and operate in alignment with the Saudi values of family, religion and politics as well (Wheeler, 2003; Yamani, 2008; Yushi, 2012). The Saudi government considers control or influence over the region's media to be a matter of strategic importance and a contributing factor to maintaining Saudi influence in the region. In addition, senior members of the Saudi power structure have a direct stake in regional media houses, such as Saudi Prince Al-waleed bin Talal who owns the Rotana media group and who also has shares in News Corp (1%) and who bought shares in Twitter worth \$300m (about £191m) in 2011 (Greenslade, 2015; Whitaker, 2011).

3.6 Conclusion

The Saudi media environment has experienced rapid change within a short period of time. From non-existence on the world map prior to the 1930s, Saudi Arabia has become an influential and unified state. Undoubtedly, economic and social improvements have been at the heart of this profound transformation. Additionally, this chapter has shed light on the demographic shifts in the Kingdom as well as on the progress with the social and health infrastructure particularly in light of the growing problem of non-communicable diseases in the country.

Collectively, these issues are combined with Saudi geography and its topographical limitations to make up the matrix of trade, policy and regional relations underpinning the drug trade. In addition, the historical and contemporary status of Saudi Arabia in the Muslim world adds further weight to its unique position. Above all, the adoption of new technologies and the shift toward greater freedom of expression is having a noticeable impact on communities within Saudi Arabia. Together, these changes and challenges in the health realm correspond with the previous chapter's depiction of the growing popularity of a cultural perspective in health communication.

This chapter has sought to bridge the gap between the literature review and the study's milieu. It has also paved the way to a discussion of the methodological procedures which will be used to excavate the research questions. In the next chapter, I will present the rationale for the study and the research paradigm.

Chapter Four: Researching Health Communication in Saudi Arabia

4.1 Introduction

This chapter seeks to explain and describe the philosophical, technical, operational and ethical elements behind this thesis, which together form the methodology for this study. My research draws on the rich and complex world of health communication while much of the data was sourced from wide-ranging field trips to Saudi Arabia.

The primary role of this chapter is, therefore, to present my research methodology and the rationale for my choice of methods. I will demonstrate that my chosen methods were appropriate to the research questions and were rigorously implemented. Various elements are further elaborated upon in the following sections.

It is worth re-stating the research questions and focus again and, in addition, explaining the rationale for doing this research at this time. A parallel argument about how the research questions influenced the study's position within prominent health communication research perspectives will be presented. This chapter will also engage with health communication research paradigms and approaches in order to demonstrate where this study, as a research paradigm, is located within the topography of health communication research.

This chapter will address the practical side of the methodology by presenting the research philosophy and the data collection methods involved. More information about sampling, access to participants, recruitment techniques, challenges and management of the field trips will be included in this section. After that, the chapter will present the research's procedural techniques used to process the collected data including the Computer-assisted Qualitative Data Analysis Software (CAQDAS). This chapter will conclude with a discussion about research quality and reliability as well as the research's ethical procedures.

By the end of this chapter, a clear understanding about the research methodology involved in this study and the mechanism of analysis will have been presented. Reference will be made to the real world challenges of this

research including how the researcher managed to override the challenges and requirements of the local context in order to find answers to the research questions. It is important to say that the researcher has tried to detail all the methodological and analytic procedures as well as the challenges faced in order to inform and assist any potential researchers who are also planning on conducting qualitative research in Saudi Arabia or the Middle East.

4.2 Research focus and research questions

This research seeks to investigate the influences posed by Saudi Arabian culture on health communication against substance abuse. This research focus cannot be isolated from the mainstream trends of health communication, to which I referred in detail in the literature review. Indeed, the study touches on a growing research area in health communication; namely, the cultural perspective (Dutta & Zoller, 2008; Harrington, 2014; Thompson et al., 2014; Wright et al., 2012). The focus of this study has naturally determined its methodological pathway. Therefore, the cultural nature of this study has been a crucial key in the process of selecting and implementing the research methodology and the research methods (Neumann et al., 2011; Thompson et al., 2014). In order to achieve appropriate answers for this dissertation and the fundamental focus mentioned above, the following questions were addressed:

RQ1-1: What influences does Saudi Arabian culture have in communicating anti-substance abuse?

RQ1-2: What cultural issues arise out of communicating anti-substance issues in Saudi Arabia?

RQ2- How has health communication against drug and alcohol in Saudi Arabia evolved?

These research questions explicitly demonstrate the focus of the research in addressing the cultural question of health communication about drug abuse and alcohol use in Saudi Arabia. There are many complex aspects embedded in these questions and I will excavate these as we proceed through the study.

This research looks at a particular genre of communication which aims to promote a better and healthier lifestyle by urging the avoidance of illicit drugs and alcohol¹. Therefore this study engages with the crucial roles of health communication; to maintain and improve public health and to prevent diseases and other dangerous behaviours including substance abuse. In the real world, this study examined a particular type of health communication in Saudi Arabia adopted by domestic governmental and non-governmental agencies and by specialised organisations that promote the avoidance of risky health behaviour. I have chosen not to include international health promotion agencies based in Saudi Arabia, for reasons I will explain below.

Because this study examines the cultural perspective of health communication against substance abuse in Saudi Arabia it is vital to shed some light on the context of this study. The focus of this study is on Saudi culture; therefore, the fieldwork activities were conducted in Saudi Arabia and the majority of the research participants were directly linked to the problem and to the context. This study does not claim to be the first health communication-related study or the first communication-oriented anti-drug and anti-alcohol study in Saudi Arabia. But there does not seem to be any previous research in the area of health communication from a cultural perspective with a focus on substance abuse. As a consequence, this study takes a pioneering position and is the first exploratory and explanatory study in this Arabic-Islamic environment (for more details about Saudi Arabia see Chapter Three).

Before moving to the practicalities of the methodology, it is necessary to explain why it was important to study this subject from this perspective at this time. The motivation behind this research can be divided into three categories; context specific reasons (Saudi), changes in risky-health behaviour and related-problems (problem specific) and shifts in the discipline's research traditions (discipline specific).

It was asserted in the previous chapter that Saudi Arabia is a young nation² that has been transformed from an undeveloped and unstructured status to a well-established and united country with many improvements in

¹ In this study, not only was the harmful use of alcohol or illicit drugs abuse covered, but also any non-medical use of drug and alcohol, which are all seen as a problem in the Saudi Arabian context.

² 23rd Sept 1932 marks the day of consolidation in Saudi political history, and is also the first National Day.

various areas, for instance in finance, health, education and technology (Al-Kazi, 2008; Al-Khateeb, 2007; Alsharekh, 2007; Alsharekh & Springborg, 2008). In addition, the positive implications of the nation-building and development processes and the social and cultural changes which have arisen since the beginning of this massive economic and political project cannot be ignored. These changes differ in their impacts and roots, but the focus here is on the intake of drugs and alcohol, and how these overlap with other changing factors.

Primarily, the dynamism of the Saudi context justifies this study of health communication. These changes have had a direct impact on substance abuse problems. In particular, the demographic transition in Saudi Arabia and its implications have become very important for a study like this. The demographic shift which Saudi Arabia has witnessed in recent decades not only shows an increase in the population and the improvements in socio-economic and health aspects, but also wide-ranging socio-cultural changes.

It is true that the Saudi population has shifted from high mortality and low life expectancy in the 1960s to low mortality and higher life expectancy in the Twenty-first Century. This represents just one example of how government development planning projects have improved national health indicators (Tabutin & Schoumaker, 2012). Indeed, the demographic shift is such that the population age structure has changed and is now a youth dominated structure with around 50% of the population under 25 years old (Arab News, 2014; CDSI, 2014). Furthermore, as a consequence of the massive infrastructure projects and industrialisation (Saudi Industrial Development Fund, 2013) and the influx of guest workers, expatriate communities currently represent 30% of the Saudi population (Arab News, 2014; CDSI, 2014). Both the changing age structure and the influx of mixed nationality workers have encouraged the researcher to examine how Saudi culture influences the ways of promoting behaviour against substance use in Saudi Arabia's new order.

Moreover, the growing cultural diversity of the migrant worker communities and the Saudi youth 'bulge' both impose extra challenges on the Saudi health care infrastructure, services and capacity (Kar et al., 2001a). Equally, the diversity of the expatriates' backgrounds has put cultural pressure on Saudi's socio-cultural components because the members of these communities hold different values, beliefs and ethical codes while often sharing

the same religion, language or nationality. These characteristics have a profound influence on how health communicators navigate their options (R. Thomas, 2006). The influx of multiple values and backgrounds has made the examination of their cultural influences on anti-substance health communication an important touchstone for the study.

Another context-oriented motivation for this study is the Saudis' distinct position in the Islamic world, their longstanding historical Islamic heritage and the influence of this tradition on Saudi culture and identity (AlRasheed, 1996; AlRasheed, 2010). Therefore, interrogating the concept of culture touches not only Saudi national identity, which is Islamic-Arabic oriented, but also Islam as whole. The Saudi identity is itself in its infancy as the country only emerged in the 1930s. Since then, the Saudi government has been making a concerted effort to unite this newly emergent nation and its peoples (Yamani, 2009; Yamani, 2000). The question of this distinctive context and the still developing process of forging a national identity is tempting ground for scholars. Another key point is the connection between globalisation and substance abuse, a further motivation for undertaking this study.

Globalisation and interdependence have seen substance abuse and alcohol misuse³ transformed into global problems (Abadinsky, 2010; Bean, 2008; CDC, 2014b; Fields, 1995; Pietschmann, 2007; UNODC, 2008; UNODC, 2014b; WHO, 2015b; Wilson & Kolander, 2003). Additional factors are the fluctuation of production, cultivation and smuggling, all of which are important international factors that remain largely out of Saudi hands. For example, the growth in opium cultivation in Afghanistan has led to a decrease in the global price and an increase in demand (UNODC, 2014e). Similarly, a deep change in the global alcoholic beverage industry has been underway as a result of globalisation as the ownership of the industry has concentrated into large corporations embracing the heavy use of marketing (Jernigan, 2009). The interdependence of the world imposes more challenges for a social problem such as substance abuse.

³ In the case of Saudi Arabia, any non-medical use for alcohol and drug is considered as a problem and not allowable.

Besides the global determination of drug supply⁴, the world is more connected than ever and the flow of goods and people across boundaries has become much easier and faster as technology evolves. As a result, there has been a significant shift in the growth of 'share' culture, 'like' culture, consumerism, mobile culture and fast growing online communication and software. It seemed important to this researcher to investigate the impact of this global trend of connectivity and technological advance to see what impact it might have on the cultural dimension of health communication especially as it concerns the prevention of drug and alcohol abuse. The problem of substance abuse itself is one of the three prime motivators which drove this study.

On a universal level, the number of the people (aged 15-64) who have used drugs in 2013 reached almost 315 million, and out of this group between 16-39 million developed drug abuse problems (UNODC, 2014e). Most significantly, the number of deaths in relation to drug abuse reached a peak of 211,000 cases worldwide in 2013 (Ibid). The harmful use of alcohol, meanwhile, was classified by the World Health Organisation (WHO) as the cause of 4% of total deaths worldwide (2014). Local contexts invariably reflect aspects of this global social problem. However, the development of the drug problem in Saudi Arabia is incomparable with the international scene. In a matter of decades the number of drug abusers reported by the official authorities increased from a handful during the 1960s to hundreds in the 1970s to more than 30,000 by 2011 (MOI, 2011). Furthermore, alcohol abuse cases figures were almost 14,000 in 2010 (MOI, 2010)⁵.

Clearly, Saudi Arabia has experienced a massive increase in alcohol and drug abuse and the nature of the problem has changed. It is beyond this chapter's scope to argue the aetiology of this scenario, but it is important to mention that the scale of the problem is not at a dangerous level in comparison to other countries similar to Saudi Arabia in terms of population size. Local figures do indicate that a particular segment of the population, aged between 20 and 30, has been most affected by the problem of substance abuse with 59.98% of all the addicts coming from this group (MOI, 2011). In addition, the

⁴ In Chapter Three, section 3.2, I referred to the rarity of hard-core drugs cultivation in Saudi Arabia as a result of topography and climate conditions.

⁵ In Saudi Arabia, there is a shortage in the statistics about alcohol abuse and consumption and especially for the years prior to 1990. This point will be made in the next chapter.

fact that single, young Saudis are overwhelmingly the victims of drug abuse while the drug dealers are generally non-Saudis, gives further nuance to the situation and complexity to its resolution.

This study sees Saudi Arabia at an important crossroads, subject to a range of powerful forces that will inevitably have a profound impact on the country and its people. These forces include demographic transition, the diversity of guest worker communities, the distinctive Islamic status of the country and the blurred boundaries and rapid advancement of communication technology. At greatest risk are the young Saudis. It is this group that I am most interested in helping by mobilising the tools and methodologies of the new discipline of health communication to better understand the substance abuse problem and its possible solutions.

In the light of the emergence of the critical-cultural perspective in the study of health communication, this study has been guided to some extent by the motivations of studying culture in health communication. As I suggested in the literature review, there are different elements behind a cultural perspective that need to be considered. These include the rapid demographic changes which occurred in the West during the Twentieth Century as a consequence of immigration and international movements (DuPré, 2014; Dutta, 2008; Harrington, 2014; Kar et al., 2001a; Kar et al., 2001c; Kreps et al., 1998; Kreps, 2014; Thompson et al., 2014; Wright et al., 2012). It was widely anticipated, that this demographic shift would continue worldwide though with dissimilarities between countries and regions (Galea & Vlahov, 2005; Schifano, 2008; Tabutin & Schoumaker, 2012). The consequences of the demographic shifts (in the West in particular, where those theoretical assumptions emerged) brought up new features and challenges to the delivery of health services and the maintaining of public health (Kar et al., 2001a; Kar et al., 2001c; Wright et al., 2012). In other words, the cultural diversity of immigrant communities and of third culture generations, plus the aging population in the West generated these approaches as the means of finding answers to these challenges.

In spite of cultural diversity and demographic change, there have been other societal and social changes which have revolutionised the importance of culture and values in health communication. For example, the rise of consumerism has transformed the concept of the patient in the traditional model

to consumer in the new business-oriented model (DuPré, 2014; Dutta, 2008; Kreps et al., 1998; R. Thomas, 2006; Wright et al., 2012). The spread of consumerism in the health care system has not led to a global shift in attitudes as, until now, the traditional view remains pervasive. The final aspect here behind the emergence of the study of the cultural dimension is the growing popularity of the social model of health (alternative medicine), which considers the psycho-social aspects of health such as illness, prevention, promotion and treatment (Adib, 2004; Dutta, 2008; Koenig, Zaben, & Khalifa, 2012; Koenig & Al Shohaib, 2014; Yuill, Crinson, & Duncan, 2010).

With so many vibrant shifts and changes in the study of health communication, this seems like a particularly good moment to reflect on the discipline and on its relevance and applicability. Health communication has expanded considerably in the complexity of its interests and approaches which now include areas as varied as consumerism, cultural diversity, new technologies and innovation (Kreps, 2011; Neumann et al., 2011). These developments have led to new perspectives on public health and health promotion and a special focus on risky-health behaviour. Currently, technological and medical advancements have tended to be limited to the study of infectious diseases and the more causative elements of mortality and morbidity which are behaviour- and environment-oriented (CDC, 2014b; Kar et al., 2001b; L. Miller, Yrisarry, & Rubin, 2011; Roberto, 2014). It is worth noting that the latest health indicators in Saudi Arabia put behavioural and lifestyle oriented diseases (non-communicable diseases) at the top of the causes of mortality and morbidity (Ministry of Health, 2013a).

These developments are all relevant as to why this study is important now. But what can I add to the debate in what is already such a vibrant discipline? This study, which investigates the impact of Saudi cultural influences on promoting health, will contribute to the growing understanding of how culture contributes to the practice and theory of health communication (Dutta, 2008; Harrington, 2014; Kreps, 2011; Wright et al., 2012). This is not to mention the desperate need to enhance health services in Saudi Arabia and promote a more context-suitable approach to campaigns that differs from, and is arguably more effective, than the traditional administrative style.

Paralleled with health communicators' interest in culture, the distinctive Saudi context gives more weight to the study in part because this specific topic has not been researched or analysed previously. This is the first work, as far as I know, to examine the role of Saudi culture in health communication relating to substance abuse. The next section highlights the methodological side of the health communication story.

4.3 Health communication research paradigms

In this section I will map the methodological approaches and the research methods of the field. I will do so to familiarise the reader with the most common methodologies in the study of the role of communication in health and also to locate the study within the field. This approach, to generate the story of health communication methodology, is based on the analysis of the available methodology and literature (mainly western-oriented) and is intended to clarify the overlap between social science and health communication.

The evolution of health communication methodology is inseparable from the development of social science methodology. Health communication has taken existing methodologies in social science and applied them to new areas such as caregiving, public health, prevention and health promotion (F. Roberts, 2011; Thompson et al., 2014). These, in turn, have been coupled with understanding about the reality of the social world in terms of what it contains and how knowledge can be obtained about it (Corbin & Strauss, 2008; Ormston, Spencer, Barnard, & Snape, 2013; F. Roberts, 2011; Saunders, Lewis, & Thornhill, 2009).

These enquiries developed as health communication evolved and grappled with campaigns and other interventions intended to change behaviour (Neumann et al., 2011; F. Roberts, 2011; Thompson et al., 2014). Furthermore, social science methodology debates and improvements fed into the narrative of health communication methodology.

Social science research and its philosophical assumptions have acted as a compass for this study to identify the appropriate approach. Saunders, Lewis and Thornhill suggest that “the research philosophy you adopt contains important assumptions about the way in which you view the world. These assumptions will underpin your research strategy and the methods you choose

as part of that strategy” (2009, p.108). It has been agreed that ontological and epistemological philosophies (perspectives or assumptions) are the group of beliefs and assumptions about the reality of the social world, the knowledge contained within it and the means for gaining access to it (Bryman, 2012; J. W. Creswell, 2013; Du Pré & Crandall, 2011; Matthews & Ross, 2010; Saunders et al., 2009).

In other words, different concepts were used by Saunders et al to describe the two ontological views of social phenomena; namely, objectivism and subjectivism (2009). Basically, objectivism (realism) refers to the separation between reality and social actors, whereas subjectivism (idealism) stands for the inseparable relationship between social actors and reality (Ibid). Both mainstream ontological understandings reflect on the assumptions about what knowledge is available in the real world, but with less focus on how to know about the real world.

Learning about the reality of the social world is the task of epistemology. Creswell defined it as “what counts as knowledge and how knowledge claims are justified” (2013, p.20). To put it differently, the word epistemology represents a collective group of assumptions about what kind of knowledge is available in the social world and the alternative ways available to learn about the social world (Ormston et al., 2013; Saunders et al., 2009; N. Suter, 2012).

The mechanism of how to know knowledge in the social world and what kind of knowledge exists has been inspired by dissimilar perspectives which have been excessively debated for many years. Accordingly, there are two families of general assumptions about researching the social world; namely quantitative and qualitative, which are affiliated with two perspectives; positivism and interpretivism (Bryman, 2012; J. W. Creswell, 2013; Daymon & Holloway, 2011; Hammersley, 2013; Mason, 2011; Matthews & Ross, 2010; D. Silverman, 2009; Whaley, 2014).

It is possible to come across other suggestions, which lead to the same conclusion for the above terms and this is one of several issues which were noted during the study’s methodological preparation phase. For instance, positivism in some publications was labelled as being part of the scientific or empiricist tradition, even though, they conveyed the same idea. Therefore, the common and shared ideas between these two terms are explained below.

Positivism is an epistemological term which describes the implementation of natural science research methods in the study of social phenomena and reality by researchers (Bryman, 2012; Matthews & Ross, 2010; Saunders et al., 2009). This epistemological stance influences the mechanics of conducting research. Firstly, this stance promotes the idea of using scientific approaches to study the social world, initially by the use of observation, recording (Ormston et al., 2013), and, in some studies, by the use of experiments (Oakley, 1998). The justification behind the use of empirical tools is the positivist belief that true knowledge is what can be observed through the senses (Bryman, 2012; Matthews & Ross, 2010). In relation to theory, the use of empirical research tools led researchers to use the inductive tradition for generating knowledge and theories (Ibid). In other words, theory, in positivism, is generated from observational activity data.

Furthermore, guided by the realism of ontology, positivism promotes the separation between values and research (value free) (Ormston et al., 2013). The followers of this perspective seek accuracy in measuring the aspects of the social world's reality. In order to achieve this, large scale of data are collected and statistically analysed (Ibid). It did not take long before researchers began to look for further possibilities to research the social world's reality.

In the middle of the Twentieth Century, a new epistemological stance was embraced - *post-positivism* - which emphasised the need to adopt a deductive tradition in the study of social world reality. This means the researcher set up hypotheses based on previous research to be tested, and the result would be either to prove the causal relationship or reject it (J. W. Creswell, 2013; Matthews & Ross, 2010). Unlike positivism, post-positivism (post-empiricism - falsificationism) does not seek a precise result, but a rough outcome with the possibility of hypothesis rejection (Ibid).

Both positivism and post-positivism have played a significant role in the development of quantitative research methods within the study of the social world (Bryman, 2012; Daymon & Holloway, 2011; Ormston et al., 2013; Saunders et al., 2009). On the contrary, qualitative research methods have been guided by the epistemological stance of interpretivism.

Interpretivism represents a collective group of insights which embrace people's understanding of social phenomena. Indeed, interpretivists focus on

the social factors of the context in order to understand social world reality (Britten, 2011; Matthews & Ross, 2010; Saunders et al., 2009). Inspired by the idealism (subjectivism) of ontology, the emergence of this perspective was a result of a long debate about the need to move beyond the use of observation and direct recording to study social problems in order to concentrate more on the perspectives of the individual.

In the same fashion, other interpretivists drew attention to the process side of creating meanings in the social world, and called it social constructivism (Constructivism). Social constructivism refers to the focus on the interaction between human actors to interpret the reality of the social world; to examine how the meanings in the real world are socially constructed (Britten, 2011; J. W. Creswell, 2013; Matthews & Ross, 2010; Saunders et al., 2009).

Both interpretivism and social constructivism are centred on the inseparable links between the social world experience and individuals, so it is obvious that research guided by this school of thought cannot claim to be value free (objectivity) (J. W. Creswell, 2013; Ormston et al., 2013). Furthermore, the nature of this stance, based as it is on participant's views, reflects the method of research and the tools used. In other words, interpretivism is best described as an inductive, affiliated perspective (C. Marshall & Rossman, 2011). Although, in recent years the interpretivists have started to use the deductive tradition to study the real world, based on previous research and theories (Ibid). Together, the interpretive and constructive traditions have contributed significantly to the emergence of qualitative methods (Matthews & Ross, 2010; D. Silverman, 2009).

These scientific-inspired methods dominated the social research spectrum after the Second World War (see Goode and Hatt *Methods in Social Research* 1952) and several decades later researchers detected the need to adopt more inclusive methods to accommodate a range of new and alternative research assumptions (Bryman, 2008). Since the 1970s social science researchers have used qualitative tools to research the social world (Ibid). Likewise, it did not take long until a new research worldview, pragmatism, developed. Pragmatism focuses on research question(s) and on suitable methods for the answers (Ormston et al., 2013; Saunders et al., 2009). Indeed, "Individuals holding this worldview focus on the outcomes of the research — the

actions, situations, and consequences of inquiry — rather than antecedent conditions (as in post-positivism)” (J. W. Creswell, 2013, p.22-23).

As a result, pragmatist researchers believe in the freedom of selecting the appropriate research tools for the research. In other words, the followers of this worldview believe in no alignment with a single perspective, but believe that what serves the purpose of the study should be adopted (J. W. Creswell, 2013; Ormston et al., 2013; Saunders et al., 2009)⁶. As a result, a new research perspective was developed and became known as mixed methods (Bryman, 2008), employing the advantage of using the strengths of each paradigm to overcome difficulties and enhance the accuracy of the research (Britten, 2011; Bryman, 2012).

This refers to the methodological practice of combining quantitative and qualitative research methods in the study of the social world (Bryman, 2008; J. Creswell et al., 2003; Morse, 2003). Mixed methods refer to the blending of methods within each school of methods; for instance, mixed qualitative methods such as the use of interpersonal semi-structured interviews and group interviews (focus groups) (Bryman, 2008). The mixing of qualitative methods is a process called *triangulation* which is intended to boost reliability (Bryman, 2012; Matthews & Ross, 2010; D. Silverman, 2009) and will be discussed later in the thesis.

Marshall and Rossman described the qualitative research purpose as “researchers valuing and seeking to discover participants’ perspectives on their worlds and view inquiry as an interactive process between the researcher and participants. The process is descriptive, analytic, and interpretive, and it uses people’s words, observable behaviour, and various texts as the primary-data” (2011, p.30). Qualitative methodology offers various methods for data collection such as interviewing, focus groups, observation, participant observation, documentary analysis and audio/video recording (Britten, 2011; Jackson, Drummond, & Camara, 2007; Matthews & Ross, 2010). Indeed, interviewing people is one of the most popular methods because of its flexibility; “Generally, semi- or un-structured, open-ended, informal interviewing is preferred to allow

⁶ For further information about pragmatism, check the following references (J. Creswell et al., 2003; Tashakkori & Teddlie, 2003).

for more flexibility and responsiveness to an emerging theme for both the interviewer and respondent” (Jackson et al., 2007, p.25).

Furthermore, qualitative academics’ adopt different approaches (strategies) in order to seek knowledge, such as phenomenology and ethnography (Britten, 2011). Phenomenology refers to those studies which aim to discover, define, and analyse personal lived experiences (C. Marshall & Rossman, 2011). Ethnography has its roots in anthropology and relies on culture as a fundamental concept. It seeks to understand specific behaviour among particular groups, especially culture by, using different data collecting techniques such as interviewing and participant observation. The focus on people and culture is what distinguishes ethnography from other approaches (Daymon & Holloway, 2011).

In contrast, quantitative methodology, or realist or positivist methodology as it is also known, concentrates on understanding the nature of the social world, and this can be described as ontological understanding (Bryman, 2012; Matthews & Ross, 2010). In other words, a realist approach emphasises the need to understand “universal laws of cause and effect” over the social world (Daymon & Holloway, 2011, p.7). Table 4.1 below contains a comparison between the two paradigms (Bryman, 2012, p.392).

Quantitative	Qualitative
Numbers	Words
Point of view of researcher	Points of view of participants
Researcher distant	Researcher close
Theory testing	Theory emergent
Static	Process
Structured	Unstructured
Generalisation	Contextual understanding
Hard, reliable data	Rich, deep data
Macro	Micro
Behaviour	Meaning
Artificial settings	Natural settings

Table (4.1) Qualitative and Quantitative comparison

Three general approaches emerge - qualitative, quantitative and pluralised - to study the social world. It was mentioned, initially, that the development of health communication study was been driven by a mixture of contributions from the advances of the research paradigms and the nature of the health communication inquiry. It is time now to present how and why these three general approaches have been integrated into health communication methodology. Researchers in this field have been influenced by the features and nature of the health care context and public health interventions, so it is not a surprise that a medical-oriented tool such as the experiment, which did not emerge from social science, has been employed by health communication researchers (Oakley, 1998).

Research methodology in health communication is inseparable from the fundamental aim of health communication studies. As the groups of studies,

theories and assumptions aim to implement the communication tools and strategies to enhance awareness, change behaviours and attitudes in relation to individuals or public health (Jackson et al., 2007; Kreps, 2011; Neumann et al., 2011). The complexity of health communication inquiry has reflected on the development of research methodology in the field. It has, for instance, encouraged initiatives to find methodological alternatives (Harrington, 2014; Kreps, 2008; Schiavo, 2014; Thompson et al., 2014). Consequently, adopting various research methods (pluralism) has been considered as the safest pathway to clarify our understanding about the complexity of health communication (Kreps, 2011; Neumann et al., 2011).

Health communication bridges research perspectives such as the scientific (dominant) and alternative perspectives such as cultural, critical, and interpretive. These three major research approaches lie at the essence of health communication (Dutta & Zoller, 2008). Initially, health communication involved studying the interaction between doctors and patients before the use of mass communication was introduced as a trigger for behaviour change (Basil, 2014a; Kreps, 2014). Academics found in the quantitative approach good opportunities to conduct inquiries successfully. Indeed, the quantitative methodology is now the most popular one for scholars conducting post-positivist projects (Dutta & Zoller, 2008).

The popularity of quantitative research methods is because of the preference for such study outcomes. In other words, quantitative outcomes are more hierarchical for health communication research because of the ways and measures that quantitative research and intervention are conducted (Britten, 2011). There is also another interpretation for the preference of quantitative methods in health communication as opposed to other methods. According to Daymon and Holloway, “managed communication is a fairly new academic discipline (which) may account for its over-riding concern to develop universalistic principles from quantitative studies” (Daymon & Holloway, 2002, p.12).

The emergence of alternative perspectives in the study of health communication (see section 2.2.1 in Chapter Two) not only introduced insights into health communication research, but also nurtured new ways of using research methodologies such as qualitative and mixed methods.

Qualitative research methods have been increasingly popular in health communication studies, even though there are still those with medical backgrounds who argue that qualitative methodologies used in health communication and health promotion are less valuable or unscientific (Du Pré & Crandall, 2011; Kreps, 2008; Whaley, 2014). In an interpretive approach, the researcher applies qualitative methods to reach a deep understanding of a particular context, text or phenomenon (Dutta & Zoller, 2008). Researchers use data analysis, such as rhetorical analysis, discourse analysis, thematic analysis or semiotic analysis (Kreps, 2008). In addition, health communication qualitative researchers typically use ethnographical methods to conduct research with the researcher uses data collection techniques such as in-depth interviews, focus groups and observation. The outcomes of implementing ethnography are usually described as rich and descriptive (Dutta & Zoller, 2008; Kreps, 2008).

Critical approaches share similar influences to qualitative and interpretive methods. However, a critical approach focuses on the balance of power in health care, and this is reflected in the tools of analysis used (Dutta & Zoller, 2008). “(Critical) analysis typically differs because of the explicit commitment to recovering hidden conflict and challenging the dominant power relationship” (Ibid, p.15). For a cultural approach it is the same; qualitative methods are preferred by academics and they use some of the data collection methods such as interviewing, focus groups, observation, ethnography and thematic analysis (Ibid).

Finally, the use of mixed methods research in health communication has increased along with the growing acceptance of qualitative methodologies in health communication (Britten, 2011). In health communication, mixed methods research provides the researcher with multiple research techniques from both a quantitative and qualitative paradigm such as in-depth interviews, focus groups, experiments, and questionnaires (Kreps, 2008). This helps the researcher cope with complications and challenges in health communication as well as the limitations of each paradigm, whether qualitative or quantitative (Ibid).

4.4 Research design

This section presents the research paradigm of the thesis and outlines the data collection techniques and the purposes behind their use. These are

closely linked to the previous two sections which described the research paradigms in health communication, and highlighted the research questions.

The focus of this study is to explore Saudi cultural influences on the communicating of health and substance abuse issues, and to retrieve the story of the emergence of health communication in the Kingdom. In this respect, a qualitative methodology is best suited for this study and contains the most useful tools to explore the reality of the social world (Brikci & Green, 2007; C. Marshall & Rossman, 2011; D. Silverman, 2009). The qualitative methodology for studying, gathering and analysing the data was selected because of its capacity to address complicated or non-researched topics which need deep understanding and access to the real-social world (Flick, 2007; Kreps, 2008). Jackson, among others, has acknowledged the essentiality of qualitative methodology to meet the methodological requirements of research inquiry (Jackson et al., 2007).

Furthermore, the status of this study as the first of its kind to address health communication about illicit drug use and the drinking of alcohol in Saudi Arabia and its cultural dimension contributed to the selection of this approach. The interpretivist perspective guided the research design because this provided a proven perspective for understanding how social actors interpret the social world around them (Britten, 2011). Both a qualitative methodology and an interpretivist perspective, therefore, have informed the use of the inductive approach in this thesis. Both of these approaches address the study's intended goals. According to Salazar et al: "logic involves deriving general patterns from your observations that may eventually become hypotheses or that may constitute a theory" (2015, p.159).

In terms of procedure, after identifying the research approach and perspective, it was necessary to select the data collection methods. Triangulation played a significant role in this decision. Triangulation means the use of more than one data collection method and in the case of qualitative methodology refers to the use of more than one research method to gather data from the real social world (Bryman, 2012; N. Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Ritchie, 2003; Salazar et al., 2015; D. Silverman, 2009).

Bryman believed triangulation was important “because much social research is founded on the use of a single research method, and as such may suffer from limitations associated with that method or from the specific application of it, triangulation offers the prospect of enhanced confidence” (2003, p.1142). Furthermore, the use of triangulation helps researchers to achieve more confidence in the findings by addressing the research topics from different angles (Thompson et al., 2014).

Therefore, mixed qualitative methods were used to build a comprehensive understanding of the research focus. In fact, the triangulation of the research methods is one of the strengths of the thesis⁷ and helps to underscore its validity. Methodologists agree on four types of triangulation; method triangulation, data source triangulation, theory triangulation, and investigator triangulation (Bryman, 2003; N. Carter et al., 2014). Only the first two types were used in this study. Data source triangulation refers to the collection of the data from different groups and through different samples. In contrast, methodological triangulation means the use of more than one qualitative data collection method (Ibid). Together, these two tactics played crucial roles in the collection of data for this thesis.

Simultaneously, the triangulation of the data source and methods is integrated below. Indeed, the challenges I faced during the methodological phase included the social and cultural aspects, including the sensitivity of the topic in Saudi Arabia, and bureaucratic obstacles. Besides identifying the challenges I faced in the thesis, the measures I took will be highlighted as well; the personal skills utilised to deal with these challenges.

4.4.1 Data Collection Methods

This study used mixed qualitative methods to gather data from the field; namely, In-depth interviews, focus groups, observation and qualitative analysis of radio advertising. The first two were the primary methods, and the rest were subordinate. Together, the interviews, focus groups and observations generated

⁷ Further details about the strengths of the thesis will be presented in section 7.5 in the final chapter (the conclusion).

naturally occurring data, (Kvale, 2007; Ritchie, 2003), while the qualitative analysis of the radio announcements was an analysis of defined media texts.

The qualitative interview is a data collection method which depends on conversation and interactive discussions between the interviewer (the researcher) and the interviewees about the topic of the research (Bryman, 2012; Fielding, 1994; Ryan, Coughlan, & Cronin, 2009). It is recognised as the most used qualitative data collection method (Ibid). There are many reasons behind this popularity with interview method flexibility being one of them. Famously, Kvale defined the interview as follows:

In an interview conversation, the researcher asks about, and listens to, what people themselves tell about their lived world, about their dreams, fears and hopes, hears their views and opinions in their own words, and learns about their school and work situation, their family and social life. The research interview is an interview where knowledge is constructed in the interaction between the interviewer and the interviewee (2007, p.2).

The consensus between qualitative methodologists is that there are three types of in-depth interview; structured (standardised), semi-structured, and unstructured (open) interviews. Structured interviews contain structured questions asked by the researcher (interviewer) to the interviewees and the data is usually analysed statistically (Fielding, 1994; Ryan et al., 2009). It differs from quantitative surveys as the interviewees responses are collected by the researcher, so the interviewees would be careful about their answers, and the number of nonresponses is limited (Ibid). The questions of the standardised interview format – what is called ‘the interview schedule’ – contained predefined questions and answers (Ibid).

Unstructured interviews share some features with the conversational method because the interviewer puts one or two main questions or points across and the discussion then involves following up the points that are raised by the interviewee (Bryman, 2012; Fielding, 1994; Ryan et al., 2009). In contrast, the interviewer in semi-structured interviews adopts a list of points or questions to be discussed. This list of questions is called an interview guide (Ibid).

Since the research questions sought a rich description and explanation about the reality of Saudi cultural influences on communicating health and substance abuse issues, and how health communication emerged in the first place, the semi-structured interview method was used to collect interviewee responses (participants). Lambert et al has argued that if the interview is designed well and the questions are carefully framed, the outcomes will reveal the truth about the social world (Lambert & Loiselle, 2008; Ryan et al., 2009). Indeed, what is good about the semi-structured interview is that “they provide an opportunity for detailed investigation of people’s personal perspective, for in-depth understanding of the people’s context within which the research phenomena are located, and for very detailed subject coverage” (Ritchie, 2003, p.36).

The implementation of the semi-structured approach contained practical steps in the design, sampling and in the access to the research participants. The first step was framing the interview guide. Bryman described the interview guide as “the term (which) can be employed to refer to the brief list of memory prompts of areas to be covered that is often employed in unstructured interviewing or to the somewhat more structured list of issues to be addressed or questions to be asked in semi-structured interviewing” (2012, p.442). Therefore, the interview guides of this thesis were developed during the second year of this PhD, especially after the researcher finished reviewing the related-literatures in 2012. Two short visits to Saudi Arabia were made to explore the situation of the Saudi drug and alcohol prevention sector as well as to build relationships with potential gatekeepers.

It is important to mention that there were two kinds of interview guide used, and the difference between them were the extra questions added to one of them, which were directed to those affiliated with the promotion and prevention organisations from both sectors – public and NGOs. Because of the nature of those participants’ work backgrounds, and their potential contributions to the research, a special interview guide was created for them. Indeed, the interview guides facilitated the relationship between the interviewer and the interviewees. Both interview guides share the primary focus of the research

questions. In fact, the use of two different interview guides re-affirms the data source triangulation in this study, by engaging with various groups. Furthermore, the interview guides were designed to fall between semi-structured and unstructured techniques in order to allow the participants to talk and express their views about what they believed to be important. However, this was constrained so the interviews did not divert from the focus of the study⁸.

In terms of the empirical work conducted, I felt it was impossible to interview everyone related to the focus of the study because of the limitations of time and finances⁹. So I picked a small group of interviewees based on a selection process, known as sampling. A small number of knowledgeable research participants is a common feature of qualitative research, and the focus is always on in-depth understanding (Daymon & Holloway, 2002; D. Silverman, 2009). Sampling refers to the process of selecting those who are important to the researcher in order to gather data that will help the investigator to find answers to the research questions (Bryman, 2012). To overcome the limitations of time and finances, three sampling techniques were used; purposive was the main technique and snowballing and convenience techniques were the secondary techniques. They correspond with the research objectives and the research methods. All three techniques were used in the selection of the interviewees.

Purposive sampling refers to the selection of the interviewees on the basis of their relevance to the research topic (E. Donovan, Miller, & Goldsmith, 2014; Kvale & Brinkmann, 2009; Kvale, 2007). The selection was made based on criteria to identify those included in the sample. This criteria consisted of three factors; the relevance to health communication in Saudi Arabia, being actively engaged in the communication efforts, and being familiar with the Saudi context. Firstly, the relevance to the promotion and prevention sector meant the interviewees were involved in the promotion against risky-behaviour at the time of the data collection. The degree of involvement was defined as the

⁸ Both the interview guides and the focus groups' questions guides can be found at the end of the thesis in Appendix one.

⁹ Further details about the limitations will come in section 7.4 in the final chapter (the Conclusion Chapter).

engagement in managing, planning and reviewing communication and prevention interventions and programmes, and that included government employees, NGO employees, and activists in the field. Secondly, the requirement of interviewees being active in the field during the data collection added more weight to their contributions to the study. Finally, familiarity with Saudi culture and the Saudi prevention sector was also considered compatible with the research focus.

Furthermore, generated from the purposive sample, snowballing and convenience samples were integrated to find further participants. These participants were intended to reflect on the insights gathered and contributed to the expansion of the sample. Snowballing sampling technique refers to contacting interviewees through other interviewees, while the convenience sample meant taking the opportunity to ask useful participants to give an interview even though this may not have been planned (Daymon & Holloway, 2002). In addition, it was important that the research participants exhibited geographical diversity. The researcher made sure that interviewees were drawn from different regions in Saudi Arabia to bring various perspectives into the study.

Based on these sampling techniques, the interviewees fell into three groups; those working in the government promotion and prevention organisations, interviewees working with the NGOs, and the last group consisting of activists and those who were not affiliated with any sector but who were active in the fight against illicit use of drugs and alcohol. In addition, the three groups above match the three features of the criteria standards mentioned earlier. In other words, the three elements of the purposive sampling played a crucial role in forming these groups. A list of the interviewees (participants) is provided but it is important to look at the steps which led to the interviews. These steps were not without their challenges. In fact, there were many obstacles throughout the whole data collection journey. To meet them, I had to employ a range of skills and features that can be counted as strengths¹⁰.

¹⁰ These skills were helpful for the whole data collection trip, and not only linked with one method.

Before the field work trip in 2012/13, I went to Saudi Arabia to explore the environment. In July 2011, I travelled to Riyadh, the Saudi capital city and also to the city of Jeddah to browse the annual statistics and records on drug and alcohol abuse¹¹. In May 2012, I began the complicated process of securing preliminary approval from the targeted organisations and interviewees to participate in the study and to get access to the data. I was fortunate to receive positive responses from many of the potential participants. In early September 2012, with my supervisors' approval¹², I went into the field to carry out the interviews, focus groups, nonparticipant observation sessions and to collect materials. The field trip took place between September 2012 and February 2013.

The pre-fieldwork trips to Saudi Arabia were essential in order to make contact with the gatekeepers of the organisations and to build a list of contacts. I drew up a list of potential interviewees and participants and noted the appropriate way to approach them. In this respect, my Saudi background was a great benefit as I was able to approach organisations and particularly individuals of high status with absolute consideration for the appropriate rules of social etiquette. In addition, my language competency as an Arabic speaker prevented this barrier from impacting negatively on the data collection. Furthermore, my affiliation to a reputable Saudi university as an academic member of staff also helped. Methodological triangulation was a useful tool in ensuring I collected data from different angles and sources (Bryman, 2003).

During the data collection field trip, different techniques for recruitment were used to get access to the research participants. Firstly, the researcher used an official approach through the use of official letters¹³ directed to the targeted organisations. Secondly, the researcher adopted the door knocking technique to get access in the field. This meant going to the interviewees' or focus groups' place of work and knocking on doors to see who was available.

¹¹ As will come in section 7.3 in the recommendations section of the Conclusion Chapter, one of the suggestions will be the entering of the statistics in the internet, and making them available online for those interested in the topic.

¹² In addition, I got the approval from my sponsor (the Saudi Cultural Bureau in London).

¹³ The researcher designed a letter written in Arabic which explained the study focus and the reason behind the empirical works and the potential benefits of the study for the Saudi society in the fight against substance abuse.

The researcher would then *briefly* explain the study's focus and would request an interview. This was the only way the researcher found to reach some of the participants because of the lack of response to telephone and email requests. However, technology was used in the arrangement of the interviews and with other data collection method, especially mobile phone contact and emails. All the participants were carefully informed about their rights and were told how the data would be used¹⁴.

Probably the greatest collective challenge to this research were the gatekeepers. Gatekeepers were critical for enabling access to almost all of the research participants, especially interviewees and focus group members. It was essential to approach those with authority officially or through personal contact in order to provide access to the field. The researcher mobilised personal and professional relationships and contacts to approach the gatekeepers, who were managers in most cases. This technique was successful to some extent in a culture like the Saudi's, where family and extended family networks are still important. The geography of Saudi Arabia as a big country challenged the data collection phase of this thesis, especially when the interviewees agreed to meet and were not located in the same city as the researcher. Therefore, careful time management and planning was required. For example, the interviews and focus groups in Riyadh were scheduled to take place over a one month period. Finally there were cultural considerations in conducting empirical work about this sensitive topic in Saudi Arabia.

These cultural considerations related to the nature of the participants' involvement. To some extent, these elements exist in other Middle Eastern countries, but to various degrees (Wahsheh, Geiger, & Hassan, 2012; Wilkins, Gladys, Margaret, & Elzubeir, 2002). Illicit drug use, drinking of alcohol and out-of-wedlock sexual activities are unlawful and are regarded with antipathy in Islamic culture. Broaching such subjects required care (Ibid). In particular, there were ethical issues surrounding the anonymity of the research participants to avoid any unintended consequences¹⁵. Therefore, the researcher informed the

¹⁴ Further information about the ethics and quality of the methodology will come at section 4.6 of this chapter.

¹⁵ Further details about the research ethics will come later in section 4.6.

interviewees about their rights to withdraw or classify some details. Each participant in this study signed an informed consent (written in Arabic) before participating¹⁶.

Another cultural issue was the reflection of the culture of honour¹⁷ in the data collection. Reputation, values and honour are important in Saudi culture (Long, 2005a; Wahsheh et al., 2012; Wilkins et al., 2002). So, besides the anonymity of the participants, the researcher also had to consider the social etiquette of approaching participants, especially females. This had to be done through official contacts with their organisations. Although there were no female employees in the drug abuse prevention sector, cultural considerations were nonetheless helpful in assuring female participation in the focus groups.

The last challenge to be faced in conducting interviews was the lack of familiarity among interviewees with the purpose of qualitative interviews. Most of the interviewees did not understand the value of an interview¹⁸ with exception of those who held higher education degrees. Therefore, the researcher made a concerted effort to explain in advance to each interviewee the purpose, focus and duration of the interview and how this data would be used. Such a step relaxed potential participants' unease and significantly increased the rate of participation and engagement.

As a result, the fieldwork trip to collect data between September 2012 and February 2013 resulted in twenty-seven semi-structured interviews based on the three sampling techniques mentioned earlier, using the criteria of

¹⁶ A copy from the Arabic informed consent and a translation copy are attached at the end of this thesis in appendix one.

¹⁷ Honour (reputation) refers to the value system governing social interactions, social situations and social relationships in Saudi Arabia. Honour is the collective reputation of the entire family (tribe) and it is inherited and should be protected by avoiding wrongdoings which could bring shame to the family (or tribe). Both Shame and Honour are central values to the morals system in Saudi Arabia. For Mitchell, "Honour defines prestige or reputation, and so the honour and shame system is linked to the political system of patrons and clients. It defines people's – usually men's – trustworthiness, and therefore their status as good and reliable patrons or clients" (2002, p.423). One of the social behaviours the Saudi should avoid to prevent damage to their reputation is the use of alcohol and/or illicit drug abuse. The sensitivity of this topic is acknowledged by Thomas (2013). Therefore, it is an issue related to the protection of honour and is very sensitive. Further details about honour will come in the next chapter.

¹⁸ The lack of popularity of qualitative methodology may be attributed to the little done in this area by the Saudi universities to promote alternative research methods, which needs further attention from Saudi educational institutions.

purposive sampling. This was a significant number of participants and, in the researcher's view, approximated the saturation point at which more data would have been superfluous. This point is described by Daymon and Holloway (2002) as the moment at which the interviewer cannot find new ideas, thoughts or insights from interviewees' responses. Indeed, it is a useful guide to help the researcher decide when to stop (Ibid). The researcher achieved good geographical diversity within the sample from the central, western, south-western, and eastern regions of Saudi Arabia, an additional indication that sufficient data had been collected. Table 4.2 (below) summarises the information about interviewee anonymity. It is important to say that getting access to Saudi Arabia's drug abuse control system and other governmental bodies to gather reliable qualitative data was a major achievement.

In Table 4.2 below, the interviewees will be referred to as participants instead of interviewees to meet the language difference between Arabic and English¹⁹. The interviews in the table below were organised based on the date of the interview chronologically. The table aims to inform the reader about the circumstances in which these interviews were conducted, the sampling techniques and the participant's relations to the topic of the study. Finally, the average of each semi-structured interview was between one and two hours and in some cases three hours. Indeed, the researcher had to interview some participants over two different days to complete the interviews, because of their busy schedule, or due to emergency calls during the interviews which meant participants had to leave and the discussion was continued at a later stage.

¹⁹ Since, those participated in the study perceived themselves as participants in the study more than interviewees, so the participant term will be used.

Anonymous	Date	Sampling Technique	Description
Participant 1	18 and 24/9/2012	Purposive	He is active in public issues through his roles in academia as an associate lecturer as well as through his daily column in one of the Saudi national newspapers.
Participant 2	24 and 26/9/2012	Purposive	He is a Saudi broadcaster, and is considered as one of those who witnessed the early days of Saudi broadcasting in the 1960s. He also has experience with the Saudi Ministry of Culture and Information. Above all, he is a social activist in public and social matters. He currently holds a teaching post at a university.
Participant 3	25/9/2012	Purposive	He worked for over fifteen years in addiction treatment as a Psychiatrist. However, he shifted career towards the health NGO sector in the Western region of Saudi Arabia.
Participant 4	26/9/2012	Snowballing through participant 3	He works as health advisor and promoter at a health promotion NGO in Saudi Arabia. Also, he graduated recently with bachelor degree in Psychiatry. He is a young activist, but engaged in face to face interaction with those who need health information.
Participant 5	3/10/2012	Purposive	He works as an Islamic and Qurannic studies teacher in one of the prestigious private schools in Jeddah, and he is responsible for one of the student activity committees in the school. He also works as a local Imam in Jeddah and has a background in Islamic studies.
Participant 6	2/10/2012	Snowballing through participant 5	He works as a headmaster of a private high school in Jeddah with over twenty years' experience in public and private schools. He holds a scientific degree.

Participant 7	3/10/2012.	Snowballing through participant 5	His job is a headmaster of a private primary school in the Western region of Saudi Arabia. He also works as a social advisor at Joinvile prison and his social science background stimulates his passion for this voluntary role.
Participant 8	15/10/2012	Snowballing through a NGO manager	He works as volunteer promoter to promote against illicit drug use, and is in one of the NGOs specialising in anti-drug and smoking cessation in Saudi Arabia. What is interesting about this participant was his history as ex-drug abuser. Now he is an activist against risky-behaviour.
Participant 9	16/10/2012	Snowballing through participant 6	He works as headmaster at one of best performing private schools. Also, he has over two decades of service in public and private education.
Participant 10	19/11/2012	Purposive	He is a manager of a drug abuse prevention department at one of the government's specialised organisations in the city of Jeddah and has over 10 years' experience in prevention and promotion activities in urban and town areas. His security background is as an officer and he has a degree in Sharia law studies.
Participant 11	28/11/2012	Purposive	He is a student advisor at a public high school for boys in the city of Mecca. Also, he works voluntarily as a psychological advisor in Joinvile prison in the Western region of Saudi Arabia and he has a Master's degree in Psychology. Besides that he leads the prayer in his local mosque (small mosque).
Participant 12	1/12/2012	Purposive	He is a famous Saudi actor in children's shows and drama. He has participated for over fifteen years in a famous educational series broadcast on Saudi public television.

Participant 13	3-12-2012	Purposive	He works as a science teacher in a public high school in a town in the Western region of Saudi Arabia. He is also responsible for the non-classroom activities committee in the school which includes drug abuse prevention and anti-alcohol promotion.
Participant 14	3-12-2012	Purposive	He works as a student advisor in a High School in a town in the Western region of Saudi Arabia. He has over 10 years' experience in student consultation including the provision of counselling about drug abuse and alcohol consumption.
Participant 15	16-12-2012	Purposive	He is the head of a drug abuse prevention department in a branch of a governmental specialised organisation in the Western region of Saudi Arabia.
Participant 16	16-12-2012	Snowballing through a personal contact	He is the deputy manager of a collaborative semi-governmental project to fight crime in the Western region, and works as an educational consultant in public education.
Participant 17	16-12-2012	Purposive	He is the manager of an NGO specialising in anti-drug and smoking cessation promotion in the Western region of Saudi Arabia. In addition, he has a Religious Studies background.
Participant 18	23-12-2012	Snowballing through participant 22	He is the deputy director of prevention programmes at an official governmental drug control organisation in the Kingdom, and he has eighteen years' experience in this field. He holds a degree in social work.
Participant 19	24-12-2012	Purposive	At the time of data collection, he worked in the Saudi National Committee for Narcotics Control in a managerial position.
Participant 20	25-12-2012	Purposive	He works as a head of an NGO specialising in drug abuse prevention. In addition, he worked for many years in the International Islamic Humanitarian sector. He also has a religious education background.

Participant 21	30-12-2012	Convenience	He is a manager of a mass media programme to promote Islamic ethics including anti-alcohol consumption, which is run by a religious-oriented governmental organisation in the Kingdom. This meeting wasn't planned by the researcher, but in a visit to the organisation's headquarters in Riyadh, the researcher met him and was invited to interview him that day.
Participant 22	31-12-2012	Purposive	He works as the head of the drug abuse prevention government services with over 26 years' experience. He has a higher education qualification in Psychology. He was one of the important figures in gathering the story of the drug prevention sector in the Kingdom.
Participant 23	31-12-2012	Purposive	He is responsible for the health promotion efforts of the Ministry of Health and has a higher degree in health promotion.
Participant 24	1-1-2013	Snowballing through participant 21	He works as the head of illicit drug abuse control in one of the military forces. He has more than 15 years of experience in this area. Most of his experience in promoting anti-drug use is with the military community and units.
Participant 25	1-1-2013	Snowballing through participant 24	He is responsible for the cure and rehabilitation of military personnel and has a psychology background besides military training.
Participant 26	1-1-2013	Convenience	He leads a team of exhibitors in Riyadh. He has been working in the department for eight years. His department is where the contact with the public occurs. The meeting with this participant wasn't planned, but during the researcher's visit to his organisation's permanent exhibition in Riyadh he was invited to participate in the study.

Participant 27	7-1-2013	Purposive	He is a manager for a drug abuse prevention public programme in the Eastern region with experience in collaboration with the oil-sector in sponsoring governmental anti-drug efforts and has a policing background.
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Table (4.2) Semi-structured interviews list of participants.

Most of the interviews above were conducted following one scenario with the participants. This scenario contained three steps. Firstly, the researcher began each session with a warm welcome to the participants and by taking some details from them (demographics)²⁰. Then, he re-explained the study objectives to the participant and his role in that as well as the research participants' rights to conceal any information. Secondly, the participants were given the informed consent document to read and sign. Written in Arabic, the informed consent²¹ covered the aims of the study, the uses of the data and the researcher's commitment to protecting the data and confidentiality, including data storage during the study period. After that, both participants and the researcher signed the forms, and each participant got a copy of his form. At the end of each session, the researcher asked the participants about any additional information or requests and then he closed the meeting with thanks. All the interviews were digitally recorded and stored in a secured personal computer belonging to the researcher, the only one who had the only access to the data. This was explained to all the participants.

In addition to these interviews, there were a series of informal chats and unplanned discussions with people in the field concerned with promoting against substance abuse in the Kingdom. Most of these talks were at the events, such as exhibitions, during visits made by the researcher. These talks brought insights and ideas to the study. It is now time to discuss the next data collection method.

The focus group method was the second primary data collection the researcher used to collect data. However, there are some terms known to

²⁰ It was used to break the ice with the participants and to start the conversations.

²¹ At the end of the thesis in Appendix One, the researcher will attach a copy of the informed consent in Arabic (the original one), and a translation.

methodologists, which may be confused with this term. In particular, group interviews and group discussions are different from the focus group, because group interviews refer to the use of qualitative interview procedures to interview a group of people simultaneously (Flick, 2007). By contrast, “group discussions on the other hand correspond to the way in which opinions are produced, expressed, and exchanged in everyday life” (Ibid, p.197). According to Morgan:

Focus groups are fundamentally a way of listening to people and learning from them. Focus groups create lines of communication. This is most obvious within the group itself, where there is continual communication between the moderator and the participants, as well as among the participants themselves. Just as important, however, is a larger process of communication that connects the worlds of the research team and the participants (Morgan, 1998, p.10).

Uniquely, a focus group combines interviews, group participant interaction and observation together, which often produces valuable data (Plummer-D'Amato, 2008). This method is distinguished from other qualitative data collection methods by the dynamism and interaction between the participants in the groups (Ibid). It is the interaction between the focus group's participants that brought the researcher's attention to the rich data which can be generated from this method. This was, indeed, the main motivation behind the use of this method in this study. Some scholars argue the elements strengthening focus group method are “exploration and discovery, context and depth and interpretation” (Morgan, 1998, p.12).

This method also produces data dependent on the contextual circumstances of the participants - the social context created within the focus groups (Hollander, 2004). Hollander identified four types of contexts; the associational context referring to the shared characteristics between the participants; the status context means the position of the participants in the context; the conversational context is the flow and types of discussions, and, relational context is about the degree of prior relationships between the participants (Ibid).

There are three key elements to be considered before conducting focus groups, especially in the planning stage (Morgan, 1997). They are ethics, time and money. In this respect, ethics refers to the confidentiality of the participants and the data and the precautionary procedures taken to protect the participants from any potential harm. The other two relate to the sources available to the researcher, which could deter the empirical works.

In short, focus group have been seen as a cost-beneficial method to collect data in considerably shorter time in order to research a number of individuals qualitatively (Flick, 2007; Lambert & Loiselle, 2008). Over time, the use of focus group has been developed to look beyond the time and money aspects to examine other epistemological issues such as the dynamic of interactions between the group's members as well as the communication styles (Kitzinger, 1995; Plummer-D'Amato, 2008). Four basic uses for focus groups were identified; problem identification, planning, implementation, and assessment (Morgan, 1998).

The justifications behind the use of focus groups in this study are related to two sets of reasons; one set links with the features of the method and the second one is related to the study topic.

A focus group is a good method for understanding information about people's perceptions and experience about a specific topic (Kitzinger, 1995; Lambert & Loiselle, 2008; Plummer-D'Amato, 2008). It is a characteristic of focus groups to make use of day-to-day forms of communication such as anger, arguing and joking in participant interactions to facilitate the exploring of shared experiences within the group (Kitzinger, 1995; Morgan, 1998). Three types of communication occur in focus groups; pre-focus group communications (about what we want to know), communication between the participants in the focus groups, and the researcher reporting the outcomes of the focus groups to the targeted audience (Ibid). There are topic-related reasons for selecting particular kinds of participants (sampling) and the objectives behind the use of the focus group.

Through the preliminary trips to Saudi Arabia in 2012/13, I reached a conclusion that I would not be able to meet many front-line communicators²² individually due to limitations of time, finances and potential restrictions²³. So, I found focus groups to be an excellent method of bringing a range of front-line communicators together under one roof to encourage discussions that would bring new insights to the study. The other targeted participants for the focus groups were young people in Saudi Arabia. This group was represented by students from public Saudi universities. Through all the preliminary trips, the literature review, in online websites and from the initial interviews, it was clear there was a strong focus on Saudi youths as the main targeted group for health communication and drug abuse prevention efforts²⁴. So the focus group was a useful method to explore their understanding of the topic. This is compatible with identifying focus groups as a good way to identify shared knowledge among the participants (Kitzinger, 1995). In addition, the purposive (theoretical) sampling technique of the study participants made it easier to use the method.

The focus groups were particularly useful for finding shared knowledge to unveil issues which might not have been available through other data collection methods (Ibid). In addition, the use of focus groups allowed a methodological triangulation of the data from the participants. Scholars present different rationales for combining focus groups with other qualitative research methods such as pragmatism, comparative purposes (parallel use), and also for completeness or to confirm information (Lambert & Loiselle, 2008). This researcher wanted to gather data from different angles to bring valuable insights as well as a broad overview into what was happening in the field. Furthermore, the combination of interviews with focus groups suited the objectives of the study well with regard to excavating Saudi cultural influences on health communication about substance abuse specifically.

²² It refers to the personnel who communicate with the public in the prevention events organised by the drug abuse and alcohol consumption prevention sector.

²³ In order not to disrupt the work of the organisations, the managers told me in the early stages of the data collection preparation that an alternative to that might be find a way to meet the workers in a less and short disruptive time.

²⁴ Further details about that can be found in section 6.5 in Chapter Six.

The focus groups phase of this study was developed in two stages; preparation and implementation, and interpretation. The interpretation stage will be discussed in the next section in a discussion of data management and the analytic approach. To conduct focus groups, qualitative academics outline procedures to be taken in this respect starting from planning, to the day of the focus group and the close of the focus group discussions. Most significantly, the group's composition, question design, recruitment, and the procedures of the focus group need to be carefully prepared (Kitzinger, 1995; Morgan, 1997; Plummer-D'Amato, 2008).

Because the focus group is a qualitative method used to explore shared opinions and understandings of the participants about the study topic, representativeness and generalisation are not part of this method's potential results (Liamputtong, 2011). As a result, the sampling of focus groups tends to be theoretical and/or purposive (Ibid). This study used purposive sampling for the selection of the groups and the participants in the focus groups. This technique dovetails with the study's main sampling technique, explained at the beginning of this section. The groups and the participants in the focus groups were carefully selected in relation to the research questions.

There were two collections of focus groups; focus groups with low-level health communicators and focus groups with young people in Saudi Arabia, the main group affected by drug abuse prevention and communication activities. Morgan (1997) described the two types as follows: "It is this homogeneity that not only allows for more free-flowing conversations among participants within groups but also facilitates analyses that examine differences in perspective between groups" (, p.36). The difference between the compositions of the two types of focus groups - heterogeneity - did not mean the absence of shared elements between the two. It was the purpose of the study to link these two groups, because both focus groups were designed to find answers to the research questions. In fact, the diversity of the focus group sources helped to limit potential bias in the data, a technique recommended by methodology scholars (Morgan, 1997).

The use of homogeneity and segmentation in building these focus groups helped the researcher select the right participants with similar backgrounds in order to maximise interactions (Liamputtong, 2011; Plummer-D'Amato, 2008). It was the segmentation which helped the researcher to identify the participants based on the desired characteristics in relation to the study topic, i.e. mainly young students at public Saudi universities for the first collection of groups, and health promoters for the second collection. Because of cultural considerations, segmentation based on sex was also adopted in conducting the student focus groups.

In total, the researcher succeeded in conducting nine focus groups with students and three focus groups with promoters. Because of the lack of women in the substance abuse prevention sector, all the participants in the promoters' focus groups were male. It was not intended or desirable, but this was the reality I faced in the field. I made efforts to bring women's voices into the study but Saudi culture prefers not to mix unrelated boys and girls, especially at university level, and, according to Saudi education policy, public education is provided in a gender-segregated environment (Ministry of Education, 1995). Therefore, sex segmentation of the students focus groups was not adopted to see if interaction would be different based on sexes, as is the longstanding belief among researchers (Morgan, 1997); rather it was adopted, because it was the only way to bring young female voices into the study.

Six focus groups of Saudi university students were conducted; three were with female students and the other three with male students. All the participants of these six groups were strangers to each other, so there were no pre-existing relationships between them before, which might have limited the dynamic between the participants (Kitzinger, 1995; Morgan, 1997; Plummer-D'Amato, 2008). Equally, there was no hierarchy because all of them had the same status as students. However, the three focus groups of the health communicators members were colleagues, because each group was conducted with a particular organisation's affiliates; therefore acquaintance between the participants in each group was unavoidable. The influence of the organisational setting situation is well-recognised in the literature (Liamputtong, 2011). In

terms of hierarchy, all the three focus groups members were communicators, with the exception of one focus group, which was held in Riyadh, where a manager of the team participated in the focus group - this was not my choice but this was the basis for allowing access to the employees²⁵. However, they were all active health communicators against substance abuse in Saudi Arabia from both public and NGO sectors in the country at that time.

Once the groups had been composed, the next step was the empirical side; recruitment (access), questions and the procedures of the focus group day. Academics have identified the categories and the contents of the groups as a required step to facilitate the recruitment phase (Morgan, 1997). Since this study used focus groups with young Saudi university students and health communication teams, there was no need for a screen mechanism to locate the participants (Ibid). Instead, I used purposive and snowballing sampling techniques and official contact with organisations to recruit the participants. When I identified the characteristics of the potential participants, I started to approach the organisations in a formal manner, because of the focus groups purposive sampling nature and the Saudi bureaucratic environment. A letter (written in Arabic) was directed to each organisation to explain the motivations, nature of the focus groups and why the organisation was selected. Such a request to access also required personal visits to these organisations. In other words, I used the knocking door tactic to arrange focus groups.

Geographical diversity was not a priority in the conduct of the focus groups, but I tried to include communicators from different spectrums, so focus groups were conducted with NGOs' affiliates and semi-governmental and governmental organisation affiliates. Similarly, the focus groups with the students were not intended to be geographically diverse, because of the financial and time limitations²⁶, and the qualitative methods focus on experience more than representativeness (Krueger & Casey, 2009; Lambert & Loiselle, 2008). However, the university students focus groups contained students from

²⁵ All the focus groups were conducted through gatekeepers - in most cases managers - so I informed those managers about the study criteria and the managers proposed the participants, which in general met the minimum criteria.

²⁶ In section 7.4 in the last chapter, further discussions about the research limitations will be presented.

different parts of Saudi Arabia with different family and economic backgrounds. My status as a member of academic staff in a Saudi public university eased the mission to gain access to conduct focus groups with students. Fortunately, all the focus groups were conducted without paying any incentives to those participants, and that was a result of my efforts to explain the potential contribution of the study, which the participants recognised. In addition, all the focus groups were in Arabic and all were recorded by a digital recorder, and that after the researcher took the consents²⁷ from the participants.

The number of the focus groups and the group's size were determined by different factors; the research questions, level of engagement with the topic, the degree of depth I was seeking and the constraints in the field (Morgan, 1997; Plummer-D'Amato, 2008). The qualitative methodology literature advises on a range of aspects to do with both large and small focus groups (Ibid). Small-size groups may limit the productivity of the groups or produce less-quantity data, while the large groups may become difficult to control, especially if the participants are highly-involved in the topic of the discussions (Ibid). As a result, the size of the study focus groups was determined by the level of depth which I sought from each category of the focus groups used. In the case of the health communicators' focus groups I was looking for deeper understanding from the participants, while in the student focus groups I were not keen on depth and large size groups was not an issue. The three focus groups of the communicators were made up of four participants each, and the male students focus groups were made up of six participants each, while the female students focus groups contained four participants in two groups and five participants in the third one. In average, each focus group took between an hour or an hour and half in length.

The groups were conducted in a sequence based on the arrangement efforts. Work on methodology suggests that segmentation and saturation of data are the main determinants of the numbers of groups (Plummer-D'Amato, 2008). It is acknowledged that the increase in the number of the focus groups does not necessarily mean new insights (Liamputtong, 2011; Morgan, 1997).

²⁷ The participants were provided with consent forms stated their rights and what the researcher going to do with the data. At the end of the dissertation, a copy of this form will be listed (Appendix One).

Similarly, simply conducting one focus group makes it impossible to gain enough insights (Ibid). All the above factors considered, the study total number of focus groups was determined by the purposive sampling and the qualitative scholar's advice of conducting more than two for each segment, so three groups for each segment were ideal and compatible with the source and time available. Table 4.3 below contains information about the focus groups anonymised to protect the groups from any potential harm. The groups were organised chronologically based on the date of the focus groups.

Anonymous	Date	Organisation	Position	Education level
Focus group1 Male students (Purposive sampling).	8/10/2012	University.	Male foundation year students.	Foundation year.
Focus group 2 Male students (Purposive sampling).	9/10/2012	University.	Male students (excluded foundation year students).	Bachelor degree students.
Focus group 1 Prevention team (Accessed via participant 10).	18/11/2012	Directorate of Narcotics Control-Drug Abuse Prevention Branch in the Western region of Saudi Arabia.	The promotion team, which is responsible for running exhibition and awareness programmes.	High school and less.
Focus group 3 Male Student (Purposive sampling).	21/11/2012	University.	Male students from different levels including foundation year.	Students from different bachelor programmes.
Focus group 2 Prevention team (Accessed via the branch manager).	6-12-2012	NGO	Promotion and prevention team.	One participant with a university degree and the rest with school education.

Focus group 4 Girl's students (Purposive sampling).	10-12-2012	University.	Female students.	University students from different levels. (Excluded foundation year students).
Focus group 5 Girl's students (Purposive sampling).	10-12-2012	University.	Female students.	University students from foundation year.
Focus group 6 Girl's students (Purposive sampling).	12-12-2012	University.	Students.	University students from all levels.
Focus groups3 Prevention team (Accessed via Participant 19).	26-12-2012	The Saudi National Committee of Narcotics Control.	Addiction call- centre employees and awareness exhibitions team.	Master and Bachelor.

Table (4.3) Focus Groups lit.

To implement this method I took two careful steps; the focus group questions guide preparations and clarifying the moderator roles (Krueger & Casey, 2009; Morgan, 1997). Based on these two elements, the methodology scholars suggested three routes depending on the nature of the research question (Ibid). More structured groups (more-standardised), less structured (less-standardised) groups, and somewhere in-between (funnel) groups (Ibid). The standardised groups required a prepared agenda to be discussed by the group's members. It is a useful way, if the groups are designed to catch the participants' thinking about particular issues, but may limit the participants in expressing what matters to them (Ibid). In contrast, the less-standardised focus groups give more room for the participants' thoughts, but bring more difficulties to the analysis and are not able to produce structured arguments (Plummer-D'Amato, 2008). So the funnel strategy is a mix between the structured and less-structured to cover both participants' and researcher's interests (Ibid). The funnel (mixed) approach was used here, and as part of that, a question guide

needed to be designed. In addition, this approach required the moderator to have skills²⁸ to run the groups (Liamputtong, 2011).

Two focus group question guides were designed; one for the student groups and the other for the communicators groups. Three levels of questions were formed based on the literatures of focus group methodology (Krueger & Casey, 2009; Liamputtong, 2011; Plummer-D'Amato, 2008), starting with much related broad²⁹ questions to open discussions. Then, transitions questions within the developing discussions were asked. All of this led finally to the key questions, which I had to ask before closing the sessions. These focus group question guides are listed in *Appendix One* at the end of the dissertation. Because of the limitations in time and funding, I conducted all the focus groups, and I also performed, the note-taker³⁰ tasks, also because of these limitations³¹.

Besides my roles in facilitating access to the group's participants and forming the group's question guides, I carried out significant efforts in conducting the focus groups as well as I was able. Booking the venues and reminding all the participants³² of the groups' scheduled times were initial steps along with the exchange of letters and visits that were required to get access, as mentioned earlier. Fundamentally, I followed a structured scenario in managing the group discussions. Firstly, I introduced the participants to the focus groups and the basis behind them. Also, as the methodology scholars recommended seating the participants in a circle form to encourage more discussions (Plummer-D'Amato, 2008) this is what I did. After that, the three levels of questions were asked. During discussions, I tried to create a positive and encouraging environment for the participants to share their views and interact with each other. Also, I tried to not come across as being biased with regard any of the views expressed.

²⁸ This term refers to the person facilitating and managing the discussions between the participants in a non-participative way.

²⁹ These questions, in general related to the topic of the study.

³⁰ A Note-taker is someone who sits with the group's participants, and records all the interactions and issues occurring during the group's discussions in the natural setting of the groups.

³¹ Further details about the limitations can be found in section 7.4 in the final chapter (Conclusion).

³² A high percentage of turnout was achieved as almost 90% of the agreed participants showed up.

It is important to say that the focus groups occurred in both natural and artificial contexts. All the male student focus groups were conducted in a meeting room at the students' university. For the female groups, the researcher used a conferencing televised network. This means I was positioned in a meeting room in the male campus while the female students remained at the female campus. All the meetings with the student groups from both genders were based according to an agreed timetable between me and the university. This way of approaching female students was the only possible and suitable way for a male researcher to reach female subjects in Saudi Arabia without violating social etiquette and public rules. On the other hand, all the three focus groups with the communicators were conducted in their work environments (offices).

Before moving to the secondary data collection methods, it is important to say that most of the research participants were Saudi with the exception of Participants 3 and 4 (mentioned in Table 4.2 above). This was not a predetermined issue or part of the sampling measure. However, it makes sense because of the study's focus on Saudi Arabia. In addition, in subsequent Chapters Five and Six I will report that Saudi nationals are the overwhelming majority in the Saudi public sector of drug abuse prevention, and there is a stark absence of cultural diversity. The student focus groups were also dominated by Saudi nationals and there were two reasons for that. First, as the previous chapter explained, this is very specifically the target group that is emphasised in Saudi government programmes. The second reason was the sampling technique by which only public university students were included, almost all of whom are also Saudi nationals. Let us now to turn to the subordinate data collection methods; observation and qualitative content for anti-drug abuse radio announcements.

Observation is a qualitative data collection method which differs from other techniques in that it emphasises the opportunity to engage in the setting upon which the research is focused (Daymon & Holloway, 2002). As Marshall and Rossman acknowledged, observation "is used to discover complex interactions in natural social settings" (2011, p.140). Jensen described it as

follows: “observation refers inclusively to a set of research activities that involve the continuous and long-term presence, normally of one researcher, and generally in one delimited locale” (2002, p.242). Methodologically, observation has been long associated with ethnography, the qualitative approach which focuses on studying culture and context (Du Pré & Crandall, 2011). Typically, ethnographers adopt observation to get direct knowledge of the study (Ibid).

Access to the social setting of the phenomena is the distinguishing feature with this approach (C. Marshall & Rossman, 2011). The engagement of the researcher in the real social world provides an opportunity to study it closely (Ibid). In fact, observing the phenomena while it is occurring is an important theoretical paradigm (Flick, 2007). Observation differs from other qualitative methods because it combines different features.

The term captures a variety of activities that range from hanging around in the setting, getting to know people, and learning the routines to using strict time sampling to record actions and interactions and using a checklist to tick off pre-established actions” (Marshall & Rossman, 2011, p.139).

It is the use of all the senses; seeing, hearing, feeling and smelling in observation, and that is in order to know how the topic of the study factually happens or works (Flick, 2007).

The engagement of the researcher in the natural setting for the research provides a number of advantages. For instance, understanding data in the setting from which it emerges provides a clear image of the social world surrounding the study topic (Daymon & Holloway, 2002). Daymon and Holloway explained that “observation enables you to identify the conscious as well as the taken-for-granted actions that informants rarely articulate despite participating in them” (Ibid, p.203).

This method takes different forms based on five measures; overt or covert participation, participant or non-participant observation, systematic or unsystematic, natural or artificial settings, and self-observation or observing the other (Bryman, 2012; Flick, 2007; C. Marshall & Rossman, 2011). Therefore,

observation can be divided to take different forms depending on the research objective (Ibid). For example, participant-observation can take different forms, such as when the researcher is known to other participants or hidden. Also, the degree of participation varies from full participation to little participation. These forms can be found in systematic or unsystematic manners, and in natural settings or non-natural ones. Likewise, non-participant observation is influenced by the same variations (Ibid).

Through practice and continuing study, qualitative scholars have theorised steps to be taken in conducting observation. Initially, after identifying the research objective, the researcher should select the time, the context and the people he aims to observe (Bryman, 2012; Flick, 2007). Then, the researcher should identify what he wants from using this method or what the issues are that need to be closely watched (Ibid). After that, the observer should start from a broad view to the context and slowly, through emerging insight, begin to narrow the focus (Ibid). Focused observation means the researcher has developed a checklist of what to concentrate on, and to record important notes (C. Marshall & Rossman, 2011). This process is known as taking field notes in a non-judgmental way and to some extent is descriptive of what has been observed (C. Marshall & Rossman, 2011; Walford, 2009; Wolfinger, 2002). In addition to observation, researchers use purposive sampling in selecting the settings and the people (Flick, 2007). Researchers are advised to stop collecting data when observation brings no new insights, indicating the saturation point has been reached (Ibid).

It is important to acknowledge that observation cannot be used in isolation from other qualitative methods (C. Marshall & Rossman, 2011). For instance, the interviewer will come into a position to observe the interviewees' acts and/or setting (e.g. offices or schools), and similar situations occur with the moderator and note taker in the conduct of focus groups. Even in ethnographic research, the ethnographer will come upon situations where he should chat formally or informally with the participants in the field for some insights, as well as the use of observation and taking field notes. Under these circumstances, observation can complement other research methods (D. Silverman, 2009).

In this study, the use of observation was not in the fieldwork trip for data collection in 2012/13 only, but I realised the need for observation and notes taking in the early stages of this study, when I went on early trips to Saudi Arabia to familiarise myself with the substance abuse communication prevention sector and to get access permissions to the participants. Keeping an eye on the routines, the structure of the sector and knowing the related organisations were helpful in the preparation path in this study. Furthermore, observation was in the study proposal as a complement to the main research methods; interviews and focus groups.

Driven by the concept of methods pluralism (triangulation) (Bryman, 2003; N. Carter et al., 2014; Kreps, 2011; Neumann et al., 2011), I selected observation to observe the context in which I met the interviewees and the focus group participants, and to engage with the social setting of the study as well as to document all important notes (field notes). In addition to the advantages of using the observation mentioned above, it was also decided to verify what the participants claim they do in terms of health communication practice and what is really done in the field. In other words, I found visiting the field, and especially the communication events, brought more insights about the reality of the research problem.

Practically, the implementation of observation took place in three stages of the study; in the preparation stage, during the data collection sessions, and during the events and visits I undertook during the fieldwork. The aspects of access, sampling, ethics, types of observation and observation steps were different for each stage. For the preparation stage, I used my personal skills to observe and get a sense of who the potential participants were and which areas to cover. There was no sampling and it was exploratory rather than focused. Secondly, observation during interviews and focus groups was within these sessions, so both sampling and ethical issues associated with these two methods were applied in observation, especially the ethics of informing the participants about my identity and what I intended to do, taking informed consents from the participants and protecting the research participants' identities. Basically, observation at this stage was non-participant observation in

natural settings where I met participants. Therefore, observation at this stage was broad³³ and devoted to observing the research participants in their real social world of health communication against substance abuse in Saudi Arabia³⁴.

Finally, observation was used during the events and visits I made to the participants' organisations besides the other fieldwork trip activities mentioned previously. Fortunately, during the fieldwork trip in 2012/13, I was invited to visit the exhibitions, offices and headquarters of the participants' organisations. In addition, I was invited by some of the participants to visit some of the health communication activities they were involved in while I was doing the fieldwork in Saudi Arabia. Together, these health communication events and visits to permanent exhibitions offered great opportunities to me to engage with the social world and observe the real experience of communicating anti-substance abuse.

These events and visits overlapped with the interviews and the focus groups, so in some cases the visits and events led to interviewing particular participants, while in other cases the interviews and focus groups led to access to visit communication activities or permanent exhibitions. Other events were observed merely without data collection. In all these events and visits, I used non-participant observation to observe the activities and issues in the exhibitions. Similar to the other research methods, these events were selected purposefully in relation to the research problem. Therefore, I did not look for a saturation point since sampling was selective. Fortunately, I got the opportunity to visit and attend activities in different parts of Saudi Arabia, as Table 4.4 below illustrates.

With regard to access and settings, I directly approached the organisers of the events and the exhibitions (through the gatekeepers in these organisations, through contacts and/or by official communication). In some

³³ It means I did not use focused observation, when the researcher developed a checklist for the issues have to be watched.

³⁴ In each session, I was looking for any posters, publications, books or any other publicity in the location of the interviews or focus groups linked with substance abuse prevention or show enthusiasm about the problem of the study.

cases I was given the opportunity by the organisers to visit their locations or exhibitions, as Table 4.4 below illustrates. Bryman et al argued that observation setting can be closed, open or on-going (Bryman, 2012; C. Marshall & Rossman, 2011; D. Silverman, 2009). A closed setting means a particular group or space required permission to join, for instance a company, factory or prison (Bryman, 2012). However, open environment refers to places or groups which do not require permission, such as cafes or public spaces³⁵ (Ibid). On-going settings refer to the necessity for building trust with participants in the setting in order to break down barriers and engage with them (Flick, 2007). None of the exhibitions, locations or campaigns I visited were closed settings. In fact, most of them were open to the public (mostly the targeted audience of the events).

Furthermore, in each event there was a key informant to help me with insights and knowledge. In some of the events, non-participant observation was used and my identity, as a researcher on an educational mission, was disclosed. In others, such as the anti-substance abuse prevention exhibitions, my identity was hidden from the public apart from some of the exhibitors who were in the events. In terms of research ethics, I maintained high measures of protection with regard to the identity of those I came across in the events. This was part of the study's ethical framework.

During the fieldwork trip, I attended ten exhibitions hosted by drug prevention organisations in the Kingdom. Four of these exhibitions were temporary, which meant there were parts of campaigns or communication programmes which had specific timeframes. The other exhibitions were permanently based at the headquarters or branches of these organisations. The last group of exhibitions highlighted how the use of public displays and scheduled seminars and lectures transformed an event (communication channel) into long-lasting tools to spread the anti-drug abuse messages. Table 4.4 below summarises some of the descriptive details about the events while providing full anonymity to protect participants identities³⁶.

³⁵ However, it may contain some dangers and potential harms to the researcher, so precautionary preparations are required.

³⁶ This is part of the study ethics strategy as will be explained later in section 4.6.

Date.	Event.	Location.	Description
4-12-2012 Event 1	Smoking is the gate to end.	A public High school (boys) in Jeddah.	This event was organised by an NGO to enhance awareness about smoking and drugs among high school students, and it was planned for one day. I was invited by the organiser. This visit to the event was a result of direct contact between me and the NGO branch manager in Jeddah.
16-12-2012 Event 2	A visit to a permanent exhibition and the clinic.	NGO Mecca branch	This exhibition was designed to promote the NGO message and activities to the visitors. I was invited to visit the exhibition by Participant 16, who managed this branch, and I interviewed him on the same day (see Table 4.2 above).
19-12-2012 Event 3	Attending a one week event in Prince Sultan educational complex in Jeddah.	Northern Jeddah.	This one week school promotion activity was organised by collaborative governmental bodies in Jeddah for one week. It was intended to promote time management and that's included avoiding risky health behaviour such as drug use. The drug abuse prevention section was managed by the Directorate of Drug Control-drug abuse prevention department in Jeddah. The access was obtained from Participant 10, and I met during this visit with some of the first prevention team focus group members. The visit was for one day of this one week long event.

24-12-2012 Event 4	Visiting the permanent exhibition of the Saudi National Committee for Narcotics Control.	SNC Riyadh.	This visit was in addition to the interview of Participant 19, who facilitated this visit, and also one member of SNC staff accompanied me in this tour. This exhibition was designed as a promotion platform and besides the committee visitors, the schools in Riyadh organised a one day trip to this exhibition in an effort to promote anti-narcotics use.
31-12-2012 Event 5	Visiting the permanent exhibition based at the General Directorate of Narcotics Control.	Riyadh.	Participants 18 and 22 invited me to visit the main anti-drug exhibition at the headquarters in Riyadh. The exhibition portrays the directorate's efforts in fighting illicit drugs and included promotional as well as security efforts. In this visit I met Participant 26, who works in the field of promoting anti-drug use in places such as schools, mosques and malls.
1-1-2013 Event 6	Visiting the Saudi military forces permanent exhibition.	Riyadh.	Both Participants 24 and 25 from the military forces invited me to visit the exhibition. This exhibition was designed for military personnel.
7-1-2013 Event 7	Visiting the permanent exhibition based at the General Directorate of Narcotics Control branch in Dammam.	Dammam.	Participant 27 invited me to visit an exhibition of the branch which he managed, in the Eastern region of Saudi Arabia. The exhibition was designed to suit the public and especially school students.
16&19&22-1-2013 Event 8	Mecca exhibition about drugs hazards during student semester break.	Hejaz shopping Mall in Mecca.	Participant 16, who managed Mecca's anti-drug abuse prevention department, invited me to visit this one week public exhibition against drug abuse. It was held in a shopping mall, and my identity was hidden apart from the promoters because this event was public.

30-31/1/2013 Event 9	With faith no addiction campaign.	Alqunfudah.	Participant 10 invited me through a phone call to visit a one week campaign camp in the city. The campaign was a collaborative project carried out by local government agencies in the city. It aimed to promote anti-drug use message from a religious perspective. It was one week long and a camp for the campaign was set up. I went for two days because of the financial limitations. Since the event was public, my identity was covert apart from some promoters, who were introduced to me.
9-10/2/2013 Event 10	The temporary exhibition for school students.	Taif City public library.	Participant 10 invited me to visit a one week anti-illicit drug abuse and alcohol use awareness exhibition. It was developed by Participant 10 in the city of Taif. It aimed to enhance awareness, especially among school students from both genders. Since this event was public, my identity was hidden from others.

Table (4.4) Observation and Events I did.

It is worth adding a final point; in taking field notes, I maintained a professional level of recording descriptive and non-judgmental comments on what had been observed. This was further to my aim of familiarising myself with the setting. I used notebooks to record his remarks. In addition, after each interview, focus group and a visit to the event, I wrote or digitally recorded reflective remarks about what had happened.

Qualitative content analysis was the second subordinate research method, and the last research method. The use of this analysis was part of the triangulation technique I used in this study. This method was applied to analyse eleven anti-drug abuse Radio advertisements³⁷. The proposed use of this method was to analyse any anti-substance abuse printed brochures or

³⁷ These advertisements were in Arabic, and I translated them into English.

advisements which I received from targeted participants during the fieldwork trip. The aim was to develop an understanding of the cultural issues which arise in health awareness materials. So with this method, I was aiming to collect qualitative data, and then analyse it qualitatively. However, this wasn't the case. During the fieldwork trip in 2012/13, I was referred on many occasions by participants to anti-drug abuse radio announcements which were also broadcast during this time. Indeed, I came across some of these radio advertisements especially via radio in the car.

I collected a DVD containing all the radio announcements from Participant 22. The responsible organisation was the Directorate of Narcotics Control in Saudi Arabia. These advertisements were designed to promote awareness about illicit drug use among the public. Each advertisement contains a dialogue between two or more individuals about drugs and the average length of each advertisement is 1.25 minutes. At the end of each advertisement, a closing sentence hoped to convey a meaningful message from the directorate. You will find these in Table 4.5, below. The circumstances of the production of these advertisements were unknown to me. This organisation, like others in the health communication sector in Saudi Arabia, doesn't have a system whereby it records procedures, or plans or responses to the campaigns³⁸. Therefore, the practical steps of producing these advertisements in terms of design and implementation are excluded, due to the lack of available information. For the same reason, the sound effects used on them will also be excluded from the analysis.

The focus of the analysis was on the content of these advertisements and on the main message. Bryman highlighted the opportunity of using qualitative content analysis and states that it will help the researcher identify themes in materials (2012). The analysis of these advertisements was compatible to the analytic approach of this study, which the next section will explain further. The following Table 4.5 sets out some of the details concerning the announcements such as the length of the advertisement and the gender of the speakers.

³⁸ For further details check section 6.4 in chapter six.

No	Length	Gender and number of speakers	The last short messages
1	One minute	Two males	"Dear citizen do not take any pill until you know it source"
2	One minute	Three males	"With drugs you lose your religion and your society"
3	1.30 minute	Two males	"Illicit drug use is the beginning of the end"
4	1:30 minute	Two males	"Drug use is a dark pit, go only with treatment and motivation to leave it"
5	1:30 minute	Two males and one female.	"With drug abuse you lose your-self and your honour"
6	1:30 minute	Three males	"What's after illicit drug use except death"
7	1.10 minute	Two males	"If the person know the end he would not walk in this way"
8	One minute	Three males students and one male teacher	"Drug abuse is the end of life and future"
9	One minute	A husband, a wife and a male physician.	"Drug misuse take those you love from you"
10	1:30 minute	A Father and a mother	"Dear father, by increasing your awareness about drugs abuse, you protect your children from destruction"
11	1:30 minute	Two males (drug addicts and a taxi driver also used to be drug addicts)	"Dear brother patient, Al-Amale hospitals were built to help you, so take initiative and step forward for treatment before it's too late"

Table (4.5) Radio Announcements list.

4.5 Data management and analysis approach

This section will explain the study's procedures of data management and analysis. It has three parts: the management of the data, the analytic approach and the practical steps taken and theoretical dimension applied to the CAQDAS software; namely Atlas ti7.

I not only designed the study and collected the data, but also put a great deal of effort into processing and analysing the data. The data was stored carefully to protect the privacy and confidentiality promised to the participants³⁹. I was able to use my proficiency in Arabic to communicate with the participants in their native language, and believe this improved the quality of the data. I have also had to translate their input, seeking to accurately convey the participants' thoughts and ideas from their original form in Arabic to their final expression in English.

In terms of the study's data, I used two methods to translate it into English. Firstly, I used the technique of translating the Arabic word for word into English, paying close attention to the meanings of the original comments. If the meaning of the translated comments was not similar to the Arabic data, I edited it so that it became closer to the participants' ideas. In the second technique, I summarised the thoughts in Arabic and then I reported them in English with reference to the participant(s) who expressed the ideas. Additionally, there were many instances in the study when two or more participants' ideas were similar. Here, I summarised the main idea in English and referred to the specific participants.

Now I would like to introduce the approach I used to manage the study data.

In a qualitative study with large-amounts of data, managing and containing that data in a consistent manner is an issue that has been debated extensively by scholars, particularly because of the wordy nature of qualitative data and of the variations in reporting and engaging with the data (Bryman, 2012; Gibbs, 2007). Therefore, scholars have tried to reach an agreement among them about the best ways to handle and manage the data. One of the outcomes was the emergence of Qualitative Data Software, CAQDAS (Gibbs, Friese, & Mangabeira, 2002). Designed as a technological solution to the challenges involved in using traditional and manual methods of doing qualitative research, the software overcomes the difficulty of retrieving data from the hardcopy version at any place or time or of finding an adequate and secure

³⁹ The next section 4.6 will address the research ethics issues in an expanded manner.

space to store the transcripts (Silverman, 2009). In other words, CAQDAS was created to help the researcher to do the work in more organised way, but did not replace the researcher.

In this study, I used qualitative software as well as other digital means, such as a digital recorder, to manage the data. Here, the term 'data management' refers to the mechanism and techniques I employed to organise, store, process and recall the data. Indeed, qualitative data management has been defined as:

The operations needed for a systematic, coherent process of data collection, storage, and retrieval. These operations are aimed at ensuring (a) high-quality, accessible data; (b) documentation of just what analyses have been carried out; and (c) retention of data and associated analyses after the study is complete (Huberman & Miles, 1994, p.428).

I incorporated conditions and standards into the study in order to maintain stability in my management approach throughout the study's duration. These included, for example, consistency in all management measures applied to data collection, comprehensiveness in covering all stages of the research, discipline in addressing data management issues and transparency in reporting my data management approach. Therefore, data management and the software function are best described as Gibbs et al. said "...CAQDAS is not a distinct method or approach to analysis, the software does not 'do' the analysis. On the contrary, a major function of the software is to help organise the analysis" (Gibbs et al., 2002, p.278-279).

In practice, I kept records about the interviews, focus groups and events such as dates, locations, meetings duration and brief background information⁴⁰. This step enabled me to identify the participants and their data. Indeed, I used a digital recorder to preserve the live interactions between myself and the

⁴⁰ The fieldwork sheet that includes all these details is attached at the end of this thesis in Appendix One.

participants⁴¹. These digital records have many advantages, such as catching the vocal reality of the interviews and the focus groups. The availability and mobile nature of digital records also meant that I could access them when I needed them and listen to them in the form that was currently convenient, i.e. from the digital recorder or on from my laptop. Therefore, familiarising myself with the data was easy especially because of its digital format.

Furthermore, on the field trips in Saudi Arabia, I received from the organisations I visited many annuals, official statistics books, and health promotion materials, including the radio announcements mentioned in Table 4.5. I also took some photographs of the exhibitions and campaigns I was invited to visit. Similarly, I recorded details about the time, source and location of these. Even if I did not directly use these materials in the analysis stage, they helped me familiarise myself with the contours of the communication and prevention sector in Saudi Arabia.

Besides the organisation of the data, I kept reflective records of my field trips in a research diary. This included what I did and situations with which I was engaged. I tried to record any thought that came to my mind during the data collection. Most importantly, I wrote field notes about the events and places I visited. These notes were helpful in the analysis phase. In general, the data management, the field trips time management and note taking were constructive and covered the organisation side of the methodology. Next, I would like to address my approach to the analysis.

Firstly, although some qualitative scholars have acknowledged the variation in reporting due to qualitative data analysis methods (Burnard, 2004), they highly recommend providing enough information about data analysis, including reporting the analysis procedures (Ibid). For this study, the analytic approach is inseparable from the study's interpretive perspective. In fact, together the research focus and the qualitative methods determined the analysis options open to the study.

⁴¹ I should acknowledge that recording meetings was carried out with confidentiality in mind, which I set out in more detail in section 4.6.

Qualitative scholars have introduced a considerable number of tactics and techniques to analyse qualitative data⁴², and thematic analysis is one of them. This form of analysis is defined as “a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (Braun & Clarke, 2006, p.79). The use of this analysis should coincide with the study’s theoretical perspective. Here, the study’s interpretive perspective for looking at the participants’ reality and experience was a crucial reason for selecting thematic analysis.

The implementation of thematic analysis has taken different forms, which has led to the existence of various ways of doing this type of analysis. ‘Networking’ thematic analysis identifies one main theme (or global theme, as it is known); other subthemes and categories branched off from the global theme (Attride-Stirling, 2001). Other scholars argued for the methods of data reduction and interpretation and the necessity of rigorous measures (Fereday & Muir-Cochrane, 2006; Huberman & Miles, 1994; Kawulich, 2004; Ryan & Bernard, 2003; Thomas, 2006). Still others, such as Heish and Shannon, and Zhang and Wildemuth, developed approaches to analyse the qualitative data in stages (Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). The conventional content analysis of Hsieh and Shannon and the qualitative content analysis of Zhang and Wildemuth are inductive-oriented, processing data through preparation, coding and refining data and interpretation (Ibid). For further information about thematic analysis in terms of its background, development and uses, see Boyatzis (1998). Further discussion about what, why and how this approach was used will follow below.

Out of this panoply of approaches, I chose a (Braun & Clarke, 2006) step-by-step guide to the thematic analysis. Braun and Clarke developed six stages for doing a thematic analysis of qualitative data (Ibid). Collectively, these are helpful in pointing to the participants’ experiences and reality (Ibid). Furthermore, the clarity of the Braun and Clarke steps was another reason for using them. The focus of these steps is not on the quantity and repetition of themed content, but on the significance of this content in relation to the

⁴² Content analysis, conversation analysis, discourse analysis are other means of dealing with qualitative data (Bryman, 2012).

research focus (Ibid). Furthermore, Braun and Clarke identified two types of approaches to do thematic analysis: an inductive one, which focusses on the data, and a deductive, theoretical one (2006). As the study aims to explore Saudi cultural influences in health communication and the story behind the emergence of this communication, Braun and Clarke stages coincided with the study's inductive approach, also known as the bottom-up or the data-driven approach.

There are several considerations when using this thematic analysis guide. First of all, there needs to be transparency about the researcher's active role in the analysis and the decisions he or she makes (Braun & Clarke, 2006). This is important because it will strengthen the research's credibility. In other words, without clarity in terms of reporting the data analysis, it becomes difficult, if not impossible to evaluate, synthesize and compare the study to others. The lack of reporting methodological procedures will also limit the possibility of replicating the study in another context (Attride-Stirling, 2001). In addition, in the Braun and Clarke guide, there are two levels of analysis: explicit and latent (Braun & Clarke, 2006). The explicit level focusses on the words used; the latent level (also known as the interpretative level), by contrast, digs deep in searching for concepts, meanings, ideas and assumptions (Ibid). Therefore, the analyst's role in this guide is interpretive.

Braun and Clarke proposed the following steps: "familiarisation with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and finally reporting the results" (Braun & Clarke, 2006, p.87). In this study, the use of these six steps was inductive in principle and the analysis level was interpretive. In accordance with the Braun and Clarke guide, I tried to be as open and transparent as I could in explaining the study's methodology, including its analytic approach. The next section 4.6 will include more details about the study's reliability. In implementing these six steps, I used a specific Computer Assisted Qualitative Data Analysis software (CAQDAS), Atlas ti 7, to help identify the themes within the data.

The justification for using Atlas ti 7 in this study lies in the reasons behind the emergence and development of the uses of CAQDAS in social science

research. As Gibbs believed, CAQDAS were created to find computing ways to simplify the process of qualitative data analysis (Gibbs, 2014). As a result, a rapid growth has occurred in the number of CAQDAS, with the first software being developed in the 1980s to around 25⁴³ programmes in 2014 (Ibid).

From the early attempts to design CAQDAS, the efforts were devoted to create a flexible, easy, friendly interface and a systematic way to handle and analyse data while simultaneously preserving the quality level of the work (Gibbs, 2014). In brief, the use of CAQDAS can be illustrated as follows:

CAQDAS software is essentially a database that holds source data, such as transcripts (including ethnographic notes), video, audio, memos and any other documents that are available in electronic form, and then supports the annotation, coding, sorting and other manipulation of them and keeps a record of all this activity. The only key advantage that most researchers using the software claim is that the programs help them to keep everything neat and tidy and make it easy to find the material they need later in the analysis (Ibid, p.281).

In practice, there are certain sub-systems or functions that form the basis of any qualitative software: document management to arrange the data (text, audio, video or pdfs) in homogenous groups with a reference system for the demographic information of the participants, which makes accessing them easy and straightforward; a memo system to explore and engage with the data set and able to record analytic thoughts and ideas; and a coding system that helps the researcher to label the data, highlight important sections within it and to make comparisons between the different categories. Additional functions include the ability to search word frequency and co-occurrence; a diagramming function for searching for connections and relationships between findings, and the ability to produce the data in a network style (Christina Silver, Personal Communication, 23-24 September 2013)⁴⁴.

⁴³ There are two types: online based and installed programs.

⁴⁴ It was part of a two-day training in Atlas ti 7 at the CAQDAS Networking Project at the University of Surrey on 23-24 September 2013.

Besides the features listed above, there were other reasons for my use of Atlas ti 7, the most important of which were the available expertise⁴⁵ and support in the university, the research questions I chose, and the methodology of my analytic approach, because “It is best to have a clear idea of how the analytic approach should be undertaken before learning the technical skills needed to use a new piece of software” (Gibbs, 2014, p.281). Another reason why I decided to use Atlas ti 7 was the software’s capacity to analyse Arabic⁴⁶ texts, audio records, videos, images, and pdfs. In other words, it suited the study’s data types: interviews, focus groups, radio advertisements and field notes.

Now I will explain the steps I took, including how I used Atlas ti 7. It is important to mention that Gibbs’s (2007) and Saldaña’s (2013) helped me with some of the practical issues involved in preparing and coding the data. For an extensive discussion of the use of software in qualitative data analysis, look at the following references (Bazeley, 2007; Friese, 2013; Silver & Lewins, 2014).

In order to reduce the study’s data, two steps were taken: data preparation and data organisation. These two steps were crucial to familiarise myself with the raw data, the first step in the Braun and Clarke guide mentioned earlier (Braun & Clarke, 2006). Data preparation refers to the measures I took to transfer the data from digitally recorded conversations to typed transcripts. It is important to mention that the digital recorder I used during the data collection phase was a very useful tool, because I was able to listen to the interviews and the focus groups during the fieldwork trip in Saudi. It helped me to become familiar with the data as well as to identify the important points that needed to be stressed in the remaining meetings. In fact, this move facilitated my immersion in the data in the pre-analysis stage and I came up with useful thinking notes.

⁴⁵ Due to the lack of any Atlas ti 7 training at the University of Stirling, I went for a two-day training course at the CAQDAS Networking Project at the University of Surrey in England and I am very grateful for the funding I received from the Communication, Media and Culture Division at the University of Stirling to cover the course fees.

⁴⁶ It was helpful in this study, because all the data were in Arabic. I will also go back to Saudi Arabia and thus felt the need to learn a software suitable for Arabic data.

After the data were collected, the data preparation shifted from listening to the audio records to transferring the data to a form appropriate for analysis. It is well-recognised that transcribing data into a typed format (text) is easiest way for a researcher to utilise qualitative research (Gibbs, 2007). It is, however, a time-consuming process, which in all cases needs further attention (Ibid). Likewise, the issues of accuracy, transcription level and detail, and confidentiality also require further consideration from researchers (Ibid).

I started transcribing the meetings after I finished all of the data collection. I used Microsoft Word 2010 to type the data, and the digital recorder to listen to the interviews and the focus groups. Simultaneously listening to and typing for the meetings enhanced the quality and accuracy of the transcripts because I was able to catch the audio reality of the meetings through the sound effects. In addition, I sent selective transcripts to the participants, who had agreed to check them. Further details about the study's reliability measures will be addressed in section 4.6.

In terms of the level of transcription, I used the verbatim style to type all conversations, and each interview or focus group was typed as one entity. However, I excluded the little chats about my research or my trip to the participant's place I used to break the ice, because I did not think these conversations worth transcribing. In addition, I did all the transcriptions of the Arabic myself, which added many advantages to the processes of data reduction and preparation. First, the use of Arabic in transcribing was to prevent the meaning from being distorted, and my language proficiency in Arabic helped me to understand and engage with the data in their original format. Second, I did all the data collection and by doing the transcribing as well, I bridged the reality I experienced and the data preparation, especially with regards to the focus group interactions.

In all the transcripts of the interviews and the focus groups, I maintained a level of confidentiality about the names, residences and organisations of the participants. In other words, I did not include any clues that might result in harmful consequences to the participants (see Bryman, 2012; Gibbs, 2007). Furthermore, I used full anonymity with regards to the participants' names, as

explained in section 4.4.1. There will be additional discussions about the research's ethical issues in section 4.6. When I finished the transcribing phase, I ended up with a set of MS Word files. At this stage, I then needed to organise the data.

Here, data organisation refers to the procedures I employed to put the data set into a well-structured order to ease coding and categorising procedures. Such a task was easy with the functions available in Atlas ti 7 for data organisation or, as previously mentioned, a document system. In Atlas ti 7, the first step in a new project is to create a 'New Hermeneutic Unit' and then to insert all of the data into this. I put all of the transcriptions, audio records and field notes into this unit, which can be found under the icon of 'P-Docs'⁴⁷. The P-Docs refers to the place in the software where all the documents are uploaded and named. In the software, each file was named by the type of data collection method, the date and the first name⁴⁸ of the participant and his or her gender, for instance, FG⁴⁹ prevention team 2, 06-12-2012, male. Figure 4.1 below captures the principal functions available in Atlas ti 7 that I used. I extracted this picture from my Atlas ti 7 file.

The left bracket in figure 4.1 covers the left tool bar in the program screen; these small icons provide quick access to the coding tools, tools for identifying quotes and writing memos. The right bracket covers the margin where the codes and memos of the opened documents appear; it helps in identifying the quotes related to the codes, as the highlighted text in the figure 4.1 below illustrates.

⁴⁷ It refers to primary document manager.

⁴⁸ For a confidentiality reason, I am not going to include any names.

⁴⁹ Focus group.

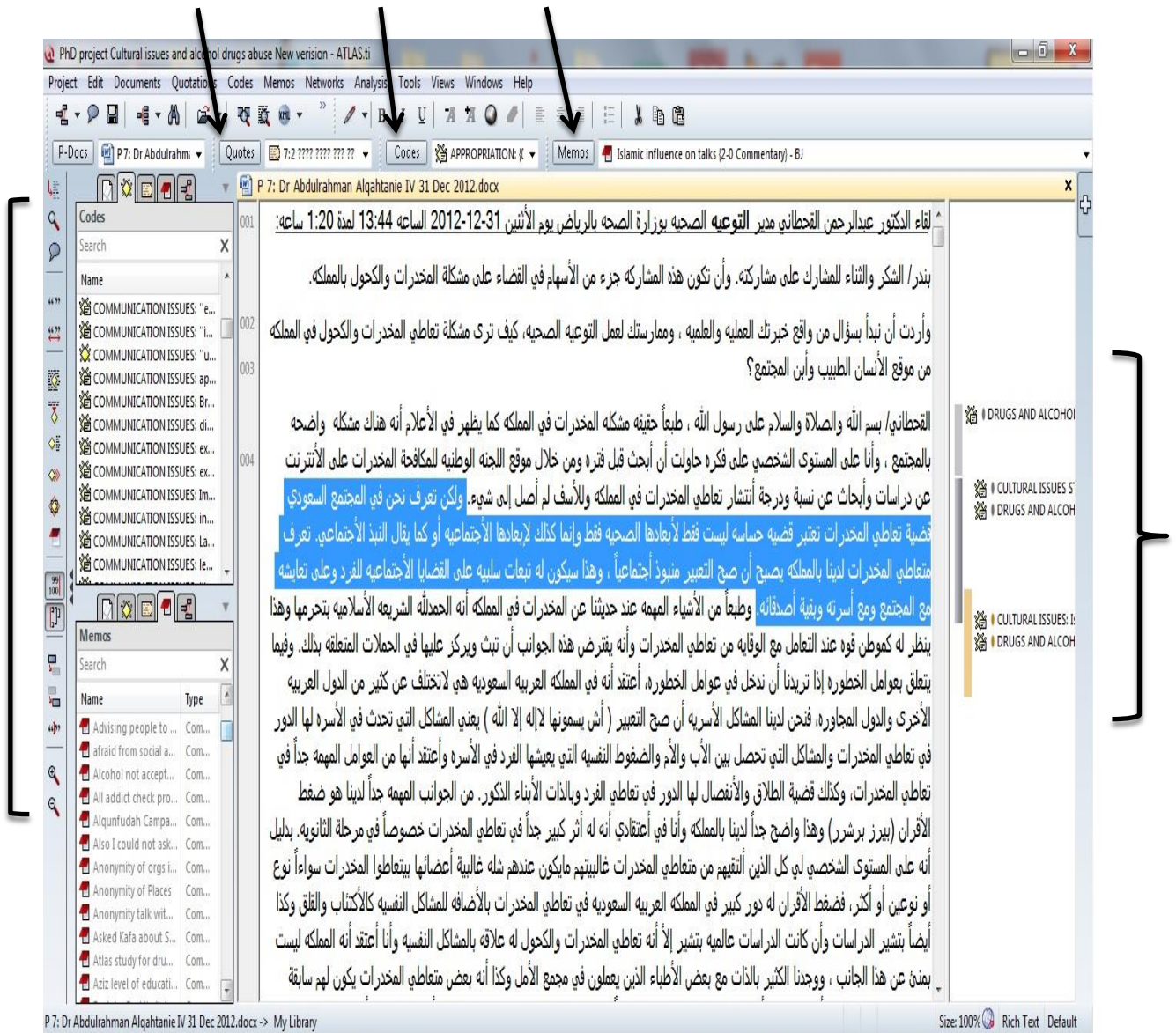


Figure (4.1) Atlas ti 7 main tools.

At the top of the figure there are three arrows; the first one from the left points to the 'Quote' icon, which contains all of the project quotes, organised in order from the first file quotes to the last file quotes. By clicking on the Quote icon, I was able to reach the quote in the middle of it is source either interview or focus group. The middle arrow points to the icon of codes. It contains all of the project codes, with descriptions about each code, which I inserted, as well as a reference to the number of quotes linked with each code. The left arrow is directed to the 'Memo' icon. The memo manager tools were particularly helpful in writing memos about codes or quotes or in writing down my thoughts about the project.

At this stage, I inserted all the materials in the software. From listening to and typing the data, I reached the preliminary conclusion that there were two substantial arguments contained in the raw data: one, the profound influence of Islamic principles on the communication about substance abuse issues in Saudi Arabia and two, the major role the Saudi government play in developing efforts to communicate about this problem. The next step was to draw conclusions from the data. Here, I followed Braun and Clarke remaining steps, which included generating initial codes, searching for themes, reviewing these themes and naming them (2006).

Through the use of Atlas ti 7's functions, I looked through the transcripts to assign codes to the data that related to the study's main focus; this process is known as coding⁵⁰. A code is defined "most often [as] a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña, 2013, p.3). All the transcripts were coded line by line to identify the initial codes and categories while bearing in mind the two arguments that emerged from the preliminary review. I coded all of the data in two rounds. The first coding cycle was applied to discover the initial codes. For this, I used elements methods for coding to code the data, these methods were basic tactics to filter and reduce the data further (Ibid). Three types of element coding techniques were used here: structural, descriptive and In vivo.

In my structural technique, I used my preliminary thoughts about the data and the research questions as directions for the coding; descriptive coding is the process of assigning a word or a phrase to a large group of words to index them (Saldaña, 2013). In vivo coding refers to the use of the participant's actual word(s) to index the texts and to the prioritisation of his or her voice if needed (Ibid). After I finished the initial coding, and a list of codes emerged, the second step was to code the data and to engage with it for a second time, this time to identify and search for themes. The codes were segmented based on similarity, and the groups of codes were compared to each other to find relationships,

⁵⁰ Simultaneously, I inserted memos about the coding and analysis as well as memos about the operations and the emergent themes.

differences and causes. In this stage, I used the networking function in Atlas ti 7 to visual these segments and their relationships in mind map form.

Consequently, these segments of codes were homogenous internally, and when a group of segments was compared to each other or consolidated, there were key ideas where some of these segments of codes matched, and these arguments were the themes. In this respect, theme is a group of codes that shares common ground in relation to the theme; at the same time, these answer the research questions. Furthermore, in accordance with Braun and Clarke's reviewing themes step (2006), I checked the evolved themes against the data set to see if the themes represented the entire data set.

At this stage, I developed a storyline that articulated an accurate story about the data. What I did next was to define and name these themes. In this stage, I focussed on individual themes in order to capture the theme's essence and to name it. Two major themes emerged, and they matched the preliminary overall impression I had reached after transcribing the data. The first theme concentrates on the Islamic influences on health communication about substance abuse with a strong emphasis on the Islamic model for intoxicant use. Furthermore, this theme argues against the current practice of communicating health and substance abuse issues. On the other hand, the second theme delivers a full picture for how the communication about substance abuse has developed, what challenges it faces, and how it will look in the future. In particular, it describes the major role the Saudi government plays in establishing communication campaigns against substance abuse.

Braun and Clarke's (2006) final step was to report the findings, and these form the basis of the next two chapters. The coming section will include further discussion about the study's ethical issues.

4.6 Trustworthiness and research ethics

Reliability and validity are key evaluation measures of research quality in the scientific paradigm (objectivism) of research. There have been many attempts by methodology scholars to apply these quality indicators to interpretive-oriented (qualitative) studies (W. Suter, 2005; Zhang & Wildemuth,

2009). However, the outcomes have been disappointing, because of the nature of qualitative-based studies. In an attempt to find alternative ways of evaluating qualitative studies, Guba developed new measures (Guba, 1981; Krefting, 1991). Away from the quantitative methodology terms for research quality assessment, new criteria and strategies were introduced. Together, they were affiliated with the concept of trustworthiness, which refers to the methodological mechanisms used by qualitative researchers to evaluate research quality (W. Suter, 2005).

“In qualitative research, trustworthiness has become an important concept because it allows researchers to describe the virtues of qualitative terms outside of the parameters that are typically applied in quantitative research” (Given & Saumure, 2008, p.895). To develop the trustworthiness of qualitative research four criteria were examined; the truth of value (confidence in the findings), applicability of the results on other group or in other context, the consistency of the data in case of replicating the study, and the neutrality of the researcher. In order to measure these criteria four strategies were developed; credibility, dependability, confirmability and transferability (Guba, 1981; Lincoln & Guba, 1985; Shenton, 2004). From this initial step, qualitative scholars have started to build and develop practical steps to implement these strategies. As a result, awareness of the importance of considering trustworthiness measures in qualitative research has grown (W. Suter, 2005).

In the preparation phase of this study and the data collection, analysis and findings producing stages I gave attention to trustworthiness and some strategies were used to maintain a good level of quality. I will discuss the research’s ethical considerations in more detail later.

Credibility refers to the procedures I took to check the accuracy of the study’s phenomena and examine the way in which these were addressed or presented. This is similar to checking the internal validity of quantitative data (Given & Saumure, 2008). Different activities were recommended by methodology scholars to enhance credibility such prolonged engagement, persistent observation, triangulation, negative case analysis, member check, the development of familiarity with the culture of the participants, rich

description and reflection on researcher backgrounds (Shenton, 2004; Zhang & Wildemuth, 2009).

In this study, I used different strategies to boost credibility. The triangulation of the data collection methods and the data sources provided me with the essential tools. Also, I planned to carry out research at different geographical sites within Saudi Arabia to increase credibility. Shenton proposed the strategy of being honest with the participants about the study's objectives and methods as a way of increasing credibility (Shenton, 2004). So I was open with the participants about the study aims and processes, and this too was part of the study's ethical framework. The use of observation in the fieldwork helped me to immerse in the field. Finally, I used a member check strategy by offering to send the transcripts of interviews to the participants to check and give feedback. Five participants agreed and took up the opportunity to look over the transcripts. The rest showed little interest or were too busy to engage in this task.

Dependability (reproducibility) is the means of ensuring the replication of the findings by applying the same methods in the same context (Given & Saumure, 2008; Zhang & Wildemuth, 2009). To achieve this, a clear description of the methodological procedures and triangulation of methods and data sources are recommended (Ibid). I adopted a rich variety of data collection methods. Transferability is described as "the need to be aware of and to describe the scope of one's qualitative study so that its applicability to different contexts (broad or narrow) can be readily discerned" (Given & Saumure, 2008, p.895). Again, the qualitative methodology scholars have suggested using in-depth description to enhance reproducibility (Loh, 2013). This, again, is the strategy I undertook. In fact, I went further and provided specific details about the context of the study and the local challenges that any researcher might face in the future such as bureaucratic hurdles. Such a step was recommended by scholars like Shenton (2004).

Finally, confirmability refers to the degree of objectivity in the study and measures the researcher's efforts to remain as neutral as possible (Given & Saumure, 2008). Bias in qualitative research is an ever-present concern, but

there are actions that researchers can take to minimise the risk (W. Suter, 2005). Qualitative methodology scholars have found triangulation, in-depth methodological descriptions and transparency about the limitations of the methods to be helpful in reducing researcher bias (Shenton, 2004). In addition to the multiple methods, I highlighted the limitations of the study in general, including the research methodology. This can be found in the final chapter of this dissertation.

Qualitative researchers are advised to pay close attention to the ethical issues of their study. Three aspects need particular care from any researcher: the protection of research participants from any potential harm, the confidentiality of the data, and the need to fully-inform participants about their roles in the study (C. Marshall & Rossman, 2011; Schutt, 2006). I took the ethical issues extremely seriously in this study on two principal grounds; the benefit of using ethical procedures in building trust between me and the study participants, and the nature of this study as a doctoral dissertation. Since this was a doctoral dissertation, I paid careful attention to the university rules of conducting research with human subjects⁵¹, consulting both my supervisory team and my sponsor in Saudi Arabia, King Abdulaziz University. I took the following ethical procedures to ensure the three ethical principles were respected.

The participants were formally approached through their managers and invitation letters from the researcher sponsor (King Abdulaziz University) were distributed explaining the study's objectives and the nature of the participants' contribution. In order to protect the participants from any potential negative consequences, I gave full-anonymity to participant identities and these were replaced with numbers (i.e. participant 1, 2, etc). A full referencing system was established, and this is described in more detail in the data collection section of this chapter. The invitation letters were intended to help the participants take informed-decisions about their involvement. I acquired signed informed consent documents from the study participants. For both interviews and focus groups, the informed consent covered issues such as the objectives of the study, how

⁵¹ The University of Stirling code of practice research degree
<http://www.stir.ac.uk/academicpolicy/handbook/code-of-practice-research-degrees/>

the researcher would use the data, the researcher's assurance to keep the collected data secured and saved, the researcher's promise of full-anonymity to the participants and the participants' awareness that the interviews and focus groups would be digitally recorded. Also, I gave my personal contact details as well as my supervision team in case any of the participants had any concerns or questions.

As promised, and in accordance with the university's code of ethical practice, I kept the raw (transcripts) and digital records for interviews, focus groups, and the field notes in a closed office accessible only by a password. All the digital data were saved in a password- computer. The ethical standards I presented to the participants increased the trust and confidence between me and those who participated in the study, which is reflected in the outputs of this research.

4.7 Conclusion

This chapter is an important part of this dissertation because it combines the keys elements of the study's methodology. The chapter provided the reader with the required information to replicate the study. It is within this chapter the reader can follow the study methodological procedures. Beginning with the explanation for why this study was conducted, this chapter locates the research methodology within the topography of health communication research. A comparison between the three main research approaches; quantitative, qualitative and mixed methods was presented and reflected upon in this chapter. In addition, the study research design was described and justified.

The study's four research methods were explained in this chapter in terms of the purposes of using them, and details were given about how they were used. In addition, this chapter highlighted some of the challenges I faced during the data collection phase and what measures I applied to minimise the effects of these challenges, especially the contextual challenges.

The data management and analysis approach was explained, including the use of thematic analysis and Computer-Assisted Qualitative Data Analysis Software (CAQDAS) (ATLAS ti 7). This chapter concluded with the measures the study took to enhance the trustworthiness and quality of the study. Most

importantly, this chapter presented the study ethical steps such as the data confidentiality and the ethical procedures to protect the participants from any potential harm. As a closing point, in this chapter I have outlined how the data were collected, proceed and analysed. In the next two chapters, the findings of the study will be presented.

Chapter Five: Communicating Islam and anti-substance abuse

5.1 Introduction

This chapter focuses on the data evolving from this study about the influences of Saudi culture on health communication against substance abuse. The chapter also engages with ideas that address the cultural issues arising out of communicating anti-substance abuse messages as well as Islam. This chapter concludes that the Islamic-orientation of Saudi Arabian culture has a major influence on health communication, specifically communication about substance abuse.

Arising from the data analysis, it is clear that the Islamic perspective impacts profoundly on the structural side¹ of the war on drug abuse and alcohol consumption, but also on contextual aspects. To name a few, the existence of a supportive environment for activities against risky behaviour, the employment of the concepts of inclusiveness and forgiveness toward addicts and abusers who have the intention to change behaviour, and the non-existence of social acceptance of such risky behaviour within Saudi society.

Furthermore, the study data endorsed some of the research participants' criticisms of current health communication aspects in the country and supported the need to create room for further development of this approach. There are two sets of critics. The first group focuses on the traditional and conventional style of current communications, and includes communicating health messages in, through and by faith-institutions as well as the lack of a participatory communication style. In contrast, the second group represents the voice of those calling for a revision of communication techniques and styles, the necessity of more communication technologies use and the need for culturally diverse efforts.

This chapter illustrates the configuration of Saudi culture and especially of Islamic culture. The role of Islamic culture in health communication against substance abuse will also be explained. This chapter will highlight the reasons behind the integration of the Islamic approach into Saudi efforts in preventing

¹ By structural, I mean the available health resources and services for those seeking treatment as well as the related legal aspects.

risky health behaviour. Then, the chapter will illustrate the Islamic model² in dealing with risky behaviour. I will go through the four components of the model; prohibition (in Arabic Haram), treatment (in Arabic Elaj), the abandonment of risky behaviour and repentance, (in Arabic Tawbah), and promotion (Da'wah). This chapter will conclude with discussions about the current health communication initiative against substance abuse and will look forward at future strategies.

It is important to justify the inclusion of religious (Islamic) verses from the Quran and Hadiths about the use of intoxicants in this chapter, and I will do this with reference to various texts as I proceed. I believe this perspective will be useful for academics, planners, strategists and managers of anti-substance abuse campaigns and programmes who are operating within a similar context where Islam is a dominant element. Indeed, it will also help those dealing with Muslim communities in a non-Islamic context worldwide as well as improve health communication and cultural strategies in Muslim nations and in Muslim communities worldwide. By the end of the chapter, the reader should have a clear understanding of the functioning of the Islamic model and its impact on health communication against substance abuse in Saudi Arabia. This chapter, along with Chapter 6, will also, address the research questions I posed at the start of the dissertation.

5.2 The Islamic-orientation of Saudi Culture: A synthesis

Islamic culture was acknowledged by most of the research participants as a protective cultural construct that, for a long time, limited the prevalence of drug abuse, drug trafficking and drug cultivation in Saudi society. Islamic culture contains a well-constructed body of teachings and beliefs, including but not limited to substance abuse, which guides believers through their lives. Participant 10 defined Islamic culture as “built on Islamic values and rules, which is guided by the two sources of Islam; the Holy Quran and Prophet Mohammed Sunna” (Participant 10, 13-11-2012). He highlighted the main characteristic as a culture inspired by the sacred book of Islam, the Quran, and by the traditions of the prophet Mohammed.

² It is a religious-based model, which strongly presence where Islam is dominantly practiced, and it gets more position in the society if the political system also guided by the Islamic rules as in Saudi Arabia.

Most important, Islamic culture has impacted directly on the Saudi worldview and also on Saudi Arabia's historical and political circumstances leading to the strong presence of Islamic cultural values. The common consensus among participants was that Islamic culture has a profound influence in Saudi Arabia. In this respect, Participant One defined Saudi culture as:

We have a large umbrella, which I call the mainstream culture. It brings us around Islam, Arabic and some morals which we all agreed on. That's my view [on] Saudi culture. Also, this cultural unity does not conflict with cultural diversity; we have in our country many regions. In fact, I consider sub-cultures as a cultural strength in our society (Participant 1, 24-09-2012).

Islam, in this participant's view, is the glue that holds Saudis together. Participant Two also argued that the common shared values among all Saudis are Islam-oriented, but with different local cultures (Participant 2, 26-09-2012). Regional customs and traditions vary within Saudi Arabia and have been recognised and well described by Al-Habeeb when he refers to Saudi Arabia's geographical space being as large as a continent (2006). He was not referring to the physical side, but to the diverse cultural and local aspects too (ibid). This diversity is demonstrated in areas such as the cuisine, dialects and folklore. But Islam remains the strongest cultural element in this country.

According to these views, the Islamic orientation in Saudi's mainstream culture³ is attributed to its roots in Islamic culture. Islamic culture is not associated with a particular race, class or geographical location. The foundation of the culture is the concept of monotheism, the belief in the oneness of God (Allah). This belief of monotheism is known as *Tawhid* in Arabic (Ayish, 1998; Ayish, 2003; Koenig & Al Shohaib, 2014). For this reason, the primary feature of Islamic culture is a God-centric (theocentric) perspective (Siddiqi, 2014). However, an Islamic orientation does not conflict with the existence of a national culture and there remains space for folklores and customs. This has been demonstrated by anthropologists who have shown that in spite of the existence of a dominant culture in society, there are always subcultures based on

³ The term dominant (mainstream) culture refers to beliefs, traditions and behaviours shared and transmitted among a group, which has the major control over the cultural institutions and society. For further details, see - Peoples and Bailey (2014) *Humanity: an introduction to cultural anthropology*; Communication between cultures by Samovar, Porter and McDaniel (2009).

geographical areas, social class, age and religion (Jandt, 2012; Martin & Nakayama, 2010). In fact, Islamic culture and values embrace the concept of diversity within local cultures and the coexistence of others. Both Participants 5 and 11 emphasised the concept of equality and recognition of differences while referring to verse 13 of chapter 49 in the Quran (Participant 5, 3-10-2012; Participant 11, 28-11-2012):

O mankind, indeed we have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah (God) is the most righteous of you. Indeed, Allah (God) is Knowing and Acquainted (Quran, 49:13)⁴.

A decade ago these teachings were transferred into formal action. In 2004, under the patron of the Organisation of Islamic Cooperation (OIC)⁵, the ministers of culture in the member states gathered in Algiers. As a result of this conference the Islamic Declaration on Cultural Diversity⁶ was issued (Islamic Declaration on Cultural Diversity, 2004). Here is a classic example of how Islamic beliefs have been converted into modern state policy.

Younos defined three concepts; Idealism, behaviourism and holism as those that are shared between Islamic cultures in different parts of the world:

To be clear, idealism means shared ways of thinking. In Islam, the Islamic idealism is Tawhid, or Oneness of God, man and universe. Behaviourism is sharing ways of behaving. Islamic behaviourism is to follow the traditions of Prophet Mohammed. And finally, holism, which are ways of thinking and behaving. Islamic holism is to follow the footsteps of the messenger as a role model for behaviour which give us Islamic culture (2013, p.3).

Another component of the dominant culture in Saudi Arabia outlined by Participant One above was the importance of the Arabic language. It is not only a spoken language, but also confers a sense of identity. It connects the Saudi with a broader pan-ethnic group worldwide, called Arabs. More than 200 million Arabs live across the Middle East, North Africa and worldwide, including the

⁴ For further information in English about Qurannic verses and their interpretation, see: www.quran.ksu.edu.sa

⁵ It was founded in 1969 to serve the interests of the 57 Muslims countries (OIC, 2014).

⁶ The conference was held in the aftermath of the September attacks and the invasion of Iraq in 2003. It contained seven articles including dialogue, sustainable development, the contribution of Islamic culture, and creativity (Islamic Declaration on Cultural Diversity, 2004).

Saudis (Nydell, 2006). The bond between Arabs, or Arabness, is naturally profound in the Middle East, and especially in the Arabian Peninsula (Saudi Arabia⁷). Montgomery and Cachia describe this Arab connection as an “impressive cultural unity” (2013). Even before Islam⁸, the eloquence of Arabic was rooted in Arab societies, illustrated by pre-Islam prose and poetry (Ayish, 1998; Ayish, 2003; Montgomery & Cachia, 2013).

The participants’ reference to the sense of kinship among Arabs did not necessarily mean the affiliation to language or to a particular race⁹ or even political unity. They insisted on a shared history, memory and culture between the inhabitants of the region stretching from the Atlantic Ocean to the Arabian (Persian) Gulf, including the Saudis. This cultural and societal unity has its roots in ancient Arabia, long before the arrival of Islam. This sense of Arabism has been portrayed as a powerful bond unrestrained by geographical boundaries: “The Algerian man in the street clearly has a stronger feeling of kinship with the Asian fellow-Arab of Iraq than with non-Arab fellow-African in Mali” (Montgomery & Cachia, 2013). In this respect, the Arab is defined as a person for whom Arabic is his or her own language, who feels they are an Arab and who feels part of the Arab community (Ayish, 1998; Ayish, 2003; Montgomery & Cachia, 2013; Nydell, 2006).

Together with Islam, Arabic has played a major role in tightening the relationships between Arabs. The religion of Islam elevated kinship between Arabs from historical-linguistic relationships to be also based on a religious affiliation. This sense of commonality integrated the Arabs into a broader group, the Muslim world. Similarly, the Saudis’ relationships and identity were strengthening internally and they also became part of these two heterogeneous groups, Arabs and Muslims. This affiliation puts the Saudis within the realm of these two groups’ general norms and values.

⁷ Nowadays, the Arabian Peninsula consists of Saudi Arabia, Yemen, Oman, Qatar, Bahrain, Kuwait and United Arab Emirates.

⁸ Two main cultural features dominated the pre-Islam era in the Arabian Peninsula; relationships and linguistic aspects (Ayish, 1998; Ayish, 2003). Preserving the personal and family (also tribe) dignity (Karama) was the centre of the unwritten codes of the Arabian tribal law on relationships (Ibid). Besides that, the concepts of genealogy (Nasab) and Paternalism (abawiyya) also tightened the relationships (Ibid). On the linguistic side, eloquence has been a commonly valued attribute among Arabs (Ibid).

⁹ The Arabs are not a group based on race, but are a heterogonous group unified by a shared language, history, culture, and political affinity in recent decades.

Arabic is not only a linguistic means of communication and sharing ideas, but it also has a religious symbolism as the Quran was revealed in Arabic¹⁰ (Ayish, 1998; Ayish, 2003). In addition, most Islamic prophetic traditions are in Arabic¹¹. It is the language of Islam and a profound characteristic of the Saudi culture and society as well as the regional culture as a whole: “The religion of Islam provided the historical impetus creating the vast society to which the Arabs belonged. Intellectual disciplines associated with religion were the flywheel that maintained a steady, even movement” (Montgomery & Cachia, 2013).

The worldwide presence of Arabic goes beyond Saudi Arabia to other countries in the Islamic world as well as to the Muslim communities worldwide. Ahmed described this process as the exporting of Arabic verses and words through the religion of Islam (2000). Arabic was diffused not only through sacred books and literature, but also through the arts and Arabic calligraphy (Younos, 2013). So through seeing, reading, thinking and discussing these artistic pieces, Muslims are encouraged to actively think about the universe and God’s place within it (Ibid). The Arabic-Islamic art of Arabesque developed out of this context. This is the use of geometric, Qurannic verse and floral patterns designed not to fulfil the desire to create art, but to demonstrate how the world is connected (Ibid).

The next component of the dominant Saudi culture is family (and extended family). All the health communicators and anti-drug activists in this study insisted on the key importance of the role of the family and extended family in the war against substance abuse. Participant Five, for instance, considered family and extended family as an important strategic partner in society’s efforts to minimise the social problem of substance abuse (Participant 5, 3-10-2012). Social scientists consider that Saudi society remains family-oriented while the extended family continue to exist as a key social institution in the Saudi social structure (Abudabbeh, 2005; Barakat, 1993).

¹⁰ There were many attempts to translate the Quran to others languages, and this project is one of them www.quran.ksu.edu.sa However, the richness and beauty of the Quran is in the classical Arabic.

¹¹ Most of the hadiths (Prophet Mohammed traditions; says) were translated into different languages, and the recent advancements in technology led to distribute them in different languages. This website is a great example <http://sunnah.com/>

The concept of family, the participants argued, was not about blood relationships but represented the foundation of society as Participant One argued in the promoters' second focus group (6-12-2012). In his study of the principles of Islamic sociology, Younos brought up the argument of the centralising family as a foundation of a healthier society (2011). In fact, Islam emphasises the centrality of caring for the family and for the extended family (Abudabbeh, 2005; Barakat, 1993). Specifically, family relationships and positive inter-society relationships are mentioned in the Quran in a range of different chapters. For instance, the issue of caring for parents is mentioned in Chapters 2, 4, 6 and 31 in verses (2:83)¹², (2:215), (4:36), (6:151) and (31:14) (Quran). Collectively, Islamic teachings¹³ embrace supportive families and put family interests over self-satisfaction and personal fulfilment (Abudabbeh, 2005; Barakat, 1993).

Family and extended family in Saudi are the first social institutions children encounter and, therefore, the norms, attitudes and traditions of these social units have a profound cultural impact (Ayish, 1998; Ayish, 2003). These norms and values are reflective and inspirational in building their understanding of life and this includes attitudes to risky behaviours such as alcohol and drug abuse. These family and extended family values differ from one region to another in Saudi Arabia (El Mallakh & El Mallakh, 1982; Nydell, 2006; Sunitan, 2008) matching the predominant anthropological perspective on the diversity of norms and traditions within human beings (AbdulJawad, 2004; Martin & Nakayama, 2010; Younos, 2013).

Most of the traditions concern weddings, celebrating success, or childbirth, clothing, hospitality and respect of the elderly (Abudabbeh, 2005). By the same token, the traditions focus on human interactions, social relationships, and hierarchical interactions. Unfortunately, there is not a reliable study of these traditions in Saudi Arabia. Because of the absence of such a study, the level of adherence to traditions in contemporary Saudi Arabia is also not available.

¹² (2:83) The number two refers to the chapter in the Quran and the number after the *colon* refers to the verse.

¹³ There is a whole book in prophet Mohammed traditions about Virtue, Enjoining Good Manners, and Joining of the Ties of Kinship, and that includes a Chapter on: Being Dutiful To One's Parents; see the following website for more information: <http://sunnah.com/muslim/45>

The importance of strong family ties in Saudi culture explains why the family is such a strong focus of state campaigns, for instance in Directorate of Drug Control public awareness advertisements (Participant 18, 23-12-2012; Participant 24, 1-1-2013; Participant 27, 7-1-2013). Good examples are advertisements number nine and ten, which were thematically analysed¹⁴. Both were distributed by the Saudi Directorate of Drug Control in 2010. The advertisement featured a dramatised conversation between a father and a mother and a physician who was giving advice to the father on how to give up illicit drug use. The advertisement finished with this phrase “Drug misuse will take those you love from you” (Advert One). Similarly, advertisement number ten was a conversation between parents arguing about how to educate their children about drugs. The last phrase in the announcement was “Dear father, by increasing your awareness about drug abuse, you protect your children from destruction” (Advertisement Ten). These two public awareness announcements highlight the use of family values and the importance of keeping the family safe in Saudi Arabia in the war against substance abuse.

While family and extended family are key sources that feed individuals with their values and understanding of the world, local traditions also emerged as important factors among the participants. Most importantly, the value of Honour (Sharf¹⁵ in Arabic) was consistently mentioned in the study data. One of the student participants shared his thoughts about honour in Saudi Arabia as the adherence to social morals and avoidance of anything which might inflict damage to the family reputation (Participant 4, focus group 1, 8-10-2012). This refers to the constant self-social control to avoid any wrongdoing or social misconduct. Such inconsistency toward Saudi social values is known by the local term of Alaibe (singular Aibe) (Participant 19, 24-12-2012).

Alaibe refers to behaviour that is not acceptable within the Saudi moral system. This behaviour varies from behaviour that is specifically prohibited in Islam to those that are not accepted according to society’s manners. For example, the students highlighted in their discussions the issue of what was acceptable to wear for formal social events. They also mentioned respect for

¹⁴ Further details about the advertisements and the analysis can be found in section 4.5 in Chapter Four.

¹⁵ Honour (reputation) means the value system managing the social connections, social circumstances and social contacts in the Kingdom. It is the collective reputation to the entire family and it inherited and should be protected by avoid wrongdoings which could damage the family reputation.

elderly people as an expected behaviour from the younger generation (Focus group 6, 12-12-2012; focus group 3, 21-11-2012). One social behaviour that clearly violates these social values is the use of alcohol and/or illicit drugs. Since alcohol and illicit drugs are prohibited in the religion of Islam, they form part of the behaviour known as *Alaibe*. When there is an overlap between socially unacceptable acts and prohibited¹⁶ acts, and this includes substance abuse, taking bribes and abusing children, these behaviours are even more strongly discouraged.

Therefore, in Saudi society, individuals try to perform good deeds to maintain their reputations and honour. They tend to avoid out of wedlock sexual interaction and criminality and instead are encouraged to work hard, acquire a higher level of education and strengthen their bond to religion. Social scientists insist the presence of honour is a prominent aspect in the study of the Arab society (Abudabbeh, 2005; Al-Khateeb, 2007; Barakat, 1993; Khalaf & Khalaf, 2009). Collectively, Islam, Arabic and local traditions are the fundamental components of Saudi culture. However, this does not mean this culture is isolated from transformation or from global changes.

5.3 Saudi identity and cultural transition

Islam, Arabic and local traditions not only contribute to Saudi cultural norms, values and ethics, but also to the Saudi national identity. They contribute to the sense of self-understanding and to how others perceive the Saudis. They are also significant when it comes to substance abuse issues, as this identity, in general, holds a set of behavioural expectations among those who identify themselves as Saudis in relation to illicit drug abuse or alcohol use. In her thoughts on Saudi culture, Participant One in the fifth student focus group shed light on this common identity: "I see myself in-between who I am and absolutely my faith in Allah (God)" (Focus group 5, 10-12-2012).

She referred to Islam as the core that connected Saudis together. Some pre-Saudi aspects of identity survive, most of these linked to regional, family or tribal ties. This corresponds to a range of literature on Saudi identity (Al-Atawneh, 2009; Bligh, 1985; Doumato, 1992; Metz, 1993; Nevo, 1998; Yamani, 2009; Yamani, 2000). Saudi identity has integrated faith, language and common

¹⁶ Since the term *Haram*, which means prohibited and forbidden in Arabic, is the one used for the forbidden and prohibited aspects in Islam (Brown, 2009).

destiny (Nevo, 1998). Furthermore, modern Saudi identity has also been structured to include allegiance to the King to preserve the presence of Islamic law and morals in the cradle of Islam (Al-Atawneh, 2009; Bligh, 1985; Yamani, 2009).

The contemporary Saudi identity evolved out of a national consolidation and a shared historical heritage, and was not the result of a colonial withdrawal. In fact, Saudi Arabia has never been colonised. It was declared a unified Kingdom on 23rd September 1932, following a long unification process led by the Kingdom's founder Ibn Saud and his supporters (AlRasheed, 2010; Farsy, 1990; also see Islam and Saudi Arabia in the Third Chapter). Since then, the Saudi authorities have been keen on facilitating the creation of a new identity to unify the people of this newly born state. The new Saudi identity does not negate but encapsulates other, older sub-identities from the territory, but offers a new general identity which is not totally separable from the history of the place (known as *Arabian Peninsula*).

When the government created *Saudiness*¹⁷, it crowned Islam and Arabic as the most important shared aspects of Saudi identity, founded on Saudi Arabia's position as birthplace and guardian of Islam's historic heritage. The Islamic identity is, therefore, rooted in a geographical area but extends to both history and religion. As Sunitan argues, for Saudis the message of Islam is part of reality (2008). It is in Saudi Arabia, where the prophet Mohammed disseminated his message and all the historical places of the call of Islam are part of the geography in which Saudis reside (Ibid). Additionally, the current political system in Saudi Arabia is founded on an Islamic basis, and Islam is the basis of governing¹⁸ (Al-Atawneh, 2009). As both Arabic and Islam are prominent aspects of Saudi identity, this has placed a set of expectations onto affiliated individuals, and this of course applies to substance abuse. In addition, Saudi Arabia's status in the Islamic world puts additional pressures on local cultures to retain the Islamic spirit and morality in the Kingdom (Nydell, 2006).

¹⁷ Furthermore, there is another growing identity, *Gulf Khalieje*, based on the shared cultural characteristics between the Gulf Cooperation Council (GCC) countries, also driven by the economic orientation of the GCC block (Yamani, 2009; Yamani, 2000). It has been attached with the emergence of the Gulf Cooperation Council (GCC) in the 1980.

¹⁸ Further details can be found in the section on Islam and Saudi Arabia in the Third Chapter.

The research participants supported the notion that Saudi culture has undergone a massive transformation in recent decades as a consequence of the projects of modernisation and development that have been implemented since the 1970s. This is borne out by the literature (Al-Khateeb, 2007; Alsharekh & Springborg, 2008; Kelly, 1980; Metcalfe, 2011; Sultan, Metcalfe, & Weir, 2011). Participant Two outlined the phases Saudi culture has been through. He insisted on the importance of both Islam and of Arabic. The first phase was described as the 'closed phase':

Our culture has been through different periods. The first time, I call it the closed culture. The situation was a result of geographical and environmental isolation and less contacts with outsiders, especially, in the deep areas of central Arabia. However, a province like Hejaz was the opposite of the dominant situation, because of the existence of the two holy mosques in the area; at that time this region's culture was more open, and still is.

As pilgrims (Hajji) come annually to visit these holy places, the contact between those pilgrims and locals is inevitable. The pilgrims from different backgrounds influence negatively and positively the Hejazi culture.

Unlike, the people of central Arabia or far away areas, this kind of interaction with different groups and strangers did not exist for them at that time. Therefore, their culture was narrow. The alternative for these locals was to travel to other parts and settle for a while or forever. So this phase depended on human interaction and mutuality (Participant 2, 26-09-2012).

He pointed out the role of Islam in bringing diversity and cultural engagement to the country. This role has continued, but on a larger scale. The geography of the country was a significant obstacle to intercultural communication and movement, because of Saudi's harsh topography (Long, 2005a; Metz, 1993). It is worth saying that the economic limitations experienced during this time in Saudi Arabia, were an additional reason for the lack of cultural engagement. The culture in this period was static and not dynamic, but the Islamic beliefs were there.

Decades later, Saudi culture experienced a second period. Participant Two described this phase as '*Openness toward the world*'.

Our country sought the path of development (Tatwir wa tanmia in Arabic). It needed proper infrastructure. Unfortunately, we did not have enough of a skilled workforce at that time to do this transformation. So the door opened to the guest workers and specialists to come and do their part in the development. There were not isolated communities, but they were integrated into the society, and the society welcomed them as well. Therefore, we could say that they cultivated some of their customs, values and traditions in the Kingdom. So it is not a closed culture anymore (Participant 2, 26-09-2012).

The beginning of the oil-led development was not only an economic, historical moment, but a turning point in Saudi culture and the beginning of a new dynamism. Saudi culture shifted from stasis to fluidity (Jandt, 2012; Lewis & Lewis, 2015). Guest workers were integrated into society, motivated by the Islamic value of living together in peace and coexistence (Islamic Declaration on Cultural Diversity, 2004; Younos, 2013). What eased this integration was the background of most of the newcomers, the vast majority of whom were from Arab or Islamic countries. Most were, therefore, familiar with the broader features of Saudi culture and many had common characteristics such as a shared language and/or religion (Aḥsan, 1992; Al-Azami, 1994).

The Saudi authorities adopted a unique approach to the challenge of balancing development and the preservation of Islamic ethics and values (Farsy, 1990; Looney, 1982; Metz, 1993). According to David Long, this equilibrium between development and the preservation of tradition was achieved as follows:

In seeking to both maintain its Islamic values and accommodate to the needs of modernisation, the regime has implemented social, political, and economic development programs at varying speeds, depending on how long the various development programs have been in place and absorptive capacity of this conservative society to embrace the changes they bring (2005b, p.29).

Yamani in her study about the implications of the transformation of Saudi Arabia concluded that two streams of features survived; traditional and modern. Saudis found themselves located between a modernising market-state society and a more traditional structure redolent with established values and traditions (Yamani, 2009; Yamani, 2000).

The dynamism continued and the next period has been described as “The open spaces time”. Participant Two, described this as follows:

Nowadays, the constraints on the media have eased. It became too difficult to censor or control everything. Nowadays, all broadcast materials enter every house from different sources. I think it played a major role in worsening the substance abuse problem and family dissonance. This newcomer (foreign and global) media found our houses without windows (Participant 2, 26-09-2012).

Direct satellite broadcasting, trans-national media content, and the increase of internet penetration in Saudi Arabia have exposed Saudi culture to neighbouring cultures and created opportunities for further connections beyond the Middle East. Conversely, Participant Two pointed out what he believed were the undesirable consequences of an unconstrained global media. He argued that technological progress in broadcasting and communication was directly related to the aggravation of the substance abuse problem in Saudi Arabia (26-09-2012). However, the reality does not really support his contention.

In theory, there is no media without control – at the very least, self-censorship – in the Middle East (Cochrane, 2007; Hafez, 2009; Hammond, 2007; Yamani, 2008). William Rugh categorised the media system in the Arab World into three types; the mobilisation media system, the diverse media system and the loyalist system (2007). The mobilisation system is where the political environment is controlled by one political party with no competitors and in which the authorities use the media to mobilise public support. In this system, ownership of the media has started to be liberalised, or sold to the private sector, while the government continues to exercise censorship over content (Ibid). In contrast, the diverse media system is characterised by a range of political parties expressing different views (Ibid). All the media owned in this system are owned by the private sector and the restrictions on freedom of expression in the law are insignificant (Ibid).

The loyalist system operates within a restricted political environment, but it is one in which the government adopts a passive attitude toward the media and does not seek to exploit it to win public support for political reasons (Rugh, 2007). This system leaves the media in private hands, but there are limitations when it comes to questioning government policies (Ibid). The government

achieves this through regulation and by using penalties to discourage the media from disobeying the rules (Ibid). So the regulations are sympathetic to the regime in power, just as the media observing bodies are loyal to it.

Rugh explained the reality of the loyalist system: “Newspaper editors and reporters may occasionally criticise lower-level bureaucrats, but as a rule they are very careful not to go too far, because of the prevailing political environment and the laws that discourage dissent” (Rugh, 2007, p.6) The Saudi media system is a loyalist system and that means the government draws the lines of what not to be criticised or discussed in the media¹⁹. Of course, recent communication technologies such as the internet and social networking provide more space and freedom to criticise in the cyber world and the Arab spring was a great example of new media power (Arab Social Media Report, 2012).

Furthermore, propositions about the media’s role in inciting violence and risky behaviour have been largely debunked by scholars. It is evident, for instance, that mediated violence is negatively correlated to the increase in violence and suicide deaths among young people in high-income states (Lewis & Lewis, 2015; Viner et al., 2011). In addition, media and public health specialists argue the media has a strong effect on the young and on adolescents’ identity building and behaviour modelling (Lewis & Lewis, 2015). However, there has been no examination of this causal relationship in Saudi Arabia, especially in relation to substance abuse. Therefore, further investigation would be fruitful.

At the present time, Saudi culture has shifted from a position as receiver and absorber during the 1970s-80s to be more interactive with the world while retaining its cultural privacy:

A new culture, you search about within the cumulus of diverse cultures, we have our culture within this globe. You cannot say we have Saudi culture isolated from the world cultures. So our culture is influenced by the global culture, and the exception maybe for the remote areas in the Kingdom (Participant 2, 26-09-2012).

The dynamism of culture, in modern times, is no longer a matter of choice. The single, global market, and the domination of the state and market in many places worldwide, including Saudi Arabia, has made dynamism, progress

¹⁹ For further details about the media in Saudi Arabia see section 3.5 in Chapter three.

and cultural change unavoidable (Yamani, 2009). In Saudi Arabia, this dynamism is expected to increase. In fact, a new wave of development is planned in the area of knowledge building and acquisition (Sultan et al., 2011), and this requires even more openness to the world and yet more reliance upon instant communication. Progress in Saudi Arabia has not come without consequences, and the growth of substance abuse has been one of them, according to Participant Two²⁰.

In fact, there is a consensus among sociologists, criminologists, social scientists and communication scholars about the positive correlation between modernisation, economic improvement and risky drug behaviour in Saudi Arabia (Al-Humidan, 2008; Al-Qashaan & Al-Kenderi, 2002; Emmett & Nice, 1996; Fields, 1995; Hafeiz, 1995; Wilson & Kolander, 2003).

Participant One agreed there was indeed a strong relationship between development and risk taking (Participant 1, 24-09-2012). Some authors have tracked the link between development and risky health behaviour (Lewis and Lewis 2015), while Richard Eckersley found that development's relationship to individualism created new obstacles to public health, not least from emerging inequality in the new global public health system (2006).

5.4 Culture and health communication in Saudi Arabia

The understanding of health, illness, disease and recovery are intertwined with individual personal experiences and other cultural factors such as family values, norms and languages (Rassool & Sange, 2014b). In many countries, culture has been linked with different roles in drug abuse and alcohol use. These links include the role of culture in the spreading of substance abuse, perceptions of problematic behaviour and the position of culture in defining social problems (Abbott & Chase, 2008; Heath, 2001; Room, 2013). Culture has been an important perspective through which to view the emergence and growth of the phenomenon (Hanson, 2013). Saudi culture has inputs in each of these areas.

This study has used an ethnographic (understanding) cultural approach to explore Saudi culture in order to understand how and where health meanings and messages are negotiated and articulated (Dutta, 2008; Dutta & Basu,

²⁰ Further details about the reasons behind the growth of the substance abuse will come in the next chapter section 6.2.

2011)²¹. Fundamentally, the Islamic aspects of Saudi culture have evolved out of the study data as the key influence in communicating health related issues and particularly around risky behaviour such as illicit drug use or alcohol abuse. This section will convey the theoretical aspect of the Islamic perspective of risky health behaviour and the logic of this perspective and its use in the Saudi Arabian context.

The findings indicate the richness and the centrality of the Islamic perspective on health, particularly its position on addictive behaviour and the use of intoxicants. The Islamic perspective on substance abuse is a comprehensive and holistic one. Islamic thinking provides a model for substance abuse prevention underpinned by certain principles. These principles are: Islamic Law on substance abuse; the Islamic position on seeking treatment and healing from addiction; the concept of Tawbah (repentance) in Islam, and, the principle of promoting virtue and preventing vice, or Islamic communication (Da'wah). The last dimension is designed to promote the three other principles collectively as well as other Islamic teachings in order to maintain Islamic manners and morals. The coming section will discuss this model in more detail, including cultural issues arising from communicating anti-substance abuse.

The Islamic-orientation of Saudi culture, the long-heritage of Islam in the country and the Saudi political environment constitute a critical frame of reference for discussions around substance abuse. Participants in the third focus group commented: "Our society is an Islamic one and it adheres to Islamic principles" (Focus group 3, 21-11-2012). Saudi mainstream culture and the Saudi identity frame the expected behaviour of Saudis even as they draw an exemplar-model of behaviour in the society. For Muslims, how Prophet Mohammed acts and what he says, collectively, represent the ideal for Muslims²². As argued by Rassool, "the life of Prophet Mohammed is full of countless examples that show his status as a role model for Muslim societies and individuals. This is characterised by an exceptional morality, good habits, noble and gentle feelings and superior skills" (2014d, p.8). The prophetic

²¹ For further details about that look at section 2.4 in the Literature Review Chapter.

²² It is from this that the term Sunni emerged, as those following the Prophet Sunna (says and acts). Further details about Sunna can be found in section 3.4 in Chapter Three.

traditions are therefore comprehensive and include references to social interactions and health (Sonn, 1996).

The religious-background of Saudi cultural influences emphasises the obligatory side of the Islamic perspective and even the legal side, since the Saudi justice system is also Islam-oriented. Also, the religious aspect of Saudi culture endorses a universalism that is also embedded in the practice of communicating anti-substance abuse messages in Saudi Arabia. The Islamic perspective, therefore, has a substantial influence on health communication in the country. The data also suggests its applicability together with the findings extend far beyond Saudi Arabia. How has this cultural worldview on health communication emerged?

Within the cultural perspective, theories on health communication have traditionally been divided into two dialectical tensions; social change/status quo and the static/dynamic nature of culture (Dutta, 2008; Dutta & Basu, 2011). The Islamic model of preventing substance abuse through culture in the midst of social change is different. It considers culture as progressive, always seeking advances in knowledge without changing the principles or beliefs of Islam. It is not monolithic, in other words. In terms of social change, the Islamic stance considers the maintenance of the health of individuals and of society as a whole as an important goal, driven by Islam's teachings around health being the gift of Allah (God) and a core connection between public health and the individual (Khayat, 2004). By contrast, interventions aimed at changing behaviour are intended to alter deviant behaviour to religiously accepted behaviour. Islam encourages an intervention-based approach to behaviour change. Illicit drug use is a good example of out of the ordinary (prohibited) behaviour that, according to the Islamic approach, needs to be changed to fall within normal bounds (Rassool, 2014a; Rassool, 2014b; Younos, 2011).

The research participants agreed collectively on the positive principles the Saudi perspective has on the issue of health and specifically concerning drug abuse and alcohol use. It constitutes, therefore, a powerful cultural influence. Since the meanings surrounding health have evolved out of the realm of Islamic culture, Participant 2 emphasised the critical role Islam plays in substance abuse prevention and communication in Saudi Arabia:

Firstly, the logic drives the communication and promotion against illicit drug abuse and alcohol use in Saudi Arabia is the Islamic logic. It functions as a base for the society and individual judgements over the abusive behaviours. This Islamic logic prohibits the intake of alcohol and drugs. It is not about your father or your mother or the authority banning such behaviours, but it is about God (Allah) forbidding it. So this religious logic is on the top of all other arguments facing this problem such as the negative social and economic impacts arguments (Participant 2, 24-9-2012).

Islamic opinion toward substance abuse and its negative effects constitute the logic around drug use and alcohol consumption in Saudi Arabia. A second aspect of this logic is science-based and follows the considerable momentum that research has made in assessing the biological and social impacts of drug and alcohol use (Fields, 1995; Rassool, 2008; Rassool, 2011; Wilson & Kolander, 2003). However, it is the religious logic that takes precedent even over science, according to Participant Two. In a subsequent chapter I will address the modern measures and regulations around drug abuse and alcohol use in Saudi Arabia. These regulatory measures are embraced not just by the Saudi authorities but also within the global environment (Pietschmann, 2007; UNODC, 2008).

Similarly, the Islamic notion of health covers other health aspects such as diet and nutrition, fitness, breastfeeding, and healthy lifestyles (Aboul-Enein, 2014; Assad, Niazi, & Assad, 2013; Baasher, 2001; EL-Islam, 2009; Jamil, 2014; Koenig & Al Shohaib, 2014; Muslim Health Network, 2015; Stacey, 2009a; Stacey, 2009b; Stacey, 2013a; Stacey, 2013b).

Furthermore, an additional feature about Islamic culture was introduced by Participant Two concerning the existence of the rules of prohibition in Islamic culture. Most of these rules are generated from Islamic teachings. Health forms part of Islamic law (Sharia Law), in which the ritual aspects, as well as human interactions are organised (Weeramantry & Hidayatullah, 1988). The purposes of such cultural/religious codes are to guide believers on economic, health, well-being and social health matters, and to resist evil impulses (Younos, 2013)²³. Most significantly, the Islamic aspects of Saudi culture have inspired Saudi

²³ These codes are not limited to the human aspects, but also include mercy to animals and care of the environment from pollution and natural disaster (Rassool, 2016; Younos, 2013).

society's overall stance around risky-abusive behaviour and substance abuse, as Participant 19 argued:

What is great about Saudi culture is the theoretical rejection of such (unlawful) abusive behaviours as well as the absence of social acceptance. Also, we should not forget the strict regulations on this matter. And what supports all that is the religious forbidden of drug and alcohol abuse in Islam and in Saudi Arabia. Therefore, our cultural structure refuses the illicit substance abuse behaviours (Participant 19, 24-12-2012).

The absence of any social popularity for drug abuse or for alcohol use is a common Saudi cultural trait. This has been formed for an array of reasons. Firstly, religious (Islamic) prohibition is the key reason for the absence of cultural acceptance. In addition, the topography of Saudi geography is not suitable for growing drugs with the exception of *Khat* plant cultivation in the South-west Mountains (Alsanusy & El-Setouhy, 2013; Manghi et al., 2009; Sheikh, El-setouhy, Yagoub, Alsanosy, & Ahmed, 2014). Therefore, the total rejection of drugs and alcohol is currently the dominant social attitude in Saudi Arabia. This view has been entrenched via Islamic education and reinforced in the culture by prevailing values and ethics.

Participant 19 pointed out there was a legal side to Saudi antipathy toward substance abuse in the Kingdom. This is the implementation of the Islamic legal framework in Saudi that led to the legal prohibition mentioned earlier. I will discuss this in more detail in the next section.

Cultural rejection of drugs and alcohol has created an environment in which responses are driven by religious beliefs and by medical evidence. Participant 23, who works at the health promotion department in the Saudi ministry of health, said:

In our talks about drug use in the Kingdom, the Sharia (Islamic Law) should not be passed over. The Islamic prohibition to drug intake should be seen as strength in dealing with such a problem in our country. In fact, we should maintain pressing on this point in our campaigns (Participant 23, 31-12-2012).

The antipathy to substance abuse is evidently an influential point in health promotion and communications in Saudi Arabia. The participant also argued that religious and legal perspectives remained relevant as they

generated fruitful social and legal ground on which health promoters and communicators could build their campaigns. His comments highlight the enduring emphasis on an Islamic perspective, together with religious teachings, in the bid to promote good health in Saudi Arabia.

In Saudi political, historical and religious circumstances, it is essential, therefore, to integrate the Islamic perspective and Islamic values with other approaches. Culture and health communication are intertwined in relation to substance abuse in Saudi Arabia and the Islamic approach on addictive behaviour will remain central in the fight against illicit drug use and the consumption of alcohol.

Saudi cultural influences go beyond an Islamic worldview and reach deeper than policy perspectives on substance abuse and regulation. From my observations during field trips and from the research participants' comments, Islamic and local traditions exert a powerful influence on the practical side of health communication, including the content of messages, the appeal used to attract the specific audience, and the communication channels hosting the campaigns.

In fact, communication is an important element in the Islamic approach, because it was through communication and preaching that Islamic teachings on the use of intoxicants and addictive behaviour have been disseminated to generations of Muslims and non-Muslims. The pattern of this communication can be understood within the religious (Islamic) realm of diffusion of the Islamic call, Da'wah. For example, the use of the mosque communication activities as well as the religious events and publications have dominated the dissemination of Islamic teachings throughout history. Further discussions on these influences in communication will come in the next section.

The religious-orientation of the approach places family and parents in particular as the main agents for the dissemination of these values. It is, in Islam, part of parents' duty to educate their young about their faith and Allah (God), and this includes intoxicant use (Rassool, 2016). Of course, parents need to consider the appropriate time to teach their children and there are naturally sensitivities surrounding the topic. Participant 22 referred to the family role as follows:

Family plays an important role in our society; it is the nucleus in nurturing children and preventing the arrival of illicit drugs to them. Also, families cultivate in the young people the rejection of any behaviours contrary to Islam and the values and traditions of the society (Participant 22, 31-12-2012).

In addition, the Saudi government has a role in disseminating these beliefs and rules for the younger generations as well as the communities. Religious establishments, institutions and schools are the main instruments the government uses to educate Saudis about Islamic teaching around health in general, i.e. Islamic rules around diet, physical activity, personal hygiene and sexual life (Aboul-Enein, 2014; Dhimi & Sheikh, 2000). For instance, Islamic teaching on nutrition were explained as:

A healthy balanced diet is a matter of faith in Islam as it allows Muslims to contemplate the relationship of the mind, the soul and the body. For this reason Islam has prohibited some foods (haram) and beverages due to their ill effects (Rassool & Sange, 2014a, p.77).

The Islamic stance on the use of intoxicants is one of these messages that the Saudi authorities send to the public. In the subsequent chapter, the strong connection between the government, the political structure and the use of Islamic discourse and institutions will be explained. This particular link was essential in the emergence of health communication (see the next chapter). It is unlikely, according to Saudi political and historical trajectories, that the Islamic approach to substance abuse will be eased.

The recognition of the role Saudi culture can play in health communication against substance abuse was not a reaction to cultural diversity or to the demographic changes. In this respect, the evolution of a culture-based approach in Saudi Arabia to communicate against illicit substance abuse was developed differently from the mainstream narrative in western literature (see Airhihenbuwa, 1989; Airhihenbuwa, 1995; Dutta, 2008).

In the Saudi environment, health communication cannot be defined only as a set of communication strategies and tactics used to exchange messages and ideas in order to change risky health behaviour deliver healthcare services, or maintain public health. Health communication in Saudi Arabia needs to be defined in terms of its relationship within the Islamic realm because, as

Participant Two mentioned, Islam provides the underlying logic of all the efforts, attitudes and regulations on health matters in Saudi Arabia (Participant 2, 24-9-2012). Therefore, in Saudi Arabia, communication activities are led by public establishments, community leaders or individuals wishing to exchange health-related information, but always complying with Islamic teachings. Specifically, Islamic beliefs about intoxicant use and addictive behaviour are vital touchstones for communicating health messages about substance abuse in Saudi Arabia.

With the prevalence of Islamic thinking and ideas in the Saudi context, and the research participants' insistence on the positive impact of Islamic rules on substance abuse guiding the entire society's stance, one might expect that taking illicit drugs would be a rare event. In fact, to some extent, this is true. The recent United Nations Office on Drug and Crime figures point to low levels of illicit drug use in the parts of the world where Islam is the major religion, including Saudi Arabia (UNODC, 2014). A similar conclusion was reached by the World Health Organisation which found low levels of alcohol abuse related problems in Saudi Arabia (WHO, 2014). Participant 18 described the status of the substance abuse problem in Saudi Arabia as one of the lowest in the region (Arab world) (23-12-2012). However, the Saudi cultural antipathy does not mean the absence of substance abuse cases or patterns of use. The next section will engage with the Islamic model for the prevention of substance abuse and communication.

5.5 Communicating the Islamic model

Islamic beliefs about health and especially about intoxicant use and addictive behaviour dominated the research participants' comments, as the main cultural influence in communicating health messages about substance abuse. In addition to the influence of Islam on the Saudi perspective as a whole, Islam has also had a powerful impact on regulations and laws in the country, the communication means and timing as well as the content of the health promotion messages. Understanding these Islamic beliefs is indispensable to explaining the communication process as well as the legal aspects.

The study data engaged with four concepts in Islam related to health and substance abuse; prohibition, repentance and forgiveness, the seeking of treatment, and the promotion of an Islamic lifestyle. These four components are

not specifically about intoxicant use or drug abuse. In fact, they are general Islamic teachings guiding believers to live according to Islamic codes. For example, the prohibition of alcohol consumption is part of Islamic teaching about what is permissible to eat or drink, and also includes prohibitions on taking bribes and adultery (Aboul-Enein, 2014; Assad et al., 2013; Rassool & Sange, 2014a). Furthermore, Islamic principles require those who are ill or in need for treatment to search for help (Rassool, 2014c). Similarly, the concept of repentance (Tawbah) and the promotion of the Islamic codes include various wider aspects such as health behaviour.

Together, the four concepts form Islam's rules about aspects that may challenge Muslims in their lives. Again, the existence of these rules in Islam matches Participant Two's arguments about Islamic culture (Participant 2, 24-9-2012). In this respect, an Islamic paradigm scholar observed:

In the Western world, a lot of emphasis is now focused on a healthy lifestyle with the potential to obtain better physical and psychological health. Islam places great emphasis on both physical and spiritual health, and Muslims are encouraged to maintain a balanced diet, and remain active and healthy (Rassool & Sange, 2014a, p.74)

As an illustration of my engagement with the four concepts in the field, the response I got from a male students' focus group at a university in Saudi Arabia in answer to my question about how they perceive illicit drug use and alcohol consumption was: "it is literally prohibited in the Quran" (Focus group 1, 8-10-2012). I frequently encountered such views in every focus group with young people, both male and female. This demonstrates a degree of awareness about the Islamic view regarding substance abuse and also shows the power of the religion (Islam) in shaping people's position on intoxicants and drugs. Indeed, the power of religion to shape people, communities and society is well-recognised by scholars (Ahmed, 2000). Besides the power of religion in framing the stance, the comment highlighted the value of the Quran as the unquestionable source of advice on life matters for Saudis. Before explaining further the four concepts of the Islamic model when it comes to drugs and intoxicant use, I will explain the Islamic perspective on health in general.

The universal understanding of health is the total status of well-being physically and mentally and socially, according to the World Health

Organisation (2014). There are, however, considerable critiques to this definition that argue it is unrealistic and ignores the influence of political and economic elements (Rassool & Sange, 2014b). Islam perceives this status of well-being as a blessing from Allah (God) to human beings and argues that Muslims have a responsibility to take care of this bounty (Khayat, 2004). "In Islam, health is a valuable resource that must be maintained in order to serve God" (Dutta, 2008, p.138). In the Prophet Mohammed tradition, Muslims should be grateful for avoiding illness and disease. In fact, health in Islam is a holistic concept intertwining spirituality and both mind and body. This holistic understanding of health contains four categories of health; the health of the soul (Sihaa Ruhiya in Arabic), body and physiological health (Sihaat Aljassed), psychological health (Siha Nafsiyyah) and community health (Sihaat Almujtam'ma) (Kasule, 2008).

Psychological and physical health in Islam fits within predominant understandings in western literature on the biological function of the body and mind. However, Islam has more space for the spiritual dimension and the status of the soul (Koenig & Al Shohaib, 2014). In this respect, spiritual health refers to the relationship of faith between Muslims and Allah, and the maintenance of this relationship. It also means, nurturing good relationships with fellow Muslims and with others. In addition, Islam considers the individual Muslim as a unit in a larger complex, society. Community health refers to the collectivist spirit of mutual caring (Kasule, 2008). These four dimensions are connected and any change or threat to one or more dimensions can lead to problems and disorder in the whole society.

The holistic and interdependent nature of health in Islam is captured by the Prophet Mohammed when he says: "You see the believers as regards their being merciful among themselves and showing love among themselves and being kind, resembling one body, so that, if any part of the body is not well then the whole body shares the sleeplessness (insomnia) and fever with it" (Al-Bukhari, 2011c). Since collectivism and interdependence are values of Muslim community members (in this case, the Saudis), a person's health is an important element in public health, and the threat to an individual person's health is a threat to the whole of society. In this way, Islam encourages caring

for fellow community members²⁴. Further, the Prophet said: “A faithful believer to a faithful believer is like the bricks of a wall, enforcing each other.” While (saying that) the Prophet apparently clasped his hands, by interlacing his fingers (Al-Bukhari, 2011b). Caring about others in society is expected of faithful Muslims.

The holistic nature of the Islamic perspective of health was mentioned by Participant 10 in a discussion on the extensive influences of drug abuse on public health. He sees the drug problem as follows:

If a natural disaster was to happen in any state, by the end of the disaster a recovery process will have begun and, at some stage, the effects will have been tidied up. However, this is not the case with the drug abuse catastrophe. If one family member falls in the quagmire of drugs, all the others will be dragged in too. All will be vulnerable to health, economic and social problems. The impact on families will be felt by entire communities. As you know our Saudi society is a combination of families and if these families, or even some of them, are affected by this problem, the whole society will pay the price. So in our work we try to protect the first defensive line in this phenomenon, which is the family (13-11-2012).

In addition to the Islam’s comprehensive perspective on health, there are various Islamic rules about health covering the four layers of health in Islam; soul, body, mental and community health. In both the Quran and in the Prophet's tradition, the teaching of Islam in health covers general health such as being physically fit, but it also provides for prevention “One of the principles of Islamic health care is to prevent suffering and disease prior to any clinical symptoms” (Rassool & Sange, 2014b, p.92). Recently, the Islamic perspective of health has emerged as a growing area in alternative and socio-medicine, for instance, (Aboul-Enein, 2014; Adib, 2004; Ahmed, 2000; Al-Omari, Hamed, & Abu Tariah, 2014; Baasher, 2001; Celen, 2014; Pridmore & Pasha, 2004).

According to Younos:

The declaration of faith is an allegiance to God, Prophet, and the rule of law within the social system. When a Muslim in his heart accepts this declaration of faith and utters it this means that he is bound by legal, ethical, moral, social, political, economic principles of Islam, not otherwise (2011, p.109).

²⁴ Muslim and non-Muslim.

One of the most important concepts for health communicators in Saudi Arabia is the prohibition on the use, cultivation, trade and transfer of illicit substances. Saudi attitudes and behaviour toward drugs and alcohol connect with a belief model about these substances, a model some scholars argue that continues to provide compelling data (Baasher, 1981; Bassiony, 2013; Michalak & Trocki, 2006; Rassool, 2014a). I am going to clarify Islam's justification for its attitude toward drugs and alcohol, and then I will briefly trace the historical evolution of Islam's stance on that before examining the contemporary implications of that in Saudi Arabia.

There is an overall agreement among Muslim Scholars and clerics that any engagement with alcohol or drugs is forbidden (Almueti, 1985; Alsadlan, 1991; Baasher, 1981; Bahnasie, 1989; Bassiony, 2008; Hafeiz, 1995; Hatta, 2010; Michalak & Trocki, 2006). The only exception is in the case of medical necessity (Almueti, 1985; Alsadlan, 1991; Bahnasie, 1989). According to this opinion, prohibition (*Tahrim* in Arabic) is evident from various verses in the Quran and from groups of Hadiths from Prophet Mohammed, the two main sources of Islam and Islamic culture.

The majority of Islamic jurists (Fiqh)²⁵, agree that the Quran verses (Aya's in Arabic) 90 and 91 in chapter six (*Surt ALmaaida*)²⁶, show how alcohol and other intoxicants are forbidden in Islam (Almueti, 1985; Alsadlan, 1991; Baasher, 1981; Bahnasie, 1989; Bassiony, 2013; Michalak & Trocki, 2006; Rassool, 2014a; Rassool, 2014b):

(90) O you who have believed, indeed, intoxicants, gambling, [sacrificing on] stone alters [to other than Allah], and divining arrows are but defilement from the work of Satan, so avoid it that you may be successful. (91) Satan only wants to cause between you animosity and hatred through intoxicants and gambling and to avert you from the remembrance of Allah and from prayer. So will you not desist? (Quran, 5:90-91).

There is little ambiguity concerning the intent or purpose of these words, with one of the strongest elements being how intoxicants distract the faithful

²⁵ It refers to the discipline of Islamic judgement over issues. In other words, it refers to the legal codes of Islam that are supported by verses from the Quran and from Sunna. It covers rituals, behaviours, trades and policies (Hallaq, 2009; Weeramantry & Hidayatullah, 1988).

²⁶ Because in the Quran the Chapter is known in Arabic as Surah (in singular) and Swar (plural).

from prayer, one of the five pillars of Islam²⁷. Another verse in the Quran is verse 195 in Chapter Two that states:

And spend in the way of Allah and do not throw [yourselves] with your [own] hands into destruction [by refraining]. And do good; indeed, Allah loves the doers of good (Quran, 2:195).

This verse indicates that the use of intoxicants is potentially damaging one or more of the five essentials of Islam, notably the essential of life (Nafs in Arabic). In Islam there are five essentials (rights) that must be protected and guaranteed to all public members; the preservation of faith practice, the protection of life, individual dignity and honour, the preservation of personal property and sound mind (Sonn, 1996). Therefore, the prospect of damages and threats to these five rights in Islam is the main motivator, and of course this includes personal and public health. Undoubtedly, the negative social and economic consequences of substance abuse are additional aspects. The Islamic prohibition against the use of any substance that affects the person's mind and functions clarifies one of the health notions in Islam, prevention (Rassool & Sange, 2014b). Islam promotes other healthy behaviours and preventive attitudes including personal hygiene, a balanced diet, physical activity, breastfeeding, teeth cleaning and preservation of the environment (Beling, 1980; Hameed, Jalil, Noreen, Mughal, & Rauf, 2002; Jamil, 2014; Mohibullah, Syed Zia-ul-Islam, & Muhammad Waseem, 2014; Stacey, 2013a; Stacey, 2013b).

These verses about alcohol and other substances that affect conscious states are common elements in the content of health communication in Saudi Arabia. The use of these religious texts not only adds a spiritual dimension to the communicating of health issues, but also the preventive spirit of Islamic health teachings. Therefore, Islamic-oriented health communication in Saudi Arabia is preventive in principle, aiming to protect health and promoting a healthy lifestyle according to Islamic codes. Besides, the preventive nature of health communication within the Islamic paradigm supports efforts to change deviant health behaviour.

²⁷ Further details about the Islamic five fundamental pillars are in chapter three, section (3.4).

In one of the events I was invited to attend, the communicators opened the awareness lecture with remarks on Islam's judgement concerning the use of harmful substances and even mentioned the Quran verses cited above (Event 1, 4-12-2012). This event was delivered in a public boy's high school. In their reasoning, the communicators told me that the Islamic messages are powerful and culturally appropriate for the Saudi milieu. In fact, I associate this situation with Participant 23's comment²⁸ about how the Islamic perspective is a powerful element in the fight against drugs and should be included more in communication efforts (31-12-2012).

The use of Islamic texts and verses in communication highlights the cultural awareness about the Saudi environment among the communicators. This illustrates a culturally sensitive approach to health communication, an approach in the literature that considers culture as a set of values that must be considered and integrated into communication practice (Airhihenbuwa & Iwelunmor, 2012; Dutta, 2008; Dutta & Basu, 2011)²⁹.

Furthermore, Islamic opinion was highlighted in one of the radio announcements produced by the Saudi Drug Control Directorate. It said: "With drugs, you lose your religion and your society" (Advertisement Three)³⁰. The message of the advert is to keep people aware of the consequences and appeal to their hearts and minds warning them against breaching the sacred law of Allah (God). It corroborates the students' impressions in the focus groups that the religious stance is always, the initial message they receive from school-based prevention events as well as from public events (Focus group 3, 21-11-2012; Focus group 5, 10-12-2012).

The Islamic perspective on drugs and alcohol is not only grounded in Qurannic verses, but also on the Hadiths for Prophet Mohammed. I came cross references in both Arabic and western literatures to these hadiths and will discuss them in more detail below (Almuetiq, 1985; Alsadlan, 1991; Baasher, 1981; Bahnasie, 1989; Bassiony, 2013; Michalak & Trocki, 2006; Rassool, 2014a; Rassool, 2014b; Sattari, Mashayekhi, & Mashayekhi, 2012). The texts indicate that Prophet Mohammed specifically prohibited substance use among

²⁸ See the previous section 5.4 of this chapter.

²⁹ Additional details about the cultural sensitive approach can be found in section 2.2 in the literature review chapter.

³⁰ I extracted it from Table 4.5 from the previous chapter.

his followers. The Prophet said “Every intoxicant is unlawful and every intoxicant is Khamr³¹” (an-Nasa’i, 2011a). Furthermore, it is reported that the prophet was specific in stating the prohibition included all intoxicants, regardless of quantity: “What intoxicates in large amounts, a small amount of it is unlawful” (an-Nasa’i, 2011b). He explained further the reason for the prohibition saying “Allah forbade every intoxicant and everything which produces languidness” (Abu Dawud, 2011b).

The illegality of substance abuse expands beyond the production, promotion, distribution and use of these substances. As the prophetic tradition indicates, “Allah has cursed wine, its drinker, its server, its seller, its buyer, its presser, the one for whom it is pressed, the one who conveys it, and the one to whom it is conveyed” (Abu Dawud, 2011a). This is a clear call to avoid any association with the use of drugs or alcohol (Baasher, 1981). The prophetic tradition draws the believers’ attention to the moral side of substance abuse, indicating this is one among a range of behaviours that are simply not tolerated among Muslims: “An adulterer, at the time he is committing illegal sexual intercourse is not a believer; and a person, at the time of drinking an alcoholic drink is not a believer; and a thief, at the time of stealing, is not a believer” (Al-Bukhari, 2011a).

Islamic judgement over drugs and alcohol is specifically related to the substance’s effects on the human body’s nervous system, particularly its impact on clarity of thought and consciousness. Some argue that only alcohol (Khamr) is mentioned literally in the Quran and the hadiths and question the extension of the ban to new psychoactive substances (Michalak & Trocki, 2006). But Islam is more general than that and focuses not on particular substances, but on the effect and consequences of those substances.

In the field, these Islamic texts were evidently primary components of the counter-communication challenge to this phenomenon in Saudi Arabia. Within this discourse, the gradual prohibition of substance abuse in the early days of Islam was commonly referred to as an important episode. Promoters argued this evolution of Islamic policy illustrated the mercifulness of the religion in

³¹ The word Khamr in Arabic means wine or any substance has the intoxicants effects.

gradually forbidding the substance. The story of Islam's prohibition of alcohol and other intoxicants is told in three stages.

In the first stage, or revelation, the Quran described how a degree of choice was given to faithful Muslims while there was an acknowledgement, too, that there were certain benefits in the use of alcohol (Almuetiq, 1985; Baasher, 1981; Michalak & Trocki, 2006).

They ask you about wine and gambling. Say, "In them is great sin and [yet, some] benefit for people. But their sin is greater than their benefit." And they ask you what they should spend. Say, "The excess [beyond needs]." Thus Allah makes clear to you the verses [of revelation] that you might give thought (Quran, 2:219)³².

By the second stage, the Prophet Mohammed, the emphasis was on avoiding alcohol to prevent it from interfering with prayer:

O you who have believed, do not approach prayer while you are intoxicated until you know what you are saying (Quran, 4:43).

The last stage was less forgiving and proclaimed a total ban on alcohol and other intoxicating substances³³:

(90) O you who have believed, indeed, intoxicants, gambling, [sacrificing on] stone alters [to other than Allah], and divining arrows are but defilement from the work of Satan, so avoid it that you may be successful. (91) Satan only wants to cause between you animosity and hatred through intoxicants and gambling and to avert you from the remembrance of Allah and from prayer. So will you not desist? (Quran, 5:90-91).

Saudi's political, historical and cultural circumstances facilitate the common acceptance of the prohibition in the Kingdom. Furthermore, these circumstances led to the formal codification of these Islamic teachings into the contemporary Saudi legal system³⁴. Further discussions about Saudi policy and rules related to intoxicants and illicit drugs are included in section 6.5 in the next chapter. The religious prohibition of substance abuse created a cultural antipathy to it too. It remains a non-negotiable pillar of Saudi society and,

³² http://quran.ksu.edu.sa/index.php?l=en#aya=2_219

³³ All these revelations were during the Prophet Mohammed life in the seventh century.

³⁴ The inspiration of the Quran and the Sunna expand beyond the personal comply with the religion rules to cover the governing system. Some commentaries on this issue may point out to the implementation of Sharia law (the Islamic legal framework), which is the case in Saudi Arabia (Farsy, 1990; Long, 2005b; Rudolph, 1984; Weeramantry & Hidayatullah, 1988).

therefore, any discussion about legalising or decriminalising alcohol or drug use is futile.

Likewise, this cultural antipathy created a social resistance to any intoxicants or drug use in public areas or any promotion of these behaviours in any form in the national media or in other imported media content. The strict Saudi Broadcasting rules³⁵, for instance, demand the removal of any alcohol consumption or drug use from the broadcasted scenes even if they were purchased from abroad (Al-Makaty, Boyd, Van Tubergen, & Whitlow, 1996; Marghalani, Palmgreen, & Boyd, 1998). However, media content on the internet and on direct-satellite channels are much more difficult to control, as Participant Two described in section 5.3 (26-09-2012). There exists, therefore, a zero-tolerance attitude to substance use and abuse within Saudi Arabia. The only exception, because of international treaties, are the foreign workers who are permitted to drink alcohol in their homes as well as in places such as diplomatic missions, but of course the use of illicit drugs remains a criminal offence.

However, this legal, cultural and Islamic negation of substance use and abuse also has allowed complacency to creep into Saudi Arabian society. The phenomenon was not put under the spotlight as outright prohibition dulled any official willingness to acknowledge its existence. In section 6.5 of the next chapter, I will highlight how the focus on health communication and promotion against alcohol abuse and alcoholism shifted in Saudi Arabia from the 1980s to the present time.

The Islamic concept of prohibition is preventative in nature and is intended to stop the problem occurring in the first place. However, Saudi Islamic culture is rich with values that promote change and support to those in need. Most importantly, the concept of *Tawbah* (repentance of sin) has emerged consistently in the study data. According to Participant 19:

The drug users have a sense of guilt when they use substances, and they do not use them with satisfaction in relation to Islam's stance on intoxicants and that's what distinguishes our society. In other places, the drug addict or alcoholic is a person with health and psychological problems and may need medical intervention. However, in our

³⁵ The Saudi media policy is based on respecting the Saudi society Islamic beliefs and values, so forbidden or prohibited issues are not permitted to be aired on TV or appear in magazines, for instance, sexual intercourse.

society it's not only a health and social problem, but also a sin that requires repentance (Tawbah). In fact, the sinful side of substance abuse helps remind people (audience) through the health promotion messages that illicit drug use is a sin. Such a tactic cannot be used in a non-Islamic context or where there is no belief in the Islamic perspective on substance abuse (Participant 19, 24-12-2012).

Just as prohibition displayed Islamic antipathy to the use of substances, the Tawbah presents the road to redemption. In fact, Tawbah appeals to the personal desire of the substance user as motivation to stop and change. Therefore, in promoting against substance abuse, health communicators in Saudi Arabia use Islamic prohibition to show both society's refusal to accept substance abuse and, at the same time, encourage abusers to embrace Tawbah in the hope that they will change behaviour and revert back to normality.

In events 3 and 9, I observed closely how the concept Tawbah was used to motivate the audience. In event 3, a school-based prevention programme, the drug control department preventive team in their presentation to the young students emphasised the illegality of consuming drugs and alcohol based on an Islamic interpretation (Event 3, 19-12-2012). Also, to meet the event theme which was about time management, the promotion team highlighted the negative implications of illicit drug abuse on time management. Likewise, communicators delivered a message on the merciful side of Islam in abandoning the behaviour and the forgiveness of Allah and the welcoming of the Muslim communities to those who had abandoned risky behaviour (Event 3, 19-12-2012). There were two patterns of communication in delivering these two notions; direct-communication with the students and through the use of printed flyers.

Similarly, event 9 was a collaborative work between public agencies in a small town to promote against drug abuse and other risky behaviours from a religious perspective (Event 9, 31-01-2013). The organisers used direct communication through lectures as main method of conveying their ideas, including reciting texts from the Quran and/or the Prophet (Event 9, 31-01-2013). Tawbah was mentioned specifically in these lectures.

The use of Tawbah in communicating around health and substance abuse underlines what Participant 2 referred to in the previous section, namely the centrality of an Islamic logic in health communication in Saudi Arabia (24-9-2012).

The implications of Tawbah extend beyond communicative efforts to the legal side of prevention. In the latest Saudi Anti-Narcotics law, there is an endorsement of a soft attitude toward drug users and addicts who voluntarily go to hospital to seek treatment, and the law is clear that there should be no charge against them unless a criminal offence had been committed (Saudi anti-Narcotics and Psychotropic Substances Law, 2005).

The concept of seeking a cure is a key component of the Islamic model of substance abuse in Saudi Arabia. Those who repent to Allah about substance abuse are encouraged to seek medical intervention. This encouragement is based on the notion in Islam that health is a gift from Allah and maintaining good health is an obligation for every Muslim (Mohibullah et al., 2014; Rassool & Sange, 2014b). This recalls one of the five essentials of Islam, mentioned earlier, the protection of life as a right for everyone. Therefore, Muslims follow Allah's teachings in the Quran about health and illness. Foremost, Muslims believe that all suffering from illness and healing and even dying are in Allah's hands. For instance, "And if Allah should touch you with adversity, there is no removal except by Him. And if He touches you with good - then He is over all things competent" (Quran, 6:17), also in another place in the Quran "And when I am ill, it is He who cures me" (Quran, 26:80).

However, the Islamic belief in God's power over illness and curing does not contradict the encouragement to seek treatment from health facilities or to take advice from science-based health consultants. In fact, the Prophet Mohammed was reported as having said on many occasions that he embraced the maintenance of good health³⁶. It is reported that he said: "There is no disease that Allah has created, except that He also has created its treatment" (Al-Bukhari, 2011d). Indeed, the prophetic traditions promote the rights of the

³⁶ There are two books of hadiths for the prophet Mohammed, one about the medicine and the other about patients. In addition, there is the prophetic medicine that contains the prophet Mohammed hadiths about broad principles of health, statements about particular illnesses such as the plague, and the prophet's statements about what believers are supposed to do. These statements are known, also, as the Prophetic Medicine (Sonn, 1996).

body, it is reported that the prophet said “Your body has a right over you” (Al-Bukhari, 2011e). In this respect Khayat said:

This right requires each one of us to feed the body when it is hungry, rest it when tired, clean it when it gets dirty, protect it against all harm, take precautions against subjecting it to illness, provide it with the necessary treatment when it suffers from disease, and not to overburden it in any way (2004, p.11-12).

Thus, there is a clear urge in Islam to keep faith in Allah (Tawakkul³⁷) and work towards recovering from illness³⁸ as well as sustaining a healthy lifestyle. Together Participants 20 and 23³⁹ pointed out that Islam urges Muslims to heal their bodies. They referred to the establishment of addiction and rehabilitation health facilities in Saudi Arabia as a response to the Islamic imperative to search for treatments and cures for illnesses (Participant 20, 25-12-2012; Participant 23, 31-12-2012). A large number of studies in neurology and on the subject of addiction over the last century have identified illicit drug abuse and alcoholism as illnesses caused by dangerous behaviour, requiring medical intervention (Bukoski, 1991; NIDA, 2005). So, the Islamic concept of seeking treatment is relevant here. Furthermore, Islam’s positive understanding of seeking treatment underpins the way in which the Saudi Drug Control Department tailored its anti-drug promotional radio advertisements. For example, in the fourth advertisement “Drug use is a dark pit, go only with treatment and motivation to leave it” (Advert four). Advertisement 11 provided information on where to go to get treatment “Dear brother⁴⁰ patient, Al-Amale hospitals were built to help you, so take the initiative and step forward for treatment before it’s too late” (Advert 11)⁴¹.

Further discussions about the circumstances behind the introduction of health services for addicts are included in the next chapter, section 6.5. On the whole, the Islamic principles of the body’s rights and the seeking of a cure

³⁷ This means reliance on God (Allah) and trusting in God’s plan.

³⁸ In Islam, illness has three possible reasons; punishment of sin, a test from Allah to the believer’s patience and gratitude, or a natural or biological cause (Rassool & Sange, 2014b).

³⁹ They both hold experience in delivering health services, Participant 23 in his role in the Saudi Ministry of Health and Participant 20 in his long experience in the Islamic Humanitarian aid sector. For further details about them see table 4.2 in section 4.4.1 in Chapter four.

⁴⁰ This means brother in Islam and in the country, because in Saudi Arabia all Saudis are brothers on the basis of Saudiness, Arabness and as part of the Islamic brotherhood. So the advert delivered a sense of identity as well.

⁴¹ I took them from Table 4.5 in the previous chapter.

facilitate addicts stepping forward to ask for help, since that is what Allah (God) urges Muslims to do and this is embedded within Saudi Islamic culture.

Besides the religious-oriented encouragement for seeking treatment, the Islamic model of substance abuse includes a fourth concept that's stimulated communication and promotes health-related information. This concept is Da'wah, the promotion of virtues and the prevention of vice. All the health communicators and preventionists in the study came to the conclusion that what they do is a religious duty to promote the rules of Islam on illicit drug use and the consumption of alcohol, and they seek Allah's rewards for this in the hereafter (Prevention team focus groups 1,18-11-2012;Prevention team focus group 3,26-12-2012). As one of the participants described it, "As a health promoter you have to believe in what you do as part of your religious duty as a Muslim. Without this belief your efforts will be meaningless" (Prevention team focus groups1,18-11-2012).

So the communication of Islamic teachings about substance abuse has emerged as a part of Islam driven by the doctrine of promoting virtue and preventing vice. Many of the participants described their work in schools, lecturing to young pupils or organising open health promotion exhibitions or distributing printed health promotion materials as activities that deepen their faith and strengthen their links to Allah (Participant 5, 3-10-2012; Participant 11, 28-11-2012; Participant 17, 16-12-2012). Participant 5 said:

When I stand in front of the students in the class and deliver to them Allah's rules on substance abuse and explain to them the Prophet Mohammed's guidelines as well, I strongly believe that I am promoting Islamic rules, so Muslims can be more responsible about the way they behave as well as preventing any misconduct. I am confident what I do will be valuable in the future for these pupils by protecting them from thinking about taking drugs or alcohol. And by doing so I am waiting for Allah's blessings and rewards (Participant 5, 3-10-2012).

In his reflective comment, he highlighted the Islamic roots of the propagation of Islamic rules, and their strong presence among health communicators. It is important, therefore, to explain the Da'wah concept.

The concept involves two elements; the doctrine of promotion of virtue and prevention of vice on the one hand, and the practical side of Da'wah on the

other hand. The doctrine of promotion of virtue and prevention of vice is deeply rooted in Islam. Indeed, the political and religious history of Saudi Arabia is full of references to the wider acceptance of this doctrine and its use by the previous states in the Arabian Peninsula and beyond (Bin Humaid, 2010). The doctrine, which is referred to in the Quran and by the Prophet, encourages the diffusion of Islamic principles among Muslims to protect the moral system and to guide Muslims to live according to the Islamic code (Al-jalal, 2010). In different chapters of the Quran there are references about this doctrine. For example, “They believe in Allah and the Last Day, and they enjoin what is right and forbid what is wrong and hasten to good deeds. And those are among the righteous” (Quran, 3:114).

Furthermore, Muslim scholars identified reasons for this doctrine, namely reinforcing the guiding function of Islamic principles, enhancing mutual care between society members, preserving Islamic values, and strengthening the religion (Bin Humaid, 2010).

So this doctrine explains the need and the duty of Muslims to keep the Islamic spirit and Islamic ethics alive in society, and to do so the Da’wah is the way to deliver these codes and teachings. As Participant 5, explained previously, the combination of activities he undertakes to promote Islamic rules about substance abuse is part of his faith (Participant 5, 03-10-2012). It is also compatible with what Ahmad el al said about Da’wah as activities aimed at strengthening and deepening the faith of Muslims to live in conformity with the rules of Islam (Ahmad, Harrison, & Davies, 2008). Islam did not put the responsibility of the promotion on individuals only. Actually, the responsibility falls on the authorities or those with political power.

In contemporary times, the state is the modern form of political power. Since, Saudi Arabia was formed on an Islamic basis⁴², the promotion and propagation of Islamic teachings is deep rooted in the Kingdom’s Basic Law and in practice. For example, Article 23 of the Saudi Basic Law declares that “the State shall protect the Islamic creed, apply its *Shari’ah*, enjoin the good and prohibit evil, and carry out the duty of calling to God” (Saudi Basic Law, 1992). In this respect, specialised Saudi public organisations are responsible for

⁴² For further details about Islam and Saudi Arabia see section 3.4 in chapter three.

promotion (see table 6.1 in the next chapter), such as the security and law enforcement agencies, medical agencies, and education authorities. However, those Muslims who work in these organisations in the country believe this work is motivated by their faith.

Furthermore, there are three approaches to deliver Islamic rules (Da'wah); first, the legal approach to what is prohibited and what is permitted in Islam (see next chapter), second, by preaching and communicating Islamic ethics, values and rules (Islamic communication) and, third, through healing (Qurannin, or spiritual healing) (Ahmad et al., 2008; Rassool & Sange, 2014b). The last approach refers to the belief in the recitation of particular verses from the Quran for patients, especially those with mental illness, as an effective way to heal the body and soul (EL-Islam, 2009; Jamil, 2014; Rassool & Sange, 2014b; Sense, 2013). This has proved a successful approach, according to recent studies (Koenig & Al Shohaib, 2014; EL-Islam, 2009; Jamil & Dutta, 2011; Jamil, 2014; Koenig, Zaben, & Khalifa, 2012; Koenig, 2012).

In keeping with the previous three concepts, the doctrine of promoting Islamic rules and a healthy lifestyle extends beyond substance abuse and covers many aspects in Islam related to health such as diet, exercise or economic issues such as the prohibition of usury. In other words, this concept is holistic in nature as a mechanism aimed at diffusing and promoting the rules of Allah among Muslims. It creates social acceptance around the work of health promoters and motivates these practitioners to carry out their work driven by their faith (Focus group 1,18-11-2012).

The four concepts of the Islamic model shed light on the health beliefs that are active in Saudi Arabia since it was founded. They promote positive aspects in relation to fighting the problems of illicit drug use and alcohol abuse such as encouraging change, inclusiveness, forgiveness, caring and prohibition. This relationship between religion and health has fascinated scholars from the medical realm, sociology and, most recently, from health communication and promotion (Koenig, McCullough, & Larson, 2001; Koenig & McCullough, 2001; W. Miller & Thoresen, 2003; Silverman, 2006).

A growing number of studies has emphasised the positive relationship between religiosity and good mental health (Koenig, Zaben, & Khalifa, 2012;

Koenig, 2008), while other studies have highlighted the attitude of risk avoidance held by members of communities driven by religious beliefs (L. Miller, Yrisarry, & Rubin, 2011). Koenig et al. have extensively examined the relationship between religion/spirituality and mental health and affirmed the positive relationship between the involvement in religious activities and good mental health. As a result, they have called for additional research into the clinical implications of such a promising area (Koenig, 2012; Koenig et al., 2001). Furthermore, the call extends to study the relationship between religion/spirituality and physical health (Koenig & McCullough, 2001; Koenig, 2004; Koenig, 2010).

Within the considerable interest in exploring the relationship between health and religion, the issues of drug and alcohol use have also been examined. The outcomes also demonstrated a positive connection between religious involvement and a relatively low level of alcohol use and/or illicit drug abuse. In their systematic review of studies about the connection between religion/spirituality and substance abuse published before 2000, Koenig et al. found a significant number of these confirmed the low level of substance abuse by individuals involved in religious activities (Koenig et al., 2001; Koenig, 2010). Furthermore, Wallace et al found that the level of addictive and risky behaviours of high school religious seniors in US colleges was low (Wallace Jr. & Forman, 1998). Similarly, other scholars have discovered a high level of abstinence from alcohol use in the United States among American Muslim college students (Arfken, Ahmed, & Abu-Ras, 2012; Arfken, Abu-Ras, & Ahmed, 2009; Arfken, Arnetz, Fakhouri, Ventimiglia, & Jamil, 2011). Although it is beyond the scope of this chapter to examine the link between religion and the prevalence of substance abuse, I will compare my data findings here to what has been done so far by other scholars in this area.

The holistic perspective to health in Islam exists where the personal, community, mental and spiritual health are intertwined; any failing in one of these has the potential to destabilise the whole health of the public. The protective meaning embedded in the concept of prohibition illustrates how a religious belief can be used to deal with a problematic health issue. As the

participants of my study revealed, the favoured view of forgiveness and integration held by Saudis toward those who want to change themselves i.e. stop abusing alcohol/drug, symbolises the strong belief in the concept of repentance (Tawbah). It also shows the existence of religious teaching in giving social support to other community members in need. The Islamic model concepts carry protection, caring and support aspects.

Indeed, the literature contains some examples of analogous attempts by researchers to discuss the precise influence of religious beliefs on health. For example, Koenig et al examined three facets of religion to discover its potential effect on health: the role of religion as a coping tactic, as a source of social support, and as a behavioural modifier (Koenig, 2008). The results showed that people depend more on religious principles and practices in times of stress and that prayer is one coping strategy. The study also showed that the level of social support within religious communities was substantial. Most significantly, religious beliefs were an important motivator for changing behaviour: “The daily, habitual decisions that we make in response to life’s temptations and challenges are often influenced by religious beliefs. This is particularly true when such decisions have ethical implications and potentially stressful consequences” (Ibid, p.57-58). Jantos et al. reached a similar conclusion in recognising the connection between prayer and improving health (Jantos & Kiat, 2007).

Although religion offers positive aspects, such as social support, a concrete moral and belief system, and a sense of existential purpose, it is not the only source (Eckersley, 2007). An individual could obtain these benefits from other places. In other words, “religion is no panacea when it comes to improving health” (Ibid, p.54). Moreover, more promising results have emerged from a systematic review of studies testing these three elements in Muslim samples (Koenig & Al Shohaib, 2014).

Muslims believe this approach to health to be the Divine law from Allah, which, in turn, impacts on their beliefs about illness, risky behaviour, and risk avoidance. All these Islamic health beliefs are positive, protective, preventive and put the health of society and individual at the centre of care and support

efforts. In spite of all this, the incidence of illicit drug use and alcohol abuse in Saudi Arabia have increased dramatically from 4,000 in the 1980s to over 30,000 by 2010⁴³ (MOI, 1979; MOI, 2011). This shift cannot be blamed on the failure of the Islamic model and its principles. Instead, it marks the failure of the Saudi substance abuse prevention and communication sector to cope with growing health and social challenges. In fact, many of the study participants (i.e. 5,16,19,20 and 23) have pointed to the way these Islamic health beliefs are communicated to young Saudis as the primary cause of this failing, despite the fact that Saudi authorities identified the young Saudis as those at high risk of falling into illicit drug use or alcohol abuse (Participant 22, 31-12-2012).

Saudi authorities' failure to communicate effectively about Islamic beliefs and substance abuse is also not the only reason for the increase. The Saudi modernisation projects of the 1960s-70s brought massive demographic change to the Saudi demographic structure. There was a substantial increase in the number of multi-backgrounds guest workers as well as the number of Saudis in general. In 1974, the total population was 7 million; by 2010, it was over 27 million⁴⁴. This demographic shift has exacerbated the problem. Furthermore, the cultural transition mentioned earlier, in section 5.3, adds more pressure to the Saudi health communication mechanism. Criticisms of the current system of health communication in Saudi Arabia will be discussed below.

The participants in this study identified four primary ways to communicate health messages related to illicit drug use and alcohol abuse. They were: through the mass media, schools, open events aimed at the public, and mosques. In all these layers of communication, the influence of the Islamic model was evident in terms of the content of the messages and the use of religious-based platforms and events to communicate health messages to the targeted audience.

Most of the health communicators, health promoters and substance abuse prevention teams I met stated that the main target audience was young

⁴³ For further details about the statistical evidence of substance abuse in Saudi Arabia look at section 6.6 in Chapter Six. Also look at charts 6.1, 6.2, 6.3 and 6.4.

⁴⁴ More details about the Saudi demographic in chapter three, section 3.2.1, and in table 3.1 in chapter three.

Saudis aged between 15 and 25 (Participants, 3,8,10,18,19 and 22), because the Saudi Ministry of the Interior's records had found that this age group was at the highest risk (MOI, 2011). Furthermore, the majority of individuals caught by Saudi law officers for substance abuse came from this age group. Those participants who work with young Saudis detailed some risk factors pertaining to this age group. First, this is the age where young people develop a sense of identity (Participant 5, 3-10-2012; Participant 7, 3-10-2012; Participant 16, 16-12-2012). The participants identified the transition from adolescent to adulthood as a critical factor. The desire to try new thing was considered as another challenge driving the substance-abuse problem within this group in Saudi (Ibid). Participant Five added that deprivation, in terms of low income and parents' separation, was also a risk factor (Participant 5, 3-10-2012).

Despite the intense focus on young Saudis, the different layers of communication were criticised by some of the health communicators and by most of the students who participated in the study. Beginning with the mass media, health communicators 10, 15, 19, 22 and 27 referred to the use of radio and television as important tools in their work to communicate messages (2012). In theory, various scholars of public communication campaigns acknowledged the crucial role the mass media can play in promoting health and changing health behaviours (Coffman, 2002; Noar, Harrington, & Helme, 2010; Wakefield, Loken, & Hornik, 2010); others also found positive outcomes through the use of mass media in health communication (Snyder, 2007; Westcott, 2014).

There are two major organisations in Saudi Arabia that are currently distributing health messages through the mass media; the Saudi National Committee for Narcotics Control and the Saudi Drug Control Law Enforcement Department⁴⁵. The use of this tactic in Saudi was accompanied by both faults and weaknesses. During my fieldwork trip, for example, I found that health communicators and promoters do not have an adequate record of their mass media activities in terms of televised advertisements, radio announcements and press releases. In other words, there is no mechanism for tracking these

⁴⁵ Occasionally, the Saudi Ministry of Health also produces mass media messages for the same segment group, young Saudis.

activities, such as what steps were taken to design the message as well as the dates, times and frequency of its broadcast. So there was a clear absence of quantitative and qualitative information about health communication activities in the mass media⁴⁶. These details about campaigns are vital for evaluation purposes and for creating future research projects⁴⁷ (Atkin & Freimuth, 2001). Therefore, it was hard to verify the participants' criticism that this level and type of communication was top down and less culturally diverse.

As I mentioned in section 4.4.1, health communication and prevention teams occasionally referred me to radio advertisements that were broadcast during my trip, but I found very little qualitative or quantitative information about their design, preparation or distribution. Furthermore, these advertisements were meant to reach young Saudis, but most of the students I met in focus groups 1 to 6 had no knowledge of the advertisements (2012). Although they were broadcast on the national radio station, they had little chance of reaching young Saudis because of the growing popularity of newly private radio stations as well as the ambiguity surrounding their broadcasting schedule. Importantly, the emergence and popularity of social media, i.e. Facebook and Twitter, in Saudi Arabia⁴⁸ has signalled a key shift in the traditional media audience.

Health communicators were also not able to identify the particular times or seasons when they used the mass media. Therefore, its use appeared to depend on the communication team's efforts and desire or be the result of a decision from the top authority, such as a minister or the general manager of the responsible organisation. There was thus a lack of proper planning for the use of mass media in anti-substance abuse communication.

In addition, the lack of information about the preparation and implementation processes of mass-media health messages should not deter us from looking at the other issues relating to communicating about substance abuse via the Saudi mass media. Participants 10, 15, 19, 22 and 27, who supervised some of these mass media campaigns, defined Arabic as the one and only language of these messages and said that Islamic health beliefs

⁴⁶ Additional discussions about that in section 6.4 in Chapter Six.

⁴⁷ Section 2.3 in Chapter Two contains further discussions.

⁴⁸ For further details, see section 3.5 in Chapter Three.

contributed to their content (2012). Indeed, none of these participants or other health communicators referred to any involvement of either young people or communities in the design of these mass media messages or campaigns. In other words, there was an overwhelming vagueness surrounding the formative stages⁴⁹ of mass-media communication.

This layer of communication exemplifies the use of a top-down communication technique, i.e. from the organisation striving to prevent substance abuse down to the audience. It aims to reach those at risk, but it is not clear whether or not the objectives were achieved or not due to the lack of any evaluation tools,⁵⁰ such as summative research, to assess the effects of the messages. This practice depicts a traditional approach to health communication, one that comes from the experts on high down to the receivers, who are expected to absorb it completely (Dutta, 2008).

As young people constitute the key target group, school-based communication activities⁵¹ were described as being central to the government's and to NGOs' efforts to combat substance abuse. Participants 3, 4, 10, 15, 16, 17, 18, 19, 22 and 27, who work for substance abuse prevention organisations, visit schools to speak against illicit drug use. Indeed, their efforts are an example of how outsourced health information services form the substance abuse prevention sector for schools. In contrast, participants 5, 6, 7, 9, 11, 13 and 14, who are based at schools (public and private), claimed that there are the internal sources for health information and events in the schools, which either run by staff or by outside health promoters. In this instance, schools coordinate with relevant organisations to enhance the students' health awareness by hosting health communicators.

Many scholars believe that recognising the potential role schools could play in the fight against drug and alcohol abuse is a good and correct first step (Helme, Savage, & Record, 2015; Wilkinson, 2013), but there are some issues that need further attention to enhance the efficacy of these efforts. Foremost, a school-based approach is ideal for addressing the needs of local communities

⁴⁹ Campaign formative and evaluation research is discussed in length in section 2.3 in Chapter Two.

⁵⁰ The discussion about evaluation will come again in section 6.6 in Chapter Six.

⁵¹ They refer to activities outside of the classroom that are not included in the curriculums.

with respect to youth and the issue of substance abuse. Usually, this approach uses segmentation to identify the target audience and the specific risky behaviour that needs to be addressed (Wilson & Kolander, 2003). However, the students I met with criticised the health-awareness events at schools. Indeed, taken with my own experience from the school-based events⁵² I attended i.e. Event 1, held on 4-12-2012, and Event 3, on 19-12-2012.

The study focus group students identified lectures, exhibits or both as the basis for health communication activities in schools. Says one:

In my high school, I remembered teachers organised a one hour lecture for someone mostly from the Mukafah⁵³ to come and speak about drug-use hazards and the enormous benefits from staying away from drugs. On other occasions, my school set up an exhibition about drug use. I went to that once, and it was a collective group of posters about the hazards of drugs and the government's efforts to seize illicit drugs. I also saw pictures of the smugglers' methods of smuggling. There were people there who answered our questions (Participant 2 in Focus Group 4, 10-12-2012).

The use of lectures and exhibitions at school-based events established direct means of communication to reach pupils. However, the student participants raised different questions about these. One student described his recollection of such an event:

In our school, we had similar events, and even the same presenters came to our school. Indeed, they delivered the warning messages about the hazards of drugs and the prohibitions of Islam, but they never sat down and talked with us about our problems or what we thought about drugs. In exhibitions, too, there was little conversation, and we were exposed to the pictures and posters about drugs. I think, the government or whoever is responsible needs to change this classic way (Participant 3 in Focus group 4, 10-12-2012).

⁵² For further details about the Events look at table 4.4 in Chapter Four.

⁵³ It means the Saudi Drug Control Law Enforcement Department in Arabic.

Although school-based communication is a key in Saudi Arabia's efforts to combat drug use, Participant Five recognised weaknesses in the schools events. He believed the lack of planning, proper preparation and design was the source of these deficiencies (Participant 5, 03-10-2012). For example, the notification of a health-awareness lecture or exhibition usually only reaches the teachers and those responsible for school health events a week or so before the proposed event. Participant Five, along with 6, 7, 9, 11, 13 and 14 confirmed that the 26th of June is an important day in the school calendar, because it is the International Day against Drug Abuse and Illicit Trafficking and most of the school celebrate it by running drug and alcohol awareness events (2012).

In contrast, all the substance abuse prevention events organised at the school level depend on personal contacts between the programmes coordinators in schools and health communicators. In fact, all the events I went to were organised through the personal contact of the two organisations' coordinators; due to the absence of planning, these were not based on the school's needs. (Event 1, on 4-12-2012, and Event 3, on 19-12-2012). Because neither the school in question nor the corresponding prevention organisation conducted the necessary research, these events were generic and not properly planned. Furthermore, the participants attending these events did not mention any measures for assessing the programme's effectiveness. The absence of evaluation and planning resulted from not using the existing theory correctly to prepare and implement substance abuse communication programmes (see Atkin & Freimuth, 2001; Atkin & Rice, 2013). While internet penetration has jumped in Saudi Arabia, especially among young people⁵⁴, these school-based programmes have not integrated this new technology. The value of including the internet in school-based programmes has been recognised by Helme et al.:

The internet has also advanced the capabilities of school-based interventions. Indeed, one of the biggest changes that the internet affords is the ability to connect with the students without the intervention staff having to walk in the classroom (2015, p.403).

⁵⁴ Further details about the internet and social media in Saudi Arabia are discussed in section 3.5 in Chapter Three.

Despite the reliance on top-down communication, the absence of dialogue with young people, and the lack of internet integration, school-based efforts still successfully communicate abstract health information about the dangers of using and abusing drugs and alcohol as well as Islamic health beliefs. The major language of these efforts is Arabic, which might isolate pupils who are not proficient in Arabic. It is thus crucial to adopt a more diverse approach in terms of the language used. Figure 5.1 below provides a good example of what a substance abuse prevention exhibition looks like. I took this picture during my visit to a school-based exhibition (Event 10, held on 9-10/02/2012). In the middle, there are tables where the organisers exhibit materials confiscated from individuals who tried to smuggle illicit substances into Saudi Arabia. The rest are posters, which the students previously described in terms of their common content.



Figure (5.1) an anti-drug promotion school-based exhibition.

Unfortunately, the same critics of the schools-based programmes were dismissive of the direct communication of the promotional exhibitions. As I found, one of the methods that Saudi substance abuse preventionists use to communicate health messages is the open exhibition. This was described by the participants as an exhibit open to anyone to come and view the exhibition's sections about drug types, the negative effect of drugs on the human body, the negative social consequences and the government's efforts to catch smugglers and dealers (Participant 24,01-01-2013; Participant 22, 31-12-2012). These messages are presented in poster-sized texts and pictures (Ibid). They are divided into sections, i.e. the government's efforts, drug types, drug abuse symptoms and the Islamic view of the matter (Ibid). There were two types of exhibitions: permanent, based at an organisation's location and open to visitors, and temporary in terms of length and location, being housed in a shopping mall or a public hall, for example. See Table 4.4 in Section 4.4.1 for more details about the events I attended. Similar to the school exhibition, the open exhibition used fear to deliver its messages. There were two types; the fear of breaching Islamic beliefs about intoxicants and concern about the medical consequences of drug use on the human body (Ibid).

Furthermore, the communication style here is also top down, from the health communicator to audience, and the language used is also Arabic. As a result, there is a clear lack of cultural diversity in this approach. Indeed, the health communicators were struggling to justify to me what theories or approaches they used in designing these events. In addition, within the health communication teams, there were no concrete ideas about the reasons for selecting certain exhibitions times and places except for the use of the Saudi National Day, 23rd September, the International Day against Drug Abuse and Illicit Trafficking, and during semesters breaks or religious holidays, because most of the public has free time to go to parks and shopping malls where these open exhibitions are usually held. I went to an open exhibition in a shopping mall in the city of Mecca (Event 8, 22-01-2013), for example, while Event 9 was held in a public square in a Saudi town (31-01-2013).

The vagueness surrounding the identity of the target group makes the achievement of an event's aims difficult if not impossible, because scholars of public communication scholars define the target group as the core to

communication success (Salmon & Atkin, 2003; Wright, Sparks, & Dan O'Hair, 2012). The use of Arabic as the language of communication isolated those attending the events who do not speak the language. All of the exhibitions I visited shared this practice. Figure 5.2 below shows a sample of smuggling methods included in one of the permanent exhibitions I visited; namely Event 5 (31-12-2012).



Figure (5.2) an anti-drug promotion open exhibition.

To end with, faith-based or mosque-based communication is common in Saudi Arabia as a means of challenging substance abuse. Inseparable from the Islamic-oriented perspective of health dominating the Saudi context; communication about illicit drug use and alcohol abuse is conducted in, by and through the mosques, a practice consistent with the country's current political system based on Islam⁵⁵. A 'mosque' in Arabic is Masjid and refers to the place where Muslims pray and carry out their rituals together. Muslims pray five times

⁵⁵ For further information about the Saudi political system, see figure 3.2 in section 3.4 in Chapter Three.

a day and have a sermon once a week, at Friday prayer⁵⁶. Together Participants 22 and 10 clarified that mosques are the centres of the communities in Saudi Arabia (2012). Indeed, they referred to the importance of using the Friday prayer sermon (khutbah⁵⁷) to reach community members, because attendance is high at this time.

The religious status of mosques impact on the possible communication opportunities to convey the health messages to the mosque's community members. Three methods were identified by local imams and health promoters; communication about substance abuse in Friday prayer sermon, the use of mosques by prevention organisations and by exhibitions outside the mosque (Participant 5 and 11, 2012). Religious institution as a hub for health communication was considered as a promising platform for various characteristics about the faith communities; the existence of health beliefs, affiliation with the religious community, strong intra-relationship and purpose for life (L. Miller et al., 2011).

Furthermore, the participants identified three types of health communication activities in mosques. First, the imam designs the health messages and communicates them with Muslims in either a Friday prayer sermon or via a prepared lecture (Participant 5 and 11, 2012). Mostly, the Imams use Islamic references about the Islamic perspective in health and substance abuse. They also use the internet to search for medical information about substance abuse to include in the sermons (Ibid). In contrast, the use of mosques as a platform for substance abuse prevention organisations is the second type (health communication through mosque). The health communicator participants⁵⁸ in focus group two referred to the use of mosques in religious events such as Ramadan or Friday prayer to deliver their presentations after the prayer finished and to distribute flyers (06-12-2012). So the Imams do not intervene in the health messages preparation, but the participants were clear that the messages were mostly about the Islamic health beliefs and scientific information about drugs (Ibid). The last communication type is providing

⁵⁶ The topic of prayer (Salah) in Islam was discussed in section 3.4 in Chapter Three.

⁵⁷ The Arabic word for Friday prayer sermon.

⁵⁸ These participants work in a NGO in Saudi Arabia.

communication and counselling services in the mosque for the community members by a mixture of health specialists and the Imams.

Constant health counselling in mosques mostly depends on size, donations and budget⁵⁹ of the mosque. The personal skills and ability of the Imam is another determinant of the level of mosque-based health communication. Furthermore, more languages need to be used and the integration of locals into the design and implementation of the mosque programmes needs to be facilitated. Faith-based communication has attracted the attention of researchers and evidence suggests it can be effective (Bader, Musshauer, Sahin, Bezirkan, & Hochleitner, 2006; Parrott, 2004). The next chapter will discuss mosque communication further in section 6.3 and additional recommendations and future directions will come in Chapter Seven.

All three layers of communication share common challenges that require further consideration. These include the absence of community-focused projects and the need for more campaigns and programmes based on communication theories. A more culturally diverse approach is recommended to enhance the efficacy of health communication programmes.

5.6 Conclusion

In recent decades the role of culture in health communication has been investigated extensively. It has proved to be a crucial strategy in sustaining health and in modifying health behaviours. This chapter demonstrated the role an Islamic-oriented culture plays in promoting health messages and in preventing risky behaviour, such as substance abuse. Since Saudi culture has Islamic historical roots, these continue to be important in the present Saudi context. The influence of Islam extends beyond culture and encompasses attitudes to health, among other beliefs and practices in Saudi Arabia.

This chapter has illustrated the major influence that Islam exerts on health communication about illicit drug and alcohol use. On the whole, Islamic health beliefs impact on Saudi society and its cultural stance towards substance abuse. The four concepts of the Islamic model contain values and principles that are encouraging to those who want to change themselves and stop abusing

⁵⁹ Because these are the mosque financial sources.

alcohol or drugs. They also support those who want to get medical treatment for addiction. Most importantly, the concept of prohibition is crucial in protecting Muslim society from risky behaviour, i.e. substance abuse. Furthermore, this chapter highlighted the preventive nature of this concept. Further discussion about the legal implications of this concept in Saudi Arabia will come in the following chapter, in section 6.5. In the same way, the Islamic concept of Da'wah has provided favourable religious grounds for fighting against the illicit use of drugs and alcohol. Saudi society respects what health communicators do because they are promoting Allah's teachings. This also underpins health communicators' understanding of what they do and forms part of the Islamic doctrine of promoting virtue and preventing vice.

The holistic perspective of health in Islam needs to be at the centre of all future health communication efforts in Saudi Arabia. In Chapter Three, particularly in sections 3.2 and 3.3, I draw attention to the Saudi development projects of the 1970s-80s and the Saudi authorities' intention of continuing to implement such programmes. This requires a communicative approach that is both participatory and inclusive.

Health communication organisations need to adopt a community-based approach in designing their programmes in order to best identify a community's needs and the problems it faces in relation to substance abuse. Indeed, the youth in Saudi Arabia should be given more space to develop these projects by engaging in formative and summative research activities. Furthermore, the Saudi authorities need to increase health education programmes for health communicators in order to improve their use of communication theories in designing communication efforts⁶⁰.

This chapter showed that Saudi health communication about substance abuse suffers from the absence of other, non-Arab voices in the effort. In other words, the government's intention to pursue development and host the nine million guest workers who already live in the Kingdom requires a more culturally diverse approach, especially in terms of language, in order to integrate their voices into the design of health communication projects.

⁶⁰ Further details about the study recommendations and future research can be found in Chapter Seven.

There is also a need to use information technology and social media appropriately and in an active way to maximise participation and interaction, especially in light of the growing popularity of social media among Saudis, in particular young Saudis. Social media provides an effective way to sustain a good connection with the audience at low cost. This chapter highlighted this aspect as a promising area in practice and in research terms. The next chapter will address the circumstances that led to the emergence of health communication in Saudi Arabia.

Chapter Six: Government-led health communication in Saudi Arabia

6.1 Introduction

This chapter continues to present the data emerging from this study. I am specifically setting out here to answer the secondary research question: *How did health communication aimed at preventing drug abuse and the consumption of alcohol evolve in Saudi Arabia?*

The previous chapter offered an analysis of the Saudi-Islamic-cultural influences in health communication against substance abuse, including the importance of the Islamic model. This chapter attempts to bridge the gap between the early days of communicating health, illness, and healing on drug and alcohol issues in Saudi Arabia and the present time. I will focus on the principles that led to communication against substance abuse¹ in the Kingdom. To my knowledge, this chapter represents the first attempt to tell the story of how health communication has been used in Saudi Arabia to combat substance abuse. The data has been gathered from the unwritten and unstructured experiences of health communicators and from the collected physical evidence (such as annual reports, national strategy documents, policy and Saudi anti-narcotics laws).

The narrative review of health communication both from its practical and theoretical aspects has become a standard approach in the field. It has proved a useful device for assessing the development of health communication, but also to identify future directions and challenges. There are many scholars who have worked in this area, but most of this work has been western-centric (Dutta, 2008; Kar et al., 2001c; Kreps, 1989; Kreps et al., 1998; Kreps, 2014). This chapter also attempts to shed light on the motivations that have been driving health communication efforts to counter the problem of narcotics and alcohol intake in this culture. Additionally, it will bring attention to the current status of anti-substance communications and highlight possible future directions.

¹ I mean by this, the introduction of health communication in modern forms such as campaigns and programmes while reflecting on the deep rooted Islamic model of drug prevention and alcohol avoidance (see sections 5.4 and 5.5 in the previous chapter for more detail).

Through the scrutiny and thematic analysis of field notes, interviews and focus groups, a group of categories has emerged from the collected data. Collectively, they form one theme, which is the convergence of health communication with the objective of limiting narcotics use and alcoholic beverage intake in Saudi Arabia. It is evident that health communication about substance abuse has been a government-led initiative from the outset.

Since the 1980s, the Saudi government has taken a piecemeal view toward the growing problem of drug addiction, abuse and trafficking. The wave of development and immigration at this time fuelled a growing problem with substance abuse which, in turn, led government to adopt a communication approach aimed at recognising the needs of substance abusers.

More specifically, a government-led anti-substance abuse communication theme evolved from four categories, which together represent the participants' story of how health communication started. The first category of codes concentrates on the 1980s Saudi government's holistic efforts to face the still growing problem of drug addiction, abuse and trafficking marking the initial point in Saudi health communication's journey against substance abuse. The second category of codes focuses on how the waves of development in the Kingdom in the 1970s and early 1980s contributed to the process of recognising the need to face substance abuse challenges, and the emergence of a communicative approach to minimise the problem.

In the third category, I extracted a common understanding between the participants, especially those with long experience in government substance abuse prevention and communication services, that the philosophy guiding these efforts was mostly inspired by the Islamic model of beliefs about intoxicants (mentioned in the previous chapter). At this point a virtual bridge between the prior chapter and this chapter is visible. The last category describes the Saudi government's response to the escalation in substance abuse prevalence that has been experienced in the 21st Century.

This chapter covers the following arguments. Starting with the findings, I first identify the drivers of communication about drug use. I then analyse the

nature of that communication and the manner in which it was implemented. I look at the early communication interventions and the shift toward tackling the problem in a communicative way. Finally, I look at recent developments and the Saudi government's response to them.

By the end of this chapter, I will have presented a detailed narrative about Saudi Arabia's early health communication programmes and the motivations that led to their creation. I will also look forward to where the current trajectory of health communication about substance abuse may end up and consider the implications of this.

6.2 The 1980s drug abuse panic

As no other scholar has written about this subject previously, some preliminary work is required to identify key players and important institutions and to trace the background of health communication in Saudi Arabia. This will also be the first time that Arabic texts, research and policies will be critiqued within the English language, hopefully opening up the field for other scholars in the future.

One of the greatest challenges to this research has been gathering the information, particularly from the 1970s and 1980s. In the end, the best source for this information was a number of key individuals who kindly agreed to share their knowledge with me on this subject. It was not easy to find these individuals and I had to dig deep to trace them. However, I was very fortunate to locate three important government officials who were directly involved in the different phases of Saudi Arabia's campaign against drug abuse and alcohol consumption². Two of these officials still work at the executive level in the Saudi Directorate of Drug Control³ in Riyadh in the prevention affairs department. The first is 'Participant 22' and has 25 years of experience in this department. The second, 'Participant 18' has 18 years of experience at the same department. The third interviewee holds a top position in the Saudi National Committee of

² Anti-Alcohol promotion activities in Saudi Arabia are not constructed well as the drug prevention sector, due to the weak responsible agencies as well as ambiguity of whom responsible. Even though both drinking of alcohol and drug abuse are prohibited in Islam.

³ It's organisationally under the Saudi Ministry of Interior supervision.

Narcotics Control and has more than 15 years in the state drug abuse prevention and security service structure.

From their stories, it is possible to narrate the early development of health communication in Saudi Arabia concerning these issues. The year 1985⁴ is recognised as the year when the Saudi authorities started to seriously consider drug abuse as a threat to society and to the economy.

Participant 22 told it to me as follows:

The problem of narcotics abuse did not exist at an obvious level at the time the Kingdom [of Saudi Arabia] was consolidated in 1932. However, King Abdulaziz, the founder of the kingdom, showed an interest in the need to pass legislation to prevent the use of narcotics.

In 1934, the first Saudi law aimed at managing the issue of drug use was introduced. Cases of drug abuse were rare in 1934 and were mostly to do with the drinking of alcohol or cannabis smoking.

Everything changed in 1976 when the government established the five year development planning projects. In order to meet our goals, the government filled the needed skilled workers from abroad.

In a matter of months, thousands of guest workers from different backgrounds poured into the country. At the same time, the number of Saudis travelling abroad to do business, study or tourism increased. This contact between Saudi society and the world led to the emergence of our drug problem.

Our country witnessed the spread of drug use in the 1980s, the growth of people travelling in and out of the kingdom, and a rising number of cases of drug use among Saudis and non-Saudis. Some of the pilgrims who arrived in Saudi Arabia used these ritual trips to smuggle prohibited narcotics. In the mid -1980s, [we had a] preliminary understanding of drug patterns and use, drug trafficking methods and routes and the needed interventions. I should not underestimate the importance of oil driven wealth into the pockets of youths in the last century was a major pull factor for drug criminal groups to establish a market in Saudi Arabia (31-12-2012).

⁴ The predominant concept of health communication in the country in the 1980s and in present time has considered only the physician-patient communication as health communication. Absolutely, such a narrow concept needs to be widened and that will be one of the study recommendations in section 7.3.

Participant 22 highlighted a number of important issues which frame strategies for dealing with substance abuse problems in Saudi Arabia. First, 1932 represents the baseline of all activities related to health, communication and substance abuse for researchers, employees, activists and strategists in the country. It is true that 1932 marked the emergence of the Kingdom on the world map of politics (AlRasheed, 2010; Twal, 2010), but of course in the pre-Saudi period, there were still issues of health, illness and healing in the Arabian Peninsula. Through my journey for this project and for the purpose of this chapter, I tried to find any published works or articles about this pre-Saudi Arabia period (19th and early 20th Centuries) in terms of health, illness and communication. I found nothing. As a consequence, one of the outcomes of this study is the identification of a gap in our knowledge about the history of communicating health and illness in the pre-Saudi period.

The first attempt to deal with the abuse of narcotics was a 1934 Saudi law that regulated narcotics use for medical and for non-medical purposes. Since the Kingdom was formed and consolidated on the basis of implementing Islamic law (See section 3.4 in Chapter Three), it is no surprise that this law was based on Islamic principles. The momentum of Islam within the Saudi political spectrum and Islam's holistic approach to intoxicant use were further motivations for the framing of the law (See section 5.5 in Chapter Five).

The introduction of a specific anti-drug law was a proactive measure, the first of a sequence of government-oriented efforts to come. Often, government interventions have been categorised by the participants in this study as a government response to a social problem. But the prevalence of the substance abuse was small in Saudi Arabia in the period between the 1934 and mid-1970s, suggesting these early actions were preventative rather than reactive.

Admittedly, oil-led development was not recognised as the only turning point in the number of drug abuse cases in the country. Saudi culture had itself reached a significant, impressionable stage. Participant 2 claimed the development and modernisation of Saudi Arabia had sparked dynamism in the culture and widened openness to other cultures (Participant 2, 26-09-2012). There is indeed a considerable corpus of literature about the correlation

between socioeconomic changes and drug abuse in Saudi Arabia and the Gulf region (Al-Humidan, 2008; Al-Qashaan & Al-Kenderi, 2002; Ministry of Health, 2013b; J. Thomas, 2013).

But it was not only the size of the problem or the cultural shifts that were significant. Also changing were the patterns of use. As Participant 1 explained:

The problem of drug use exists in our country from the old days. But what I have noticed recently is the change in the reasons why drugs are used and the ways of using it. I remember when I was a kid that khushash (Cannabis) plants were prescribed by Tabibe Shabies (local folk pharmacists and healers)⁵ to treat some illness. Also in recent times, some of the psychoactive drugs were legally prescribed. However, at that time our society size was small and that explains why the smallness and vagueness of the problem existed. (Participant 1, 18-09-2012).

Participant 1 raises some important points. First, the common use of herbs and drug plants as medicine was reasonably widespread before the introduction and expansion of the modern health system. Such a phenomenon is not specific to Saudi Arabia. In fact, the healing use of herbs and drugs is well documented in the addiction literature (Abbott & Chase, 2008; Rassool, 1998; Rassool, 2011). Next, the collectivism of communities and their capacity to detect and face misuse and misbehaviour were seen as a constraint on drug addiction. This affirms the collectivism of the Saudi cultural argument presented in the previous chapter. The use of drugs for healing has not stayed stable for long, however.

The industrial and petrochemical phase of Saudi development has brought many changes and new patterns to its modern citizens. As one participant in a communication promoter focus group pointed out:

Initially, the Hubob (drug pills in Arabic) were exchanged between the Taxis and Truck drivers. They were used to fulfil the drivers' need to deliver loads between cities. Later, Captagon pills became more

⁵ It refers to the cultural inspired alternative medicine which is a form of collective practices to treat illness by herbs and reciting Qurannic verses in case of mental illness (Adib, 2004; EL-Islam, 2009; Jamil, 2014; Yehya, 2014).

popular for the positive side of keeping the drivers awake during night shifts. It turns out to be a stimulant to enhance work performance. However, the perception of enhancing performance was extended to sport, sex and folklore dances (Participant-Focus group 9, 26-12-2012).

The shift from drug use for healing to more potentially addictive practices to achieve different objectives did not remain static either. Soon, the wave of modernisation impacted on Saudi Arabia and patterns changed once more. At the same time the world was struggling with the global epidemic of cocaine and crack abuse in the 1980s (Forman & Lachter, 2011; Foundation for A drug-free world, 2014; Lachter & Forman, 2011; Wilson & Kolander, 2003). In the period before the 1980s, the role of health communication in Saudi Arabia was taken up by the mosques.

6.3 Mosque Communication

Participants in this research consistently agreed that mosques have played a fundamentally important role for centuries in efforts to eliminate the use of alcohol and promote Islamic beliefs, teachings, ethics and values. Since Islam emerged in the Arabian Peninsula, mosques have been the one institution that have existed consistently in society's social structure since the Seventh Century. Many scholars affirm the mosque's central position as connecting point between Islam and the region's memory, history and political system (AlRasheed, 2010; Metz, 1993).

Participant 20, who has served in the international Islamic humanitarian sector⁶, agreed that the mosques in Saudi Arabia are vital centres where community members pray together five times a day, attend Friday (weekly) sermons, learn about religion and keep updated with community matters and the world. Also, in the old days before formal education, mosques were centres of education where both male and female children⁷ learned writing, reading and mathematics. Part of the education process at the mosques is to understand

⁶ He went to places such as Bosnia and Herzegovina, Pakistan, Sudan and Serbia. Additionally, he worked as a CEO for an international Islamic Humanitarian agency in Saudi Arabia.

⁷ However, the teaching was in separable places or different times for each gender.

Islamic beliefs and ethical codes, including beliefs about substance abuse (Participant 20, 25-12-2012).

This is a very different model from the Western paradigm and its focus on individuals, behaviour change and interventions. However, the collectivism and religious orientation of Saudi culture explains the integration of mosques in the process of drug prevention prior to the emergence of the formal communication interventions. This shift also did not ease mosque involvement, but embraced it⁸. Furthermore, the political nature of Saudi's theocracy was sympathetic to the involvement of faith institutions in the process of tackling intoxicant abuse (Al-Atawneh, 2009). This also matched Saudi culture's Islam-based perspective on substance abuse (see the previous chapter).

The sociocultural, religious and political justifications for the involvement of mosques in the process of passing religious beliefs through generations cannot be isolated from the fact that the electronic media in Saudi Arabia and formal education were not introduced on a mass basis until the second half of the last Century. For instance, the official start of TV broadcasting was in 1965 with radio preceding TV in 1948 (Al-Makaty, Boyd, Van Tubergen, & Whitlow, 1996; Boyd, 1970; Boyd, 1999; Marghalani et al., 1998). Similarly, the education situation was poorly developed with less than 400 pupils enrolled in elementary schools in 1969 up to 862 by 1979 (Farsy, 1990). This shortage in education and telecommunication infrastructures explains the structural basis that led to the mosques' domination of drug prevention pre-1970.

Given these points above, mosques have had a privileged position in this Islamic society as the conveyer of the religious message and the social hub for support and networking. Throughout the history of Islam, mosques have delivered education, healing, social counselling and charity to the poor (Al-yaum, 2010; Al-Yusife, 2014). A study of 416 mosques in the United States found, for instance, that many had marital and relationship counselling functions as well as religious and other roles (Ali, Milstein, & Marzuk, 2005). In Saudi Arabia it was not too surprising, then, that mosques were the first line of

⁸ As the previous chapter, the use of mosques and Islamic communication still a common health communication practice.

defence in the prevention of substance abuse, particularly in the 1970s and earlier.

The key mechanism for communication on health matters at that time was the preaching⁹ within mosques. In these pre-development boom days, the communication on substance abuse consisted of three components; the message, the communicator and the communicative methods. The messages originate from the two main sources of Islamic teachings; the Quran and the Sunna. The communication actors in this process were the mosques (the Masjid) and the preacher (the Imam, the Muslim community, religious leader) from one side and the receivers were the mosque attendees (*Jama'at Al-masjid*) and other non-Muslims resident in the districts.

The communication of the messages between the two parties adopted one or more of these communication levels; Speech communication, group communication or printed-audio communication. These communication styles were compatible with the basic functions of the mosques as a place to pray and receive knowledge about ritual worship and its etiquette. Therefore, the communication styles in the mosques before 1979 were very much in line with their traditional tasks and duties in the community.

Likewise, in the pre-1979 period, mosque communication for educational purpose was directed at young pupils with a focus on transferring information about Islam and necessary life skills (AbdulJawad, 2004; Ministry of Education, 1995). Indeed, mosque communication has been touched by old media methods such as loudspeakers, radio, printing, audio tape recorders and broadcasting through TV and radio. From a theoretical perspective, the mechanism of mosque communication shares to some extent the linear nature of early communication paradigms such as Laswell's 1948 model and Shannon and Weaver's linear model (Butterick, 2011; Fiske, 2002; McQuail & Windahl, 1993; McQuail, 2010). Mosque communication has an answer for each of Laswell's five questions about communication; who, says what, in which, to whom and with what effect? (Ibid). The preacher (Imam) is the communicator

⁹ Da'wah and Mawa'za in Arabic, it is in the Islamic model mentioned in section 5.5 in the previous chapter. The point of promoting for virtue and prevention of vice in Islam and that's relationship with substance abuse.

who delivers the message of God through alternative channels to reach the mosque attendees¹⁰ and the local community to pass on Islamic teachings with the intent to influence the targeted audience. In the same manner, mosque health communication overlaps with some features of *the Shannon-Weaver model (1949)*. The diagram below 6.1 shows this mosque communication from a linear perspective.

Although communication through mosques is evidently linear in nature, there is an additional cultural-religious factor which adds an interactive dynamic to this linearity. This is the concept of collectivism (*Takafel*) and reinforcement (*Mutaba'ah*). This latter notion provides the Imam with a legitimate reason to provide additional support and Muslims with an appropriate avenue to ask questions about non-religious matters. Besides these counselling and educational elements, the Imam naturally has a responsibility to clarify any misunderstandings about religion among community members.

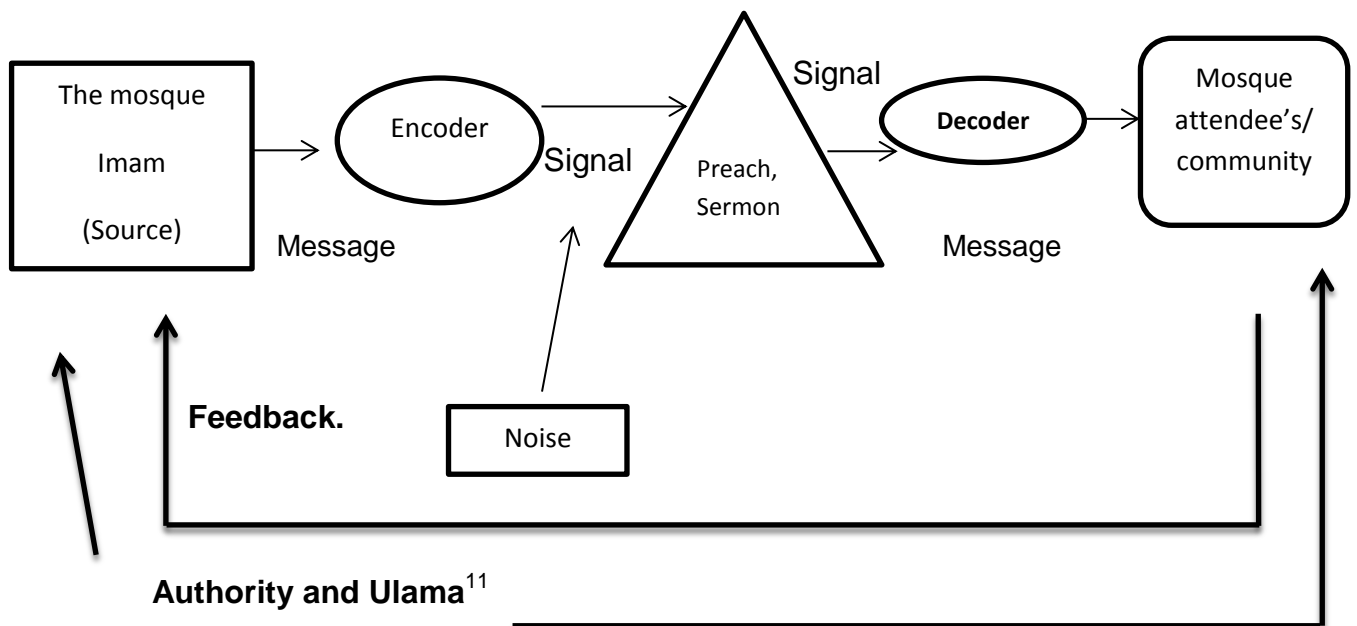


Diagram (6.1) The Mosque Communication anti-substance abuse in pre-1979 in Saudi Arabia

¹⁰ In Islam there is no religious hierarchy or membership to mosques. Every mosque opens to Muslims to come and pray in it as well as to non-Muslims to come and learn about the religion and the community.

¹¹ Ulama refer to Muslim scholars and specialists in Islamic teaching (Qurannic, hadiths, Sunna and jurisprudence).

As a result, two-way communication has been a common feature of mosque communication. This pattern, underpinned by interactivity and by mutual trust and understanding, has continued to be a feature of mosque communication up until the current time.

The model in diagram 6.1 is similar to Norbert Wiener's modification (who added the feedback element) to Shannon-Weaver's model of communication (Littlejohn, 1999). The feedback element functions not only to alert the Imam whether the message has been received, but also functions to receive any messages, questions or comments from the mosque attendees. Mosque communication has been described as symmetrical in nature (Butterick, 2011; Grunig & Hunt, 1984). While the static nature of Islam's fundamental beliefs and values¹² restrict any change in its principles, this communications process does open the door to discussion of other issues.

The managers and promoters interviewed for this dissertation added another significant component, *supervision*, to the model. The supervision of the mosques by religious scholars (Ulama) adds an additional layer of communication and feedback while the government provides legal, structural and financial support. These two bodies are influential in the work of the Imam and the messages he distributes. However, it is hard to be specific about the degree of supervision and efficiency, as this varies from mosque to mosque and is primarily concerned with religious interpretation. There is also very little data from the period prior to the 1970s in which this matter is discussed or recorded, as Participant 20 confirmed (Al-Sadhan, 1980).

Mosque-based communication is community-based in nature and is affected by the religious nature of the communication initiator and the content of the messages. It highlights not only the importance of this social and cultural structure in confronting risky health behaviour, but also its limitations. It was the mosques that fulfilled communication needs in the Saudi health system at that time, primarily through the mosque's pulpits (*Minbars*). I believe this evidence endorses the cultural perspective on health communication and the centrality of

¹² For example, the belief in the oneness of god (Allah), and Prophet Mohammed is his messenger is a fundamental belief cannot be reversed.

culture in health communication in Saudi Arabia (see Airhihenbuwa, 2010; Dutta, 2008; Iwelunmor et al., 2014). I will return to this in the next chapter.

Though the mosques have been playing a primary role in delivering Islamic beliefs about illicit drug use and alcohol consumption in Saudi Arabia for years, nonetheless the number of incidents of drug and alcohol use has increased rapidly since the mid-1970s. This raises the question of why this has occurred in spite of the functioning of mosque communication systems. Evidently, the momentum of modernisation, development and contact with the outside world has exceeded the mosques' capacity to cope. The mosques have generally responded slowly to these challenges and with health promotion and education efforts failing to keep up, government entered the fray in 1979 with a series of anti-substance abuse awareness programmes.

Participants in this study see the mosques' slow response to modernisation as a sign of conflict between traditionalist and innovative communication methods. Participants 18,19, 20 and 22 agreed the problem was not the effectiveness of the content of the mosques' awareness messages, and was also not to do with the status of the mosques in society. Instead, the problem was as much about inadequacies of the mechanism of communication as it was about the global-nature of substance abuse (2012).

In the 1980s, the development of a shared global culture of substance abuse, along with well-connected and managed illicit drug criminal networks, began to pose a clear challenge to Saudi authorities. The attractiveness of drugs and alcohol was given a further gloss by Hollywood and through imported media content rendering the old, traditional prevention methods of mosques simply inadequate. In addition, a growing diversity of guest workers sparked culture shock and a clash of values which put pressure on Saudi authorities to relax restrictions (Participant 10, 19-11-2012). Mosque communication, in any case, could hardly compete with the attractive and effective ways of reaching the younger generation digitally. Globalisation was making its presence felt even at the cradle of Islam.

In spite of this, mosque communications remain a prominent player in the promotion of health and education in Saudi Arabia (see the previous chapter). Mosques are in effect the bridge between Saudis and communications aimed at preventing substance abuse. Once again, there is no record or history of this relationship nor evaluation of its importance highlighting the need for this research and for further work.

6.4 The absence of performance recording and measuring

None of the organisations I visited or people I interviewed had implemented any proper methods of archiving or referencing previous communication campaigns, interventions or programmes. According to Participant 18, “No, we do not have archives for our campaigns, exhibitions and programmes, but we in the Directorate recognise internally our works and success every two to three years, we also evaluate ourselves from the feedback and comments we receive from other governmental organisations verbally or written” (23-12-2014).

Moreover, the lack of archiving was common practice in the past. At the time I started gathering data for this study in 2012/13, there were managerial requirements within government departments to record spending and internal/external communication documents. In addition, I witnessed alternative attempts to use quantitative techniques to count the activities, distributed materials, substance abuse cases, annual statistics and brief communications about activities and media relations.

But until this study, there had been no attempt to document the development of communication interventions nor consider the theoretical background, objectives, plans, outcomes or even lessons of what and how health had been communicated in Saudi Arabia. There was no system to record which programmes had been carried out nor documents indicating strategic planning. It is commonly assumed that documenting campaigns and programmes is essential in order for future attempts to be navigated effectively and measured. Such data is a fundamental input for programme formative and evaluation research (Atkin & Rice, 2013; Backer et al., 1992; Breitbart et al., 2006; Coffman, 2002; E. Crawford & Okigbo, 2014).

6.5 The first intervention

The social, economic, and cultural circumstances that led to the increase of the substance abuse problem pushed the Saudi authorities to introduce a multifaceted intervention, which was described by the participants as a reactive-oriented and sponsored by the government. Yet, in the eighties, the Saudi research facilities were immature in terms of understanding the etiological causes of substance abuse in the Kingdom, and it took time to reach preliminary understandings of that. Subsequently, alternative studies were conducted by Saudi universities and specialised governmental agencies to know more about the epidemiological and etiological aspects of the problem in Saudi Arabia (Al-Ghaferi et al., 2013; Al-Humidan, 2008; Al-Qashaan & Al-Kenderi, 2002; Alsanosy et al., 2013; Al-Sanosy, 2009; Alsanosy et al., 2013; A. ALshareef, 2008). However, further statistical-based and national epidemiological studies for the phenomenon are still needed.

The most noticeable feature about the first intervention was the focus on drug abuse only. The prevention of alcohol consumption posed a more complex set of challenges and policy planners veered away from tackling it. International conventions against substance abuse did not include alcoholic beverages, though some agreements did exist on regional conventions led by the Arab league and the Gulf Cooperation Council (GCC).

Even though avoiding alcohol is called for literally in the Quran, as the previous chapter explained, international reluctance to criminalise alcohol consumption together with the low level of alcoholism on record in Saudi Arabia prompted questions of responsibility¹³. Generally, there was an attitude in the country, especially pre-1980, that Saudi Arabia was not really being affected by the problem of substance abuse, and alcoholism in particular, compared to other regions of the world. As an example, the total number of lifetime abstainers from alcohol was much higher in the Middle East than in Europe between 1993 and 2009 (WHO, 2014).

¹³ In the fieldwork trip, I noted that the promotion against alcohol abuse takes little interest from the Drug Control Department and that with the weak efforts made by the official responsible department about promoting against alcohol in Saudi Arabia, the Department for the Promotion of Virtue and the Prevention of Vice.

The low level of substance abuse among Saudis in particular and Muslims in general was attributed to religious conviction. Studies in the US (about the college's population, particularly) seemed to confirm the relationship between Islam and low rates of risky health behaviour (Abu-Ras, Ahmed, & Arfken, 2010; S. Ahmed, Abu-Ras, & Arfken, 2014; Arfken, Ahmed, & Abu-Ras, 2012; Arfken, Abu-Ras, & Ahmed, 2009; Arfken, Arnetz, Fakhouri, Ventimiglia, & Jamil, 2011). Some studies found religion (Islam) acted as a protective factor (Koenig & Al Shohaib, 2014).

It is true that Saudi official figures for substance abuse were very low. For instance, in 1966¹⁴, 1967, 1968, 1969 and 1970 the total number of drug abusers were estimated at 128, 49, 38, 60 and 56 respectively (MOI, 1975). Indeed, there were no records of substance abuse for the period between 1970 and 1975 from the Saudi police¹⁵(Ibid). Soon, however, the numbers started to rise. By 1980 the official number of drug abusers had reached almost 3,000 (MOI, 1978; MOI, 1979; MOI, 1980). In terms of alcohol, there was not a single record of alcohol offences between 1966 and 1975 (MOI, 1975). During these years the Saudi population was around six to seven million people (CDSI, 2010; Looney, 1982). Of course, the accuracy of these figures and methods of collection require attention.

Records began to be collected during the early days of the Saudi government as bureaucratic procedures were built into the system (Al-Sadhan, 1980) but the figures didn't reflect the reality of drug abuse prevalence. To study the pre-1979 period in terms of statistics and prevalence, due to the absence of local data, the only way would be through international organisations or through other cross-national studies.

It is, of course, a mistake to adopt only a comparative approach or to rely on statistics to understand the extent of the substance abuse problem. As Schumacher, Milby and Bukoski argue, substance abuse is a multi-layered

¹⁴ In this year the Saudi authority began to record the security incidents in an annual manner and divided them into tablets and chapters based on the responsible departments i.e. immigration, police, drug control and firefighter. So the year 1966 is the baseline for the criminological records in Saudi Arabia. It was part of the Saudi government bureaucracy revolution in 1960s (Al-Sadhan, 1980).

¹⁵ In the period between 1966 and 1975, the police in Saudi Arabia was the only active organisation documenting the incidents and cases of substance abuse.

problem with overlapping and diverse causes which requires a multi-levelled approach to prevention (Bukoski, 1991a; Schumacher & Milby, 1999).

The process of recording drug and alcohol consumption in the Kingdom only began in earnest as late as 1989 when some structured annual figures were introduced by various government departments. Before this, some data was collected by the police from 1966 until the launch of the Drug Control Law Enforcement Department in 1972 (Mukafhat Almuqadrat in Arabic مكافحة المخدرات). By the 1980s, along with some Drug Control Department figures, the newly introduced mental and addiction illness hospitals annual records also provided some information. In the early 1990s, the Department for the Promotion of Virtue and the Prevention of Vice (Hia'at Alamr bil Alma'rof wa Alnahi an Almunker in Arabic هيئة الأمر بالمعروف والنهي عن المنكر) also started to publish annual figures.

What is problematic about the epidemiological information about substance abuse is the various sources of the data as well as the different nature of the data depending on the collector. Table (6.1) below summarises the statistics of substance abuse; sources, types and timing available by the time of this study's fieldwork in 2012/13. I built this table based on my experience of looking at these publications during my field trips to Saudi Arabia.

Number	Source	Timing	Data Nature
1	Saudi Security Status (Ministry of interior)	Annual	A summary of the statistics of criminal incidents in Saudi Arabia, including Alcohol-related cases.

2	Saudi Drug Control Law Enforcement Department (Ministry of Interior)	Annual	The annual report conveys information about the incidents of drug abuse and the quantity of the seized materials. It contains eleven sections including the number of drug abusers, those accused of dealing, the amount of seized drugs, the distribution of cases based on region, month and type of drugs, the nationalities of the accused and the agencies handling the cases.
3	Mental and Addiction Hospitals (Ministry of Health)	Annual	In Saudi Arabia there are three medical complexes for mental illness. Each year a press release contains the number of in&out patients (Addicts-Mental ill) published by each complex individually.
4	The Department for the Promotion of Virtue and the Prevention of Vice.	Annual	Publishes an annual book with a section about cases of alcohol and drug managed by the department.
5	The Saudi Borders Control Forces and Costal forces (Ministry of Interior)	Annual	The department publishes the number of substances smugglers and illicit drugs seized annually.
6	Customs and Duties (Ministry of Finance)	Annual	Annual statistics about seized drugs and alcohol in Saudi Ports.
7	Security Patrols (Ministry of Interior)	Annual	These forces are deployed in the street to prevent crime before it takes place. This includes substance abuse. Annual figures are published by the Ministry of the Interior.

8	Directorate of Saudi Prisons (Ministry of Interior)	Annual	Publishes the number of convicts and detainees in Saudi prisons accused of drug and alcohol abuse or distribution.
9	Traffic Police Department (Ministry of Interior)	Annual	Publishes yearly figures about traffic accidents caused by driving under the influence of alcohol and drugs, also traffic tickets issued for driving under the influence of intoxicants.
10	Ministry of Justice (Courts)	Annual	Issues annual statistical data on substance-related convictions in the Saudi courts.

Table (6-1) Statistics of substance abuse; sources, types and timing available by the time of this study's.

There are considerable challenges to collecting and analysing the available data in order to get a comprehensive picture of the extent of drug and alcohol consumption in Saudi Arabia. The following points illustrate the difficulty of gathering this data:

1. Annual figures are published by five different organisations; the Ministries of the Interior, Justice, Finance, and Health and the Department for the Promotion of Virtue and the Prevention of Vice. All of these datasets are published in hard-copy format, with no online databases available. So it takes considerable effort and time to find these books and browse through them. Moreover, the restrictions on access to these books make it more difficult. The only option was to go to big public and university libraries in Riyadh and Jeddah to read these books and to photo-copy the important pages.
2. Many of these figures contradict each other or overlap. For example, the Drug Control Department publishes figures about all the incidents of drug offences (use, dealing and smuggling) in which the department or other law enforcement agencies have some involvement i.e. Police, National

Guards, Army and Costal Guards, but does not include drug offences inside prisons or the number of convicted prisoners for drug offences.

3. The Saudi mental illness institutions publish the number of patients who received treatment for drug use disorders and addiction, but there is no clarity over how any of these patients were self-reporting or how many were transferred to the hospitals by the authorities.
4. The accumulated number of prisoners, patients and users over the years is not available.
5. Ambiguity surrounds the transition of drug offence detainees to convict status over the years. There is evidently a lack of statistics coordination between the law enforcement authorities and the courts.
6. None of these statistics look at substance abuse patterns or attitudes at the household or school level. There is no national quantitative survey to measure the patterns of substance use. There are many examples of good practice in this regard, including the US 'Monitoring the Future' survey which gathers data on adolescent drug use in the school population, the NIDA¹⁶ National Household Survey, the Drug Abuse Warning Network (DAWN) (Lachter & Forman, 2011; Wilson & Kolander, 2003), the Parents' Resources Institute for Drug Education survey (PRIDE) and the Youth Risk Behaviours Survey, too, both in the US (Wilson & Kolander, 2003). In Europe, there is the British Crime Survey and the European Monitoring Centre for Drugs and Drug Addiction (Bean, 2008; EMCDDA, 2014).
7. There is no behavioural surveillance survey within the available data on Saudi Arabia. The gold standard example of a behavioural survey to deter risky-health behaviour is the Behavioural Risk Factor Surveillance System (BRFSS) conducted by the Centres for Disease Control and Prevention in the US, which started in 1983. See the following for more details (CDC, 2014a).

¹⁶ It refers to the National Institute on Drug Abuse in the USA.

8. In terms of illicit drugs and alcohol trading in the Kingdom, there are no official or institutional figures available to the public¹⁷, with the exception of the figures about seized drugs and alcohol by Saudi authorities. However, some attempts to get to this material have started to surface (Robins, 2014; Robins, forthcoming 2015).

While incomplete, the available data does provide helpful insights into law enforcement activities, but not the patterns of use or the prevalence. This is the very data that Kolander, among others, suggests is necessary to engage in drug use surveillance and to observe the consequences to health of drug abuse (J. Thomas, 2013; Wilson & Kolander, 2003). Criminal records are also useful. Al-Ghaferi has drawn attention to the lack of formal, structured methods to measure prevalence and patterns of drug abuse in the Gulf States region (Al-Ghaferi et al., 2013).

Besides the apparent rarity of alcohol use incidents, according to the participants, the question of responsibility emerged as an important second reason as to why alcohol did not get equal attention with drugs. According to Participant 18:

Sure, when I speak about drugs, I talk from my official position in the sector, but I cannot give you accurate details about alcohol, because it is not our department's¹⁸ responsibility to deal with alcohol-related issues. However, what applies to drug addiction in term of rules about seeking treatment is similar to those on alcohol.

Author: So who's responsible for health communication against alcohol use in our country?

Participant 18: Well, Alamal Medical Complexes are responsible. Partly, we are responsible for seizing alcoholic drinks. If someone was caught in one of our operations, then we would send the cases to the responsible department. Although our Department concentrates on drugs (23-12-2012).

¹⁷ There might be governmental internal reports about the business of illicit drug and alcohol, but may be not available for public.

¹⁸ He works for the Saudi Drug Control Law Enforcement Department.

The issue of responsibility has been a regular topic in my discussions with the research participants, especially those who work in government departments. The discussion in this matter was not only about the question of anti-alcohol promotion, responsibility or even the 1980s initiative, but also the lack of integrating anti-alcohol measures into present initiatives¹⁹. From an organisational point view, it is normal that every entity focuses on narrow objectives, and this appears to be the case with the substance abuse prevention public sector in the Kingdom. However, the uneven attention given to alcohol use conflicts with the cultural and Islamic principles mentioned in the previous chapter.

Clearly, there is a collective understanding among government employees not to violate or intervene in other public entities' responsibilities. For example, the Drug Control Department has no role in the rehabilitation and education of convicted drug abuse prisoners, because that is the Directorate of Prisons' responsibility. Most of the participants pointed out that the responsible institutions for the prevention of alcohol consumption was the Alamel Mental Illness Medical Complexes along with the Department for the Promotion of Virtue and the Prevention of Vice (DPVPV).

It was impossible to access these medical complexes to verify their responsibilities and I was also prevented from meeting officials from the health education divisions. The elaborate bureaucracy instituted by the Saudi Ministry of Health would have required far more time than I had available (see the methodology chapter). However, I did get a chance to study their websites, collect some brochures and have an informal discussion with a psychiatrist with connections to these institutions. I found that these complexes direct their health awareness education mostly to the patients and their families. The hospitals do host educational events at local schools (see Al-zaide, 2011). These community services are only available in the cities where these complexes are located, namely Riyadh, Jeddah and Dammam. Promoting alcohol abstention forms part of these community-based health education efforts.

¹⁹ This was one of my observations from the field trips in 2012/13.

Similarly, the DPVPV focuses on two dimensions from a moral perspective; promoting virtuous behaviour (good deeds)²⁰, and preventing vice (bad deeds)²¹. The drinking, selling, producing and use of alcohol form part of these two dimensions. To put it differently, the DPVPV promotes alcohol abstention and trade in alcohol both by the use of force and through health awareness education. The organisation hunt downs²² alcohol black market dealers and users. Besides, the arrests, the DPVPV runs promotional activities²³ in the communities and prisons. This includes health awareness messages about alcohol and drugs. So the prevention of illicit alcohol use is one component of the DPVPV's duties. Unlike the mental illness complexes, the DPVPV has branches across the country, but the capacity and efficiency varies from one place to another; and from towns to cities. Furthermore, there appeared to be very little coordination between the two organisations, according to research participants.

The evident lack of attention given to anti-alcohol promotion sheds light once again on the issues of prevalence and responsibility. There is no organisation dedicated to promoting alcohol abstention in Saudi Arabia and most of the current establishments consider alcohol prevention as a secondary duty.

Unlike organisations from the public sector that take a role in substance abuse prevention, the NGOs, which are philanthropic in nature, are more overarching, and in some cases the promoters address tobacco, drugs and alcohol in one event. For example, on December 4 2012 I attended a school-based event organised by a health promotion charitable entity based in Jeddah. It was held at a public high school (boys). The title of the event was "Smoking is the gate to destruction". It took around three hours for the whole event, and the

²⁰ It refers to the promotion of Islamic rituals, morals, values, and beliefs among the communities in Saudi Arabia (DPVPV, 2008).

²¹ It refers to the promotion against non-Islamic ritual, morals, alcohol use, drug abuse, pornography, and public orders (DPVPV, 2008).

²² Through it centres well-equipped patrols always raid the local under cover illegal distillers. The police support the raids with manpower in needed cases (Hawwari, 2001).

²³ These activities vary from lectures at mosques, schools, prisons, festival, books fairs, exhibitions, printed materials, radio and televisions coverage and programmes (DPVPV, 2008). Recently, the Department made short promotion clips, which were aired on television channels, YouTube, and radio (Participant 21, 30-12-2012).

messages were delivered through oral communication. The speakers went through the hazards of smoking and signalled that alcohol and cannabis use were correlated outcomes (Event1, 4-12-2012).

One local campaign entitled “With faith, there would be no addiction”²⁴, is a perfect example of the overarching attitude among the Saudi charity and NGO sector to combatting drugs and alcohol. As the organiser of the event made efforts to bring together the public and NGOs organisations in one place to educate the public. This campaign was managed by the local Office (semi-government) for Islamic preaching and Promotion (Event 9, 30-31/1/2013).

This rooting of preventative activity in Islam is a characteristic common among these organisations. Indeed, this is true for most of the philanthropic sector in the Kingdom. The presence of Islam is commonly discerned in organisations’ visions, techniques, messages, and sources of inspiration. In spite of this common view, there is still a reluctance to tackle contemporary alcohol use in Saudi Arabia, an ambivalence that is further undermined by poor coordination between the public sector organisations and NGOs. Certainly the campaign against drug abuse has been far more heavily emphasised than measures aimed at alcohol abstention.

The diagram (6.2) below illustrates the flow of the early initiatives in the 1980s.

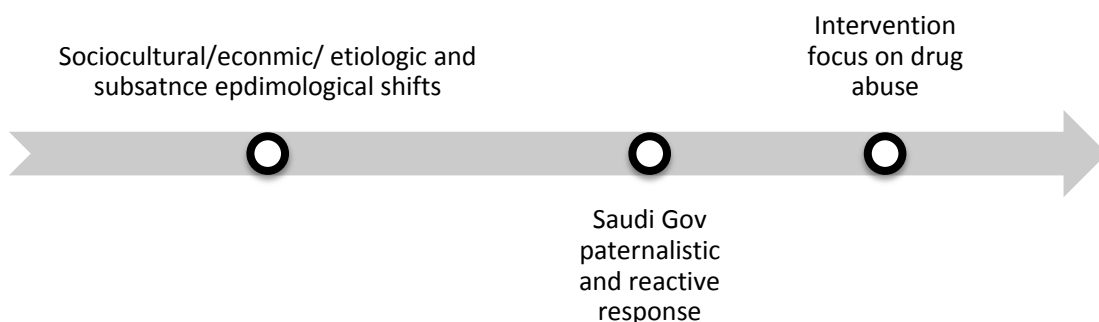


Diagram (6.2) the reactive nature of the Saudi first intervention against drug abuse in the 1980s.

²⁴ A one week campaign held in Alqunfudah city, 400 km south of Jeddah on the coast of the Red Sea. It aimed to promote about the risky-health behaviours such as alcohol use, drug abuse, violence and gambling to the youth in the community.

The response of the Saudi government to the rising threat of substance abuse in 1980 was not one dimensional. Participant 22 summarised the campaign at this time:

In 1980, the problem of drug use among the Saudi youths had increased and the seized drugs and smugglers caught by the authorities were considerable. At that time the need to establish hospitals and rehabilitation facilities was unavoidable because of the growing community of drug abuse patients, even though the number of patients was still small.

Therefore, in 1983, the decision was made to build three hospitals for mental illness and addiction. Following that, in 1985, the Ministry of Interior thought of two aspects of this matter. Firstly, the authority established a national committee to disseminate the promotional messages and to enhance societal awareness about the hazards of drugs along with the enforcement effort, which was in place at that time. Secondly, concerns over the growing trafficking and smuggling of drugs led the Ministry of the Interior to propose imposing the death penalty on the drug smuggling and trafficking. In 1987, the supreme Ulama scholars' committee issued a fatwa endorsing the government's (King) decision to apply the death penalty to drug trafficking and smuggling.

Also the National Committee to Control Narcotics was formed in 1985, and HRH the president of the Presidency of Youth Affairs was appointed as the chair of this committee. The committee was concerned mainly about youths and dedicated its efforts to educating them about the dangers of taking drugs. The acceleration of prevention efforts across multiple fronts was considered an adequate response in the 1980s era to the challenge of drug use prevention (31-12-2012).

Participant 22 also drew attention to important details concerning the first national intervention effort:

1. The government was the key-player behind most of the measures, and this continues post-1980.

2. The multifaceted feature of this intervention sheds light on the government's intention to cultivate and build a culture of prevention to face the problem of drug use.
3. The comprehensive nature of the approach was evident through the combination of security-based enforcement efforts together with rehabilitation, promotion, and policy efforts.

In an illustrative manner, diagram (6.3) reviews the components of the 1980s government intervention:

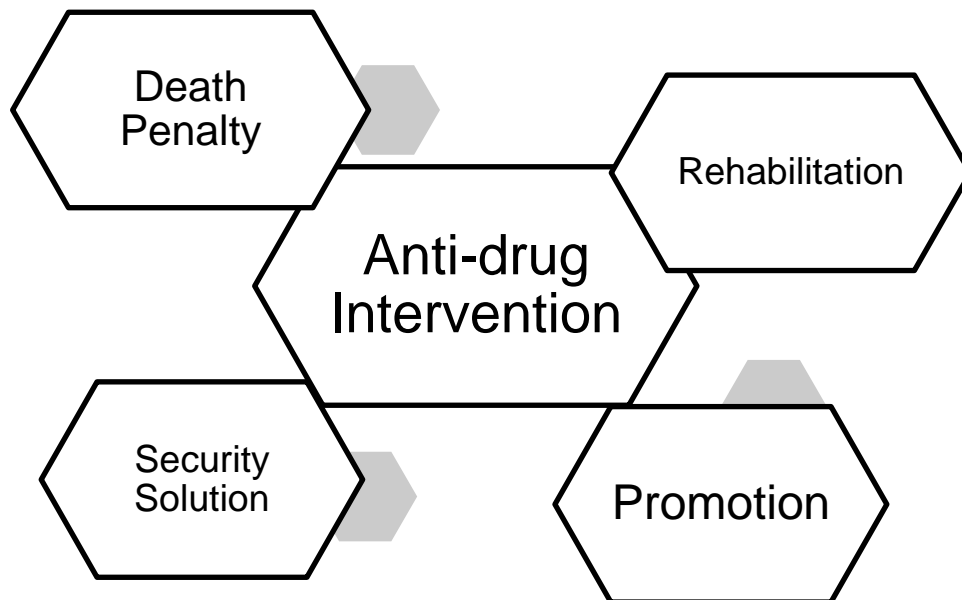


Diagram (6.3) the 1980s intervention components

As this move against illicit drugs was the first of its kind in Saudi Arabia, there is little with which to compare it. It was the outcome, however, of a series of programmes to tackle the problem, which I will now highlight.

The elimination of drug use among the Saudi youth was the key and shared objective of the anti-drug intervention in 1980 (Participant 22, 31-12-2012). First and foremost, this was a government-led initiative. This focus on the youth followed preparatory research (Atkin & Freimuth, 2001; Coombs, 2004) carried out by the Saudi authorities. This approach led to an Arabic language-oriented communication campaign.

The focus on youth was an acknowledgement of the demographic bulge that this generation had become by the 1980s²⁵. Also, the preparatory research and the Saudi security internal reports pointed to the young section of the society as the most affected by this problem. Therefore, the attention of the efforts focus on them. Besides the internal reasons, beyond Saudi Arabia, the world at that time was facing a drug epidemic (cocaine) and a similar focus on youth and young groups had developed in other places, for instance, the successful “*Just Say No*” campaign in the US in the 1980s (Forman & Lachter, 2011; Lachter & Forman, 2011). In summary, there four components of the Saudi first anti-drug abuse intervention; security, death penalty, rehabilitation and promotion (communication).

A long standing component of anti-drug abuse prevention is through law enforcement, in particular a crack down on criminal networks. In his interview, Participant 10 was very clear about this issue. He insisted that the hunt for illicit drug black market dealers and users was a cornerstone of government’s approach from the 1980s onward (19-11-2012). The development of security efforts to reduce the illegal market in drugs can be traced back to the 1934 Anti-Narcotics Law, when possession of dealing in or using drugs were classified as criminal acts (Participant 22,31-12-2012). Moreover, the establishment of the police in 1925 and then The Ministry of the Interior in 1951 (Farsy, 1990) were both structural measures aimed at maintaining the rule of law, including the fight against drug trafficking and use.

Two decades later, the Drug Control Law Enforcement Department was established (Algamdi, 2007; A. ALshareef, 2008). It has dedicated most of its activities to minimise the spread of illicit drugs. According to Participant 18, “Even though we have made progress in incorporating drug awareness into our duties, the seizure of drugs is still the core business of our department” (23-12-2012). In fact, most of the department’s manpower is directed toward these security efforts, a source of frustration for those in the department who are more interested in prevention and education. In fact, all branches of this department are occupied by security officials with not a single civilian employee involved

²⁵ Further details about the demographic shift in Saudi Arabia see section 3.2 in Chapter Three.

even in prevention activities (Participant15, 16-12-2012; Promotional team Focus group1,18-12-2012). The shortage of manpower in the drug prevention sector is one of the key challenges.

It is not only the drug control law enforcement department and the police who are responsible for reducing drugs, but many other organisations introduced by the government to strength security generally. They include the Coast Guard, Border Control and Customs and the Traffic Police as well as the Department for the Promotion of Virtue and the Prevention of Vice. The local justice system also plays an important role in the enforcement and prevention apparatus.

The diversity of these organisations and the variety of their functions and responsibilities has made accessing reliable data in the area difficult (see Table 6.1). In order to maximise the efficacy of the Saudi drug control system, the government has continued developing the regulations and rules on narcotics. Most significant, of course, was the classification of drug trafficking as a capital crime.

While it was the fatwa²⁶ of 1987 that enabled the government to implement its wish to impose the death penalty on traffickers and smugglers, the Saudi counter-illicit drug regulations date back to the *1934 law*. It is worth noting that this law (*see the previous chapter for more detail*) was not just an anti-drug and alcohol law, but a formalisation of Islamic culture which had survived in the Arabian Peninsula since the emergence of Islam in the seventh Century.

In this respect, Participant 22 explained how internal regulations were developed after the 1934 law. In 1975, modifications were made to include punishments on the illicit drug business (31-12-2012). After that, the death penalty was incorporated in the 1987 amendment of the Saudi Narcotics

²⁶ Refers to the religious opinions issued by well-respected Islamic Scholars, in Saudi Arabia the Permanent committee of scholarly Research and Iftaa holds this role (Ulama) under the supervision of the Department of Scholarly Research and Iftaa (The Permanent Committee of Scholarly Research and Iftaa, 2015).

Control Law. In recent years, policy has started to include drug prevention, generating new laws and strategies.

The development of Saudi's internal illicit drug use control policy cannot be understood separately from Islamic opinion on substance abuse. As the previous chapter illustrates, Islam occupies the central position in Saudi efforts to challenge the growing substance abuse problem. In short, the Islamic perspective on drugs and addiction forbids any non-medical intake of substances which may affect the nervous system or consciousness (Alsadlan, 1991; Assad, Niazi, & Assad, 2013; Baasher, 1981; Baasher, 2001; Bassiony, 2013; Hafeiz, 1995; Iqbal, 2000; Michalak & Trocki, 2006; Rassool, 2014a; Rassool, 2014b).

Participant 2, an experienced broadcaster, said the Islamic perspective was the logic which underpinned all efforts against illicit drugs and alcohol (24-09-2012). The Islamic influences in Saudi anti-narcotics policy is a consequence of the long historical connection between Islam and the land and peoples of the Arabian Peninsula. Islam is indeed embedded into the modern Saudi political system (see the third and fifth chapters for more details). Therefore, all the Saudi anti-narcotics laws of 1934 and 2008 and the amendments of 1975 and 1987 adopted the same principles of Islamic prohibition, justified by the effects of the substance on consciousness, health, the economy and the security of the society and of families.

Second, capital punishment was introduced under particular circumstances as a means of confronting the escalation of drug abuse prevalence among Saudis sparked by shifts in demography, the growth of international passengers and trade and the increasing scale of seized drugs. Participant 22 believed that:

The death penalty for drug traffickers, who committed the same crime more than once, was a very strong, effective and determined policy to reduce the problem of drug abuse at that time. I believe the first five years after the start of the death penalty the number of drug-related cases such as trafficking, smuggling and abuse decreased. I should not underestimate the role of media in promoting the newly introduced policy. Unfortunately, that didn't work for long because the

criminals developed new methods and routes for smuggling, and new technologies too. Nowadays, the drugs come in tens of millions of pills (31-12-2012).

Participant 22 agreed the death penalty had only worked for a short while as a deterrent. Others argued it continued to be an important element in the anti-drugs campaign. Participant 19 hailed the effectiveness of capital punishment, but acknowledged the strong opposition to its practice from the world community and from human rights activists. In his own words:

The death penalty was one of the means to face the phenomenon when it started to hit the kingdom. Although, the world did not understand the importance of the punishment as a deterrent to the substance abuse problem, human rights groups and international economic circles portrayed the Kingdom as a country where people were beheaded for no sufficient reasons. The death punishment was part of a group of punishments to deter drug trafficking and smuggling. However, there are pre-conditions and the punishment has not been applied without these conditions being met (24-12-2012).

While both Participant 19 and 22 agreed on the short-lived effectiveness of capital punishment, Participant 19 argued the negative stereotype of capital punishment was a reflection of the stereotyping of Sharia (Islamic) law in general among human rights activists (Akbarzadeh & MacQueen, 2008). He did concede, however, that international pressure had pushed the Saudi authorities to tighten the procedure of capital sentence cases.

Besides these internal policy and law efforts to structure the role of law into the overall strategy of drug control, Saudi Arabia joined the international community's collective efforts to criminalise the illicit drug business. The managers of the drug prevention departments and the strategists I interviewed explained that by the time of the 1980s anti-drug intervention, Saudi Arabia had already joined the Single Convention on Narcotic Drugs of 1961 (amended in

1972²⁷), the Protocol, Convention on Psychotropic Substances of 1971²⁸, and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988²⁹(A. ALshareef, 2008; UN treaties, 2015; UNODC, 2013). These conventions were formed to establish a platform for international collaboration in fighting drugs and corruption (Ibid).

As the drug abuse phenomenon is so multileveled, causing destructive consequences for individuals, communities and for the states in which they reside, the world agreed on the need to create multilateral institutions to coordinate between states. As a result, the United Nations Office on Drugs and Crime (UNODC) emerged in 1997 out of the integration of the United Nations Drug Control Programme and the Centre for International Crime Prevention. The UNODC's objective was to support member states in implementing international treaties, combating drugs as well as doing research and analysis to develop more understanding about the phenomena (A. ALshareef, 2008; UNODC, 2013). Likewise, the International Narcotics Control Board (INCB) was established to monitor the drug abuse problem worldwide.

Saudi Arabia and other regional states signed alternative collaborative treaties. Most of these efforts were funded by the Arab League. In 1986, the Arab Unified Model Law was ratified by member states³⁰. Before long, an Arab strategy against illicit drug use and psychotropic substances was in place. These efforts were followed by the introduction of the Arabic dictionary (lexicon)

²⁷ The 1961 single convention on narcotics drugs (was amended in 1972) is first comprehensive international attempt to combat drugs problem in two fronts; reduce drugs abuse and use by monitoring and control illegal drugs production and legalise drugs production for medical purposes; secondly, enhance the international collaboration to tackle drugs trafficking (INCB, 2014; UNODC, 2014c). 119 narcotics drugs are listed under this convention and it called the **yellow list** (ibid).

²⁸ This convention was introduced in 1972 to face the growing and varieties of psychoactive drugs and that by creating international monitors to control these substances depend on them influence on the body nervous system as well as them medical use too (INCB, 2014; UNODC, 2014a). A list of these substances attached to this convention to guide member states in combating these substances and it called the **green list** (ibid).

²⁹ This convention is recognised as the first international attempt to combat illegal drugs business by establishing international platform to exchange information as well as criminals, what was unique about this convention is the measurements to face money laundry, drugs trafficking and psychoactive drugs manufacture (INCB, 2014; UNODC, 2014d). A list called the **red list** was developed under this convention to assist member states in this process (ibid).

³⁰ Saudi Arabia, Egypt, Syria, Iraq, Lebanon, Jordan, Palestine, Yemen, Kuwait, Bahrain, Qatar, United Arab Emirates, Oman, Sudan, Libya, Tunisia, Algeria, Morocco, Mauritania, Somalia, Djibouti and Comoros.

of drugs and psychotropic substances in 1991. Subsequently, the Arab treaty of illicit drugs and psychotropic substances control was signed in 1994 (Arab Office for Drug Affairs, 2015). Like the international community, the Arab League founded an office to coordinate between the member states in order to apply these treaties.

In 2008, Saudi Arabia and the other Gulf States³¹ formed the Criminal Information Centre to Combat Drugs³² to coordinate the cooperation between member states and to reduce the drug abuse problem in the region (GCC Criminal Information Center to Combat Drugs, 2008). Most of these diverse international agreements supplement Saudi drug control policy measures already in place.

These conventions were additional motivators for the Saudi authorities to develop their own national measures. Further, the commitment to fulfil these agreements led to internal review and to improved data and facilities. While the first Saudi drug control law was introduced in 1934, the real development took place from the 1970s when a Drug Control Law Enforcement department emerged and the law was modified to enable punishments specific to drug traffickers. The bureaucratisation of the Saudi public administration in the 1960s and 1970s (Al-Sadhan, 1980), and the improving economic circumstances due to the 1970s oil boom, also contributed to the acceleration of Saudi drug control actions.

Through my discussions with the participants who manage the government prevention programmes, I was impressed by the cohesion between them in acknowledging the government's willingness to deal with substance abuse issues. It is important to reflect on international efforts to control drugs before Saudi Arabia ratified the Single Convention in 1961. Diagram (6.4) outlines the point at which the world started reacting to drugs in 1909 and how the emergence of Saudi Arabia on the world political map and Saudi's first anti-drug initiatives intersected with that.

³¹ Kuwait, Bahrain, Qatar, United Arab Emirates and Oman.

³² See (GCC Criminal Information Center to Combat Drugs, 2008) for more details about the internal system and the charter.

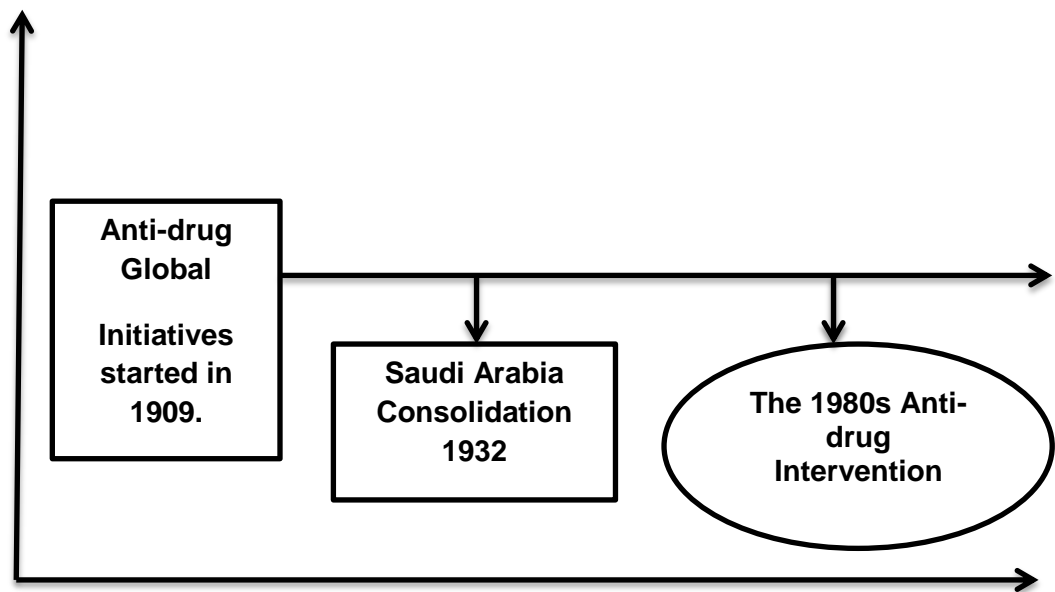


Diagram (6.4) The Timeline of international drug control system development.

In 2008, the UNODC published a review of international drug control efforts (Pietschmann, 2007; UNODC, 2008). The 1909 international meeting called to confront the opium epidemic is considered the first international anti-drug initiative. Various collective international acts followed the establishment of the 1909 International Opium Commission (Ibid). Of course this was before Saudi Arabia had been created (AlRasheed, 2010; Vassiliev, 2000) though it was not long after Saudi's emergence before it joined these international initiatives.

Few historians of the Arabian Peninsula during the first half of the Twentieth Century mention any international engagement to deal with substance abuse problems (AlRasheed, 2010; J. Habib, 1978; Teitelbaum, 2001; Vassiliev, 2000). The first Saudi interaction was evidently its participation in the 1961 Single Convention on Narcotic Drugs (Participant 22,31-12-2012; Participant19,24-12-2012). In order to identify the pre-1961 efforts that Saudi Arabia did not join³³, the following table (6.2) was extracted from the two reviews of the international drug control system in 100 years (Pietschmann, 2007; UNODC, 2008).

³³ Also there are many countries like Saudi Arabia in this matter.

No	Date	Description
1	1909	The International Opium Commission in Shanghai.
2	1912	The Hague International Opium Convention in Netherlands.
3	1920	The establishment of the Advisory Committee on the Traffic in Opium and Other Dangerous drugs.
4	1920	The League Health Committee.
5	1925	The 1925 drug control convention under the League of Nations supervision.
6	1925	The establishment of the Permanent Central Opium Board.
7	1931	The Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs.
8	1931	The establishment of the Drug Supervisory Body.
9	1936	The Convention for the Suppression of the Illicit traffic in Dangerous Drugs
10	1946	The establishment of the Commission on Narcotic Drugs (CND) as the United Nations policy making body in drug-related matters.
11	1948	Synthetic Narcotics Protocol.
12	1953	Opium Protocol limited opium trade to medical and research uses.

Table (6-2) the international drugs conventions before Saudi Arabia joined the conventions. Sources: (Pietschmann, 2007; UNODC, 2008).

Undoubtedly, these conventions not only provide platforms for nations to collaborate together to tackle drug problems, but some of their measures are to be found in the current international drug control system. These include the step-by-step model to develop an international drug regulatory scheme, the compulsory drug limits based on the nation's health needs, the drug

export/import authorisation certification model and the principle behind scheduling drugs based on the level of hazard they pose (Pietschmann, 2007; UNODC, 2008). None of these conventions included Alcohol³⁴.

Furthermore, the promotion and anti-drug abuse communication dimension did not attract UN attention. A mediation body to coordinate between states was established in 1997 (UNODC) and an International Day against Drug Abuse and Illicit Trafficking was introduced every June 26 in 1988 (UNODC, 2014b). The agreed consensus within the UNODC and beyond was that promotion and public education around illicit drugs should be context specific. Therefore, the responsibility for promotion fell on the local and national specific organisations (Pietschmann, 2007; UNODC, 2008). In recent years, the UNODC has launched a global initiative to enhance awareness about the dangers of illicit drug abuse (World Drug Campaign, 2015).

The decision to leave education and communication on illicit drugs to be decided by communities based on their specific needs, is compatible with the prevailing scholarly assumption that community education interventions supplemented by mass media messages constituted an effective way of changing public knowledge, attitudes and behaviour concerning risky health behaviour (Abroms & Maibach, 2008b; Alcalay, 1983; Basil, 2014a; Beato & Telfer, 2010). While global efforts to share the principles and practice of communication against drug abuse are positive steps, this should not overshadow the importance of the local context. As Dutta among others has argued, *top-down communication* from NGOs or health organisations is not always the most effective strategy particularly in non-developed and developing states (Dutta & Basnyat, 2010). So sharing ideas rather than a single programme may be preferred in some contexts.

³⁴ Since the nineteenth Century, in different countries, many regulations and rules have been issued or cancelled in order to organise the alcoholic beverages industry and consumption attitudes (Wilson & Kolander, 2003). Even though all these national and local policy attempts did not lead to any international agreement in the nineteenth Century or early twentieth Century, public attention was focused on drug abuse especially, when it reached epidemic level (UNODC, 2008; Wilson & Kolander, 2003). Wilson and Kolander believe the social harms of alcohol abuse are more evident than those of drug abuse and that this did not change between 1800 and 2000 (2003).

The third component of Saudi's anti-drug intervention strategy was the creation of health facilities to provide treatment and rehabilitation services both to the mentally ill and to patients with addiction disorders (Participant 22, 31-12-2012). This illustrates a shift in the official attitude away from considering substance abuse a religious-security matter only to a more public health-oriented view as well. Since the 1980s public health specialists have tended to agree that drug abuse, addiction and alcoholism are chronic diseases caused by lifestyle (Bukoski, 1991a; Bukoski, 1991b; NIDA, 2005; Schumacher & Milby, 1999). Drug abuse and alcoholism were seen as risky-health behaviour problems exacerbated by the growing health burden from non-communicable diseases (CDC, 2014b). By building hospitals and addressing drug abuse and the drinking of alcohol as a health problem, this signalled an important change of direction in Saudi Arabia.

Among others, Abdel-Mawgoud reviewed the development of treatment programmes in one of the Al-Amal medical complexes³⁵ in the city of Dammam. He noted the shift from medical based treatment in the second half of the 1980s to a more inclusive 'Bio-Psycho-Social' treatment model (Abdel-Mawgoud, Fateem, & AL-Sharif, 1995). As a result, drug and alcohol addicts were considered patients needing help and medical intervention. Saudi Arabia had moved on to a new pathway.

Besides the religious and legal discourse on drugs and alcohol, there has also been a switch in Saudi Arabia to a rational discourse of risks and benefits, a strategy that has proven successful at encouraging behaviour change. Behaviour change is, of course, a critical tool for successful prevention of drug and alcohol addiction as many scholars have found (Abdel-Mawgoud et al., 1995; Bukoski, 1991a; NIDA, 2005).

The official view has therefore moved from considering that substance abuse is forbidden by divine law and requires repentance ("Tawabh") to one that views addicts as patients in need of treatment. This has not eradicated repentance from Islam. But it has accentuated other aspects of the Islamic

³⁵ Al-Amal means in Arabic 'hope', the name was given to the addiction and mental illness hospitals in Saudi Arabia.

model (see the previous chapter) in which individuals are encouraged to seek treatment and healing. Advertising the available options for getting treatment from addiction and alcoholism has, therefore, been a permanent dimension in communication against substance abuse.

The establishment of hospitals not only provided health care to those in need, but also enabled research to be conducted in order to gain a better understanding of the substance abuse problem (J. Thomas, 2013). Many studies have emerged from scholars affiliated to these institutions (Alibrahim et al., 2012; Alsanosy et al., 2013; Bassiony, 2009; Bassiony, 2013; Hafeiz, 1995; Iqbal, 2000; Salem & Ali, 2008).

Recently, these hospitals have been struggling to deal with the growing number of patients. The government has been criticized for failing to expand the addiction services beyond the three current locations or allowing the private sector to play a role. Under pressure, the Ministry of Health has announced it plans to open a mental health hospital in each region as well as new mental illness out-patient clinics at each public hospital. It has also promised to review current policy and regulation to allow the private sector to provide rehabilitation services. With these reforms, the Ministry of Health claims its capacity to deal with addiction and mental illness will be doubled to 6,000 beds by the end of the project (Ministry of Health, 2015b).

When I brought up this point with the study participants, both Participant 22 and 23 insisted the government had been quick to move to expand these services (Participant 22, 31-12-2012; Participant 23, 31-12-2012). However, this was an expected response from public employees to defend what was evidently a more sluggish response under pressure from the international community. In the end, though, it is true that the Saudi government admitted the need to open more hospitals in a strategic response to population growth and the imperative needs of the health services. The action was certainly reactive in nature, but this matched the whole range of government interventions from the 1980s.

The disease model of addiction has played a considerable role in the 21st Century Saudi policy of dealing with narcotics abuse. It was reflected in the

Saudi strategy against narcotics in 2007 and in the tolerant approach toward drug abusers in the Saudi Anti-Narcotics and Intoxicants Law of 2005. Since 2005, Saudi drug laws have given the illicit drug user the right to receive free health and rehabilitation services from the government with the added protection of discretion and anonymity (Saudi anti-Narcotics and Psychotropic Substances Law, 2005). In fact, the law insisted that special treatment should be afforded to school students and adolescents (Ibid). The tolerance and support is predicated on the addict making a voluntary approach to the health facilities. Any drug or alcohol user or possessor, however, if caught by police or the authorities could face a range of criminal charges up to and including capital punishment in the event of multiple dealing convictions.

It is important to point out that non-Saudi drug or alcohol users are excluded from the free health care and rehabilitation on offer to nationals. This has created health disparities among the illicit-drug user population, not all of whom are Saudi citizens (confirmed by Participants 7, 9, 10,11,18,19,22 (2012) and by prevention team focus groups 1,2,3 (2012)).

Among those working to promote abstinence from drugs or alcohol, the new move toward greater tolerance was warmly welcomed, but there was less concern over the continued criminalisation of drug and alcohol possession and use. Since such behaviour is prohibited by Islam, the foundation of the Saudi legal system, it is unlikely that drug or alcohol possession or use will be decriminalised any time soon. Indeed, the introduction of harm reduction programmes is not possible given prevailing cultural and social attitudes. However, the harm reduction approach to illicit drug use has been implemented in some Islamic countries³⁶ such as Malaysia, and has achieved positive outcomes (Kamarulzaman & Saifuddeen, 2010; Reid, Kamarulzaman, & Sran, 2007). The main objective of harm reduction programmes is to minimise the negative effects related to illicit drug use, especially needle sharing among injecting drug users. The research on this approach indicates positive outcomes

³⁶ The scholars of this trend based their work on the Islamic principles of the preserve the five necessities; the protection of the faith, life, intellect, progeny and wealth, and the harm reduction is a preventive act from further damages, see the following reference for details (Kamarulzaman & Saifuddeen, 2010).

so far (Stimson & O'Hare, 2010). As an evidence-based strategy, providing sterile needles, syringes and clean places to take drugs, has proven to be effective³⁷ in minimising health risks such HIV and Hepatitis B. The City of Vancouver's programmes have succeeded in reducing needle sharing from over 40% in 1996 to less than 2% in 2011 (Ti & Kerr, 2014).

The provision of health care for drug users was justified on the basis of Islam's theoretical principles about the human duty to offer care and help. Islam's treatment of health as a right has indeed been adopted by the World Health Organisation's regional office in the region (Khayat, 2004). So a health perspective on drug and alcohol has emerged in Saudi Arabia and is likely to become increasingly influential.

Before approaching the last element, communication, it is worth re-emphasising the continuity of the three previous actions; law enforcement, legal measures, and the creation of health facilities to deal with narcotics abuse as a disease. These measures represent the foundations of Saudi policy toward controlling illicit-drugs. Such measures have been adopted elsewhere under similar circumstances of a growing drug problem. In the late 1970s and 1980s, for instance, the United States introduced federal laws, prevention and treatment programmes and research facilities like the National Institute of Drug Abuse (NIDA) to cope with the evolving issue (Lachter & Forman, 2011). In the Arab world, in his review of the status of the narcotics industry in the Emirate of Dubai, Philip Robins reported how the government of Dubai, in the 1950s, tightened customs procedures in order to tackle illicit drug smuggling (2014).

Diagram (6.3) illustrates the four dimensions of the 1980s anti-narcotics intervention. The last dimension of the matrix is communication and promotion. It is to this aspect that I now wish to turn. According to Participant 22, in his summary of the Saudi Government's post-1980 anti-drug initiative:

In 1985, the Ministry of the Interior devised two approaches to the drug abuse problem. Firstly, the authority established a national committee to disseminate promotional messages and to enhance

³⁷ However, some argue that the social, political and ideological perspectives still imposing challenges to the implementation of these programmes (Ti & Kerr, 2014).

societal awareness about the hazards of drug, and then there was the security effort which was in place at that time (31-12-2012).

Also the National Committee to Control Narcotics was formed in 1985, and HRH the president of the Presidency of Youth Affairs was appointed as the chair of this committee. This committee is focused on the youth and dedicates all its efforts to educating them about the dangers of consuming drugs (Ibid).

The Saudi government's agreement that communication had a role to play in eliminating the problem of substance abuse in the country was an interesting and positive development. In most other contexts, academics had pushed governments to accept the advantages of communication strategies in the battle against drugs (Dutta, 2008; Kreps, 2014; Paek et al., 2010; Schulz & Hartung, 2010; Wright et al., 2012). In Saudi, it was the government who initiated the approach. The main purpose for the newly-created Saudi National Committee for Narcotics Control in 1985 was specifically to enhance awareness and educate the public about the dangers of drugs. Though most of the educational efforts were directed toward youths, in accordance with the stance of the intervention as a whole, the committee clearly looked for other methods beyond policy or enforcement to reduce the demand for drugs.

Commentators and scholars identify the creation of the committee as a turning point in the war against drugs in Saudi Arabia (Algamdi, 2007; Alofie, 2012; A. ALshareef, 2008). Similarly, communication and campaigns scholars have been promoting the critical role of communication to contribute to public health (Abroms & Maibach, 2008a; Beato & Telfer, 2010; Silk et al., 2011; Snyder, 2007; Wakefield et al., 2010a). So the Saudi push toward communication, was a decision that reflected best practice and the latest thinking from the world's experts. But how did this symmetry of purpose come about?

From the outset, communication was considered an essential way of adequate information was conveyed to the Saudi public to limit the number of

existing drug abusers and to deter the initiation of new users. Theoretically speaking, the communication effort of this intervention was a classic example of the top-down (nanny state style) effort, in which the government tells the subjects about the dangers they susceptible to and directs them how to avoid these dangers (Grunig & Hunt, 1984; Helme et al., 2015; Kopfman & Ruth-McSwain, 2012; Logan, 2008).

Furthermore, the communication objective of enhancing awareness and educating the public influenced the implementation of communication practice. In fact, current scholarship confirms the importance of the association between campaign aims and the practical side of the campaign (Atkin & Rice, 2013; DuPré, 2014; Schiavo, 2014; Silk et al., 2011). In order to achieve these aims, mixed communication strategies were often adopted from the 1980s onward.

In the current anti-drug matrix in Saudi Arabia³⁸, communication has not been limited to the 1980s emphasis on warning and informing, but now provides publicity and information about the other governmental efforts to minimise the phenomenon of drug abuse. All the participants from public sector drug prevention organisations agreed the government's efforts to introduce a three dimensional strategy had achieved a degree of success with the public and in the media.

In the 1980s, the government was the primary initiator of communication on health matters with supplemental support from the mosques³⁹. Consequently, communication developed around two streams; government public relations activities to inform the public (Saudis and non-Saudis) about the governmental measures and efforts in place; secondly, health communication (focused on Saudis) through public agencies to reduce the problem of drug abuse by merging communication techniques with scientific knowledge.

Participant 10 described the importance of using “scientific facts” in the communication strategy (19-11-2012). These facts provided information about the hazards of taking drugs on the body's physiology and health and highlighted the medical signs of drug abuse to help families identify the signs of addiction.

³⁸ It refers to 2012/13 the time of this study empirical work.

³⁹ They are supervised and funded by the Saudi government.

During my field trips, I witnessed many examples where this tactic was used not only in promotional publications, but also in broadcasted messages on radio and TV. For example, the third radio advertisement closed phrase was “what’s after illicit drug use except death” (Advert six)⁴⁰ and that stressed one of the approved facts that substance addiction and abuse could cause sudden death or suffering. This fact was used in another radio advert “Drug abuse is the end of life and future” (Advert eight).

Public relations-generated stories were distributed both by public organisations which did not ordinarily participate in communication activities (such as the *Drug Control Force* or *Border Force*), but also by communication agencies such as the National Committee. Besides the messages about drug use’s harmful consequences, the committee disseminated information on the other aspects of the strategy. The committee, in other words, has improved public awareness about the punishments imposed for drug abuse and smuggling in the kingdom, about successful security operations against the illicit drug trafficking networks and about the available treatment facilities for those in need.

Since the 1980s, there have been two streams of health communication messages against drug abuse; first, an *explanatory* stream about the Saudi drug control system and its positive outcomes; next *awareness and persuasive messages* about the harm of drug abuse. Both of these had a *purposive nature*, with an objective of eliminating drug abuse among Saudis and among Saudi youths in particular. These two streams of communication are still to be found in the present Saudi communication campaign against drug abuse, especially the government one.

The mechanism of Saudi anti-drug communications in the 1980s (discerned from the evidence given by research participants 1,10,18,19,20 and 22) has strong similarities to what is known in the literature as the public information model⁴¹ described by Grunig among others (Butterick, 2011; Dutta, 2008; Grunig & Hunt, 1984; Yeomans, 2006). In effect, the information source

⁴⁰ The full list of the radio advertisements is in the table 4.5 in section in 4.4.1 in Chapter Four.

⁴¹ It was compatible with the 1980s popularity of the using the model in public health communication, especially in the control or semi-control media environment.

(the communicator) was the government's anti-narcotics agencies with the intention of reaching the public (the Saudis) with a special interest in school populations and the youth with the overarching aim to disseminate anti-narcotics awareness messages. The diagram 6.3 highlights the concentration of the model on youth.

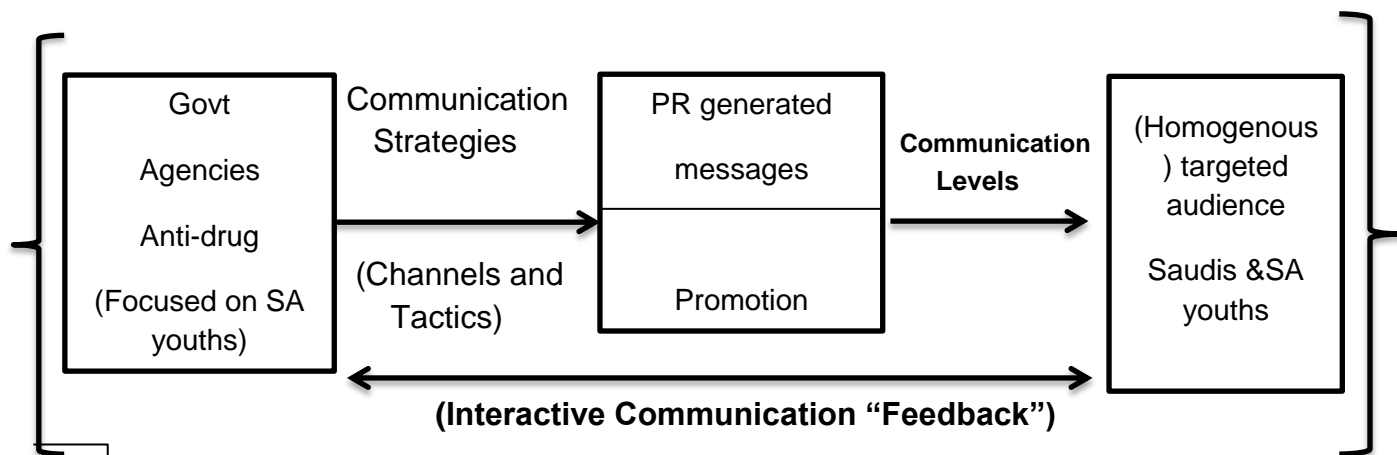
In his comparison between the Saudi National Committee's role in the 1980s and the revived committee in 2007, Participant 22 observed:

Undoubtedly, the committee's role was to disseminate awareness and knowledge of the hazards of drugs within Saudi society only. This was the promotional objective of the committee. They went about this by the preparation, design and implementation of promotion programmes either for publication or broadcast on radio or television. The Saudis were the targeted groups of the committee (31-12-2012).

Through discussions with participants from the drug prevention sector, I realised the Saudi model of health communication did not function in a way described by the Public Information Model (Grunig & Hunt, 1984). This is because of the alternative methods that were adopted during this intervention, along with subsequent efforts. For this reason, I would describe the Saudi model as a mixed or multi-approach communication strategy.

Diagram 6.5 below presents in graphic way the anti-drug health communication strategy of the 1980s, still considered the foundation of the current substance abuse prevention and communication model in the Kingdom. It was evolved from a combination of communication models as well as from Saudi conventional communication methods. Indeed, it has strongly influenced communication about drugs and health issues since then. In contrast, recent anti-substance abuse interventions in the Saudi have witnessed a range of strategic modifications to the communication mechanism, including the arrival of NGOs as a new, key player in the campaign against non-communicable diseases (NCDs), as I will describe later.

The Saudi anti-drug health communication model consists of five components; sender, channel, messages, audience and setting. Three of these elements were explained before, but communication means (channels) and the setting needs more clarification.



→ **The context** (the Saudi setting); this factor covers; the media and *anti-drug climate* worldwide, the *dominant culture* (Arabic/Islamic), Saudi government *supervision over the mass media* in the 1980s, *contextual changes*⁴², and *the multi-diverse guest workers* even though the cultural diversity perspective was not considered⁴³

Diagram (6.5) Saudi anti-drug health communication model in the 1980s.

In accordance with the *top-down model*, the communication flow, as the arrows show above moves from left to right, from the sender to the targeted groups. In order to achieve the intervention aims, the Saudi National Committee for Narcotics Control and the other governmental specialised organisations used different communication strategies available at that time, especially mass communication. But, in truth, all of these channels in the pre-internet era were under government supervision and control, including the mass media (see chapter three for more details about media in Saudi Arabia). Therefore, critiquing or questioning government policy, efforts, socioeconomic and consequences was not possible within the media ecology at that time. The apparent diversity of communication channels could not hide the fact of government control of communication content.

⁴² More details about that are included in the first section of this chapter about the 1980s intervention motivations, and there are more in chapter three.

⁴³ During that time the guest workers were expected to enculturate the SA culture (acculturation).

As revealed by participants 18,19 and 22, the communication channels were determined by the nature of the communication content. Indeed, mass media channels and media relations techniques were useful to distribute public relations-generated stories, whereas a mix of mass, conventional (group) and interpersonal communication channels were used for the promotional messages (2012). The nature of the communication did not only reflect the selection of the channels, but the communication levels as well.

As an illustration, the drug control department used press releases to disseminate information about successful arrest and seizure operations as well as the executions of drug traffickers. Similarly, mental illness and addiction complexes promoted the available services in the Saudi mainstream media. The Saudi National Committee for Narcotics Control tried alternative ways to reach their audience, including the use of posters, brochures, booklets, lectures, school visits, seminars and exhibitions. Committee publications also contained public relations-generated information such as available health services contact details and the number of police call centres to report suspicious activities.

I questioned the reasons behind the public relations-generated stories in the anti-narcotics agencies, communication, and the explanation I got from the participants from these organisations was that the intention was to keep stakeholders informed about their activities. In particular, they wanted to inform citizens and other government and non-government organisations in the Kingdom that the agencies were active in cracking down on illicit drug networks but wanted to help addicts. Such a stance was repeated to me several times by participants 10, 11, 15, 16, 18, 19 and 22 (2012), all of whom believed the basic strategy was to let the public know that the government was active in fighting illicit drugs.

The main aim of these communications in the 1980s, therefore, was to attract the media's attention. Information and public relations material – such as human interest stories about successfully reformed addicts – was provided to convey the progress of various efforts and initiatives. The use of public relations content in this context is compatible with scholars' basic understanding of public relations as maintaining a good relationship between the organisation and the

stakeholder or the government and the public (Butterick, 2011; L'Etang, 2008; Seitel, 2011; Theaker, 2004; Yeomans, 2006).

The practice of disseminating news about government's efforts against drug abuse through public relations content continues to be a key element of present practice in Saudi Arabia. Advancements in technology have also helped these agencies to expand their activities and incorporate new methods of communication. Significantly, Islam-oriented health content⁴⁴ is now also embedded into public relations-generated messages.

The use of the mass media in the 1980s to deliver public relations-generated and awareness messages fitted the characteristics of the potential audience (Saudi) at that time. This was not only because of the media's ability to reach the masses, but also because of the mass media capacity to disseminate messages among illiterate people (Al-Kazi, 2008; Farsy, 1990).

According to Participant 18, "I wish I had some photos of our exhibitions and display booths 15 or 18 years ago. At that time our activities were very simple and personal" (23-12-2012). Simplicity, non-theory based efforts and an absence of archiving were clear features of communication in the 1980s. This simplicity was the result of three elements: First, this intervention was the first of its kind in Saudi, so there was no previous experience of health communication about drug abuse, with the exception of the conventional, faith-generated communication from the mosques. Second, health communication as a discipline was still in its infancy at this time, and few institutions provided training in this topic. Also there was little international collaboration. For example, conferences were few and far between and were almost always held in the West (Harrington, 2014; Kar et al., 2001c; Kreps, 1989; Kreps et al., 1998; Kreps, 2014; Wright et al., 2012). Finally, the public information model did match the work of Saudi agencies (such as the National Committee and others) in the 1980s. As Diagram 6.5 (above) shows, the context impacts heavily on all the Saudi model elements. The public information model provides a

⁴⁴ For instance, the Ministry of Islamic affairs reports about the mosques activities in facing the substance abuse phenomenon, also the Saudi drug control authority claim that their act against drug abuse is on the basis of the Saudi government adherence to the Islamic teachings. Further details are in the previous chapter.

comprehensive view, considering all elements at that time which affected the communication process.

The global and domestic anti-drugs climate in the 1980s was an influential factor in terms of policy (see Fields, 1995; Forman & Lachter, 2011; Lachter & Forman, 2011). Indeed, the 1980s witnessed the emergence of new conventions and more collaborative efforts in the international system of drug control (Pietschmann, 2007; UNODC, 2008). So the local and international spheres were in favour of action against drug abuse.

In terms of the media environment in the country, government censorship ensured close control over the media agenda on drug abuse. This supervision has continued, though with less control due to the emergence of new media and technologies⁴⁵. The Islamic perspective on addictive behaviour, hygiene and health has continued to be a prominent part of official Saudi anti-narcotics efforts and policy. “The logic that drives the promotion against drug and alcohol abuse is the Islamic logic” according to Participant 2 (24-9-2012). Examples of this were the inclusion of Islamic verses in the communication content as well as the continuing role of the mosques in the promotion of anti-drug messages. The government, in other words, has continued to rely on the social communication by mosques (faith-based institutions) to face the problem of drug abuse (see previous chapter).

Although, the authorities recognised the national cultural position, other cultures did not receive similar attention. Saudi Arabia in the 1980s witnessed the early waves of major social-lifestyle changes. As mentioned in Chapter Three, age and nationality structures shifted dramatically as a consequence of oil wealth and improving economic and health standards. In addition, there was a huge influx of foreign workers from multiple nationalities and cultures (CDSI, 2010; CDSI, 2014; Tabutin & Schoumaker, 2012). Ignoring cultural diversity continues to be a feature of the design, implementation and evaluation of health programmes in Saudi Arabia.

⁴⁵ For further information see section 3.5 in Chapter Three.

This was confirmed during my field trip in 2012/13. Asked why all the messages, content and design of programmes were devoted exclusively to a Saudi-Arab-Muslim audience, this was justified in two ways. First Participants 10, 11, 15, 16, 17, 18, 19 and 22 agreed that the problem of drug abuse (illicit drug use) statistically is more common among the Saudi than any other nationalities in the Kingdom (2012). By contrast, only Participant 23, who works in the Ministry of Health, admitted the lack of theoretical and structural capacity in the system of communication and prevention (31/12/2012).

The Saudi figure of illicit drug abuse is much higher than the non-Saudi, because of the high proportion of youth among the Saudi. Guest workers tend not to engage in risky behaviour. However, there are undoubtedly many non-Saudis living in the country who take drugs and drink alcohol to excess. So the need to add cultural diversity thinking into health communication and prevention is now imperative in Saudi Arabia. As the third chapter of this thesis indicated, 30% to 35% of the population in Saudi Arabia are non-Saudi nationals.

Furthermore, all the participants from the official authorities responsible for illicit drug control draw attention to the domination of non-Saudi among the illicit drug dealers and smugglers, something the official figures over many years confirm (MOI, 1975; MOI, 1979; MOI, 1980; MOI, 2010; MOI, 2011). Evidently, only a culturally diverse approach to communication on drug-related issues will enable the authorities to reach drug smugglers from multiple backgrounds or to constrain the black market in illicit drugs. As discussed in the literature review of this thesis, a cultural perspective on health communication can be expected to reach marginalised groups in society and give them a chance to discuss and express their ideas (Dutta, 2008; Dutta & Basu, 2011; Dutta, 2014).

The prevailing paradigm of communication and prevention encompasses Islamic values in dealing with the drug-related problems, and uses Arabic as the main medium by which messages are conveyed. Non-Arabic speakers, both Muslims and non-Muslims, have therefore been excluded. This too poses challenges in Saudi Arabia to anti-drug and anti-alcohol initiatives.

I have mentioned that Dutta, among others, critiqued the dominant (scientific) paradigm of health communication that was prevalent in the 1980s as too focused on individual cognition to the exclusion of the cultural element (Airhihenbuwa, 2010; Airhihenbuwa et al., 2014; Dutta, 2008; Dutta & Basnyat, 2010; Iwelunmor et al., 2014). Similarly, the prevailing Saudi paradigm considers local and Islamic factors, but does not integrate cultural diversity. Both the dominant (scientific) and Saudi paradigms share the feature of imposing a set of ideas on inconsistent recipients. This approach to related-drug abuse problems contradicts Saudi modernisation and development plans, especially the necessity for guest workers (see Chapter Three). The paradox is a good example of how top-down communication in particular situations may be far less effective than interactive communication. There is no question that in some situations, there is an imperative to open communication channels with recipients, to receive feedback, suggestions, and complaints or just to assess progress. One-sided communication between human groups such as interpersonal, group and public communications need to be converted into a two-way asymmetrical model, such as the one developed by Grunig et al (Grunig & Hunt, 1984; Yeomans, 2006). This is supported by the Saudi experience.

By contrast, outreach and publicly-distributed messages are at the core of mass mediated communication. The arrow in Diagram 6.5 with two directions between the agencies and the targeted audience represents the shift toward asymmetrical from symmetrical ways of communication (interactive communication). However, the prevalence of this depends in Saudi Arabia, to a large extent, on the programme manager and to what extent he or she understands the benefits of adopting this style.

It is important to note that the health communication messages disseminated in the 1980s by the Saudi National Committee and other governmental organisations were carefully considered for the accuracy of the content and information. Participants (such as 18, 19 and 22) who experienced working in the 1980s in the field described the considerable effort that was taken to carefully review messages for errors and misunderstandings (2012).

Certainly, government supervision and involvement was an essential component of the communication process and closely matches features of the public information model, notably the delivery of true information (Ibid). In addition, it shows the Saudi authorities were interested in providing the correct message to achieve high and effective impacts on public health knowledge, attitudes and behaviours.

Through the journey of this thesis, I have searched for answers about the story of health communication against substance abuse in Saudi Arabia. An anti-drug campaign, in particular, has gained a special focus. It was called the *AlQafilah campaign*⁴⁶, meaning the anti-drug campaign caravan (1990). Besides the anti-drug element of this campaign, the emergence of public health awareness and the placing of communication concepts on the public and official agenda marked a profound shift in the way in which public health problems were managed.

In the following section, I will describe this campaign based on information gleaned from the participants in my research as well as from some of the original works written about it.

Saudi's first anti-drug campaign was a memorable episode for many of those who were involved in it. Participants with years of experience in the sector (such as Participants 18,19, 20 and 22) refer to the campaign as one of the foundations of anti-drug communication in the country. For all of them, the campaign's legacy is something that needs to be analysed and used to learn from and improve.

The campaign slogan "Say No to Drugs"⁴⁷ (in Arabic *La le Almuhadirat*) has been carved into Saudi memory and is commonly recalled when the issue of drug prevention or communication is raised. Officials with years of experience (Participants 18, 19, 20, 22, and 24) but also young people who were part of the

⁴⁶ The known information about the caravan campaign originated from the published materials either academic or media outlets or organisational communication or word of mouths (Al-Anzi, 1991; Al-Beshr, 1990; Aloffie, 2012).

⁴⁷ Aloffie believed the National committee and the campaign committee inspired by the 1980s popular US anti-drug campaign slogan "just say no" (Aloffie, 2012; Lachter & Forman, 2011).

focus groups (1, 2, 4, and 5 (2012), most of whom were born years after the campaign, all remembered the slogan.

All brought up the banner of the campaign into the discussion as something assumptive about drug prevention in Saudi Arabia. Fortunately, the slogan matched with the Islamic zero-tolerance with intoxicants and drug intake.

Launched in 1990 by the newly established Narcotics Control Committee, the slogan was not only a vehicle for the delivery of the promotion message, it also matched Islam's intolerance of intoxicants (Al-Anzi, 1991; Al-Beshr, 1990; Alofie, 2012). The Anti-drug campaign caravan was the committee's solution to the problem of how to reach the public in a creative way, besides the routine media outreach and the normal media coverage of illicit drug issues in the country (Ibid). Therefore, the caravan tour around Saudi's cities and towns was perceived as a new dimension in drug abuse prevention⁴⁸.

This campaign used the community-education approach to health communication to achieve the goal of reaching the unreachable in Saudi's towns and cities (Abroms & Maibach, 2008b; Alcalay, 1983; Helme et al., 2015; Wilkinson, 2013). Although the media and mass media were used by the campaign, direct communication (interpersonal and group levels) was the primary mechanism of the campaign. The programme in every city consisted of; a caravan⁴⁹ tour over ten kilometres around the city or the town, a scheduled programme in the campaign theatre and exhibition⁵⁰, and live media coverage (media relations tactics) (Al-Anzi, 1991; Al-Beshr, 1990; Alofie, 2012).

⁴⁸ Basically, the campaign mixed between non-traditional methods and excitement, and the name itself illustrates the idea of the campaign (Alofie, 2012). The campaign used a caravan of vehicles, motorcycles, trucks, a carriage pulled by horses carrying a military music band, helicopter through scattered of flyers while the caravan moving on routes and camels with anti-drug banners (Al-Anzi, 1991; Al-Beshr, 1990; Alofie, 2012). Together with an exhibition, camp and stage (theatre), the caravan toured twelve Saudi cities in 45 days (Ibid). Furthermore, the ministry of information assigned two teams to update the media industry about the campaign activities; one from the Saudi television and radio to send daily bulletins about the campaign from where it was, and the second team was from the Saudi Press Agency (Al-Beshr, 1990).

⁴⁹ The caravan length was 600 meters (Al-Beshr, 1990).

⁵⁰ To demonstrate that the following tools and tactics were used in the exhibition and camp such as the use of drug samples, students' art works, and videos about the drug law forces accomplished operations, and the printed short messages about the negative outcomes from the drug intake (Al-Beshr, 1990; Alofie, 2012).

In the years since, some of these campaign methods and tools of communication have been integrated into other prevention initiatives. Not only has the caravan idea been passed on within drug prevention communication, but also the organising of exhibitions. The campaign's ingenious methods of attracting attention and delivering the messages are considered a pull factor for the media to cover the events as well as the targeted groups to attend them.

As a first attempt, the "Say No to Drugs" campaign worked well in the public mind, but behind the scenes the quality of the campaign management was less than impressive. All the commentators agreed, for instance, that no evaluation element had been built into the campaign design (Al-Anzi, 1991; Al-Beshr, 1990; Aloffie, 2012). There was, therefore, no way of knowing how effective it had been. The lack of expertise and experience were acknowledged as factors that restrained the efficacy of the initiative. Only one Masters level study has been conducted to examine the influence of direct-communication, and it did find positive impacts for the campaign on the illicit-drug users' willingness to seek treatment. However, there was no progress or summative evaluation research after the campaign.

6.6 Evaluation, Progress and New Direction

The question of evaluation cannot be isolated from the absence of a system to document or record the communication campaigns and interventions. You may recall Participant 18's words, "No, we do not have archives for our campaigns, exhibitions and programmes, but we in the directorate recognise internally our works and success every two to three years, we also evaluate ourselves from the feedback and comments we receive from other governmental organisations in writing or in person" (23-12-2014). The field trip of this study confirmed for me the non-existence of a well-developed or managed evaluation process in the Saudi drug abuse prevention sector. This was the case during the 1980s for the first ever Saudi anti-drug abuse intervention, and has been so in all the subsequent years. However, I did ask the research participants whether the first intervention impacts were measured.

There are some figures and statistics available, especially from the security forces, according to Participant 22:

After the precautionary measures implemented by the government, the level of illicit drug-use decreased. Especially after the opening of the specialised hospitals, the introduction of the death penalty and the beginning of the National Committee. I believe between 1988 and 1992 the problem was contained and even the beds in the addiction hospitals were not fully occupied (31-12-2012).

The only evaluative evidence was the amount of the seized illicit drugs as well as the number of those caught using them. There was, therefore, no theory-based evaluation of the first anti-drug intervention, nor did this happen in the years to come. To verify this claim⁵¹, the Saudi Ministry of the Interior's annual statistics⁵² were reviewed in the period before, during and after the intervention. These figures are visualised in the following chart 6.1.

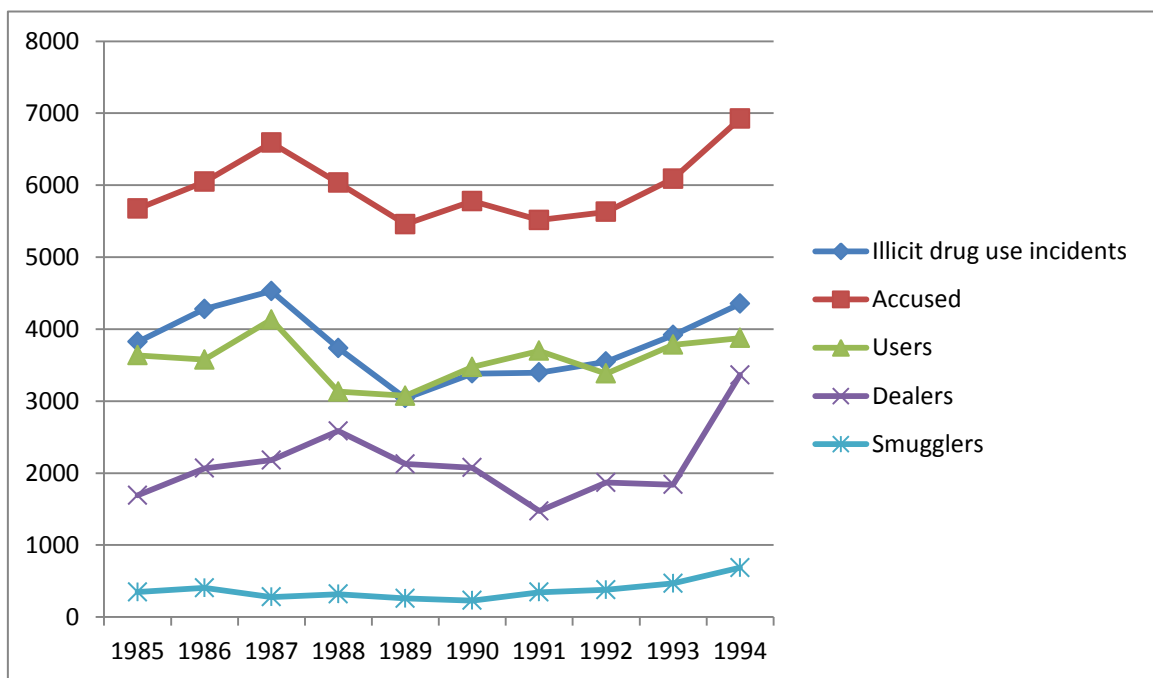


Chart (6.1) Saudi Ministry of Interior Drug-related statistics between 1985 and 1994.

⁵¹ The claim of the 1980s intervention effectiveness in reducing the number of illicit drug users was mentioned by several participants.

⁵² These figures were extracted from the Saudi Ministry of Interior annual books for the years between 1985 and 1994.

The official figures indicate a decrease in all the drug-related trends during the early years of the intervention, particularly the illicit drug business. There are two possible reasons for this. First, the death penalty was introduced. Second, the multifaceted nature of the intervention brought positive outcomes. Chart 6.2 shows the impact of these measures, notably capital punishment, on the quantity of seized illicit drugs.

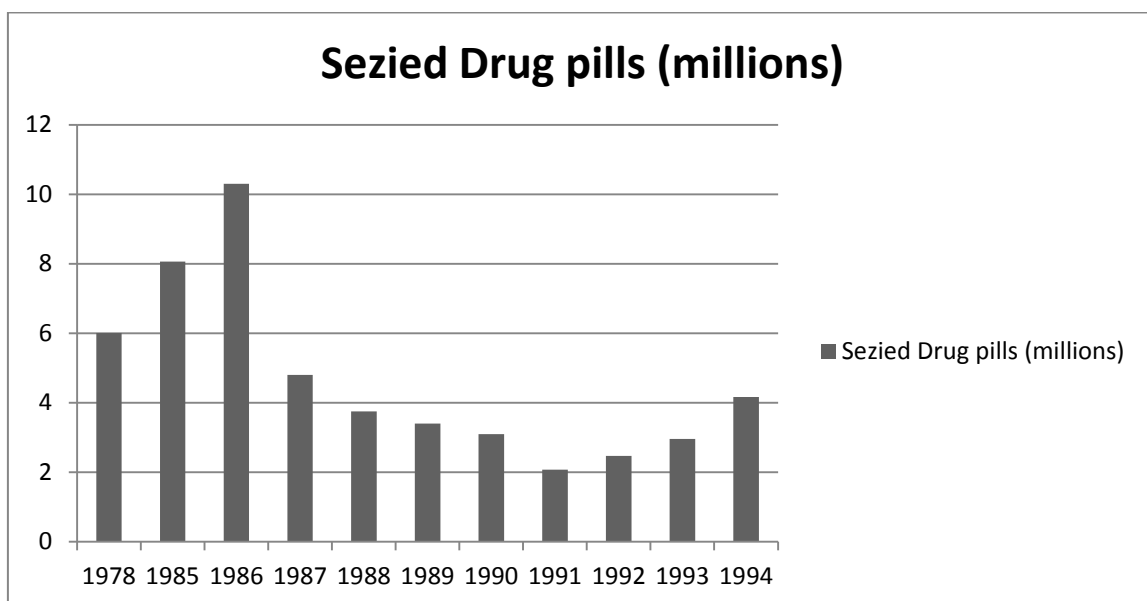


Chart (6.2) Seized Drug pills in Saudi Arabia between 1978 and 1994.

Since the death penalty for drug smugglers was activated in 1987 in Saudi Arabia, the number of seized drugs halved. However, the situation has shifted again from the mid-1990s. In fact, regional drug smugglers succeeded in absorbing the effects of the Saudi regulation⁵³. Participant 22 noted there had been changes in the global illegal drug market too.

After 1993, the problem started to reverse and cases of illicit drug use have started to rise, even though security efforts were in place. But it is the growth in the global market of illicit drug that leads to that. I can summarise the reasons as; an increase in production in the producing countries, secret drug factories in neighbouring

⁵³ Together the increase in illicit drug production in the region and the security instability in neighbouring countries have provided the illicit drug smugglers with opportunity to find new smuggling routes. Of course, these networks took the risk by sending desperate, poor, mules without considering the possibility of being caught and executed. It is deprivation and economic needs behind the mules taking the risk.

countries⁵⁴, and growth in the heroin and cannabis (hashish) trades in the region. (31-12-2012).

Though the participants who experienced this period agreed there had been a temporary decrease in the official Saudi statistics, this is impossible to verify without proper evaluation mechanisms or completed studies. As a result, this chapter endorses the call for further research on the 1980s initiative and stresses the necessity of introducing an archiving system and well-designed evaluation procedures to gather ideas and data about the anti-drug effort (see the next chapter for further calls).

Besides the temporary reduction in drug seizures and prosecutions, an important positive outcome of the first campaign was the acknowledgement of communication and promotion as vital elements in the fight against risky-health behaviour such as drinking alcohol and drug use. The first intervention also established the basis for the current Saudi system of drug control, prevention and health rehabilitation.

This strategic step to use organised and government-sponsored communication to fight drugs in Saudi was not without the contribution of the Islamic perspective on health guiding the effort. The opening of the hospitals is an example of how health infrastructure and religious-inspired promotional messages can be integrated into communication. It connects with the argument of human body rights and the Islamic teaching to believers in seeking treatment from illness (see section 5.5 in the previous chapter).

Reliance on the quantity of seized illicit drugs and alcohol, and the number of incidents of substance use in measuring the impacts or the effectiveness of the communication campaigns and programmes has been in force since the 1980s. The Ministry of The Interior has issued some figures about the growth of the problem, including data about the educational

⁵⁴ The illicit drugs are cultivated and produced in neighbouring countries such as Lebanon, Iran, Yemen and Egypt. Therefore, any changes in these countries' illicit drug markets as well as the smuggling routes will reflect on Saudi Arabia. Some scholars argued this phenomenon (J. Marshall, 2012; Robins, forthcoming 2015).

background of the users⁵⁵. The chart (6.3) below shows the high degree of illiteracy among drug addicts in Saudi Arabia.

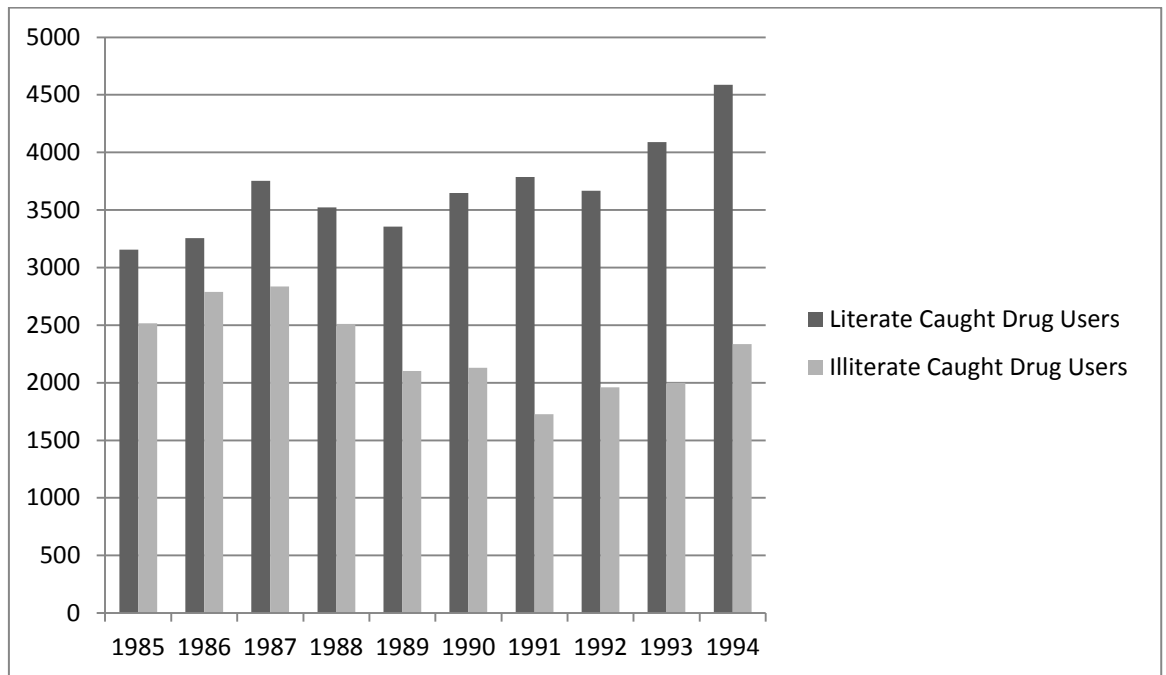


Chart (6.3) Literacy level among Drug addicts in Saudi Arabia between 1985 and 1994.

The high proportion of illiterate drug users in the 1980s is justification for why the first intervention relied on the mass media to reach those at risk, and why the messages were in Arabic (as explained above). Furthermore, the figures match with the rise in the literacy rate that Saudi Arabia experienced from the late 1970s to the 2000s. Therefore, the chart above shows steadily increases in the number of educated/literate users. The high percentage of youth in the Kingdom and the high level of literacy, suggest a reliance on the mass media is no longer a match for the new society. This reinforces the call for interactive and participatory communication as well as for tailored programmes, as I discussed in section 5.5 in the previous chapter. Again, participatory communication is essential in order to hear the non-Saudi residents in the kingdom.

The absence of evaluation methods and documentation of communication efforts, as explained by participants 1 and 23, has largely been

⁵⁵ These figures were extracted from the Saudi Ministry of the Interior's annual books for the years 1985 to 1994.

due to the lack of a theoretical basis to communication about drug abuse prevention (2012). Said Participant 23:

The problem in our work is that we do not have proper planning for our health promotion national and media campaigns. If there is planning it would be inaccurate or conducted by non-specialists. As you know, there is a new approach to design and managing campaigns, which is Social Marketing. However, we in our organisation claim that we use it, but the reality contradicts that. In fact, there are some areas in campaign design and management which need further work. Most importantly, campaigners in our department do not do segmentation of targeted groups based on risk factors or the demographics very well. Also, the problem of discontinuity of the campaign and the sudden appearance and disappearance of campaigning is one of the problems we need to address. So, there is not continuity in the programme's development. (31-12-2012).

There is consensus among participants from the Saudi public drug abuse prevention organisations and among the NGOs that there is a shortage of expertise in campaign management, health communication and in health promotion in these organisations. Indeed, participants 10, 16, 17, 18, 19, 20, 22, 23, 24, 27 acknowledged this has been a persistent problem until now, and have said it was a necessity to introduce more special training in communication, campaign and alternative approaches that includes new technology and cultural diversity. In particular, the lack of expertise has encouraged the continuing use of conventional communication methods such as the top-down communication and communication in, by and through mosques (see the previous chapter section 5.5).

By the mid-1990s, government-led efforts had eased. Branches of the Saudi Directorate of Drug Control continued to focus mainly on undermining the illegal drug networks, but some work continued on the promotion side as well, often in partnership with related organisations. However, during the 1990s and the early 2000s, the numbers of drug users and the quantity of drugs seized by the Saudi authorities had soared. The recent World Drug Report issued by the UN stated that 25% of the seized amphetamine pills in Asia were recorded in

Saudi Arabia (Khattab, 2013; UNODC, 2014e). The Chart 6.4 below contains the figures between 1999 and 2011 for those caught by the Saudi authorities for using illicit drugs in Saudi Arabia⁵⁶. There is a clear difference between the figures of the 1980s (see chart 6.1) and following years. About 4000 users were caught in the 1980s rising to over 30,000 by 2010.

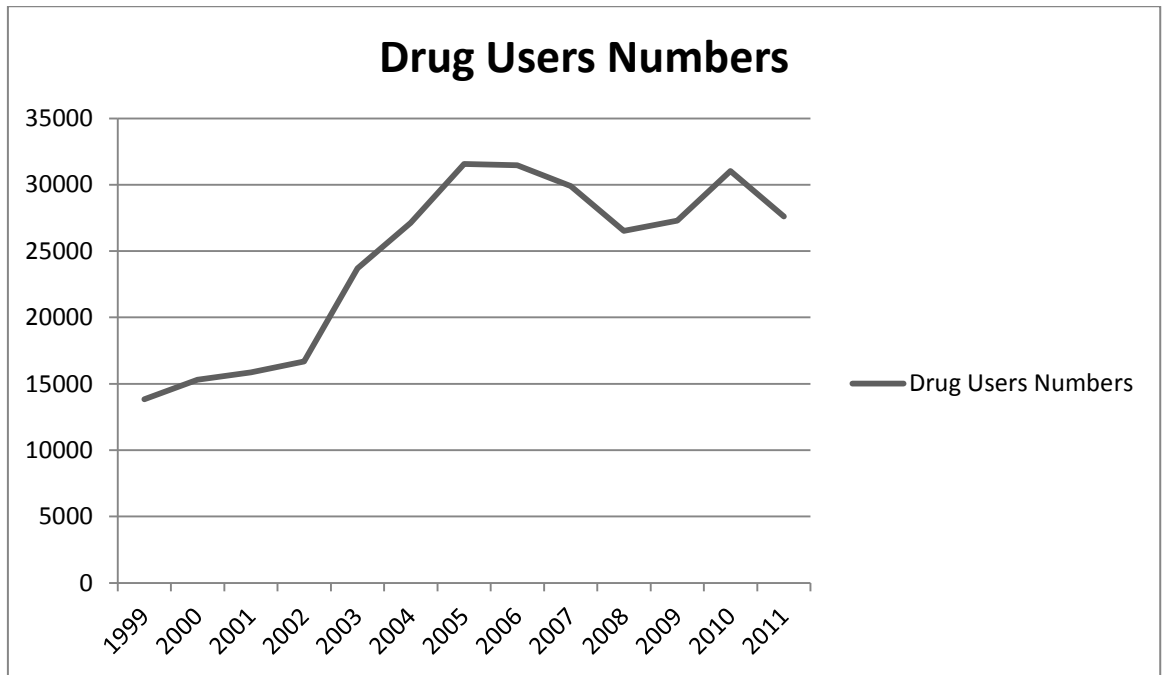


Chart (6.4) Illicit Drug users caught between 1999 and 2011 in Saudi Arabia.

These figures raised the alarm in the Saudi government and efforts were made to revisit the 1980s measurements and update them. Of particular concern given the improved prevention measures introduced in 2005, was the recognisable growth in the number of illicit drug users, as the chart above shows. Participant 22 summarised the strategic shift:

The problem got worse, and that required raising Drug Control from a Department in the Ministry of the Interior to Directorate level with more manpower and funding. That was in 2006. In addition, in 2007, the Saudi Ministers Council reactivated the Saudi National Committee for Narcotics Control with the Minister of the Interior as its head. Also, it included many related ministries in its membership, and notable people and businessmen. In 2008, the Saudi National Strategy to Combat Narcotics was issued to shape related policies

⁵⁶ These figures were taken from the annual books for the Saudi Ministry of Interior for the years between 1999 and 2011.

and to coordinate the specialised organisations. Also, it gave more roles for the education, religious and media institutions in the prevention and promotion side of the fight against illicit drug use (31-12-2012).

A number of key strategic shifts in government's management of the drug abuse problem are evident. The re-introduction of the Saudi National Committee to be the top authority responsible for strategic planning was important. In fact, both participants 19 and 22 acknowledged the change in the National committee's function from a committee responsible for the design and implementation of the promotion programmes⁵⁷ to responsibility for policy and strategic planning (Participant 19, 24-12-2012; Participant 22, 31-12-2012). However, none of the new measures made mention any intention to introduce a National Household survey or referred to data collection of Risky-health Behaviours survey. This again shows the urgent need to consider all the relevant statistics and data when designing strategy aimed at combatting illicit drug abuse.

The second shift was the development of a Saudi strategy on substance abuse containing seven objectives; to identify the types of drug abuse, characteristics and purposes; to gather all the conventions, law and Saudi government decisions in relation to Narcotics use and psychoactive substances; to develop prevention plans; to develop current treatment plans and programmes; to activate and develop rehabilitation, and, to develop and activate regional and international collaboration to combat drugs; and develop drug control methods. Each objective contains special aims and mechanisms to achieve it (SNCNC, 2007).

The strategy is strong on content, but the implementation has lagged and the continuity has been inconsistent. Saudi NGOs specialising in quitting smoking and drug abuse problems have been brought in to assist.

One participant (10) pondered whether government's dwindling commitment was a way of minimising the negative impact of the drug problem

⁵⁷ Such as the campaign "Say No to Drugs" mentioned in the previous section.

on the country's reputation: "In the last four years, there have been improvements, but in a different way to the past, especially with his highness the Minister of the Interior's recommendations to equalise security efforts and prevention. This is our new direction, to put prevention as the first line to protect the society" (19-11-2012). The new direction needs further consideration of future research to measure the effectiveness of the strategic shift and the changes in the real world.

6.7 Conclusion

The first health communication campaign/intervention in Saudi Arabia against risky-behaviour regarding substance abuse took place in the 1980s. Since then, a sequence of campaigns, programmes and interventions have been implemented. Under pressure from both internal and external elements and against a background of the continuing growth of the illicit drug trade globally and locally, the Saudi government has acknowledged the urgent need to intervene. It understands that this response needs to be more nuanced and sophisticated than the old method of relying on the mosques. The first intervention against drug abuse, which took place in the 1980s, established the foundations of a medical and rehabilitation-oriented perspective but also cultivated the notion of communication as a necessity in the campaign against drug abuse in the Kingdom.

Both collaboration and a wide-ranging approach were the common characteristics of the 1980s health communication campaigns/intervention. To some extent, these continue to be represented in the essence of present practice, especially in the government-sponsored programmes. The first intervention founded a system driven by law, policy and government support to tackle the drug abuse problem and it required collaboration between the special government organisations and a multi-dimensional approach.

This review of the emergence of health communication highlights the connection between state-building in Saudi Arabia and the late start of manageable drug abuse prevention programmes. Indeed, the beginning of health communication in Saudi Arabia was based on government's decision to tackle the problem of illicit drug use. Due to the nature of Saudi Arabia's political

system, Islam occupies a central position in official perspectives toward health and addictive behaviour. This has, indeed, been at the core of the first intervention as well as in subsequent initiatives. Also, the development of government-led health communication did not stop the social roles of the mosques in the promotion against substance abuse.

Health communication in Saudi Arabia has largely normalised due to the move from conventional-religious communication to organised, contemporary communication methods. Scholars such as Sood argue this is a step in the right direction and will help Saudi develop more sophisticated methods such as around information provision, social marketing and strategic planning (E. Crawford & Okigbo, 2014; Sood, Shefner-Rogers, & Skinner, 2014). However, the current status of health communication in Saudi Arabia contains many aspects that need to be addressed.

The shifts in the demography as the country's development and modernisation project continues, and the absence of considerations of cultural diversity has necessitated a far more diverse and inclusive approach to health communication programmes against substance abuse. A phase of participatory communication is now imperative to enhance the efficacy of the interventions. Dutta's culture-centred approach offers potentially the best theoretical paradigm for achieving this shift⁵⁸. Furthermore, as this chapter has stressed, the lack of reliable or consolidated statistics will continue to hamstring scholars' efforts to grapple effectively with these issues and will prevent policy being based on adequate information.

This chapter has noted the lack of theory in the design, implementation, and evaluation of the first communication intervention, and the absence of proper evaluation methods in current health communication campaigns/interventions in Saudi Arabia. In the next chapter, I will make further recommendations to the Saudi substance abuse prevention sector, one of the strengths of this study as a whole.

⁵⁸ See the second chapter section 2.4 for further details.

Chapter Seven: Conclusion and Recommendations

7.1 Introduction

This chapter will synthesise the issues and findings of the study and consider their implications in terms of the research questions. I will set out the answers I have been able to find and plot possible ways forward for further research. In addition, I will outline how the study findings inform the literature of health communication. In order to carry out these tasks, the chapter has been divided into six sections.

First, the findings of the study will be presented and will be correlated with the research questions. Then, I will reflect on what these answers mean for the field and for the practice of health communication in Saudi Arabia. Furthermore, this chapter will highlight the study's contributions to mainstream health communication literature. It will propose a number of recommendations based on the findings and will consider both the strengths and limitations of the findings as a whole. After considering possibilities for future research, I will endeavour to pull all the ideas contained within this work together. Let us turn, first of all, to the findings.

7.2 Key Findings and contributions

This section will discuss the study's collective findings. In order to do this, I will first highlight the key results before going into more detail. Then, I will describe what these findings add to the current debate in health communication literature, specifically, how they confirm some aspects of the literature while contradicting others, and the key differences.

The findings of this dissertation can be grouped into two themes: one, understanding the influence of Islam on communications aimed at preventing substance abuse, and two, evaluating the critical role played by the government in distributing health communication messages.

Overall, the findings from both themes collectively and emphatically support the necessity of including the dimension of culture in health communication. This supports the stance of a growing number of scholars in the

field¹, in particular, the recommendation from Dutta and others to integrate culture into the heart of designing, implementing and reviewing health communication efforts (Basu & Dutta, 2009; DuPré, 2014; Dutta, 2008; Dutta & Basnyat, 2010; Dutta & Basu, 2011; Jamil & Dutta, 2011). Furthermore, the study points out the usefulness of participatory communication within health communication programmes for integrating the marginalised and creating a space for their voice to be heard.

By the same token, the findings' reference to culture in health communication extends to the key role religion--in this instance, Islam--plays in preventing risky health behaviour and explains the emergence of this role. The previous two chapters have portrayed the Islamic perspective and the reasons behind the integration of this model into Saudi Arabian culture and life. The Islamic perspective on health in general and especially that concerning addictive behaviours such as gambling and substance use, inform and guide Saudi health promotion activities as well as its education and communication efforts. This perspective is fundamental to Saudi's cultural antipathy to the illicit use of drugs and to the consumption of alcohol because of the effective absorption of Islam into the country's political system.

Indeed, as I demonstrated in Chapter Five, Islam's teachings contain specific reference to a prohibition on substance abuse while endorsing the need for the treatment and rehabilitation of the afflicted. Islam also encourages the promotion of its principles to its believers and beyond to other communities.

The presence of these Islamic teachings and principles in Saudi Arabia and in other Muslim communities has acted as a protective factor in these societies, with international statistics confirming comparatively lower levels of alcohol addiction, marijuana smoking and sexually transmitted diseases (Al-Mazrou, Al-Jeffri, Fidail, Al-Huzaim, & El-Gizouli, 2005; Filemban et al., 2015; Gray, 2004; Madani, 2006). Furthermore, the presence of an Islamic model in Saudi has had a direct impact on both the channels of communication as well as the content. Health awareness messages have been disseminated in

¹ For further details about the current debate in health communication look at sections 2.2.2 and 2.4 in Chapter Two.

mosques for centuries and it was from these institutions that Saudi's first organised effort to prevent drug abuse was attempted.

On their own, however, the mosques have struggled to cope with the pressures of modernity. Growing demand from the youth for drugs and alcohol and changing technologies have forced health communicators to adopt a more modern approach. In fact, Islam encourages open debate within and between communities (Younos, 2011; Younos, 2013). This suggests an effective preventative effort is still possible within the framework of Islam, though there is still work to be done in order to cope with important contemporary shifts, such as Saudi's rapidly evolving cultural diversity. Additional comments and ideas, including those about the necessity of adopting a culture-centred approach and the introduction of a more culturally diverse perspective will be discussed in section 7.3.

Certainly, it is necessary to critique the top-down communication model used by promoters and mosques and to evaluate the old way of communicating about substance abuse, which contained Islam-oriented messages but often failed to listen to those at risk or meet their needs. It is evident that the use of participatory communication is more likely to avoid cultural obstacles such as language and to give space to young people and the most vulnerable and marginalised groups to express their views (Dutta, 2008; Dutta & Basu, 2011; Kreps & Kunimoto, 1994).

The strong presence of the Islamic teachings in the findings reveals a fruitful avenue for further research (*see the future research section 7.6 below*). This perspective has already attracted a great deal interest from scholars and a large corpus of work has developed. However, these efforts have frequently been subject to duplication, discontinuity and poor design (Adib, 2004; Ahmad & Harrison, 2007; Ahmad, Harrison, & Davies, 2008; Ahmad, Harrison, & Davies, 2009; Al-Omari, Hamed, & Abu Tariah, 2014; Bader, Musshauer, Sahin, Bezirkan, & Hochleitner, 2006; Celen, 2014; EL-Islam, 2009; Ezenkwele & Roodsari, 2013; Grand Imam Gadul Haq, 2000; Hameed, Jalil, Noreen, Mughal, & Rauf, 2002; Hamjah & Mat Akhir, 2014; Jamil, 2014; Koenig & Al Shohaib, 2014; Laeheem & Binwang, 2013; Rassool, 2014; Salem & Ali, 2008; Sheikh,

2007). In spite of all this work, very few scholars have attempted to address the question of Islam in health communication and health care or have taken a culturally sensitive approach (Ahmad et al., 2008; Al-Krenawi & Graham, 2000; Hasnain, 2005; Kumpfer, Alvarado, Smith, & Bellamy, 2002; Shrank et al., 2005).

This thesis also presents, for the first time, a narrative about how communication against drug abuse and the drinking of alcohol started in Saudi Arabia. The 1980s marked a shift in the country from being dependent on mosque-based efforts to the development of government-sponsored drug abuse prevention programmes to fight the growing problem. The previous chapter highlighted the Saudi government's domination of health communication against risky health behaviour. Comprehensive and collaborative steps were taken to establish a system of control and punishment and to start recording data and statistics. This period saw the emergence of organisational thinking as a strategy. Driven by their values, Islamic institutions, however, have continued fighting to the use of drugs and alcohol. Their interventions are still hampered by a lack of providing reliable data, including the absence of proper evaluations and an adequate documentation system. The need for an efficient surveillance system to monitor risky health behaviour has also been noted in the previous chapter.

It is important to mention the dynamism of Saudi culture as it absorbs the waves of guest workers and changes as a result. It does this while holding the mantle as the leader of the Islamic world by virtue of the legacy of its holy sites and history. The country takes its duty to communicate the Islamic perspective to a global community of believers seriously.

This study introduced new insights into the field literature by examining the practicality of health communication in Saudi Arabia as well as the theoretical basis behind this practice. In fact, the findings extended the literature spectrum to cover such a new context as Saudi Arabia, an Islamic-inspired context. Besides exploring what was going on in Saudi Arabia, the study was able to determine if the mainstream health communication literature is

applicable to this context. In the end, it proved that some aspects of the literature are viable, while others are not.

Starting with the study's overall examination of the literature², it found that Saudi culture played a positive role in communicating about health and substance abuse issues as well as in the local regulation. The deep influence of this culture stems from the Islamic perspective of health and the strong presence and acceptance of this perspective in the kingdom. The promising role that religion and faith can play in resisting risky health behaviours gave the examination of the cultural dimension of health communication a narrower and sharper focus. For example, scholars addressed health communication and culture in specific diseases such as child malaria (Iwelunmor, Idris, Adelokun, & Airhihenbuwa, 2010), HIV/AIDS (Airhihenbuwa, Makinwa, & Obregon, 2000; Airhihenbuwa, 1989; Airhihenbuwa & Obregon, 2000), traditional healers (Jamil & Dutta, 2011) and sex workers (Basu & Dutta, 2009).

Moreover, the study's emphasis on the role Islam plays in confronting substance abuse and other health issues coincides with scholars' recent calls to start discussing the relationship between religion, health and health promotion. Miller et al, 2011 and Parrott, 2004, for example, advocate investigating the role of faith institutions and beliefs in health care and health promotion.

The study presented the growing concerns among Saudi youths about the need for health promoters to dialogue with them to better address their needs and approach them more effectively. Collectively, these concerns focussed on shifting the role of the audience from active passive to an active one, particularly in terms of making and circulating health meanings. In this vein, academics such as Lewis and Lewis recommend that health communicators consider the receivers of their messages as an active rather than a passive end to the communication channel (2015). This parallel between the ongoing theoretical debate and the participants' thoughts led me to examine whether this occurred with other aspects of the health communication literature.

² It refers to the health communication and campaigns literature mentioned in sections 2.2 and 2.3 in Chapter Two.

As the previous chapter brought together the experiences and narrative of Saudi Arabia's first health communication initiative against drug use, the value behind writing the history of the health communication profession is well respected and recognised by scholars. Kreps, among others, sees recording and following the steps of early and past health communication efforts as the key to improving the theory, efficacy, evaluation and practicality of future efforts (Hannawa et al., 2014; Kreps, 1989; Kreps, 2014). This also creates an opportunity for sharing experience and for learning from others' success and failure (DuPré, 2014). The Saudi experience can consequently help interested scholars to study and understand the stories of other, neighbouring countries, especially with the shared regional characteristics of oil-led economic improvements and state building, as well as the joint history and geography. My study should prove especially useful to those interested in looking at the experiences of the Gulf Cooperation Countries such as UAE, Qatar, Oman, Kuwait, Bahrain and Oman. Similar examinations have been done by economists in tracing the region's economic history (Al-Kazi, 2008; Alsharekh & Springborg, 2008; Sultan, Metcalfe, & Weir, 2011; Weir, Sultan, Metcalfe, & Abuznaid, 2011).

This study was the first of its kind to be performed in Saudi Arabia with these specific participants. This, taken together with study's rich outcomes is a reflection on the study's research methodology, i.e. qualitative. To put it differently, the research results affirmed that the use of a qualitative methodology is an effective way to examine the unexplored and complicated social world. In fact, the semi-structured interviews, focus groups and observation gave me the opportunity to engage with the participants and hear their experiences. This practice of combining data collection methods is embraced by methodology scholars in health communication and is referred to as 'methods pluralism' (Angrosino, 2007; Kreps, 2011; Lambert & Loiselle, 2008; Neumann, Kreps, & Visser, 2011).

Another aspect of the literature that emerged in the findings was the positive role of religion in health promotion, which confirmed what Koenig and others have achieved in finding a positive correlation between religious beliefs

of health and health care efficacy (Koenig, McCullough, & Larson, 2001; Koenig, 2005; Koenig, 2008; Tolson & Koenig, 2003). In fact, there are a considerable number of studies that elucidate the positive relationship between religious beliefs and better mental health (Koenig, Zaben, & Khalifa, 2012; Koenig, 2012; Koenig & Al Shohaib, 2014). Section 7.6 of this chapter will examine possible directions for further future research.

All these aspects of the findings proved what Mohan Dutta believed to be the strongest reason for studying culture in health communication, namely the fact that culture is where all these health discourses and meanings are discussed and created (Dutta, 2007; Dutta, 2008). Therefore, my study added more support to those scholars who endorse the necessity of studying and exploring the cultural dimension of health communication (Airhihenbuwa, 2010; DuPré, 2014; Dutta, 2008; Miller, Yrisarry, & Rubin, 2011; Parrott, 2004). However, not all of the study findings affirmed the literature's ideas; some aspects of these actually ran counter to the current debate regarding health communication.

Two key points of the study contrasted with the literature debate: the origin of the current health communication against drugs and the theoretical roots of the dominant health communication in Saudi Arabia.

In the previous chapter³, I discussed how the Saudi government initiative in the 1980s was marked by the research participants as the initial step in launching a new form of health communication away from the old mosque-based efforts. Beside the valuable information this chapter added to our understanding of the history of health communication in the kingdom, there is another lesson to be learned. The origin of the anti-drug abuse efforts was a result of the government's commitment to protect the young population from illicit drug use. In contrast, leading health communication scholars have acknowledged the intellectual debate in academia as the trigger behind the emergence of health communication in the West (Kreps, Bonaguro, & Query, 1998; Kreps, 2014).

³ For further details refer to sections 6.2 and 6.5.

As I argued in the literature review chapter, the pioneer study of Korsch et al. in looking at the influence of verbal communication between paediatricians and patients in their relationships was the first academic push for further research (Korsch, Gozzi, & Francis, 1968). After that, other scholars, i.e. transcultural nursing and public health experts, recommended potential positive roles for communication strategies in health studies and practices (Morse, 2003; Morse, 2012). Through the 1970s and 1980s, more promising studies emerged from academia and the scholarly institutions reached grow (Hoving, Visser, Mullen, & van den Borne, 2010; Kreps, 2014; Paek, Lee, Jeong, Wang, & Dutta, 2010; Schulz & Hartung, 2010). Therefore, public health organisations in the West, the World Health Organisation and NGOs embraced health communication as a supplementary strategy to the medical paradigm.

On the other hand, the development of health communication in Saudi Arabia was not academic-oriented, but an act of government, one that continued for a while. Recently, Saudi Arabia witnessed different academic attempts to question and investigate health communication efforts. These can be considered as new momentum for academia in the kingdom. Therefore, the next section 7.3 will present collective recommendations that include but are limited to boosting scholarly efforts and institutions. The reversal in the origin of health communications between Saudi and the West shows how t the differentiation of this communication is based on the surrounding context and internal aspects; scholars have recommended studying the history of health communication to identify such differences (DuPré, 2014; Kreps, 1989; Kreps et al., 1998; Kreps, 2014). However, it would be impossible to frame a universal conception of how health communication evolves.

The study found another key dissimilarity from the literature, namely that there is a different theoretical root for the cultural dimension of health communication in Saudi Arabia. In theory, the cultural perspective in health communication resulted from a scholarly debate led by post-colonialists and critical theorists such as Airhihenbuwa, Obregon, Dutta, Basu, Jamil, Basnyat, Kreps, and Lupton. This debate focused on the urgent need in the 1980s to review cultural competency measures and applications in health

communications mainly in America (Airhihenbuwa, 1989; Airhihenbuwa & Iwelunmor, 2012; Dutta, 2008; Kreps & Kunimoto, 1994). There were different reasons for this academic appeal: the demographic changes in the first world, the 1960s-70s waves of immigration to Western nations, the changing of the household and family structure, the changing of the age structure, the changing of patient perception and the rise of consumerism, as I discussed in Chapter two sections 2.2 and 2.4.

In Saudi Arabia, the theoretical roots for the dominant health communication perspective are theological and religious-oriented. Since the study presented the Islamic model for health and substance abuse as the main navigator of all health communication efforts against substance abuse in the country, see sections 5.2, 5.4 and 5.5 in Chapter five. The Islamic inspiration reflected on the communication channels used, such as the mosque, the messages' content, and the stance of Saudi society towards illicit drug use. For that reason, the post-colonialist perspective in mainstream literature is not applicable to the Saudi environment. Furthermore, Saudi Arabia has not been colonised by any foreign power, therefore, the justifications for the use of post-colonial arguments by Airhihenbuwa, Dutta, Basu, Jamil and Basnyat cannot be implemented in Saudi Arabia.

It is important to note that, in discussing the differences between the results of the study and the ideas advanced in the literature, I do not seek to denote one as right or wrong. In fact, the differences show how the experience of health communication differs from one place to another. Similarly, the study's affirmation of some of the literature's arguments does not imply the universality of these ideas, because, hypothetically, they may fail in another context. Therefore, how to explore different health communication experiences is what can be learned from these differences. In this respect, I am going to introduce some additional ideas that can be taken from this thesis.

Firstly, the presentation of the Islamic perspective of health and substance abuse issues is an invitation to the scholars to look beyond the margins of literature. In other words, researchers should find other possibilities of approaching health problems and alternative ways of improving health status

and minimising health problems. One way of doing this is to research unexplored contexts, as has been done in this study, because each culture is rich in values and principles that can be new grounds for health communicators. This study showed some examples, such as the strong and active presence of the Islamic model, the active role of faith institutions, and the different experience of health communication development. All these factors emerged from the chosen context, Saudi Arabia. Therefore, this study calls on scholars to explore others cultures to find what they can contribute to health communication studies.

This study brought localism back to the scene of health communication; the research participants' comments on the need to include local community members in the design, implementation and evaluation phases of health communication is an additional idea to how health communication should be conducted in Saudi Arabia, especially with high⁴ proportion of youth in the country. A local, community-based approach entails working with the stakeholders from the community to receive the message of how, when and in what way communication should be (Basil, 2014; Haas, 2014; Helme, Savage, & Record, 2015; Wilkinson, 2013).

In section 6.3, the concept of mosque communications was discussed to explain traditional methods of health communication in Saudi Arabia and the current use of mosques in the contemporary practice of this communication. It portrayed how communication campaigns evolved. It can be categorised under the new stance of studying communication campaigns in developing countries in order to understand procedures, patterns, problems and potential solutions, as Roberto et al. did (Logan, 2008; Roberto, Murray-Johnson, & Witte, 2011).

The last lesson to learn from this thesis comes from the valuable information about the four concepts of the Islamic model described here⁵ and how they can be used by practitioners when designing a programme in a predominantly Muslim country or directed to a Muslim minority group. The value of forgiveness, the logic behind the Islamic prohibition, the Islamic preference

⁴ The presence of a high percentage of youth in a community reflects on the type of the health problems there.

⁵ For more details about the Islamic model see section 5.5.

for seeking treatment for drugs abuse, promotion (Da'wah), all of these aspects can be used effectively in health communication campaigns and intervention. There were some attempts to use Islamic institutions, i.e. mosques and Islamic texts, to communicate with the Muslim minority about health issues such in Germany and the results were positive and promising (Bader et al., 2006). A similar effort should be carried out with reference to substance abuse issues in a similar context to Germany among the Muslim minority.

In addition, the Islamic model shows no sign of conflict with the concept of cultural diversity, and the Islamic declaration on cultural diversity of 2004 (Islamic Declaration on Cultural Diversity, 2004) insisted on Islam's recognition of the differences and existence of others, which was clear in verse 13 of chapter 49 in the Quran. Therefore, there are no religious obstacles to prevent the Saudi health communication authorities from adopting a culturally diverse approach to health communication and to at least use more than one language when communicating with guest workers. In the following sections, I will expand on the findings and their implications for practice and for scholarship.

7.3 Recommendations and implementations

The recommendations of the dissertation constitute practical advice generated from this research, directed to the field of health communication and substance abuse prevention in Saudi Arabia. They share one essential objective: the improvement of the status quo of health communication about substance abuse in Saudi Arabia. They vary from structural-oriented to theoretical recommendations. This section focuses on the improvement of scholarly efforts, in particular the consideration of a wider range of theoretical ideas in the preparation of communication programmes, the integration of cultural diversity and the enhancement of anti-alcohol use promotion and structural measures.

In light of the infancy of the health communication and promotion fields in Saudi Arabia (see the previous chapter), the Saudi government urgently needs to encourage and support academic efforts to conduct further research in health communication, education and health promotion with a particular focus on the role of culture. Financial support is, of course, essential to the development of

the field. Driven by the previous experiences of health communication growth elsewhere (Hoving et al., 2010; Kar et al., 2001c; Kreps, 2014; Paek et al., 2010; Schulz & Hartung, 2010), the development of the field should be facilitated in two, parallel ways; theoretical (academic) and practical.

In terms of the scholarly route, there is much to be done if one refers to current measures for assessing the state of health communication and looks, for instance, at scholarly activities such as the number and quality of academic journals and the range of scholarly organisations, academic departments, university programmes and available publications (Paek et al., 2010; Schulz & Hartung, 2010). Unfortunately at present, health communication does not have strong profile in the academic spectrum in Saudi Arabia. There is no a single dedicated scholarly journal for health promotion, health education or health communication. Unsurprisingly, there are no health communication departments in the country and there are only a few modules and only one master's programme on health promotion and education.

The situation is not much better for scholarly publications and academic textbooks. Disconnected, infrequent and un-thematic, the local health communication literature is generally in poor shape. Therefore, the authorities should launch an academic post or institute and group all these efforts together. It would also be helpful to launch a scholarly association to bring interested scholars together to network and publish more organised and thematic works. Indeed, this study also recommends starting a journal dedicated only to communication in health care, health issues and health education. Inevitably, research in health communication and promotion would increase and accumulate as a result of such a move, along with an awareness of the importance of the field. Past experience in other countries suggests that these kind of efforts and improvements will have positive outcomes (Hoving et al., 2010; Kreps et al., 1998; Paek et al., 2010; Schulz & Hartung, 2010; Sood et al., 2014).

It is true that Saudi Arabia has transformed from an unsophisticated health system in the 1930s to a well-structured one by the 2000s (see section 3.3 in Chapter Three), and this is reflected in the structure of health scholarship.

At present, there are 36 scientific, scholarly associations in Saudi Arabia devoted to various medical specialities such as stroke, obesity, diabetes, paediatrics, family medicine, public health and health informatics (SSFCM, 2015)⁶. A considerable number of journals, conferences and medical schools have emerged, most famously the *Saudi Medical Journal*⁷. However, none of these deal specifically with communication in related health areas. Within these scholarly activities there is also little attention given to communication or promotion. So the expansion and organisation of the medical scholars' community with a special focus health communication, education and promotion are recommended.

This call extends media and communication scholars in the Kingdom. Saudi scholars in this field have witnessed a remarkable rise since the 1970s and a new array of colleges and departments have been opened. Indeed, in 2002 the first Saudi academic association devoted to media and communication studies⁸ was launched, and in 2010 the first association for Public Relations and Advertising⁹ was established as well. Both provide great platforms for scholars, students, policymakers and media professionals to interact and benefit from each other. Health communication, however, is not generally included in these organisations' activities. This reinforces the need for a greater effort at strengthening health communication as an academic discipline in Saudi Arabia.

The early stages of the field should not be seen as a weakness or a disappointment, but as an opportunity to increase collaboration with other academic activities in the region and beyond. In other words, Saudi scholars should engage with the international research community's collaborative platforms such as the International Communication Association (ICA), the European Communication Research and Education Association (ECREA), the European Association for Communication in Healthcare (EACH), the National Communication Association (NCA) in the US and the International Association for Media and Communications Research (IAMCR).

⁶ Saudi Society of Family and Community Medicine (SSFCM).

⁷ <http://www.smj.org.sa/index.php/smj>

⁸ <http://samc.org.sa/en/>

⁹ <http://sapra.org/>

The infancy of the field extends far beyond academic life. Health communication at present in Saudi Arabia continues to be located within the patient-doctor relationship or in the mosques. Effective communication is routinely excluded from programmes aimed at combatting drug and alcohol use while most current academic efforts belong to either medical institutions or sociology- and criminology-oriented establishments. So the development of the structure of health communication scholarship will ease that.

Paralleled with the need for better-structured academic efforts in health communication, this study supports more theory-based public communication campaigns and interventions, in order to maximise their effectiveness. The previous chapter offered a glimpse of health communication's journey to combat substance abuse in the country and one of the key challenges was a lack of theory-based communication campaigns and interventions. The linking of campaigns and interventions with best practice and the latest research was something many of the research participants mentioned. Of course, the development of academic institutions will increase awareness among those working in the field about advances in theoretical knowledge, including the latest frameworks, applications and approaches in promoting health and substance abuse prevention. Atkin, among other scholars, has argued that the use of theory-based approaches in the design, implementation and evaluation of communication campaigns and interventions is a positive step-forward (Alofie, 2012; Atkin & Rice, 2013; Atkin & Rice, 2014; Salmon & Murray-Johnson, 2001). I refer to this in more detail in the literature review chapter of this dissertation (see section 2.3 in Chapter Two).

It is worth replicating the successful experiences of health behaviour change programmes which have been based on theory and supported by a careful analysis of the targeted audience. The famous North Karelia project in Finland, the Minnesota Heart Programme, and the Stanford Three Community project and Five-City programme were all successful, community-based initiatives aimed at tackling cardiovascular health problems (Basil, 2014b; Puska, 2002; University of Minnesota, 2012)¹⁰. So there are strong precedents

¹⁰ Further details in section 2.2.1 in the literature review chapter.

for the successful use of theory-based communication programmes and interventions in different contexts¹¹.

At the same time, the establishment of a system to archive, document and record all the major¹² communication activities, is strongly recommended. There is an information gap in the health communication literature in Saudi Arabia in general and, in particular, a lack of data about previous anti-substance abuse communication campaigns and interventions (*see the previous chapter*). This lack of data continues to undermine the efforts of even the new health communicators and promoters in Saudi Arabia. Therefore, the responsible organisations should act and find a way or a method of recording the campaigns and gathering as much detail as possible in a way that could be shared.

Most significantly, the Saudi Directorate of Drug Control, the Saudi National Committee for Narcotics Control, Al-Amal Mental Illness and Addiction Medical Complexes, and the Ministry of Education should establish an integrated, online system to collate all the details about the communication campaigns and interventions carried out by these organisations. This should include the aims, scope, targeted groups, procedures of audience analysis, message design, tactics used in the campaigns, length, evaluation procedures and the measured outcomes and lessons learned. This data would constitute an invaluable resource and would also enhance collaboration between all these organisations. The sharing of these details would also help prevent the duplication of mistakes already made in Saudi Arabia and elsewhere.

Fortunately, given technological advancements and the high penetration of the internet in the Kingdom¹³, the creation of a website with a database available to authorised users¹⁴ is an achievable objective. Furthermore, part of the data should be made available to the NGOs in Saudi Arabia and to

¹¹ I should not neglect the role of mass media in the previous programmes above.

¹² I specified the major programmes, as a start, and then the system or the programme of recording should expand and cover most of the communication activities.

¹³ See section 3.5 in Chapter Three.

¹⁴ They should be the health communication and substance abuse prevention practitioners.

interested researchers. With such a tool, it would be highly likely that programmes would enjoy increasing effectiveness and quality.

Neither is it only communication campaigns that need to be documented. This work also calls for a better organised statistics system for the epidemiology of substance abuse in Saudi Arabia as a whole. As the previous chapter acknowledged, the diversity of databases on different aspects of the substance abuse problem, has led to overlapping figures and the absence of accumulated figures. Datasets compiled in other countries, such as school-based and household surveys (such as those conducted by the NIDA in the US) also need to be introduced in Saudi Arabia. The lack of epidemiological figures about substance abuse and the absence of a behavioural survey about non-communicable diseases have made it more difficult to determine the risk factors and prevalence of risky-health behaviour¹⁵. In order to fill this urgent shortage in knowledge, new measures should be introduced to measure the problem in terms of behaviours and prevalence and to make this data available online to interested parties and individuals.

Furthermore, the establishment of an annual conference is necessary to gather all health communication practitioners, public health organisations, academics and interested parties into one event to share experiences and to raise awareness about the current challenges. A similar effort has been underway for decades at the United States Centres for Disease Control and Prevention, CDC¹⁶, and great outcomes have been achieved. It is true that in Saudi Arabia there have been attempts to bring interested individuals and groups together in one annual get-together, but these meetings have been inconsistent in terms of themes and not adequately inclusive and, as a result, were discontinued, So this study recommends to the Saudi government that it needs to take the lead and finance an annual conference to bring interested parties and scholars together to reflect on the latest theoretical insights on health communication in general and in substance abuse prevention in particular in the Kingdom.

¹⁵ The best example is the Behavioural Risk Factor Surveillance System (BRFSS) conduct by the CDC in the US <http://www.cdc.gov/brfss/>

¹⁶ Look at <http://www.cdc.gov/healthcommunication/index.html>

As I have outlined in the previous two chapters, the dominant paradigm for communicating health, drug abuse prevention and anti-alcohol use in Saudi Arabia, is profoundly influenced by the Islamic belief system and Arabic. In fact, Islamic-Arabic inspired anti-drug abuse campaigns and interventions are the only attempts that have been made in the Saudi sphere, even though Saudi Arabia has made transformative progress on the path to modernisation in the last Century and remains keen to continue. With only campaigns in Arabic available, even with the high number of non-Arabic speaking guest workers in the Kingdom, it is still common practice to routinely and mistakenly exclude non-Arabic speakers from the scope of the governmental and NGO anti-substance abuse promotion efforts.

As a result, this study concludes that the special agencies and government in Saudi Arabia should integrate more cultural diversity into their communication programmes. Most importantly, the use of more languages in all aspects of health communication and promotion in general and particularly in substance abuse prevention is strongly recommended. This is likely to have positive outcomes. This cultural sensitivity (barriers) approach to culture in health communication has achieved good results in communication on health related-issues and in health care settings (Airhihenbuwa, 2010; Airhihenbuwa & Iwelunmor, 2012; Dutta, 2008; Iwelunmor et al., 2010; Iwelunmor et al., 2014; Rassool, 2014c; Schouten & Meeuwesen, 2006).

The call to include cultural diversity in health communication and promotion against substance abuse is nonetheless compatible with the Saudi government's intention to proceed with further modernisation and development projects in the future. The presence of non-Arabic speakers in the Kingdom will continue, therefore, making cultural diversity an imperative.

It's important to re-emphasise here, as mentioned in the fifth chapter, that there is no clash between Islam and cultural diversity. In fact, Islam encourages intercultural relationships and living in peace with respect to others' beliefs and values. This has been declared unequivocally in the Islamic declaration of cultural diversity (Islamic Declaration on Cultural Diversity, 2004), while in practice, Saudi Arabia has welcomed millions of workers in the past

decades to work and live in the Kingdom. So fertile ground exists for the introduction of a cultural diverse approach to health communication, though this should, of course, be sensitive to Islamic values.

This study has shed light on the limited anti-alcohol health communication/promotion campaigns and interventions that have been implemented in the Kingdom. This has been due largely to conflicts over responsibility between the government agencies and a lack of funding for the NGO sector. To date, communication against alcohol abuse has been left to the mosques. The mosques have supplemented the message with Islamic beliefs around intoxicants. This method has started to struggle in its efforts to prevent alcohol and drug consumption.

The growing population of tech-savvy young Saudis and their interconnection with others across the globe, has meant the traditionalist method alone is proving inadequate to resist the pressures of modernisation¹⁷. With alcohol now promoted in diverse formats by major multinational corporations (Jernigan, 2009), the need for structured anti-alcohol use campaigns and intervention becomes crucial.

The use of well-organised communication campaigns and interventions have been in place for decades in different places and have achieved mostly positive outcomes. The famous 'Don't drink and drive' campaign in the United Kingdom achieved good results supplemented with reforms to related policy and law (Elder et al., 2004; Westcott, 2014). In theory, as the literature review chapter highlighted, the community and education approach to health communication has become popular in addition to the mass media element (Basil, 2014a; Helme et al., 2015; Kopfman & Ruth-McSwain, 2012; Wilkinson, 2013). So, more communication campaigns and interventions against alcohol use are needed. These efforts should be designed according to local (community) needs and should empower the community to participate. They should also be inclusive and engage non-Saudi or non-Arab communities about risky behaviour. Furthermore, this call does not mean the abandonment of the

¹⁷ Further details in section 5.5 in Chapter Five.

mosques' role in the fight against alcohol use as well as the prominent presence of Islamic principles.

Another key recommendation, is the critical need to better coordinate efforts between substance abuse prevention organisations in the Kingdom. This includes, but is not limited to, collaboration between the public and private sectors in order to coordinate the private sector's social responsibility initiatives. A recent example of this kind of initiative was a Saudi petrochemical company's project to build a 300 bed mental illness and addiction hospital in Riyadh (Ministry of Health, 2015b). Research participants from Saudi health promotion NGOs highlighted some of the sector's important shortcomings, including a lack of funding, poor coordination with the public sector, a lack of expertise and the lack of activities in rural areas or outside metropolitan areas. As a result, additional support for the NGOs is strongly supported in order to achieve overall improvement in the Saudi substance abuse prevention sector.

Finally, the emergence of social media and social networking websites as the fastest growing electronic means of communication with all of the features they contain as well as their growing global penetration make them a particularly important and valuable resource in Saudi Arabia particularly. Therefore, the use of social media¹⁸ is a necessary component of contemporary health communication campaigns and interventions in general and especially against substance abuse in Saudi Arabia and beyond. There are many advantages of using social media such as to reach a diverse audience; to gain direct interaction and engagement with the public; to overcome boundaries; mobility; the sharing of culture, and the potential for user-generated content and inclusivity (R. Alshareef, 2015; Heldman, Schindelar, & Weaver, 2013; Kilaru, Asch, Sellers, & Merchant, 2014; Korda & Itani, 2013; Neiger et al., 2012). The Saudi authorities should develop the use of social media from being merely a communication shuttle¹⁹ to the generation of messages and content that will genuinely engage the public. There are issues concerning social media that

¹⁸ For further details about the social media in health communication see this review (Moorhead et al., 2013).

¹⁹ For example, the Directorate of Drug Control in Saudi Arabia Twitter account is more like a one way communication, which all tweets seem like directed messages and they are little engaged with comments, and in general less active account, @Mokafha_SA.

need to be addressed, including how to evaluate its impacts, the implications of focusing on individual receivers, along with other aspects (Heldman et al., 2013; Moorhead et al., 2013). There are, furthermore, cultural considerations relevant to the Saudi context that should get attention as well.

The inclusiveness of the social media in the communicating of health and substance abuse issues creates an opportunity for more participatory communication to occur, and increase the chances for the most marginalised voices to be heard (Smith, Mateo, Morita, Hutchinson, & Cohall, 2015; Wallerstein & Duran, 2006). This is compatible with the previous call for greater inclusivity and a more diversified approach. Social media provides an ideal platform for this kind of outreach and further research in this area is strongly endorsed.

Even though Saudi figures about technology use and internet penetration have considerably increased, the presence of the substance abuse prevention and communication agencies have also increased. However, many of the organisations studied in this research operated poor or ineffective websites, infrequently updated and with low levels of interactivity. This was something many of the research participants commented on. As a result, the Saudi special authorities and professionals should adopt a more interactive approach to Web 2.0 and its application. Greater innovation in applying and using internet-based campaigns and interventions is also strongly recommended (Kilaru et al., 2014). The next section will cover the limitations of the study.

7.4 Limitations of the Current Findings

The limitations of this study have mostly arisen in the way the research was conducted. The limitations, indeed, say much about the challenges embedded in the Saudi context which will face subsequent researchers. So it is important to note these limitations which were generally context specific or research approach-oriented.

The dominant conceptualisation of health communication in Saudi Arabia remains concentrated on doctor-patient communication. There is some recognition of communication in, within, and by the health care system. But

overall, this narrow view of communications when it comes to health, illness and well-being illustrate the immaturity of the state of the health communication discipline, if not its infancy, in Saudi Arabia. Truly, health is an ideal area within which to develop such new forms of communication, compatible with the experiences of other places where health communication also developed initially in a medical context (Dutta, 2008; Kar et al., 2001c; Kreps, 1989; Kreps et al., 1998; Kreps, 2014; Wright et al., 2012). However, it remains critical that this narrow perception of health communication is overcome.

In terms of the impact of the popular perception of health communication in Saudi Arabia in this study, I used my personal skills to minimise the impacts of the predominant understanding. Throughout my field trip, I corrected some of the participants' ideas about the communicating of health and illness. This predominant idea relates to the nature of common stereotypes about the field in some countries. Certainly, the expansion of research activities and facilities in the field would widen the perspective about the concept in the Kingdom.

As I have said previously, it is not just the infancy of health communication as a field that is a challenge. There is also an absence of historical background. In other words, there has been very little study of communication around issues such as illness, health and well-being in Saudi Arabia. This lack of scholarly attention has generated additional limitations²⁰.

A range of indicators are now used to study the emergence of health communication in the US and in Europe and Asia (Harrington, 2014; Kar et al., 2001c; Paek et al., 2010; Schulz & Hartung, 2010). Unfortunately, none of these are available in Saudi Arabia, nor are there journals, conferences, institutions, study programs or textbooks that make use of the data. To my knowledge, there is no single academic journal dedicated²¹ to health communication or to health promotion or health education in Saudi Arabia. Moreover, the institutional situation isn't much better. In the Kingdom, there is no single academic department or research group focusing on the study of communication in health

²⁰ Which might challenge any researcher in health; communication, promotion, and education in subsequent research.

²¹ Similar to *Health Communication Journal* or *Journal of Health Communication* in the US or the *Communication and Medicine Journal* or *Patient Education and Counselling Journal* in Europe.

or illness issues. There is also not a single book in Arabic available on health communication, to my knowledge.

Although, there is no single research strategy that could overcome the absence of previous works. I did not see this as a limitation only, but also as an opportunity to shed light in this area and encourage other scholars to continue with further research in this area. In fact, among health communication scholars, the study of the history and development of communicating health issues is recognised as vital to the field (Dutta & Souza, 2008; Hoving et al., 2010; Kreps et al., 1998; Paek et al., 2010; Schulz & Hartung, 2010).

Next, there were some limitations generated as a result of the nature of the research methodology paradigm. Foremost, the findings of this study were generated from small, targeted groups; so generalisation based on these findings is not intended by the researcher. In fact, qualitative research methodology is known for the rich understanding it generates to the subject under the investigation (Bryman, 2012; J. Creswell, 2013; D. Silverman, 2009)²². It is true that the findings of this study were enriched by the experiences of those who participated in the interviews and the focus groups, but this cannot be generalised to other countries.

Although there are weaknesses in the use of mixed qualitative methods, I was nonetheless able to access deep into people's experiences of health communication, in particular concerning non-communicable disease such as substance abuse, the impact of Saudi cultural influences and the usefulness of the research methodology to bundle together the narrative of communication (Du Pré & Crandall, 2011; Joubish, Khurram, Ahmed, Fatima, & Haider, 2011; Kreps, 2008; F. Roberts, 2011; Thompson et al., 2014). However, I did face two quite serious methodological constraints; the presence of the gatekeeper in the health sector, and the absence of women's voices.

On my data collection trip, I tried to meet the health promotion teams in the AL-Amal addiction complexes, but I met with obstacles and bureaucracy. The administration asked me to fill an ethical form with a summary about my

²² Further details in section 4.3 in Chapter Four.

research and the research questions, and to present that to the hospital research committee²³. The committee had the power to give me access, or not. Unexpectedly, a condition for the permission was that I would have to present my interview transcripts to the committee again for approval as well as to get the committee's approval before publishing any of the study's results. Many obstacles prevented me from following this pathway and applying to the committee. Firstly, as a PhD student, I had limited time to collect the data, especially as an international student based in the UK, and I anticipated that each hospital application would take considerably more time and effort than the inclusion of other participants in the sample. Since, each hospital required me to apply in person, my finances were unlikely to cover all the travel. Required trips became an extra obstacle. In addition, there was a range of other important considerations that preventing me applying for access including the right to confidentiality of my interviewees, the copyright of my work and the requirement to gain permission before publication.

I concluded it would not be possible to overcome such organisational limitations²⁴ within the constraints of my resources and time. The regulations of the hospitals were not specific to particular research methods but covered any research access such as interviews, surveys or focus groups. Therefore, I excluded the health promotion department specialists at the Al-Amal complexes²⁵ from my sample. Of course, the addict-oriented institutions play secondary roles in the Saudi substance abuse prevention and communication sector in general. On the other hand, the hospitals' efforts for the patients and around family education should not be underestimated. Under these circumstances, the study of such organisations' efforts is strongly recommended with the aforesaid requirements in mind.

In order to minimise the impacts of this set-back, I was lucky enough to gain access to the head of the health promotion department in the Saudi

²³ In each addiction complex there was a research committee responsible about the hospital research activities independently from the ministry of health and other addiction hospitals in Saudi Arabia.

²⁴ I totally understand the reason behind such a strict regulation for the protection of the team, patients, and the hospital.

²⁵ Al-Amal (Means Hope in Arabic) complexes are the hospitals treat mental illness and drug addicts. Three major complexes in the Kingdom with group of addiction wards in several Mental illness hospitals (check the previous chapter).

Ministry of Health. This was an interview that gave a great deal of insights into the strategic aspects. Also, I studied the addiction hospitals' websites to glean whatever I could about their education and promotion activities.

Women are poorly represented in the top management of the drug abuse prevention sector in Saudi Arabia. Therefore, there was little chance of interviewing women. This was further exacerbated by social etiquette and by the prohibition on contact with the women in Saudi Arabia. I tried my best to interview women who worked as social activists or philanthropists, academics or columnists. My attempts failed for a variety of reasons from busy schedules or disinterest to remote geographic locations or lack of response to my requests. I tried new methods of approaching some of the handful of potential women interviewees through emails and social media such as Twitter and Facebook, but this also was not successful.

In order to minimise the impact of this absence of women's voices in the sample, I arranged focus groups with female students to see how they understood health communication. Young women were of course part of the main targeted group (*Saudi youth*) by the agencies of substance abuse prevention. Although I did use a closed circuit television network²⁶ to conduct the focus groups with the young women, I did gain access and was able to facilitate useful discussion in the groups. In addition to the female university students, I was also able to access participants from different regions of Saudi Arabia as well as people involved in NGOs, philanthropic societies and Exhibitions in Saudi Arabia. In this way, I was able to bring different voices from the reality of the social world into the study. I do believe, however, that this study holds more strengths than limitations. It is to these strengths that I now turn.

7.5 Strengths of the Current Findings

This study contains a number of key elements that underline its contribution to scholarship and to the field. These strengths fall into three areas;

²⁶ In Saudi Arabia, there are television networks in the public universities to facilitate communication between the male academic staff and female students.

the context of the study; the topics under the microscope; and the research methodology.

This is the first study of its kind that addresses health communication against substance abuse in Saudi Arabia. It is also the first one that has focused on the cultural perspective of health communication in Saudi Arabia in general and particularly in relation to drug abuse and alcohol consumption. Therefore, this thesis has established the foundations for further studies based on the real world experiences that underpin the work as a whole. Furthermore, the consideration of the Islamic heritage of Saudi Arabia adds further import to this study. The findings show that religion retains a critical role in health communication in Saudi Arabia. This study, however, looks further ahead and examines how the modernisation and transformation of Saudi Arabia have increasingly impacted on the area. This, too, is new ground in scholarship.

The focus of the research questions on one of the growing non-communicable diseases (NCDs) (illicit drug use and harmful drinking of alcohol²⁷) is compatible with worldwide calls to conduct further research into these aspects, including the functioning of health communication (CDC, 2014b; Memish et al., 2014b). So the focus of this thesis has been a response to the gaps in the field. In fact, worrying international figures about NCDs and Saudi's own figures add yet more urgency to the study²⁸. The study's focus on both alcohol and drugs has made the study more comprehensive and has teased out similarities such as in the cultural stance on risky behaviour. The design of the research, the analysis and the reliability of the data all reflect strong aspects of this work.

Because of the exploratory orientation of the research question, this study has made use of mixed qualitative methods to gather data from the real world. The triangulation of the thesis research methodology and the extensive data gathered through the research instruments, including semi-structured

²⁷ However, the thesis addresses any non-medical use of alcohol in Saudi Arabia as a behaviour need to be deterred, because of the Islamic prohibition (See Section 5.5 in Chapter Five).

²⁸ The UN latest figures such as the WHO reports and the World Drug Report highlighted the inevitable needed actions to eliminate such risky-health behaviour (UNODC, 2014e; WHO, 2014). Similarly, the recent Saudi statistics draw attention to the same phenomenon (MOI, 2010; MOI, 2011).

interviews, focus groups, observation and the thematic analysis of Radio advertisements, have made the findings robust and replicable. In other word, the comprehensive nature of the research sample is a particular source of pride for the researcher. There are, though, other measures of trustworthiness²⁹ that strengthen the outcomes of the thesis.

For instance, the full anonymity of research participants was employed to protect them. The participants signed informed consent documents and were fully briefed about the nature of their participation and the way in which the data would be used, saved, and, later after the study had finished, destroyed. Not only would the identities of the participants be protected, but also the confidentiality of the data. As I explained in Chapter Four, I employed careful procedures to save digital and hard copies of the data in securely-locked computer and a secured-room with only the researcher having access. In addition, interviews were conducted in real environments and participants were invited to examine the transcripts. All these measures have enhanced the strength of the findings.

Lastly, my familiarity with the Saudi work environment and culture helped me on many occasions. My attendance of a range of events including exhibitions, campaign lectures and permanent exhibitions, provided an excellent opportunity for me to engage with the activities and practices taking place in the real environment. In fact, being a Saudi myself, I gained a fortunate advantage. Understanding the social etiquette of approaching participants, employing popular ways of organising interviews, empathising with the Islamic background of the participants, and holding the status of a university member of staff all contributed to this study high level of access and to the quality of the data.

7.6 Further Research

This study raises almost as many questions and concerns as much as it clarifies others. I can propose various recommendations for further research but they have different sources. Some are driven by the findings of the study while others are a response to the study's limitations. I will start with hints for future

²⁹ For further details go back to the trustworthiness section 4.6 in Chapter Four.

directions based on my study's outcomes and my observations. After that I will shed light on other possible future directions.

One of my most important findings has been the necessity and value of studying the cultural dimension of health communication. There have been many reasons put forward by largely western-based scholars supporting this approach, not least changes in demography, migration and travel patterns as well as a growing global awareness of cultural differences (Airhihenbuwa, 2010; Airhihenbuwa & Iwelunmor, 2012; Airhihenbuwa et al., 2014; DuPré, 2014; Dutta, 2008; Kar et al., 2001a; Lewis & Lewis, 2015). Consequently, this study has paralleled a number of others which have also called for more research which applies the concept of culture to communicative efforts aimed at enhancing health status. I attempt to clarify this call more precisely below.

This study concludes that the religion of Islam contains beliefs and values which deter and limit the problem of drug abuse and the drinking of alcohol and which favours social resistance to substance abuse. This Islamic approach to health covers other related issues such as hygiene, sexual relationships, nutrition, fitness and smoking (Ghouri, Atcha, & Sheikh, 2006; Grand Imam Gadul Haq, 2000; Hameed et al., 2002; Khayat, 2000; Khayat, 2004; Koenig, 2012; Koenig & Al Shohaib, 2014; Muslim Health Network, 2015; Radwan et al., 2003; Shablak, 2008; Stacey, 2009a; Stacey, 2009b; Stacey, 2013a; Stacey, 2013b; The Amman Declaration, 1996). Under these circumstances, I add my voice to those scholars' who have proposed the need for further research into the roles of religion and faith in health communication (L. Miller et al., 2011; L. Miller & Rubin, 2011; Parrott, 2004) and, in particular, the role of religion in health communication about substance abuse. This should not be perceived as an Islam-only invitation as the call is to study the role of any religion or spirituality in influencing health communication against substance abuse (Çoruh, Ayele, Pugh, & Mulligan, 2005; R. M. Eckersley, 2007; Ellison & Levin, 1998; Kagimu et al., 2013; Koenig et al., 2012; Levin, Chatters, & Ellison, 1998; W. R. Miller, 1998).

There are other scholars who have made progress in addressing the positive relationship between religion, spirituality, health and healing. The

considerable results obtained by these scholars will be very useful for any researcher interested in pursuing this important set of relationships (H. Al-Omari et al., 2014; Celen, 2014; Koenig, 1998; Koenig, McCullough, & Larson, 2001; Koenig & McCullough, 2001; Koenig, 2005; W. Miller & Thoresen, 2003; G. Silverman, 2006).

In Saudi Arabia, there is still more to be done in understanding the structure and consequences of the Islamic approach and more on this is further recommended. For example, a content analysis of recent media campaigns in Saudi Arabia to assess the prevalence of Islam-oriented messages would be interesting. So too would an investigation into the use of Islamic methods to deliver health messages, such as the Friday prayer sermon, mosque symposiums, scholar's lectures and mosque publications. Specifically, the religious leaders (Imams' and Ulama³⁰) play crucial roles in Muslim communities, and this includes promoting Islamic beliefs about health, illness and wellness. In recent years, there has been some work investigating the multifaceted roles Mosques could play (Ali et al., 2005; Bader et al., 2006).

Since the Islamic approach is universal in nature, attached to the religion of Islam, and is generally holistic in its approach, therefore an investigation of the presence of the Islamic perspective to health in other cultures (either Islamic-oriented or not) is highly recommended. The findings of this kind of inquiry will give more insights to the health institutions in these environments in relation to the capacity Islam may be able to provide in health care (i.e. delivering-promoting). In other words, the outcomes of the study will add more understanding to the role of culture in health communication. Cultural competence (as a barrier) and cultural understanding would be particular beneficiaries of this expansion of the research agenda (Dutta, 2008; Kreps & Kunimoto, 1994; Tseng & Streltzer, 2008). This research would help, too, in enhancing the efficiency of promoting and communicating health.

Another recommendation would be to study the role of mosques in promoting anti-drug abuse and alcohol abstinence in western countries. An exploratory study to examine activities conducted by mosques is needed. More

³⁰ An Arabic word refers to the Islamic studies scholars' and jurists'

narrowly, it would be important to study the patterns, content and the intersection between Islamic culture and local cultures in the mosques. Some work has been carried out in this regard (Ali et al., 2005; Bader et al., 2006; Jantos & Kiat, 2007). This kind of study would make a fascinating parallel to studies on the imperative of multiculturalism in the west and work grappling with the questions of diversity and integration (DuPré, 2014; Dutta, 2008; Kar et al., 2001a).

As I argued earlier, the absence of cultural diversity in the current communication against substance abuse is one of the key findings of the thesis. Of course, I endorse more cultural sensitivity in health communication, especially the need to use more languages than Arabic in the communication³¹ of substance abuse issues (Dutta, 2008; Dutta & Basu, 2011; Kreps & Kunimoto, 1994; Northouse & Northouse, 1998). Due to this absence, I endorse a further study³² to investigate current patterns of using the concept of cultural diversity in health communication efforts and the possible ways to strengthen cultural diversity in order to enhance communication effectiveness. Since, multiculturalism and cultural diversity remain out of mainstream Islamic culture, it would be interesting to see Saudi Arabia reverse that trend with reference to the Islamic principles.

Furthermore, it was evident during my research that there is a gap in the historical studies and narratives about health communications in the time before Saudi Arabia emerged as a state. Throughout my research journey, I could not find any sources in the literature about the communication of health issues, and particularly about substance abuse. Studying these aspects will contribute to the understanding of how communication about health issues evolved during this period and the ways in which meanings and practice were mobilised to fight the use of intoxicants and drugs. Many health communication scholars have embraced this trend of study to build a comprehensive picture about the practice of health communication (Hannawa et al., 2014; Kar et al.,

³¹ The use of different languages should be included in the printed communicated messages and the verbal one.

³² Mostly, the use of qualitative methods with the health communication team's leaders to explore the possible ways to integrate cultural diversity in health communication as well as the challenges facing the implementation of more cultural diverse programmes are strongly recommended.

2001c; Kreps, 1989; Kreps et al., 1998; Kreps, 2014; Paek et al., 2010; Schulz & Hartung, 2010).

Some³³ would argue that before Saudi Arabia's emergence as a state, the region was not very sophisticated. It is unlikely there were many well-organised health campaigns conducted in the pre-Saudi era. But this should not stop us studying Saudi Arabia in the pre-development period. In the absence of institutions and organised-interventions I expect, based on the findings of this study, to find that the social structures and the cultural establishments such as mosques played major roles in promoting health in that period. Now let us turn to the second set of recommendations.

This study reached the conclusion that no other researcher had attempted to excavate the history of health communication in substance abuse prevention in Saudi Arabia. Further historical reviews of the communication of other health-related issues such as cardiovascular disease, obesity, diabetes, smoking, high blood pressure and metabolic syndrome in the country is recommended. This has special relevance given the alarm raised recently by local and international figures about the risks currently facing public health in Saudi Arabia due to the rise of risky health behaviour and by both non-communicable and chronic diseases (Al-Daghri et al., 2011; Alquaiz et al., 2014; Amin, Al Sultan, Mostafa, Darwish, & Al-Naboli, 2014; Desouky, Omar, Nemenqani, Jabbar, & Tarak-Khan, 2014; Malki, 2014; Memish et al., 2014a; Memish et al., 2014b; Ng, Zaghloul, Ali, Harrison, & Popkin, 2011).

Additionally, recent studies and figures about the prevalence, trends, and patterns of non-communicable disease contained worrying figures, making the call for awareness, education and health communication campaigns and interventions urgent (Memish et al., 2014a; Memish et al., 2014b). This study recommends, therefore, further focused investigations into the role of health communication in non-communicable disease prevention and related issues. This is particularly important given the rarity and discontinuity of well-managed health communication campaigns against NCDs in Saudi Arabia (as I noted during the field trip of this study).

³³ Such as scholars' or commentators' in the field of history of communication and health studies.

Since I could not get access to the *Al-Amal mental and addiction health complexes*, the study of health communication in Saudi rehabilitation facilities and the promotion of treatment and abstinence from risky behaviours could provide fertile ground for future studies. Indeed, further research on health communication in the care of addicts in Saudi Arabia is essential to understanding prevailing communication styles, techniques, messages, and in identifying key-players. Due to the lack of previous studies in this area, an exploratory and explanatory study would be highly recommended. Though researchers should beware the obstacles, ethical and bureaucratic, to obtaining access to these facilities.

In acknowledging the lack of women's voices in this study, for the reasons I have described above, a study of the role of women in health communication against substance abuse in the Kingdom is crucial to assess the current contribution of women and to identify the barriers preventing more positive roles for them. A qualitative study focused on the handful of female health promoters and anti-drug activists would enrich our understanding about the practice, needs and challenges facing them.

There is currently a low degree of participatory communication for those needing health communication messages, especially around substance abuse in the Kingdom. Because some groups in Saudi Arabia remain voiceless and marginalised, this makes the importance of participatory communication even more crucial. Research conducted from a culture-centred perspective will add more insights into the practice and literature of health communication in the country. Since Dutta, among others, the urgent need to study the role of culture in making health meanings and in promoting healthy lifestyles has been expressed (DuPré, 2014; Dutta, 2008; Dutta & Basu, 2011; Dutta, 2014). These calls provide a potential platform for marginalised voices and embraces giving more space to local cultures to develop behavioural change efforts (Dutta, 2007; Dutta & Souza, 2008; Dutta, 2010). Alternative groups could be put under the spotlight too, such as the guest workers, youths (Saudi and non-Saudi), and women. This kind of approach will address youth demands for more open and interactive communication and for alternatives to the traditional top-down model.

The use of an *action research approach*³⁴ to conduct cultural centred studies will provide the researcher with the tools to explore the effectiveness of health communication. A group of scholars have already published work on this approach (Basu & Dutta, 2009; Dutta & Basnyat, 2010; Jamil & Dutta, 2011), and it would be useful for interested researchers in the Middle East, and in Saudi Arabia in particular to look at these previous attempts.

Finally, the dynamic and continual development of social media and the culture of interactivity, sharing and convergence all embrace demands for further investigations to identify the uses, positive outcomes, limitations and/or obstacles in the use of social media and social networking websites by health communication campaigns in health-related issues and particularly substance abuse (Moorhead et al., 2013). This call acknowledges the importance of local culture and the particularities of the Saudi context. Indeed, potential researchers should address the presence of anti-drug abuse and anti-alcohol use content in the social media as well as Islamic-oriented content.

7.7 Conclusion

This chapter has presented different perspectives based on the results of this study to further investigate practice and knowledge in health communication in Saudi Arabia. Most notably, this thesis delivers valuable insights gleaned directly from the research participants, who have long and relevant experience in this matter. The study has also made use of the annual publications³⁵ of the official Saudi specialised organisations and of examples of health messages³⁶ about drug abuse prevention and Islam's original teachings and sources (the Quran and the Sunna). So we have mixed live, human experience with statistics, theory and theological sources.

Health communication incorporates a wide range of meanings, including any strategy aimed at delivering health information to change risky health behaviour, influence policy or expand services (DuPré, 2014; Hannawa et al., 2014; Schiavo, 2014; Sparks & Villagran, 2010; Wright et al., 2012). As practice

³⁴ For further details look at (Bryman, 2012; J. Creswell et al., 2003; D. Silverman, 2009).

³⁵ They include the international and Saudi relevant statistics.

³⁶ They refer to the radio advertisements.

and knowledge, health communication has witnessed shifts from patient-doctors communication only to communication interventions and campaigns based on predictions and behavioural change theories. Nowadays, cultural-based efforts³⁷ are growing in popularity. Paralleled with insightful improvements in health communication, scholars have been documenting that practical interventions have been accumulating positive outcomes (Abroms & Maibach, 2008b; Haug, 2004; Hornik, 2002; Noar et al., 2010; Noar, 2006; Puska, 2002; Snyder, 2007; Wakefield et al., 2010a).

Apart from shifts in the field that inspire me to continue my work in this area, I am fascinated too by Saudi's internal aspects and changes in attitudes and strategy around non-communicable diseases, especially the use of illicit drugs and the drinking of alcohol. As the dissertation has pointed out at various stages, there has been very little research conducted into health communication in Saudi Arabia, particularly concerning risky behaviour such as substance abuse. It is hoped this thesis will begin to address this gap in the literature. The primary research question concerned the importance of Saudi's cultural influences and required a review of the story of health communication regarding substance abuse prevention in the Kingdom.

This thesis has highlighted the primacy of culture in addressing health communication in Saudi Arabia. It includes recommendations on how to conduct further inquiries, particularly concerning the role of religion (Islam), the role of women, the empowerment of marginalised groups and the need to address cultural diversity and participatory-communication in the Kingdom.

New understanding of the role of Islam and of Saudi government policy and practice have been the primary contributions of this thesis to knowledge. My work shows the government has certainly been an important director of practice³⁸. However, I have also drawn attention to Islamic teachings about health and the avoidance of addictive behaviour such as intoxicant use and gambling. Islam also promotes the principle of promoting against risky health

³⁷ Further information in sections 2.2 and 2.4 in Chapter Two.

³⁸ See section 6.5 in the Previous Chapter.

behaviour³⁹ and also seeks rehabilitation and healing. The holistic nature of Islam has been clearly presented, covering as it does a wide range of human behaviour from personal hygiene and breastfeeding to nutrition, based on the recitation of Qurannic verses (Aboul-Enein, 2014; Assad et al., 2013; Baasher, 2001; EL-Islam, 2009; Grand Imam Gadul Haq, 2000; Jamil, 2014; Stacey, 2009a; Stacey, 2009b; Stacey, 2013a; Stacey, 2013b; The Amman Declaration, 1996). This study invites interested parties to further investigate the role of Islam in communicating about other health issues in Saudi Arabia or in other Muslim countries or communities in the world. Furthermore, the lack of attention given to cultural diversity approach was an obvious weakness in present communication campaigns/interventions against substance abuse, which needs further attention from the managers in the field as well as from researchers.

The Islamic perspective on health for body and soul has existed since the emergence of Islam in the Arabian Peninsula in the Seventh Century. This study draws the attention of researchers to other faiths and spiritualities to find out more about these areas might also add to the study of health communication, as some scholars have already suggested (Khalid, 2006; Koenig et al., 2012; Koenig, 2012; Koenig & Al Shohaib, 2014; L. Miller & Rubin, 2011).

Finally, this study has had significant impacts on me as a novice researcher and on my experience in life. I believe this experience will be valuable for me in the future as I attempt to transfer the information I have gained during my academic career to help to increase my country's competencies and health outlook. It has been a very long but memorable experience.

³⁹ More details in section 5.5 in Chapter Five.

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Appendix One

Fieldwork details sheet:

Data collection methods: Interview, focus group or event	Date:
Interview (or focus group or event) Number:	Meeting duration:
Location:	
Name:	Gender:
Age:	Nationality:
Profession:	
Background:	
Experience:	

Sample of Invitation Letter¹

Date:

Ref:

To whom it may concern

I am delighted to inform you that I am currently in the progress of completing my doctorate thesis on 'Health Communication and Culture in Substance abuse issues in Saudi Arabia' at the University of Stirling in the United Kingdom. This research is undertaken as part of my doctorate programme under the supervision of Dr Adrian Hadland at the Communication, Media and Culture Division (CMC).

In brief, my research aims to look at the Saudi culture influences on health communication of anti-substance abuse issues, and subsequently hopes to find how this health communication evolved in Saudi Arabia. The study design identified criteria for the study sample, which will mainly focus on those active health communicators, health promoters and activists from both the Saudi public sector and the Saudi NGOs.

Therefore, I would be grateful if you could kindly allocate some of your time for a meeting to discuss some of your valuable thoughts and insights about the study topic. I believe your experience will contribute valuable information to the research. I attached with this letter, an endorsement letter from my supervisor as well as from sponsor, King Abdul-Aziz University.

Therefore, I will be in touch with you to find a suitable time. I really appreciated your help and kindness.

Thank you

Bandar ALjaid

Bandar.aljaid@gmail.com

Mobile Number:

¹ An English translation of the original Arabic letter.

Interviews guide:

Present the study aims.

Fill the fieldwork details sheet (demographic information):

- 1- What is the problem of substance abuse in Saudi Arabia? Reasons? Why?
- 2- What issues arise out of communicating about illicit drug use and alcohol abuse?
- 3- Are these issues differing in their significant to health communication about substance in Saudi Arabia?
- 4- What influences does Saudi Arabian culture have in communicating anti-substance abuse?
- 5- What cultural issues arise out of communicating anti-substance issues in Saudi Arabia?
- 6- How has health communication against drug and alcohol in Saudi Arabia evolved?
- 7- What are the circumstances led to the development of health communication against substance abuse in Saudi Arabia?
- 8- What challenges and limitations faced the health communicators' and the Saudi responsible authorities?
- 9- What is the future for health communication against substance abuse in Saudi Arabia?

Additional questions for those affiliated with the substance abuse prevention organisations from both sectors – public and NGOs.

- 1- Could you tell me please about your department (or organisation) functions, roles and aims?
- 2- How your department (organisation) plan, implement, manage and evaluates health communication and prevention programmes? Why?
- 3- What is the role of the media in that?
- 4- What are the challenges of the future?

Close the interview and thanks the participants.

Students' Focus groups guide:

Introduce the group members to each other.

Present the study aims.

Fill the fieldwork details sheet (demographic information):

Broad Opening Question:

- 1- What do you know about the problem of substance abuse in Saudi Arabia?

Transition Questions:

- 1- How do you receive health communication messages about substance abuse?
- 2- What are the most important issues in the messages you receive?

Key Question:

- 1- What influences does Saudi Arabian culture have in communicating anti-substance abuse?
- 2- What cultural issues arise out of communicating anti-substance issues in Saudi Arabia?

Sum up the major ideas, Close the focus group and thanks the participants

Substance abuse prevention teams Focus groups guide:

Introduce the group members to each other.

Present the study aims.

Fill the fieldwork details sheet (demographic information):

Broad Opening Question:

- 1- What do you know about the problem of substance abuse in Saudi Arabia?

Transition Questions:

- 1- Could you tell me please about your department (or organisation) functions, roles and aims?
- 2- How this department (organisation) plan, implement, manage and evaluate health communication and prevention programmes? Why?
- 3- What are the most important issues in the health messages?

Key Question:

- 1- What influences does Saudi Arabian culture have in communicating anti-substance abuse?
- 2- What cultural issues arise out of communicating anti-substance issues in Saudi Arabia?
- 3- What are the challenges in the future?

Sum up the major ideas, Close the focus group and thanks the participants

Informed consent form² (Interviews)

Please read the information below before you sign the form to take part in the study.

Aim of the study:

This study aims to understand health communication and substance abuse issues. Particularly, this study focuses on the Saudi cultural influences in health communication about illicit drug abuse and alcohol consumption.

Dear participant, your participation is a crucial contribution in the fight against substance abuse in Saudi Arabia and I am very thankful for your time.

1.	I am fully aware that this study is part of a PhD degree at the University of Stirling in the United Kingdom.	<input type="checkbox"/>
2.	I have been given the chance to ask questions about the study and my role in it.	<input type="checkbox"/>
3.	I agree that my participation is voluntary.	<input type="checkbox"/>
4.	I acknowledge that the interview will be administered by the researcher (Bandar) and will take at least an hour.	<input type="checkbox"/>
5.	I agree that the researcher will use a digital recorder to record the interviews, and he will take some notes during the interview.	<input type="checkbox"/>
6.	I fully understand that the researcher will keep the field work data in a safe place and will destroy it after the conclusion of the study.	<input type="checkbox"/>
7.	<p>I have been given information about the study's data confidentiality procedures with regards to names, pseudonyms and anonymization³:</p> <ul style="list-style-type: none"> • I would like my name to be used and understand that what I have said or written as part of this project will be used in presentations, publications and other research outputs so that anything I have contributed to this project can be recognised. 	<input type="checkbox"/>
	<ul style="list-style-type: none"> • I do not want my name used in this project. 	<input type="checkbox"/>
8.	I am aware that the researcher will use the study findings in his thesis and related publications.	<input type="checkbox"/>
9.	I am fully aware that only the researcher and his supervisors at the University of Stirling will be authorised to look at the study data in order to preserve the confidentiality of the data.	<input type="checkbox"/>
10	I was informed that I have the right to withdraw from the interview at any time during or after the interview. I also have the right to stop if I need to and I have the right to not answer some questions if I so choose without having to give any justification.	<input type="checkbox"/>

² An English translation for the original Arabic informed consent form.

³ For further details about that check chapter four, section 4.4.1.

