



Batarfi, Sabreen Saleh (2026) *The feasibility of implementing asset-based approaches to health in a Saudi rural/peri-urban community context: the case of Al-Jumum*. PhD thesis.

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The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Peri-Urban Community Context: The Case of Al-Jumum

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Master's degree in Health Administration
Bachelor's degree in Health Care Administration

Submitted in fulfilment of the requirements of the Degree of Philosophy in Health and
Social Policy

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Month and Year of Deposition to the Library

Abstract

This thesis examines the feasibility of implementing asset-based approaches to health (ABA) in Saudi communities, addressing a significant gap in public health research within the Kingdom of Saudi Arabia and broader global south contexts. The study explores the factors that influence the feasibility of implementing asset-based approaches, operationalised through examining community assets, policy impacts, implementation barriers, and key influencing factors.

Employing a qualitative methodology grounded in critical realism and methodological bricolage, the research was adapted from an initial rural focus to concentrate on Al-Jumum, a small city that serves rural communities. The study's three empirical focal points—healthy city initiatives, volunteering programmes, and health coaching—served as proxies for examining ABA feasibility through existing interventions sharing characteristics which align with broad ABA principles. Data collection utilised a three-stage approach: initial interviews with citizens and primary care centre workers, focus groups exploring collective perspectives, and individual interviews with local and national policymakers. This was supplemented by observational methods and documentary analysis of health policies and community records.

Asset mapping reveals diverse tangible and intangible community resources across Al-Jumum. However, analysis conducted using a realistic evaluation framework identifies significant implementation challenges. The analysis reveals four key tensions that fundamentally shape implementation feasibility. First, governance structures create complex dynamics between hierarchical control and community empowerment, where emerging bottom-up initiatives must navigate traditional top-down approaches. Second, gender dynamics present both barriers and opportunities, requiring careful balance between respecting traditional norms and fostering inclusive participation. Third, tensions between individual versus collective approaches highlight challenges in balancing personal empowerment with community mobilisation within culturally appropriate frameworks. Fourth, findings illuminate both the conservative and transformative potential of asset-based approaches, revealing how implementation strategies must negotiate between incremental change and systemic transformation.

This research makes four original contributions to knowledge. First, it advances implementation science methodology by demonstrating how existing health interventions can serve as implementation pathways for asset-based approaches, offering a novel

framework for leveraging established programs rather than creating entirely new structures. Second, it develops context-specific methodological approaches for assessing asset-based community development implementation in global south contexts, addressing gaps in culturally responsive evaluation frameworks. Third, it contributes to global south health policy scholarship by providing empirical evidence of how international health promotion models can be adapted within global south cultural and governance systems. Fourth, it informs health systems transformation policy by demonstrating the need for reduced dependency on centralised control and greater policy flexibility to enable community-driven health approaches in Saudi Arabia and similar contexts, with implications for how health systems can integrate bottom-up and top-down approaches more effectively.

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Acknowledgement

This doctoral journey has been profoundly shaped by the remarkable individuals who have accompanied me along this path, each contributing uniquely to both my academic development and personal resilience. Their collective support has transformed what could have been an isolating endeavour into a collaborative achievement that reflects the power of human connection and shared commitment to knowledge advancement.

First and foremost, I would like to express my deepest gratitude to my mother, Fatmah, whose unwavering belief in my potential has served as the bedrock upon which this entire academic pursuit was built. Her encouragement transcended mere words, manifesting in countless acts of sacrifice, and understanding that allowed me to pursue this dream despite the considerable challenges involved. Through late-night phone calls offering comfort during difficult times, she demonstrated that maternal support knows no geographical boundaries. Her faith in my abilities often exceeded my own, providing the crucial foundation of confidence that sustained me through moments of doubt and uncertainty. Though my father passed away many years ago, the values he instilled in me regarding the importance of education and perseverance have remained guiding principles throughout this academic pursuit.

My siblings have each contributed distinctively to this achievement, creating a network of support that proved invaluable throughout this demanding process. My sister Seba provided emotional anchoring through her consistent presence, whilst my brothers Abed and Mohammed offered both practical assistance and brotherly encouragement that reminded me of the importance of family bonds even across vast distances. Abed deserves particular recognition for his extraordinary commitment during the data collection phase of this research, where his dedication extended far beyond familial obligation to become genuine partnership. His role proved essential in navigating the practical and cultural complexities of conducting fieldwork in rural Saudi Arabia. He served as my driver to remote locations that would have been difficult to access independently, leveraged his local networks and cultural understanding to facilitate connections with community members, and provided crucial support by accompanying me to interviews where cultural norms around gender dynamics required male presence. His willingness to dedicate significant time to these research activities, whilst maintaining sensitivity to local customs and demonstrating genuine interest in the scholarly process, exemplified the kind of collaborative family support that made this cross-cultural research both feasible and ethically appropriate.

The generosity of the Saudi Electronic University and the Saudi government through their scholarship programme has made this doctoral pursuit financially viable and academically possible. This institutional support represents more than mere funding; it embodies a national commitment to developing my knowledge that will, hopefully, benefit Saudi society. The opportunity to study abroad whilst maintaining connections to my home country has enriched both my academic perspective and my appreciation for the importance of international scholarly exchange in developing my personality and refining my independent personality. This generous support allowed me to pursue my academic aspirations and contribute to the advancement of knowledge in my field. Without having this scholarship, I would not be able to pursue this degree.

The scholarly guidance provided by my supervisors, Dr. Alistair Hunter and Dr. Alexander Whitelaw, has been transformative in ways that extend far beyond the completion of this thesis. Their patient mentorship, rigorous academic standards, and constructive feedback have not only shaped this research but fundamentally influenced my growth as a critical thinker and independent researcher. Through their example, I have learned that true scholarship requires not merely technical competence but intellectual humility, ethical commitment, and genuine dedication to advancing knowledge for the broader benefit of society. Their willingness to challenge my assumptions whilst providing supportive guidance created the optimal conditions for my intellectual and academic growth.

Additionally, I wish to acknowledge my friends, especially Rasha, whose friendship, has been a source of power throughout this journey. They have provided the social connection and emotional resilience necessary to maintain perspective throughout this extended academic commitment. Their ability to offer both distraction from academic pressures and engagement with my research interests created a balanced support system that prevented the isolation that often accompanies doctoral study. Their presence in my life has made the challenges more bearable and the achievements more meaningful.

Finally, I would like to express my heartfelt gratitude to my fiancé, Abdo, who joined me later in this journey but whose presence made a significant difference. He brought a dimension of companionship and emotional support that proved essential during the most intensive periods of research and writing. His understanding of the demands inherent in doctoral study, combined with his ability to provide both practical assistance and emotional sustenance, exemplified the kind of partnership that makes ambitious undertakings achievable. His presence transformed what could have been an increasingly

solitary final phase into a shared endeavour characterised by mutual support and collective celebration of progress achieved.

This doctoral journey has unfolded against a backdrop of profound personal loss, beginning with the passing of my grandmother, and concluding with the death of my uncle, with several other family bereavements occurring throughout these years of study. The geographical distance from family during these periods of grief presented particular challenges that tested my emotional resilience and commitment to completing this research. However, these experiences of loss also deepened my appreciation for the fragility of life. The strength I discovered through navigating these difficulties whilst maintaining academic focus has become an integral part of my identity as a person.

The completion of this thesis represents not merely individual achievement, but collaborative success made possible through the extraordinary generosity, patience, and support of all those mentioned above. Their diverse contributions—whether emotional, practical, intellectual, or spiritual—have woven together to create the conditions necessary for sustained academic work of this magnitude. I am profoundly grateful for their presence in my life and their investment in my success, recognising that this accomplishment belongs as much to them as it does to me. Their collective support has not only made this research possible but has also demonstrated the fundamental truth that meaningful achievement emerges from community rather than isolation, and that the pursuit of knowledge gains its greatest value when it serves to strengthen our connections to others and our commitment to addressing the challenges facing us. I am forever grateful for their contributions to my academic and personal growth.

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Printed Name: Sabreen Batarfi

Signature:

List of Abbreviations

ABA	Asset-Based Approach
ABCD	Asset-Based Community Development
BOE	Bureau of Experts at the Council of Ministries
CFIR	Consolidated Framework for Implementation Research
CMO	Context-Mechanism-Outcome
CTC	Communities That Care Coalition
DNCC	Deans of Nursing Colleges Committee
ETEC	Education and Training Evaluation Commission
GCPH	Glasgow Centre for Population Health
GMPH	Greater Manchester Population Health
HCA	Healthy Cities Approach
HCN	Healthy Cities Network
HOPE	Healthy Outcomes through Patient Empowerment
HRSD	Ministry of Human Resources and Social Development
MOC	Model of Care
MOE	Ministry of Education
MOH	Ministry of Health
NCAAA	National Commission for Academic Accreditation and Assessment
NCE	Nursing Continuing Education
NHS	National Health Service
NORC	National Opinion Research Centre
NPT	Normalisation Process Theory
NTP	National Transformation Program

OSCE	Objective Structured Clinical Examination
PARIHS	Promoting Action on Research Implementation in Health Services
PHC	Primary Healthcare
PHE	Public Health England
RE	Realistic Evaluation
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
RHIH	Rural Health Information Hub
SAQF	Saudi Arabia Qualifications Framework
SCFHS	Saudi Commission for Health Specialties
SDG	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SOC	Systems of Care
UK	United Kingdom
UNV	United Nations Volunteers
US	United States
WHO	World Health Organization

Chapter 1 The Introduction

Asset-based approaches to health promotion represent a fundamental paradigm shift from deficit-focused models that emphasise community problems and needs towards strengths-based frameworks that recognise and mobilise existing community resources, capabilities, and wisdom (Kretzmann and McKnight, 1993). Despite growing recognition of their potential to empower communities and reduce health inequalities, the evidence base for asset-based approaches remains heavily concentrated in global north contexts, with limited understanding of their feasibility and implementation in conservative cultural settings (Bortel et al., 2019). This gap is particularly pronounced in the Middle East, where hierarchical governance structures, traditional gender roles, and religious frameworks may significantly influence how community-based health interventions are conceived, accepted, and sustained (Mobaraki and Söderfeldt, 2010, Khosravi et al., 2024). The Kingdom of Saudi Arabia presents a compelling context for examining asset-based health implementation, given its ongoing health system transformation under Vision 2030 - a comprehensive national reform programme aimed at diversifying the economy, modernising governance, and transforming public services including healthcare delivery from a centralised model towards more decentralised, community-engaged approaches. This transformation represents a fundamental shift from traditional paternalistic healthcare models towards participatory frameworks that emphasise prevention, community engagement, and holistic wellbeing (Vision2030, 2016).

Rural Saudi communities, in particular, face unique health challenges whilst possessing rich cultural assets including strong kinship networks, religious traditions, and indigenous knowledge systems that remain largely unexplored in contemporary health promotion discourse. However, defining rurality is far from straightforward. Internationally, scholars have increasingly challenged the assumption that rural and urban areas can be clearly distinguished through population size, density, or administrative classifications alone (Cloke, 2006, Gkartzios, 2024). International organisations such as the United Nations and OECD have similarly acknowledged significant variation in how countries define rural areas, leading to the development of harmonised frameworks for international comparison rather than a single universal definition (OECD/European Commission, 2020, United Nations, 2017, European Commission et al., 2021). In the contemporary Saudi context, these definitions are particularly complex because some places combine rural histories with urban expansion, municipal development, family and tribal networks, and changing patterns of health service provision. The case study considered in this thesis, Al-Jumum,

reflects this complexity. Although it is connected to the wider Makkah region and has experienced urban and infrastructural development, it also has a recent rural history and remains socially and culturally connected to surrounding villages and rural communities. For this reason, this thesis understands Al-Jumum as a rural/peri-urban Saudi context, where rurality is shaped not only by geography, but also by social history, community identity, service access, and relationships with surrounding rural settlements.

The implementation of asset-based approaches in conservative contexts presents distinct challenges that are poorly understood in current literature. Traditional implementation science frameworks, developed primarily in global north contexts, may inadequately address the cultural, religious, and social complexities that characterise conservative societies (Yapa and Bärnighausen, 2018). More broadly, there is limited rigorous evaluation of asset-based approaches' feasibility and effectiveness, with insufficient attention to how local contextual factors fundamentally shape implementation outcomes (Ward, 2021). Research demonstrates that asset-based community development requires pre-existing community resources—including experienced local activists, accessible venues, and established activity programmes—to achieve sustainable impact, challenging assumptions about universal applicability (*ibid.*). Similarly, conventional asset-based community development models, rooted in individualistic assumptions about community agency and empowerment, may require substantial adaptation to function effectively within hierarchical decision-making structures and collective cultural values (Smith, 2021).

This research originated from my personal and professional interest in health inequalities between rural and urban communities in Saudi Arabia. As an academic in Saudi Arabia prior to embarking on my doctoral studies, I observed that rural communities continue to face significant challenges in accessing adequate health services, whilst possessing rich cultural and social resources that remain largely unrecognised and unmobilised. My engagement with health promotion literature, combined with the transformative ambitions of Vision 2030, led me to asset-based approaches as a potentially suitable framework for the Saudi context. I was particularly drawn to this approach because it had not been formally implemented in Saudi Arabia, representing both a significant research gap and a practical opportunity to contribute to ongoing health system transformation efforts.

As a Saudi woman working in academia, I acknowledge that my positionality shapes this research in important ways. Whilst my cultural background provides an insider understanding of the social, religious, and gender dynamics that characterise Saudi communities, I recognise that my urban academic experience differs from the lived

realities of rural community members. This awareness has informed my methodological choices throughout the research, ensuring that community voices and perspectives remain central to the investigation.

1.1 Research Aims, Questions, and Literature Gaps

The primary aim of this thesis is to examine the feasibility of implementing asset-based approaches to health in a Saudi rural/peri-urban community context. This research contributes to theoretical debates in implementation science and community development by extending understanding of how asset-based interventions might operate within conservative cultural contexts. The research findings illuminate the extent and nature of community assets available for health promotion whilst identifying the cultural, policy, and implementation factors that influence the feasibility of asset-based approaches in such settings. A secondary aim of this research is to contribute methodologically to implementation science by demonstrating how realistic evaluation frameworks can be applied to examine implementation feasibility rather than intervention outcomes, extending the framework's application to earlier stages of the implementation lifecycle through the innovative use of existing health interventions as proxy indicators for asset-based implementation potential.

This research addresses critical knowledge gaps in asset-based implementation within hierarchical, collectivist contexts through five interconnected research questions. The primary research question examines what factors influence the feasibility of implementing asset-based approaches to health in a Saudi rural/peri-urban community context, extending asset-based community development theory beyond its global north origins whilst addressing implementation science literature's limited engagement with community-led interventions in conservative cultural contexts (Castro et al., 2010). The research questions that have guided this investigation are:

- 1- What are the assets of a Saudi rural/peri-urban community that could have impacts on health?
- 2- What are the barriers that hinder the provision of adequate health services?
- 3- What factors could affect implementation decisions?
- 4- What is the impact of current health policies on the possibility of implementing asset-based approaches?
- 5- How can decision makers and community members influence implementation possibilities?

The operationalisation of these research questions through focused inquiry reflects specific literature gaps and theoretical considerations that this study addresses. The question regarding assets of Saudi rural/peri-urban communities that could impact health addresses asset-based literature's limited engagement with conservative cultural contexts and the need for more sophisticated asset typologies that capture culturally specific resources including religious networks, traditional knowledge systems, and hierarchical social structures. This question extends beyond conventional asset mapping approaches developed in global north contexts to examine how assets function within collectivist decision-making processes and conservative gender arrangements, contributing to theoretical understanding of asset identification and mobilisation in global south contexts. The investigation of barriers hindering adequate health service provision addresses the intersection of implementation science and health systems literature, examining how existing service delivery models and professional practices may constrain asset-based implementation (Damschroder et al., 2009). This question extends beyond conventional barrier identification to examine structural and cultural constraints that may require fundamental system reorganisation rather than incremental adaptation, contributing to understanding of transformative implementation processes in conservative societies.

The examination of factors affecting implementation decisions addresses realistic evaluation literature's limited engagement with pre-implementation feasibility assessment and decision-making processes (Greenhalgh et al., 2015). Realist evaluation, developed by Pawson and Tilley (1997), focuses on understanding "what works, for whom, in what circumstances" through context-mechanism-outcome configurations. This question contributes methodologically by applying realistic evaluation principles to understand how stakeholders evaluate potential interventions and make implementation decisions, extending the framework's application to earlier stages of the implementation lifecycle. The examination of current health policies' impact on the possibility of implementing asset-based approaches addresses implementation science literature's insufficient attention to macro-level policy contexts. This gap is particularly evident in understanding how these policy contexts interact with community-level implementation processes. This question is particularly significant given Saudi Arabia's ongoing health system transformation under Vision 2030, which creates unique policy conditions that may simultaneously enable and constrain asset-based approaches, contributing to implementation science by examining how top-down policy frameworks interact with bottom-up community initiatives in centralised governance systems. Finally, the investigation of how decision makers and

community members can influence implementation possibilities addresses gaps in understanding stakeholder agency and power dynamics in implementation processes, particularly in contexts where traditional authority structures may significantly influence intervention acceptability and sustainability (Wallerstein et al., 2017).

1.2 Core Concepts and Definitions

The interdisciplinary nature of this research necessitates careful definition of key concepts, as terminology around community health interventions varies significantly across disciplines, cultural contexts, and implementation settings. Terms such as health promotion, community health, primary healthcare, and asset-based approaches carry different meanings depending on whether they are employed within clinical practice, public health policy, community development, or implementation science contexts (Proctor et al., 2011). This definitional ambiguity is particularly pronounced when examining how globally developed frameworks might be adapted for culturally specific contexts, where concepts may carry different implications or be understood through alternative epistemological lenses (Castro et al., 2010). Furthermore, the translation of theoretical concepts across cultural and linguistic boundaries can alter their meaning and practical application, potentially leading to misalignment between intended interventions and local understanding (Temple and Edwards, 2002). The following definitions establish the specific meanings employed throughout this thesis, providing conceptual clarity essential for understanding how asset-based approaches might be implemented within conservative cultural contexts whilst maintaining theoretical precision across the multiple disciplinary perspectives that inform this research.

Asset-Based Approaches (ABA) refer to community development strategies that identify and mobilise existing community resources, capabilities, and wisdom rather than focusing on deficits and needs (Kretzmann and McKnight, 1993). This encompasses asset-based community development (ABCD) and asset-based health promotion approaches.

Health Promotion is defined by the WHO as "the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 2021), through addressing social determinants and community empowerment.

Community Health refers to health initiatives that operate at the community level, involving collective action and community participation in health improvement activities (Campbell and Murray, 2004). This approach recognises communities as active agents in health improvement rather than passive recipients of services, focusing on mobilising local

resources and social networks to address health challenges within existing cultural contexts (Wallerstein et al., 2017).

Rurality refers to a contested and context-dependent concept that can be defined through population size, population density, administrative classification, distance from urban centres, service access, and social or cultural identity (Cloke, 2006, Gkartzios, 2024). Definitions of rural areas also vary across national and international contexts, making comparison between countries difficult (Ghosn, 2025). In this thesis, Al-Jumum is understood as a rural/peri-urban Saudi context because it combines recent rural history, links to surrounding villages, urban development, family and tribal networks, and health service access challenges.

Primary Healthcare follows the WHO definition from Alma-Ata, emphasising community participation, prevention, and addressing social determinants of health (World Health Organization, 1978).

Public Health refers to "the science and art of preventing disease, prolonging life, and promoting health through organised efforts of society" including environmental sanitation, infection control, health education, medical service organisation for early diagnosis and preventive treatment, and developing social systems that ensure adequate living standards for health maintenance (Winslow, 1920). This approach differs from clinical medicine by focusing on population-level interventions and organised community action rather than individual patient care (Peters, 2009). Public health encompasses both preventive measures and the creation of social and environmental conditions that support health across entire populations, requiring intersectoral collaboration and government coordination to address health determinants at the community level (Marmot and Wilkinson, 2005, Frenk et al., 2010).

Implementation Sciences are "the scientific study of methods to promote the systematic uptake of evidence-based interventions into practice and policy and hence improve health." (Foy et al., 2015). This field encompasses examining how various factors influence the behaviours of healthcare professionals, patients, and organisations across different settings including clinical, community, and population-based environments.

Conservative contexts refer to social environments in which traditional gender norms, hierarchical social structures, and resistance to rapid social change prevail. These contexts are often underpinned by religious and cultural frameworks that prioritise collective

values, family obligations, and social conformity over individual autonomy (Kandiyoti, 1988, Cislighi and Heise, 2020).

1.3 Theoretical Framework and Methodological Orientation

This study's conceptual approach emerges from the synthesis of asset-based community development theory (Kretzmann and McKnight, 1993), implementation science frameworks (Damschroder et al., 2009), cultural adaptation models (Castro et al., 2010), and realistic evaluation methodology (Pawson and Tilley, 1997). This integration creates a comprehensive theoretical foundation for understanding the complex dynamics that influence feasibility of community-led health interventions in conservative contexts, addressing critical gaps that have limited previous scholarship's ability to understand how asset-based approaches operate within hierarchical governance structures and culturally specific contexts.

Asset-based community development literature provides essential foundations for understanding how communities can leverage existing resources and capabilities to address health challenges. Developed by Kretzmann and McKnight (1993), this approach emphasises mobilising community assets—including individual skills, associational connections, and institutional resources—rather than focusing on deficits and needs. The framework proposes that sustainable community development emerges when residents identify, connect, and mobilise these existing strengths through locally driven initiatives. However, this body of work demonstrates significant limitations when applied to global south contexts, where different cultural values, governance structures, and resource constraints may fundamentally alter how asset mobilisation operates (Kretzmann and McKnight, 1993, Bortel et al., 2019). The literature's concentration on individual agency and informal networking may not adequately address contexts where collective decision-making and formal hierarchies shape community action.

Recent UK research by South and colleagues provides important evidence supporting asset-based implementation while highlighting contextual challenges. Their evaluation of neighbourhood-based ABCD programmes demonstrates how asset-based principles can be operationalised in practice, revealing both the potential for community-led health initiatives and the complexity of implementation processes (Woodward et al., 2021). This work particularly emphasises the collaborative evaluation methods necessary for capturing asset-based outcomes, extending beyond traditional deficit-focused measurement

approaches to develop asset-oriented evaluation frameworks that respect community knowledge whilst generating robust evidence (South et al., 2024).

Implementation science literature offers sophisticated frameworks for understanding how interventions translate from theory to practice (Nilsen, 2015), providing systematic approaches to examining the complex process of moving evidence-based interventions into real-world settings (Proctor et al., 2011). The Consolidated Framework for Implementation Research and other prominent implementation models focus primarily on organisational and system-level factors, with insufficient attention to community-level implementation dynamics and cultural accommodation processes that are essential for asset-based approaches. Asset-based approaches require fundamental shifts in power relationships between professionals and communities, and often operate through informal networks and social structures that conventional implementation frameworks struggle to capture. These frameworks demonstrate geographical bias towards global north healthcare systems, limiting understanding of implementation processes within centralised governance structures and resource-constrained environments characteristic of many global south contexts.

Cultural adaptation models provide frameworks for modifying evidence-based interventions to fit specific cultural contexts, recognising that interventions developed in one setting may require substantial modification to be effective and acceptable in different cultural environments (Castro et al., 2010). Bernal and Sáez-Santiago (2006) distinguish between surface-level adaptations (language, materials, settings) and deep-structure modifications that address cultural values, beliefs, and social norms. However, existing cultural adaptation literature demonstrates limited engagement with asset-based approaches, focusing primarily on adapting deficit-focused interventions rather than exploring how strengths-based models can be culturally responsive. The intersection of gender, culture, and health intervention literature reveals complex dynamics that significantly influence implementation feasibility, particularly in conservative cultural contexts where traditional gender roles may both constrain and enable women's participation in health initiatives. Whilst feminist literature emphasises empowerment and challenge to patriarchal structures (Pederson et al., 2014), this approach may prove counterproductive in contexts where gradual, culturally sensitive adaptation strategies are required to achieve sustainable change.

Woodward et al.'s (2021, p.20) comprehensive review of current ABCD evidence reinforces the importance of cultural responsiveness, particularly noting that "asset-based

approaches cannot be transplanted from one place to another without wider consideration and understanding of local context and circumstances." Their analysis of recent evaluations demonstrates how successful ABCD implementation requires organisational culture change, community ownership, and commitment over time, highlighting the fundamental shift from rational to relational ways of working that asset-based approaches demand.

Realistic evaluation literature provides methodological frameworks well-suited to understanding complex, context-sensitive interventions, yet demonstrates limited application to asset-based approaches and insufficient engagement with global south cultural contexts (Pawson & Tilley, 1997). However, the framework's application has concentrated primarily on professionally led, formally structured programmes rather than community-led initiatives that operate through informal networks and emergent processes.

The research adopts a critical realist philosophical position, recognising that whilst our knowledge of implementation processes is socially constructed and culturally mediated, there exist underlying mechanisms and structures that influence how interventions operate across different contexts (Bhaskar, 1975). This perspective acknowledges multiple ways of understanding implementation feasibility whilst maintaining that systematic investigation can reveal patterns and mechanisms that have explanatory power beyond specific local contexts. Hence, a realistic evaluation approach has been employed throughout, utilising Context-Mechanism-Outcome configurations to understand how asset-based approaches might work differently across various cultural and institutional settings. This philosophical alignment is supported by South et al.'s (2024) practical application of realistic evaluation methodology to asset-based approaches, which demonstrates how CMO configurations can effectively capture the complex relational dynamics that characterise community-led health initiatives whilst extending the framework's application to pre-implementation feasibility assessment. The choice of realistic evaluation methodology emerges from these literature gaps and the need for analytical frameworks capable of capturing complex, context-sensitive implementation processes, whilst its attention to underlying mechanisms provides tools for examining how asset-based approaches operate through informal networks and cultural practices embedded within conservative cultural contexts.

1.4 Significance and Innovation of the Study

This research makes significant theoretical contributions to asset-based community development by addressing critical gaps in understanding how these approaches operate in global south contexts. The limited evidence base for asset-based approaches in contexts characterized by hierarchical governance structures, collective decision-making processes,

and traditional social arrangements represents a substantial limitation in current theory (Bortel et al., 2019). Most documented applications emerge from global north countries where asset-based principles have been integrated with formal health and social services, creating important blind spots regarding cultural appropriateness and sustainability. This research extends asset-based community development theory by examining how community assets—including kinship networks, religious traditions, and indigenous knowledge systems—might be systematically identified and mobilised in conservative cultural contexts. The Saudi Arabian setting provides particularly valuable insights for decolonising asset-based theory by demonstrating how these approaches must be adapted to work within existing social structures rather than attempting to transform them, offering alternatives to externally imposed interventions that may not align with local values and practices.

The study introduces significant methodological innovations to implementation science by addressing the field's limited engagement with pre-implementation feasibility assessment. Current implementation science frameworks typically focus on post-implementation evaluation rather than understanding implementation potential before costly programme deployment. This research develops a novel approach of using existing health interventions as proxy indicators for asset-based implementation feasibility, allowing researchers to assess community readiness and capacity by analysing how communities currently mobilise resources and engage in health-promoting activities. This methodology directly addresses what (Eccles et al., 2005), as cited in Nilsen (2015), describe as the "expensive version of trial-and-error" that characterises traditional implementation approaches, providing foundational understanding of implementation potential before costly programme deployment. This methodological approach builds upon South et al.'s (2024) collaborative evaluation framework, which emphasises the importance of working with communities throughout the research process whilst maintaining analytical rigour. Their identification of six key design features for asset-based evaluation - including coherent asset-based models, diverse evidence sources, and developmental collaborative approaches, provides important methodological guidance for examining implementation feasibility in culturally specific contexts without imposing external frameworks that may conflict with local values.

This methodological contribution is particularly valuable for contexts where formal asset-based programmes do not exist, providing tools for understanding implementation feasibility without imposing external frameworks that may not align with local values. The

research also contributes to implementation science by examining how global north-derived theoretical frameworks require adaptation for application in contexts characterised by centralised governance and resource constraints, addressing the field's geographical bias towards developed healthcare systems.

This research extends realistic evaluation methodology by applying Context-Mechanism-Outcome configurations to understand asset-based implementation feasibility in conservative cultural contexts. This study demonstrates how realistic evaluation can capture the complex, relational dynamics that characterise asset-based approaches whilst maintaining analytical rigour in understanding implementation processes. The research contributes methodologically by showing how realistic evaluation can be used for pre-implementation feasibility assessment rather than only post-implementation evaluation, providing frameworks for understanding how cultural and institutional factors enable or constrain community-led health initiatives. This methodological extension is particularly significant for global south contexts where implementation processes may operate differently due to distinct governance structures and cultural practices.

The practical significance of this research extends to health policy and practice in Saudi Arabia and similar contexts undergoing health system transformation whilst maintaining strong cultural foundations. The research findings provide evidence for policymakers regarding the potential role of community assets in health promotion, identifying specific types of community resources that might be mobilised whilst highlighting policy conditions that could enable or constrain asset-based implementation. This evidence is particularly relevant given Saudi Arabia's Vision 2030 commitments to improving population health outcomes whilst reducing healthcare costs through preventive approaches and community engagement. For health practitioners and community development professionals, the research offers insights into how asset-based approaches might be adapted for implementation in conservative cultural contexts, providing guidance for navigating cultural sensitivities whilst promoting community empowerment through culturally responsive approaches that work within existing social structures. The research contributes to understanding how top-down policy frameworks can create enabling conditions for bottom-up community initiatives within centralised governance systems, offering valuable insights for health system transformation efforts globally.

1.5 Thesis Structure

This thesis comprises seven chapters that build progressively toward understanding the feasibility of implementing asset-based approaches to health in Saudi rural/peri-urban

communities through examination of existing health initiatives as proxy interventions for implementation potential. Chapter 2 provides a comprehensive literature review divided into two main parts: Part I examines the conceptual and analytical framework, including theoretical foundations of asset-based approaches, implementation science frameworks, and realistic evaluation methodology, whilst Part II focuses on the Saudi context, analysing the health system transformation, gender dynamics, and cultural and religious considerations that characterise Saudi Arabia.

Chapter 3, Research Methodology – Weaving Methods, Voices, and Contexts, describes the research methodology, discussing the philosophical foundations of realistic evaluation whilst explaining how this framework has been adapted for examining implementation feasibility through existing health initiatives as proxy indicators. The chapter details the research design, data collection methods, and analytical approaches used to understand how current health initiatives in Al-Jumum demonstrate asset-based potential, with particular attention paid to ethical considerations and cultural sensitivities that informed the research process, demonstrating how methodological choices reflected the study's commitment to culturally responsive research practices.

Chapters 4, 5, and 6 present the empirical findings through three detailed case studies of health initiatives in Al-Jumum, each serving as proxy indicators for asset-based implementation feasibility and analysed using realistic evaluation's Context-Mechanism-Outcome configurations to understand their alignment with asset-based principles. These three proxies—the Healthy Cities Network, volunteer groups, and health coaching—were selected because they represent existing health initiatives that embody key asset-based principles such as community engagement, resource mobilisation, and empowerment processes, allowing the research to assess implementation potential without requiring new programme development. Chapter 4, Al-Jumum's Healthy Cities Network, examines how the WHO Healthy Cities approach has been implemented locally, exploring the tension between top-down policy directives and bottom-up community engagement whilst assessing consistency with asset-based principles. Chapter 5, Al-Jumum's Volunteer Groups, investigates local volunteering initiatives, analysing how community members mobilise social capital and collective action for health promotion whilst considering cultural and religious motivations for voluntary service that may indicate community readiness for asset-based approaches. Chapter 6, Health Coaching, explores individual-level health promotion approaches, examining how peer support and community knowledge sharing contribute to health behaviour change whilst maintaining cultural

sensitivity and religious alignment, providing insights into mechanisms through which asset-based approaches might operate in conservative cultural contexts.

The final chapter, chapter 7, Discussion and Conclusion - Analysing Asset-Based Approaches in Public Health Initiatives, provides integrated analysis of the findings across all three proxies, demonstrating how community assets, policy contexts, and implementation factors interact to influence asset-based implementation feasibility in Saudi communities. The discussion situates the findings within existing literature whilst highlighting the study's contributions to asset-based community development theory, implementation science, and realistic evaluation methodology, concluding with implications for policy, practice, and future research. Through this comprehensive examination of existing health initiatives as proxy indicators for asset-based implementation potential, the thesis establishes both the theoretical foundations for understanding asset-based approaches in conservative contexts and the empirical evidence necessary for informing policy and practice decisions in similar settings globally.

Chapter 2 The Literature Review

2.1 Introduction

This chapter establishes the theoretical and conceptual foundations for examining the feasibility of implementing asset-based approaches to health in Saudi rural/peri-urban communities. It also provides the institutional and policy context surrounding the Saudi health system, and wider socio-cultural context of Saudi Arabia. Through a comprehensive review of relevant literature, it develops the conceptual framework that underpins this research whilst identifying the theoretical gaps that this study addresses.

The chapter is organised around key conceptual domains essential for understanding asset-based implementation in conservative contexts, followed by specific contextual analysis of Saudi Arabia. The conceptual and analytical framework section examines the theoretical foundations and global applications of asset-based approaches, implementation science frameworks and their limitations in global south settings, realistic evaluation approaches for complex community interventions, and gender dynamics in conservative contexts. The Saudi context section then provides comprehensive analysis of the Saudi Arabian health system transformation, specific gender dynamics within Saudi society, and cultural and religious considerations that shape health promotion approaches.

The literature review adopts a critical perspective, examining not only what existing literature reveals about asset-based approaches and implementation science, but also analysing the cultural and epistemological assumptions underlying these predominantly global north-derived frameworks. The scope encompasses theoretical literature spanning community development, implementation science, health systems research, and cross-cultural adaptation studies. It includes empirical studies from both high-income countries where asset-based approaches have been more extensively implemented and the limited available evidence from global south contexts. Particular attention is paid to literature addressing rural implementation challenges, gender dynamics in conservative societies, and cultural adaptation processes in health promotion interventions. The review also incorporates relevant policy documents and grey literature related to Saudi Arabia's health system transformation, providing essential context for understanding the policy environment within which asset-based implementation would occur.

This study employs a pragmatic narrative literature review approach, which allows for the examination of diverse theoretical perspectives and empirical evidence across multiple disciplines without the constraints of systematic review protocols (Green et al., 2006, Rother, 2007). A narrative review is particularly appropriate for this research given the

interdisciplinary nature of the inquiry, spanning asset-based community development, implementation science, cultural adaptation, and health systems research (Klein, 2008). This approach enables the integration of theoretical frameworks with limited empirical evidence from conservative contexts (Adams et al., 2017), whilst accommodating the inclusion of grey literature and policy documents essential for understanding the Saudi Arabian context. The narrative review methodology also allows for the critical examination of epistemological assumptions underlying predominantly global north-derived frameworks, supporting the study's decolonising objectives (Smith, 2021, Chilisa, 2019).

The literature search employed approaches across multiple databases including PubMed, Google Scholar, ScienceDirect, and the University of Glasgow Library electronic resources, using combinations of key terms related to asset-based approaches, community development, implementation science, cultural adaptation, Saudi health systems, and rural health promotion. Search terms included asset-based community development, asset-based health promotion, implementation science, cultural adaptation, Saudi Arabia health system, rural health promotion, community empowerment, and conservative contexts. Additional searches were conducted using Arabic terms and databases to capture regional literature and policy documents. The search strategy adopted an iterative approach, with initial broad searches followed by targeted searches based on emerging themes and citation tracking from key papers. Grey literature searches included government policy documents, organizational reports, and conference proceedings relevant to Saudi health system transformation and community development initiatives. The temporal scope primarily focused on literature from 2000 onwards, coinciding with the emergence of contemporary asset-based approaches and implementation science, whilst including seminal earlier works that established foundational theoretical concepts. Literature selection prioritised theoretical contributions, empirical studies from rural or conservative contexts, implementation science frameworks applicable to community-based interventions, and studies addressing cultural adaptation processes. Given the limited literature specifically addressing asset-based approaches in conservative or global south contexts (Bortel et al., 2019), the review necessarily encompasses broader community development and health promotion literature that provides relevant theoretical insights for understanding implementation processes in such settings.

This literature review contributes to theoretical framework development by synthesising insights across multiple disciplines to create a comprehensive understanding of asset-based

implementation processes in conservative contexts. Rather than simply applying existing frameworks developed in global north contexts, the review critically examines their underlying assumptions and identifies adaptations necessary for application in contexts characterised by hierarchical governance, traditional gender roles, and collective decision-making processes. The theoretical framework development process involves three stages: first, deconstructing existing theories to identify culturally specific assumptions and universal principles; second, examining empirical evidence from similar contexts to understand how cultural and social factors influence implementation processes; and third, synthesising insights to develop adapted frameworks that maintain theoretical rigor whilst accommodating cultural and contextual specificities that may not be adequately addressed in existing models. This approach reflects broader debates in development and implementation science about the need for more culturally responsive theoretical frameworks that avoid imposing global north conceptualisations of empowerment, participation, and community development whilst maintaining commitment to evidence-based practice and sustainable health improvement outcomes (Smith, 2021, Yapa and Bärnighausen, 2018).

As this literature review draws on evidence from different international contexts, it is important to clarify how this thesis uses the terms Global North and Global South. These terms have been criticised as broad and sometimes reductive conceptual categories. They can group very different countries, societies, and experiences into two simplified categories, which may hide important differences and inequalities within countries themselves (Dados and Connell, 2012). They are also not only geographical terms, but are connected to political, historical, and economic relations, including colonial histories and unequal global power relations ((Dados and Connell, 2012, Mahler, 2018). Mahler (2017) explains this by referring to “Souths in the North” and “Norths in the South”, showing that privilege and disadvantage can exist both between and within societies. This is relevant to Saudi Arabia because it is a high-income Islamic country (Muhammad, 2019), but it is also a non-Western context that is largely absent in much of the literature on asset-based approaches and implementation science. Therefore, this thesis uses the terms Global North and Global South cautiously, as broad analytical terms to discuss inequalities in global health knowledge production and the dominance of frameworks developed mainly in Western and high-income settings.

2.1.2 Defining Rurality in Global and Saudi Contexts

Rurality is widely recognised as a contested and context-dependent concept, with no single definition that can be applied across all countries and settings. Traditional definitions have often relied on measurable characteristics such as population size, population density, agricultural activity, distance from urban centres, settlement patterns, administrative classification, or access to services (Cloke, 2006, Gkartzios, 2024). However, these indicators alone do not fully explain how rural places are experienced, represented, and understood by residents, policymakers, and researchers (ibid). Scholars have therefore challenged simple rural-urban binaries and argued that rurality should be understood as a multidimensional and relational concept, shaped by social, cultural, historical, economic, political, and symbolic dimensions (Cloke, 2006, Gkartzios, 2024, Gkartzios et al., 2020). This is important because places may contain both rural and urban characteristics, and residents' understandings of rural identity may continue even where demographic or administrative indicators suggest increasing urbanisation.

International organisations and governments have also recognised the difficulty of defining rurality in a consistent way. A joint methodological manual developed by the European Commission, the Statistical Office of the European Union, the Organisation for Economic Co-operation and Development (OECD), the Food and Agriculture Organization of the United Nations (FAO), the United Nations Human Settlements Programme (UN-Habitat), and the World Bank highlights that national definitions of rural and urban areas vary significantly, making international comparison difficult (European Commission et al., 2021). In response, harmonised approaches such as the Degree of Urbanisation framework classify settlements into cities, towns and semi-dense areas, and rural areas using population grids, density, and settlement patterns (OECD/European Commission, 2020, European Commission et al., 2021). However, these frameworks are intended to support comparison rather than replace national or local understandings of place. They also show that rurality is better understood as a continuum rather than a fixed category, because many settlements occupy intermediate positions between large urban centres and rural hinterlands (OECD/European Commission, 2020, du Plessis et al., 2002). This is particularly relevant for research concerned with health and service access, because the choice of rural definition can influence which populations are included, how inequalities are measured, and how policy responses are designed.

These definitional issues are especially important in Global South and Middle Eastern contexts, where rapid urbanisation, peri-urban expansion, migration, infrastructure

development, and uneven service provision often blur the boundaries between rural and urban areas. In these contexts, rurality may not refer only to isolated agricultural villages, but also to places located near expanding cities that continue to maintain rural histories, family networks, cultural practices, and service-access challenges (Follmann, 2022, Tacoli et al., 2025). Peri-urbanisation is therefore useful for understanding places that are socially, economically, and spatially connected to urban centres while still retaining rural characteristics (Follmann, 2022). In the Near East and North Africa region, rural-urban differences also remain important because rural and semi-rural communities may continue to experience inequalities in infrastructure, employment opportunities, education, and healthcare access (Ogunbodede et al., 2015, Sedik, 2018). Therefore, although rurality is conceptually contested, it remains a useful category for examining how place, service access, social relationships, and health inequalities interact.

In Saudi Arabia, rurality is also difficult to define through one single measure. Some Saudi health literature defines rural areas as places with fewer than 5,000 people, and rural populations have been discussed in relation to differences in education, health staffing, facilities, and access to health services compared with urban areas (Moafa et al., 2020). Other literature highlights the continuing importance of inherited customs, family connections, agricultural histories, and strong social relations in Saudi rural communities, although these characteristics should not be treated as fixed or universal features of all rural places (Abdul-Salam et al., 2014). Al-Jumum reflects this complexity. Although it is connected to the wider Makkah region and has experienced urban and infrastructural development, it also has a recent rural history and remains socially and culturally connected to surrounding villages and rural communities. For this reason, this thesis uses rurality as a useful but qualified analytical context. It does not claim that Al-Jumum represents all rural communities in Saudi Arabia, the Middle East, or the wider Global South. Rather, it treats Al-Jumum as a rural/peri-urban Saudi context through which to examine how asset-based approaches might be understood and implemented in a place where rural histories, urban connections, family and tribal networks, service-access challenges, and community identity overlap.

Part 1: Conceptual and Analytical Framework

2.2. Asset-Based Approaches: Theoretical Foundations and Global Applications

Asset-based approaches to health promotion represent a fundamental paradigm shift from deficit-focused models that emphasise community problems and needs towards strengths-

based frameworks that recognise and mobilise existing community resources, capabilities, and wisdom. Sequentially, this section examines the core principles, theoretical foundations, and global applications of asset-based approaches whilst identifying significant gaps in evidence from global south and rural contexts that this research seeks to address.

2.2.1 Origins and Core Principles

The contemporary asset-based movement emerged from John Kretzmann and John McKnight's (1993) seminal work, *Building Communities from the Inside Out*, which fundamentally challenged traditional community development approaches that portrayed communities as collections of problems requiring external intervention. Their foundational work established asset-based community development (ABCD) as a systematic approach to recognising and mobilising community strengths, introducing key concepts that continue to shape asset-based practice across multiple sectors. Kretzmann and McKnight identified three categories of community assets: primary assets including individual skills and capacities of community members and citizen associations that connect people around shared interests; secondary assets comprising formal institutions located within the community such as schools, healthcare facilities, and religious organisations; and potential assets including resources located outside the community but accessible through strategic partnerships and advocacy efforts.

The asset-based paradigm represents a fundamental epistemological shift from the deficit-based thinking that dominates traditional health and social services. Deficit-based approaches typically begin with comprehensive assessments of community problems, needs, and deficiencies, often resulting in interventions designed by external experts to address identified gaps through service provision or capacity building that may inadvertently reinforce dependency relationships (Ravaghi et al., 2023, Martin-Kerry et al., 2023). In contrast, asset-based approaches begin with systematic identification of existing community strengths, capabilities, and resources, recognising that sustainable development emerges from mobilising and connecting local assets rather than importing external solutions that may not align with community values, priorities, or cultural practices (Kretzmann and McKnight, 1993). The following table shows the main differences between the two approaches.

Table 2-1 Asset-Based versus Deficit-Based Approaches in Health

Aspect	Asset-Based Approach	Deficit-Based Approach
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Primary focus	Strengths, assets, and capabilities of individuals and communities (Garven et al., 2016, Ebersohn and Mbetse, 2003).	Problems, needs, deficits, and pathologies within communities (Martin-Kerry et al., 2023, Kretzmann and McKnight, 1993).
Health perspective	Promotes wellbeing and positive health; focuses on what makes people healthy (Hopkins and Rippon, 2015).	Treats illness; focuses on disease and risk factors (Fogarty et al., 2018b).
Role of people	Coproducers of health; empowered to control their lives (Foot and Hopkins, 2010, Garven et al., 2016).	Passive recipients who need professional intervention (Freire, 1970/2020, Laverack, 2009).
Community orientation	Focuses on what communities have and can contribute (Kretzmann and McKnight, 1993, O'Leary et al., 2011).	Focuses on what communities lack (Fogarty et al., 2018b, Fogarty et al., 2018a).
Working philosophy	Works with people rather than to them (GCPH, 2011, Garven et al., 2016).	Works on behalf of people based on professional judgement (Nanez et al., 2024, Gonzalez, 2023).
Empowerment	Builds community capacity and control over resources (Wallerstein, 2006b, Garven et al., 2016).	Maintains professional control over decision-making (Rifkin, 2014).
Sustainability	Builds on existing assets for long-term sustainability (Hopkins & Rippon, 2015).	May create dependency on external services (Martin-Kerry et al., 2023).

The core principles of asset-based approaches centre on community ownership, local knowledge recognition, and empowerment processes that build community capacity for autonomous action (Mathie and Cunningham, 2003, Laverack, 2006, Blickem et al., 2018, Foot and Hopkins, 2010). The community ownership principle emphasises that effective development tends to be more successful when driven by community members themselves rather than external agencies, recognising that sustainable change requires local

commitment, control, and responsibility that can only emerge when communities have genuine authority over development processes (Mathie and Cunningham, 2003). Local knowledge recognition acknowledges that communities possess sophisticated understanding of their own contexts, challenges, and potential solutions that external assessments frequently overlook or undervalue, requiring development approaches that privilege community wisdom whilst integrating rather than replacing external expertise (ibid). Empowerment processes focus on building individual and collective capacity for analysis, action, and reflection that enables communities to address current challenges whilst developing capabilities for ongoing development and adaptation to changing circumstances (ibid).

These core principles reflect broader movements in development theory towards more participatory, democratic approaches to social change that challenge traditional power relations between professionals and communities whilst promoting more inclusive forms of development that honour cultural diversity and local autonomy (Freire, 1970/2020, Chambers, 1994). The emphasis on starting with assets rather than deficits creates different psychological and social dynamics that may enhance community engagement, motivation, and ownership compared to approaches that focus primarily on problems and needs.

2.2.2 Theoretical Underpinnings and Conceptual Framework

2.2.2.1 Assets Definitions and Classifications. In health contexts, assets can be defined as the collective resources that individuals, communities, and organisations possess to protect against negative health outcomes, promote health, and increase life chances (Garven et al., 2016). Asset-based approaches are place-based, relationship-based, and citizen-led (ibid). Stuart (2013) describes asset-based approaches as "a strategy for sustainable community driven development", whilst Morgan and Ziglio (2007) define assets as "any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing and to help to reduce health inequalities." The primary focus of asset-based approaches is on individual and collective psychosocial attributes, including self-esteem, aspiration, confidence, optimism, and sense of coherence, alongside intangible resources such as knowledge, experience, skills, and social capital (Foot and Hopkins, 2010).

Understanding the assets at different levels is essential for asset-based approaches to work effectively. Assets are typically classified into three interconnected levels that represent different scales of intervention and resource mobilisation, corresponding to micro-, meso-,

and macro-level frameworks commonly used in community development and health promotion literature.

Table 2-2 Asset Classifications

Level	Characteristics and Examples
Community level (Macro)	Physical assets (community buildings, sports facilities, natural resources) and the seven capitals framework (financial, built, social, human, natural, cultural, political). Represents community development approaches that mobilise human capital, skills, knowledge, and social attributes to facilitate strong community networks and social change (Garven et al., 2016).
Organisational level (meso)	Assets of organisations, public bodies, and services including buildings, land, money, employment opportunities, and institutional power. Requires coordination to ensure support rather than undermining of community empowerment (Garven et al., 2016).
Individual level (Micro)	Internal resources of every person, both innate and acquired. Includes personal skills, knowledge, experiences, social connections, and psychological resources such as resilience, self-efficacy, and sense of coherence. Reflects individual values, beliefs, and life experiences (Garven et al., 2016, Foot and Hopkins, 2010).

Understanding the assets at these three levels is essential for the asset-based approach to work effectively. In order to better understand the assets at the three levels, it is important to recognize individuals' skills, abilities, knowledge, and interests (Foot and Hopkins, 2010). Also, it is essential to recognize the connections and networks in the community (Foot and Hopkins, 2010). In addition, realising the effectiveness of local communities, voluntary associations, and resources of public and private organisations that support the community and enhance wellbeing is essential for understanding assets across all three levels (Foot and Hopkins, 2010). Moreover, it is more important to acknowledge that the asset-based approach is a community-driven, long-term, open-ended approach which provides less predictable and certain outcomes (GCPH, 2011). These outcomes take time to implement. When working with communities, the asset-based approach is not a 'one size fits all' approach (GCPH, 2011). It requires careful negotiation on an individual basis and the ability for communities to build trust with professional staff (GCPH, 2011).

However, mixed and blended approaches, combining top-down ‘traditional’ approaches with bottom-up approaches, are needed sometimes to reduce confusion and conflict about services, ownership, and how much and to what extent the community can participate (Bergdall, 2012). Even when the ultimate goal is, for example, empowerment and local capacity building, external management could be needed during the implementation process to encourage people (Bergdall, 2012). Sometimes, people may be consulted and given a role to engage and participate at the beginning; seeking their participation would be important to help implement asset-based approaches successfully (Bergdall, 2012).

Thus, asset-based approaches tend not to work separately, especially in communities where they use deficit or traditional approaches to deal with different circumstances (Hopkins et al., 2020). ABA should not be viewed as mutually exclusive. The former is needed to complement the deficit approach to shift the focus from preventing disease to building health (Hopkins et al., 2020). For this, the top-down and bottom-up approaches are explained in the following table for all the three levels of assets to clarify how each one of these approaches works in each level.

Table 2-3 Asset-Based Approaches: Top-down versus Bottom-up Dimensions

	Top-down	Bottom-up
Individual level	Individuals have few to no opportunities to express ideas and explore alternative solutions. Personal assets are identified and utilised according to externally determined priorities and programmes (Zhou et al., 2021).	It creates an empowering environment through allowing people to share information, provide suggestions, and achieve better outcomes (Zhou et al., 2021). It focuses on coordination and integration.
Community level	Communities receive specific tasks and directives from higher administrative levels and are expected to implement them at the local level. Community assets are mobilised according to external mandates (Eby, 2018).	It represents broad community collaboration with stakeholders who have fundamental understanding of local people and their needs. Community assets are identified and mobilised through participatory

		processes driven by community priorities (Eby, 2018).
Organisation level	Organisations and institutions make strategic decisions that cascade down to lower levels. They hold decision-making authority, identify objectives and implementation strategies, frame roles and regulations, and set overall direction for asset utilisation (Eby, 2018).	Organisational assets are mobilised through responsive approaches that address community needs and opinions. Decision-making processes incorporate grassroots input to ensure organisational resources support community-identified priorities (Eby, 2018).

Seeking to change to a community-led and asset-based approach is challenging. It is not a copy and paste process. It needs to be customised based on the assets and valuable resources of each community. It is also important to understand and consider people's needs in order to succeed in implanting this approach and achieve its goals. In addition, it needs to be considered at all these levels in order to implement and develop asset-based approaches successfully (Hopkins et al., 2020).

2.2.2.2 Theoretical Foundations. Asset-based approaches draw theoretical strength from multiple disciplinary traditions that provide complementary perspectives on community development, social change, and health promotion processes (Kretzmann and McKnight, 1993, Morgan and Ziglio, 2007). These theoretical underpinnings help to understand how assets function within complex social systems and how they can be effectively mobilised for health promotion and community development. The key theoretical foundations examined in this section include social capital theory, community empowerment theory, and salutogenic theory.

Social capital theory, particularly as developed by Robert Putnam, James Coleman, and Pierre Bourdieu, offers crucial insights into how social networks, trust relationships, and civic engagement create resources that can be mobilised for individual and collective benefit. Putnam's (2000) analysis of social capital distinguishes between bonding social capital (connections within homogeneous groups that provide solidarity and support), bridging social capital (connections across different social groups that facilitate access to diverse resources and opportunities), and linking social capital (connections across hierarchical levels that enable influence and advocacy). This typology provides valuable

analytical tools for understanding how asset-based approaches can enhance community capacity whilst addressing social inequalities that may limit some community members' access to resources and opportunities. Coleman's (1988) work on social capital formation emphasises the role of social structures in creating resources for action, demonstrating how family networks, community organisations, and institutional relationships generate social capital that facilitates individual achievement whilst contributing to collective capacity. His analysis of how social capital emerges from closure in social networks and intergenerational relationships offers important insights for asset-based practice, particularly regarding the importance of strengthening existing social connections whilst creating new opportunities for relationship building across different community segments. Bourdieu (2011) more critical analysis of different forms of capital—economic, cultural, social, and symbolic—provides essential perspectives on how asset-based approaches must navigate existing power relations and structural inequalities that influence asset distribution and accessibility within communities.

Building upon these insights into how social capital enables collective action, community empowerment theory provides crucial theoretical foundations for understanding asset-based approaches as processes of consciousness-raising and collective action. Researchers such as Nina Wallerstein and Glenn Laverack have developed empowerment frameworks specifically for health promotion contexts, demonstrating how asset-based approaches can address both individual empowerment and community development goals through processes that build personal self-efficacy whilst strengthening collective capacity for addressing social determinants of health. Laverack (2001) adaptation of empowerment theory for health promotion demonstrates how asset-based approaches can support progression from individual behaviour change towards collective action for social and political change, providing theoretical frameworks for understanding how asset-based health promotion can contribute to broader social transformation whilst maintaining focus on immediate health improvement goals. His empowerment continuum model illustrates the dynamic relationship between individual and community empowerment, showing how personal capacity building and collective action reinforce each other in sustainable community development processes. Wallerstein's (2006) work on participatory health promotion emphasises the importance of community control over health promotion processes, demonstrating how empowerment occurs when communities have genuine decision-making authority and can mobilise their own assets to address health challenges. This perspective aligns closely with asset-based principles by recognising communities as

active agents of change rather than passive recipients of interventions, supporting approaches that work with communities rather than implementing programmes for them.

Salutogenic theory, developed by Antonovsky (2002), contributes to asset-based thinking by focusing on factors that promote health and wellbeing rather than disease causation. Antonovsky's concept of sense of coherence—comprising comprehensibility (cognitive component), manageability (instrumental component), and meaningfulness (motivational component)—offers insights into how community assets contribute to health promotion through processes that enhance individual and community capacity for navigating challenges whilst maintaining health and resilience. His identification of generalised resistance resources including knowledge, experience, identity, coping strategies, social support, and cultural stability provides frameworks for understanding how diverse community assets can contribute to health promotion when appropriately recognised and mobilised.

Asset-based community development (ABCD) models have evolved significantly since Kretzmann and McKnight's foundational work, with various organisations and researchers including Morgan and Ziglio, Hopkins and Rippon, and Foot and Hopkins developing practical frameworks for implementing asset-based approaches across different contexts and sectors, particularly in health promotion and public health settings.. The ABCD Institute has continued developing methodologies for asset mapping, relationship building, and community mobilisation that maintain fidelity to core principles whilst adapting to diverse cultural and institutional contexts. These models emphasise the importance of starting with individual assets and associations before engaging institutions, recognising that sustainable community development requires strong foundations in personal relationships and informal networks that provide the social infrastructure necessary for broader institutional engagement and systems change.

2.2.2.2 Critiques and Limitations of Asset-Based Approaches. Despite the growing interest in asset-based approaches, it is important to acknowledge that ABCD and related asset-based models have also been subject to critique. Critical scholars argue that these approaches can sometimes be used in ways that shift responsibility for health and wellbeing from the state to communities, particularly in contexts of austerity, limited public funding, and reduced public services (Friedli, 2013, MacLeod and Emejulu, 2014). From this perspective, the language of community strengths and local assets may risk hiding wider structural inequalities if it is not linked to questions of power, resources, and social justice. MacLeod and Emejulu (2014, p. 446) describe this risk as “neoliberalism

with a community face”, where community empowerment can become a way of expecting communities to solve problems that are shaped by wider economic and political structures. Morgan (2014) similarly argues that asset-based approaches should not replace attention to needs, inequalities, and the social determinants of health, but should be used alongside these concerns.

These critiques are important for this thesis because the aim is not to present asset-based approaches as a simple solution to rural health inequalities. Rather, the study examines whether and how such approaches could be feasible in Saudi rural/peri-urban communities, whilst recognising that community assets cannot replace formal health services, adequate resources, or supportive policy frameworks. This is particularly relevant in rural health contexts, where community-led initiatives may support local improvement but cannot by themselves resolve wider structural challenges such as workforce shortages, service underinvestment, and long-term sustainability (Locock et al., 2025). Therefore, this thesis approaches asset-based approaches as complementary to, rather than a substitute for, state responsibility and broader health system reform.

2.2.3 Global Applications and Evidence Base

The application of asset-based approaches varies significantly across different geographic, cultural, and economic contexts, with most documented evidence emerging from global north countries where asset-based principles have been integrated with formal health and social services. This distribution of evidence creates important gaps in understanding how asset-based approaches function in diverse cultural, political, and economic settings.

2.2.3.1 Applications in Global north Countries. Most research about asset-based approaches has been conducted in global north countries such as UK, European countries, and the USA, with significantly fewer studies from other world regions such as the Middle East and Africa (Bortel et al., 2019). The United Kingdom has been particularly prominent in developing asset-based health promotion, with the Glasgow Centre for Population Health (2011) providing influential frameworks for integrating asset-based principles with population health improvement strategies (GCPH, 2011). UK applications demonstrate how asset-based principles can enhance both individual empowerment and population health outcomes through various community-led health improvement initiatives that focus on building upon existing community strengths rather than addressing deficits (Hopkins and Rippon, 2015).

2.2.3.2 Evidence from Global south. On the other hand, documented applications of asset-based approaches in global south contexts remain limited, with most examples emerging from international development organisations rather than indigenous community development initiatives (Lough et al., 2018). This geographical concentration creates important blind spots regarding cultural appropriateness and sustainability when implemented in contexts characterised by different governance structures, social organisation patterns, and relationships between communities and formal institutions compared to the predominantly global north contexts in which asset-based theory was developed.

However, Hessin's (2015) comprehensive study of asset-based community development in rural Egypt provides rare empirical evidence from the Middle East. Examining implementation through the Egyptian Society for Endogenous Development across three rural communities, this research revealed a customised six-step process adapting Kretzmann and McKnight's framework to Egyptian rural contexts, demonstrating significant outcomes including local economic development, job creation, and enhanced social cohesion. Key challenges included lack of trust between external developers and communities, cultural differences requiring sophisticated navigation, and transforming development concepts from passive consumption to active citizenship. The documentation of both successful implementations and failure due to cultural misunderstanding provides crucial insights into conditions necessary for effective asset-based implementation in conservative, hierarchical societies.

2.2.3.3 Asset-Based Approaches and Rural Health. In health settings, asset-based approaches have been used more widely as a new relational shift with more focus on strengths and positive health (Hopkins and Rippon, 2015). This approach challenges health services to work more collaboratively and in less transactional ways to transform their relationship with communities, nurturing people's strengths and resources to enable them to identify problems and find solutions that promote self-esteem and resilience whilst reducing reliance on professionals (Hopkins and Rippon, 2015, Foot and Hopkins, 2010). Asset-based approaches can help reduce demand and dependency by developing people's knowledge, skills, and confidence to manage their own care, enabling a shift towards more empowering service delivery approaches that address health inequalities (McLean et al., 2017, Marmot and Bell, 2012)

Several complementary approaches share asset-based principles, including coproduction, which recognises and mobilises assets that both public sector and residents possess to

achieve better outcomes, and recovery-focused mental health services that build resilience and empower people to have control over their lives (GCPH, 2014).

2.2.3.4 Rural and Peri-Urban Implementation Contexts. In rural areas, where barriers include shortage of healthcare providers, transportation challenges, and stigma associated with mental health conditions, asset-based approaches help residents develop confidence and take responsibility for their own care (NORC, 2020, RHIH, 2021).

Rural and peri-urban contexts within conservative societies present additional implementation complexities. Hart et al. (2005) identify rural areas as possessing distinctive social capital patterns characterised by strong internal networks but limited external connections, creating both opportunities and barriers for intervention implementation. Noguera and Freshwater (2016) characterise peri-urban areas as geographical zones that combine rural and urban characteristics, featuring rural social structures and community relationships alongside greater access to urban infrastructure and services, requiring implementation approaches that can navigate these mixed contexts effectively.

Rural asset-based initiatives demonstrate diverse applications across individual, organisational, and community levels. Examples include social isolation interventions in North Yorkshire that combine community development teams with person-centred approaches (PHE, 2018); proactive health coaching programmes in Sweden serving older patients with multiple conditions (GMPH, 2016); a coordinated action and a group-based intervention by promoting social capital to alleviate loneliness and improve health among older people in rural-urban area in Spain (Coll-Planas et al., 2017); behavioural health coaching for rural older adults with diabetes and depression in the United States (Naik et al., 2012); and community coalitions addressing youth health through partnerships between agencies, schools, and local organisations in the United States (RHIH, 2019). These examples illustrate that whilst asset-based approaches can bring development and improve community health and wellbeing, most initiatives rely heavily on organisational-level coordination and support, with local institutions playing crucial roles in empowering individuals and strengthening communities.

2.3 Implementation Science and Cross-Cultural Adaptation

2.3.1 Current State of Implementation Science

Implementation science has emerged as a distinct field focused on understanding how evidence-based interventions can be successfully integrated into real-world settings.

Proctor et al. (2011) define implementation science as the scientific study of methods to promote systematic uptake of research findings and evidence-based practices into routine practice, with the goal of improving health service quality and effectiveness. The field has developed numerous frameworks to guide implementation processes, with Nilsen (2015) identifying 61 distinct frameworks, models, and theories in his taxonomic review, categorised into process models, determinant frameworks, and evaluation frameworks.

Among these, the Consolidated Framework for Implementation Research (CFIR) represents one of the most comprehensive approaches, synthesising constructs from 19 implementation theories across five domains: intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation process (Damschroder et al., 2009). CFIR has been widely applied to structure qualitative data analysis (Kirk et al., 2015), though its complexity may pose challenges for novice users. Alternative approaches include Normalisation Process Theory (NPT), which examines how interventions become embedded through social processes of coherence, cognitive participation, collective action, and reflexive monitoring (May and Finch, 2009). Determinant frameworks, such as PARIHS and RE-AIM, highlight context, facilitation, and adoption factors that influence implementation success.

Another influential framework is Greenhalgh et al.'s (2004) diffusion-dissemination-implementation continuum, which distinguishes between three key phases in how innovations spread through healthcare systems. Diffusion represents the passive spread of innovations through social networks and informal channels, often occurring naturally without coordinated effort (*ibid.*). Dissemination involves active and planned efforts to spread innovations to specific target audiences through structured channels and communication strategies. Implementation constitutes the structured process of putting innovations into practice within specific organisational contexts, involving systematic adaptation and integration into routine practice (*ibid.*). This continuum recognises that innovations follow different pathways to adoption and that understanding these phases is crucial for developing appropriate strategies to support uptake of evidence-based practices. The framework emphasises that different stakeholder roles, communication channels, and support mechanisms may be required at each phase to facilitate successful adoption and sustained use of innovations.

Despite these theoretical advances, implementation science has predominantly focused on high-income, global north contexts (Yapa and Bärnighausen, 2018). Most frameworks have been developed and validated within urban, well-resourced settings with established

healthcare infrastructure. Bernal and Sáez-Santiago (2006) observe that evidence-based interventions are typically developed and tested with populations from dominant cultural groups, raising questions about their relevance when applied across cultural boundaries. This global north focus represents a significant limitation for understanding implementation processes in diverse resource-variable contexts.

2.3.2 Realistic Evaluation and Implementation Research

Building upon these implementation science foundations, realistic evaluation offers methodological approaches that may be particularly suited to understanding implementation processes in complex, culturally diverse contexts. Realistic evaluation emerged in the mid-1990s as a response to the perceived inadequacies of traditional evaluation paradigms, developed primarily through the seminal work of Pawson and Tilley (1997) in their foundational text *Realistic Evaluation*. This approach was conceived as a direct challenge to the dominant experimental and interpretivist evaluation methods that had previously characterised social programme evaluation. Pawson and Tilley argued that traditional experimental designs, whilst valuable in controlled laboratory settings, failed to capture the complexity of real-world social interventions, particularly their sensitivity to contextual variations and the mechanisms through which they operated (Pawson and Tilley, 1997).

The philosophical underpinning of realistic evaluation is firmly rooted in critical realist ontology, as developed by Roy Bhaskar (1975, 1979), which posits a stratified reality consisting of empirical, actual, and real domains. Within this framework, realistic evaluation seeks to uncover the underlying generative mechanisms that produce observable patterns and outcomes, recognising that these mechanisms operate differently across various contexts (Pawson, 2013).

The cornerstone of realistic evaluation is the Context-Mechanism-Outcome (CMO) configuration, which provides a structured approach to understanding how, why, when, and for whom interventions work (Pawson and Tilley, 1997). This model fundamentally shifts the evaluation question from the traditional (does it work?) to the more nuanced what works, for whom, in what circumstances, and why? (ibid.). Context refers to the pre-existing social, economic, cultural, and institutional conditions that influence how programme mechanisms operate. Mechanisms represent the underlying reasoning, cognitive processes, and behavioural responses that link programme resources with outcomes. Outcomes encompass both intended and unintended consequences of programme implementation (ibid.).

Realistic evaluation has found extensive application within health and community development contexts, particularly for evaluating complex interventions that operate across multiple levels and involve diverse stakeholders (Craig et al., 2008). Realistic evaluation demonstrates particular relevance for studying asset-based approaches to health, as these interventions are inherently complex, multi-component interventions that work through empowerment mechanisms and are highly sensitive to local contexts and community characteristics (Kretzmann & McKnight, 1993). Ward's (2023) application of realistic evaluation to asset-based community development in Scotland provides a significant example of how this methodology can illuminate the contextual factors that enable or constrain asset-based implementation. Her research demonstrated that asset-based approaches require specific pre-existing resources—including experienced activists, accessible venues, and established activity programmes—to achieve sustainable impact, highlighting how realistic evaluation can capture the complex relationships between community assets, contextual conditions, and implementation outcomes (ibid.).

2.3.3 Implementation Gaps and Challenges

Cross-cultural adaptation remains a critical challenge in implementation science. Castro et al. (2010) highlight that successful adaptation requires understanding how cultural values, social structures, and power relations shape intervention feasibility. However, systematic approaches for addressing these factors remain underdeveloped. Most adaptation frameworks, including those proposed by Bernal and Sáez-Santiago (2006), emphasise surface-level modifications—such as language translation or imagery—rather than examining the appropriateness of transferring global north-derived interventions to fundamentally different cultural settings.

A review of current literature reveals particular gaps in understanding implementation within conservative social contexts where traditional gender roles, religious frameworks, and established social hierarchies may influence intervention acceptance and sustainability. Smith (2021) argues that implementation of global north-derived interventions in global south contexts often involves imposing external definitions of problems and solutions whilst marginalising local knowledge systems. This critique highlights the need for decolonising approaches that centre local knowledge and strengthen rather than undermine existing community capacities.

Asset-based approaches, which emphasise mobilising existing community strengths rather than addressing deficits, remain under-researched in cross-cultural implementation. While theoretical foundations are well established (Kretzmann and McKnight, 1993), empirical

studies examining implementation across cultural contexts are limited. The literature on asset-based approaches is predominantly concentrated in global north contexts (Bortel et al., 2019), with minimal attention to adaptation in conservative societies where community participation patterns, gender dynamics, and decision-making structures differ from global north assumptions. Power dynamics further complicate implementation. Wallerstein et al. (2017) note that achieving genuine community partnership requires sustained attention to imbalances in power and authority, yet many studies fail to account for historical, political, and economic relationships between stakeholders.

2.3.4 Implementation in Conservative Contexts

Conservative contexts can be understood as social environments that maintain traditional social structures and cultural practices, often characterised by hierarchical governance systems and collective decision-making processes that may differ significantly from the individualistic assumptions underlying many global north health interventions (Cislaghi and Heise, 2020). Implementation within conservative contexts presents unique challenges that are poorly understood in current literature, as most implementation science frameworks assume liberal democratic values such as individual agency, participatory decision-making, and gender equality that may not align with conservative social structures (Yapa and Bärnighausen, 2018).

Conservative societies often maintain traditional social structures, religious frameworks, and cultural practices that may conflict with assumptions underlying global north health promotion approaches, such as agency and participation. Mobaraki and Söderfeldt (2010) document how local interpretations of Islamic laws and social norms significantly impact health service access and utilisation in Saudi Arabia, suggesting that implementation strategies must carefully navigate existing cultural and religious frameworks rather than attempting to circumvent them.

Gender dynamics represent a particularly critical consideration for implementation in conservative contexts. Traditional gender roles may limit women's participation in public health initiatives whilst creating different patterns of family decision-making that affect intervention uptake (Alyaemni et al., 2013). Research demonstrates that gender norms—defined as unwritten rules of acceptable actions for men and women—profoundly affect women's access to healthcare, employment opportunities, and health-related decision-making (Cislaghi et al., 2022). The World Health Organisation recognises gender as a critical social determinant of health, emphasising that gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their

enjoyment of good mental, physical health and wellbeing (World Health Organization, 2015a). This recognition has prompted extensive research into the complex ways through which gender intersects with other social determinants to shape health experiences.

The concept of gender extends beyond biological sex differences to encompass socially constructed roles, behaviours, expressions, and identities that societies attribute to men and women (Andermann, 2010, Wood and Eagly, 2012). These gender constructs vary significantly across cultures and contexts, influencing not only individual health behaviours but also the design and implementation of health promotion interventions (Visnudharshana and Henry, 2024, Cislighi and Heise, 2020). A comprehensive analysis of 97 countries revealed that whilst some nations show alignment between progressive gender norms and women's employment equality, others exhibit stark mismatches, particularly in regions where traditional gender roles remain deeply entrenched (Cislighi et al., 2022). Krieger (2003) argues that gender operates as a fundamental cause of health inequalities, creating systematic differences in exposure to health risks, access to resources, and opportunities for health-promoting behaviours.

Global health literature demonstrates consistent patterns of gender-based health disparities, though the specific manifestations vary considerably across different cultural contexts. The global evidence indicates that gender inequities manifest differently across cultural contexts, with women in many societies facing barriers to healthcare access due to economic dependence, limited mobility, and cultural restrictions on decision-making autonomy (Sen and Östlin, 2008). In Pakistan, for instance, research identified major barriers to healthy dietary choices among women, including proscribed gender roles and lack of women's autonomy, power, male domination, and abusive behaviours (Barolia et al., 2017). Similarly, studies from Afghanistan demonstrate how gendered societal norms create complex dynamics where women may gain access to community resources but remain subject to male decision-making authority (Najafizada et al., 2019). Conversely, men often experience poorer health outcomes in areas such as mental health help-seeking, preventive care utilisation, and engagement with health services, partly due to masculine norms that discourage vulnerability and care-seeking behaviours (Courtenay, 2000).

Several theoretical frameworks provide insight into gender dynamics in health promotion, with the ecological model emphasising how individual, interpersonal, community, and societal factors interact to influence health behaviours (Cislighi et al., 2022). Gender-transformative health promotion frameworks suggest that interventions can either maintain, exacerbate, or reduce gender-related health inequities, depending on their design

and implementation (Pederson et al., 2014). The concept of intersectionality proves particularly relevant in conservative contexts, where gender intersects with religious beliefs, socioeconomic status, and cultural traditions to create unique experiences for women (Aldossari and Chaudhry, 2024). For instance, women's social networks, often stronger and more health-focused than men's, can serve as valuable mechanisms for health promotion interventions (Kawachi and Berkman, 2001). Similarly, traditional women's roles in family health management can be leveraged to improve community health outcomes whilst respecting cultural norms and expectations.

Traditional gender roles may limit women's participation in public health initiatives whilst creating different patterns of family decision-making that affect intervention uptake (Alyaemni et al., 2013). However, these same structures may also provide assets for health promotion, such as strong family support networks and community social capital, that can be leveraged for intervention success when appropriately recognised and engaged.

The concept of quiet encroachment proposed by Bayat (2013) offers insights into how social change occurs in contexts where overt challenges to existing power structures may be inappropriate. Bayat developed this concept through his extensive research on social movements and everyday politics in the Middle East, particularly examining how ordinary people in countries like Iran and Egypt navigate authoritarian contexts to create incremental social change (Bayat, 1997; Bayat, 2010). Quiet encroachment refers to the silent, prolonged, and pervasive advancement of ordinary people into the propertied classes, public spaces, and political processes from which they are formally excluded (Bayat, 2013). Unlike organised social movements that openly challenge power structures, quiet encroachment operates through everyday practices of non-compliance, gradual occupation of spaces, and informal economic activities that collectively transform social relations without direct confrontation with authorities (Bayat, 2010). Bayat's analysis demonstrates how marginalised populations in Middle Eastern societies - including women, urban poor, and rural migrants - create meaningful change through persistent, small-scale actions that accumulate over time to shift social norms and power relations whilst avoiding the risks associated with open resistance (Bayat, 2013). This perspective suggests that implementation in conservative contexts may require supporting gradual, informal changes rather than formal programmes that directly challenge traditional arrangements. However, empirical research examining how quiet encroachment principles might inform health promotion implementation remains limited.

The tension between conservative and transformative approaches to development represents a fundamental challenge in designing health promotion interventions in culturally conservative contexts. Conservative approaches prioritise working within existing cultural and social frameworks, respecting traditional values and institutions whilst seeking gradual improvements in health outcomes, whereas transformative approaches may challenge existing power structures and social norms to achieve more dramatic changes in gender relations and health equity. Participatory approaches in conservative contexts require careful navigation of cultural sensitivities and power dynamics, with research on asset-based approaches with children and youth finding that projects with the highest level of adherence to ABCD principles also had the highest level of participation (Agdal et al., 2019). However, implementing participatory methods in conservative societies presents unique challenges related to gender roles, authority structures, and cultural norms.

Studies from conservative contexts demonstrate that participatory approaches must be adapted to local realities, with research on male involvement in maternal health in Nigeria showed that embedding local cultural norms along with co-opting gendered beliefs enhanced intervention effectiveness (Adeleye et al., 2011). This suggests that participatory methods can be successful in conservative contexts when they work within, rather than against, existing cultural frameworks.

However, purely conservative approaches risk perpetuating existing inequalities and failing to address fundamental structural barriers to health equity (Sen and Östlin, 2008). Evidence from conservative contexts reveals both opportunities and challenges for transformative development approaches, with research from Afghanistan demonstrating that gendered social norms around the division of labour tend to privilege women in terms of access to resources at the community level, but it is men who hold leadership positions that ultimately decide how the resources are to be distributed (Najafizada et al., 2019). This highlights the complex power dynamics that must be navigated in conservative settings. Kabeer (2005) argues that empowerment requires not only working within existing frameworks but also challenging the underlying power relations that create and maintain disadvantage. This suggests that effective health promotion may require some degree of transformation in gender relations and social structures. Conservative approaches to development typically emphasise stability, tradition, and gradual change, whilst transformative approaches advocate for more radical restructuring of power relations and social norms. Research suggests that the most effective interventions in conservative

contexts may combine elements of both approaches, respecting cultural values whilst promoting positive change (Pederson et al., 2014, Adeleye et al., 2011).

Studies on gender-transformative health promotion argue that interventions exist on a continuum from gender-blind to gender-transformative, with the most effective approaches being those that are gender-responsive and work to enhance both health and social outcomes (Pederson et al., 2014). This suggests that in conservative contexts, gradual transformation may be more sustainable than radical change. While ABA is often depicted as a radical approach, insofar as it breaks from traditional deficit models, it may offer a potential middle ground between conservative and transformative strategies, as by identifying and building upon existing community strengths and resources, these approaches can promote positive change whilst respecting cultural values and working within existing social structures. For instance, programmes might leverage women's existing social networks and health knowledge whilst gradually expanding their roles and responsibilities in community health leadership.

Current frameworks provide limited guidance on navigating the cultural, religious, and social complexities of conservative contexts. Emphasis on fidelity to original intervention designs may be inappropriate when fundamental assumptions about agency, gender, and community participation differ. Addressing these gaps is critical for implementing asset-based health interventions in contexts such as Saudi rural/peri-urban communities, which rely on recognising existing local strengths and fostering culturally congruent participation patterns. Understanding these implementation challenges requires detailed examination of the specific cultural, political, and health system contexts within which interventions will be deployed. The Saudi Arabian health system provides a particularly relevant case study, as it represents a context undergoing significant transformation whilst maintaining strong cultural and religious foundations that influence health promotion approaches, creating both opportunities and constraints for implementing community-based health promotion initiatives. The following section examines the evolution and current state of the Saudi context.

Part 2: Saudi Context

2.4 The Saudi Arabian Health System: Transformation and Context

Building on the implementation science frameworks and cross-cultural challenges examined in the previous section, this section explores the specific context of the Saudi Arabian health system and its ongoing transformation. The Saudi health system's evolution

reflects broader patterns of modernisation, globalisation, and cultural adaptation that have characterised the kingdom's development trajectory.

2.4.1 Pre-Oil Era: Traditional Foundations

Prior to the discovery of oil in 1938, Saudi Arabia existed as a traditional and isolated society characterised by a predominantly pastoralist and subsistence agricultural economy and cultural insularity. The Arabian Peninsula had been under Ottoman Empire control from the 16th century onwards, though this control was often nominal in the interior regions where tribal autonomy remained strong (Al-Rasheed, 2010). The Al-Saud family emerged as a significant force in the 18th century, establishing the first Saudi state in alliance with the religious reformer Muhammad ibn Abd al-Wahhab, but faced repeated challenges from Ottoman forces and regional rivals (Al-Rasheed, 2010, Vassiliev, 2001). The modern Kingdom of Saudi Arabia was established through the conquests of Abdulaziz Al-Saud (Ibn Saud), who unified most of the Arabian Peninsula under his rule between 1902 and 1932, formally proclaiming the Kingdom of Saudi Arabia in 1932 (Al-Rasheed, 2010).

Almtairi (1985b) describes this period as one where the population was predominantly nomadic and engaged primarily in herding and agriculture. The society operated with low literacy rates and reduced life expectancy, yet maintained cultural practices deeply rooted in Islamic traditions and Bedouin customs (ibid.). The economy was heavily dependent on pilgrimage revenues generated by the annual Hajj and limited agricultural production (Al-Rasheed, 2010). The social structure was characterised by tribal affiliations and traditional patterns of authority that emphasised collective decision-making, respect for elders, and strong kinship networks (Almtairi, 1985a), features that align closely with ABA principles of recognising and mobilising existing social resources and collective capacity for problem-solving (Foot and Hopkins, 2010).

The healthcare landscape during this period was entirely informal, relying on traditional Islamic medicine and indigenous healing practices (Khalil et al., 2018). These traditional healthcare foundations demonstrate remarkable alignment with contemporary asset-based approaches to health promotion. Traditional healers served as community assets, utilising locally available resources including herbal medicine, cupping therapy (Al-hijamah), religious healing, and therapeutic use of honey (Khalil et al., 2018; MOH, 2023). This system exemplified core asset-based principles by identifying and mobilising existing community strengths—traditional knowledge, indigenous healing practices, and local resources—whilst maintaining deep integration with religious and social frameworks

(MOH, 2023). The traditional healthcare model represented a holistic approach that integrated physical, spiritual, and social dimensions of human wellbeing, reflecting an understanding of health and illness as interconnected with community, environmental, and spiritual factors—a perspective that resonates with contemporary asset-based health promotion approaches that emphasise community assets and social determinants of health.

The linguistic and cultural context of pre-oil Saudi Arabia was dominated by Arabic language and Islamic traditions. Arabic served as a means of communication and as a repository of cultural knowledge, religious instruction, and traditional wisdom that connected Saudi communities to broader Islamic civilisation whilst maintaining distinctive local characteristics shaped by Bedouin heritage and the desert environment (Al-Rasheed, 2010). Al-Rasheed (2010) notes that the history of Arabic in Saudi Arabia reflects a complex interplay of local and global forces, with the language serving as both a marker of cultural authenticity and a medium through which external influences were filtered and adapted to local contexts. The society's emphasis on family relationships, tribal solidarity, and Islamic principles created cultural foundations that included extensive social networks, traditional knowledge systems, and community organisation patterns that served functions in maintaining social cohesion and providing mutual support during times of economic hardship or social stress.

2.4.2 The Oil Discovery: Catalyst for Modernisation (1938-1950s)

The discovery of oil in Dammam in 1938 by the Aramco Oil Company marked a pivotal transformation in Saudi Arabia's trajectory. Al-Khateeb (1998) describes this development as creating a complex dynamic of economic dependency where the country's primary source of wealth became controlled by foreign interests, whilst simultaneously initiating rapid modernisation and cultural transformation. The oil industry's development was heavily reliant on foreign oil companies that were granted concessions by the Saudi government to explore and extract oil, creating patterns of economic dependency and technological transfer that would continue to shape Saudi Arabia's relationship with the global economy (Almtairi, 1985b). Ayub et al. (2014) characterise this period as involving incremental changes and innovations developed through Westernisation whilst the country maintained its unique cultural and political characteristics.

The oil revenues generated enormous wealth that enabled comprehensive national development initiatives. The government implemented a series of five-year development plans designed to improve all sectors of society through infrastructure development, education expansion, healthcare provision, and economic diversification efforts (Almalki

et al., 2011, Al-Rasheed, 2010). These development plans involved establishing new ministries and governmental institutions, expanding opportunities for education and employment particularly for women, and creating comprehensive social services (Almalki et al., 2011) The transformation involved navigating the process of modernisation whilst attempting to preserve traditional cultural values and Islamic principles that formed the foundation of Saudi identity and social organisation (ibid.).

The rapid urbanisation and modernisation that followed oil discovery led to significant cultural transformations, including changes in family structures, social networks, and traditional support systems that had previously served health-promoting functions within communities. AlHaq and Smadi (1996) documented how the spread of Westernisation in Saudi Arabia became visible in people's daily life and communication patterns, educational systems, healthcare practices, and economic activities. This Westernisation occurred within a broader context of cultural preservation and Islamic revival that ensured that traditional values and practices continued to play roles in shaping Saudi society (ibid.). The government's approach to modernisation demonstrated a strategy that aimed to adopt global north technologies and practices whilst preserving cultural and religious values that formed the foundation of Saudi identity (AlHaq and Smadi, 1996, Ayub et al., 2014).

2.4.3 Establishment of Modern Healthcare Infrastructure (1925-1980)

The modernisation of Saudi Arabia's healthcare system began before the full impact of oil wealth was realised (Almalki et al., 2011). The first public health department was established in Mecca in 1925, reflecting recognition of the need for formal healthcare infrastructure to serve both Saudi citizens and the religious pilgrims who travelled to the holy sites annually for Hajj and Umrah ((Almalki et al., 2011, Al Otaibi, 2017). This department assumed responsibility for monitoring and providing free health services to both citizens and pilgrims through the establishment of a network of hospitals and dispensaries. The establishment of healthcare infrastructure in Mecca demonstrated the government's commitment to public health whilst recognising the international responsibilities that came with Saudi Arabia's role as the guardian of Islam's holiest sites (ibid.).

The formal healthcare structure was further consolidated with the establishment of the Ministry of Health (MOH) in 1951, marking the beginning of a systematic approach to national healthcare provision (Walston et al., 2008, Al Otaibi, 2017, Almalki et al., 2011). This institutional development represented a shift from traditional, community-based healing systems towards institutionally-based professional medical care that drew upon

global north biomedical models and expertise (Khalil et al., 2018). Notably, some of the earliest biomedical health initiatives in Saudi Arabia were actually established at the instigation of foreign oil companies, particularly the Arabian American Oil Company (Aramco), which initiated the first documented nursing education classes in 1948 through an American male nurse working for the company (Aljohani, 2020). These early corporate-led health initiatives established healthcare facilities and training programmes to serve their workforce and surrounding communities, creating a precedent for global north medical practice in the kingdom. Khalil et al. (2018) report that the modernisation process was heavily influenced by global north medical paradigms and required extensive reliance on foreign experts and advisors to develop healthcare infrastructure, train personnel, and establish service delivery protocols. The MOH's establishment marked the beginning of a centralised approach to healthcare governance that prioritised standardisation, quality assurance, and equitable access whilst creating regulatory frameworks that would eventually encompass both public and private healthcare providers.

The Saudi healthcare system that emerged from this modernisation process evolved into a mixed model. Khalil et al. (2018) and Sebai et al. (2001) report that this comprised 60% government-managed services through the MOH, 20% delivered by other governmental sectors including the ministries of interior, higher education, and defence, and 20% provided by private sector entities. The MOH assumed comprehensive regulatory authority that included oversight of health products and pharmaceutical supplies, establishment and monitoring of service quality standards, determination of pricing mechanisms for both public and private services, and allocation of budgets across healthcare facilities and regional health directorates (ibid.). Walston et al. (2008) notes that this extensive regulatory framework enabled standardisation of healthcare services and ensured compliance with national health policies. This represented a shift from community asset mobilisation towards professional service delivery, potentially reducing communities' sense of ownership and capacity for health-related problem-solving. The system's emphasis on free healthcare provision across primary, secondary, and tertiary levels represented government commitment to ensuring universal access to healthcare services, achieving improvements in basic health indicators including immunisation rates, maternal health outcomes, and control of endemic diseases (Almalki et al., 2011).

2.4.4 Transition to Primary Healthcare Approach (1978-2000s)

The adoption of Primary Healthcare (PHC) principles following the 1978 Alma-Ata Declaration represented a significant paradigm shift in Saudi Arabia's healthcare

philosophy. Almalki et al. (2011) report that this involved moving from predominantly curative approaches that focused on treating existing health conditions through hospital-based models towards more comprehensive and preventive models of care that emphasised health promotion, disease prevention, and community engagement. Prior to this transition, healthcare services in Saudi Arabia were predominantly curative, providing treatments for existing health problems through expensive institutional approaches that required extensive hospital infrastructure and specialised personnel. This transition reflected core asset-based principles by recognising communities as active partners in health improvement rather than passive recipients of medical services, and by emphasising the mobilisation of community resources and local capacity for health promotion activities.

The PHC approach introduced a preventive strategy designed to minimise disease occurrence and promote population health through comprehensive approaches that addressed not only medical treatment but also health education, environmental health, nutrition, maternal and child health, and community participation in health improvement activities (Almalki et al., 2011). This strategy built upon work that had been initiated by former health offices and maternal and child healthcare centres but represented a more systematic and comprehensive approach to prevention and health promotion (*ibid.*). Significantly, the Alma-Ata Declaration explicitly recognised that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care," (World Health Organization, 1978), reflecting asset-based principles of community empowerment and resource mobilisation. After the Alma-Ata Declaration, the Saudi MOH decided to activate and develop preventive health services through adopting the PHC approach as one of its key health strategies. Al Otaibi (2017) notes that primary care centres were seen as a way to empower local communities and promote self-sufficiency.

In 1980, a ministerial decree was issued mandating the establishment of primary care centres throughout the country. Al Otaibi (2017) and Almalki et al. (2011) report that these centres were designed to focus on eight core elements: educating citizens about health problems and ways of preventing and controlling them; monitoring supply of safe water and basic sanitation; promoting food supply and proper nutrition; providing comprehensive maternal and child healthcare; immunising children against major communicable diseases; preventing and controlling local endemic diseases; providing proper treatment of common diseases and injuries; and ensuring provision of essential medications. This comprehensive approach represented a departure from previous hospital-based service delivery models,

though the actual implementation of primary healthcare services remained largely clinic-based and professionally dominated.

Al Otaibi (2017) reports that adopting the PHC strategy achieved success in specific areas such as vaccination programmes and prenatal care, contributing to improvements in national health outcomes including reduced infant mortality rates, increased life expectancy, and better control of communicable diseases. However, the country began experiencing rising rates of lifestyle-related diseases such as diabetes, hypertension, and cardiovascular conditions that were attributed to changing societal habits, dietary patterns, urbanisation, and social transformation associated with economic development and cultural change (Almalki et al., 2011, Alhejely et al., 2023). These emerging health challenges highlighted aspects of clinic-based approaches and institutional service delivery models that were designed primarily to address acute health conditions rather than the complex determinants of chronic diseases, driving the need for more comprehensive health system transformation.

2.4.5 Vision 2030: Healthcare Transformation Program

Saudi Arabia launched Vision 2030 in 2016 as a strategic framework for economic diversification and national development (MOH, 2018). Memish et al. (2022) report that healthcare transformation represented one of eight key themes within the broader National Transformation Program (NTP) that aimed to reduce the country's economic dependence on oil revenues whilst improving quality of life, government efficiency, and private sector development. Chowdhury et al. (2021) describe the healthcare transformation component as designed to restructure the health sector into a comprehensive, high-quality system whilst expanding privatisation of public healthcare services, which aligns with Vision 2030's broader economic diversification objectives by reducing government expenditure on healthcare provision whilst creating opportunities for private sector investment and employment in healthcare industries (MOH, 2018). This transformation initiative emerged from recognition that the existing health system faced challenges related to changing disease patterns, demographic transitions, rising healthcare costs, and the need for more sustainable approaches to health promotion (ibid.).

The kingdom established a new Model of Care (MOC) designed to help understand the current state of the health system, collect learning from previous experiences, and achieve the new health vision through systematic transformation of healthcare organisation and delivery approaches (Chowdhury et al., 2021). The MOC is based on six Systems of Care (SOC) that organise health services around patient needs and care trajectories: keeping

well (health promotion and prevention), planned procedures (elective care), women and children (maternal and child health), urgent problems (emergency and acute care), chronic conditions (long-term condition management), and last phase of life (palliative and end-of-life care). This framework represents a departure from the institutional and specialty-based organisation that emerged during the 1950s modernisation period towards a patient-centred and needs-based approach that echoes elements of the holistic, community-oriented healthcare that characterised pre-oil Saudi Arabia (ibid.). The SOC approach cuts across different service layers to support individuals to stay well and help them regain health when care is needed, outlining 42 coordinated interventions designed to streamline the Saudi healthcare system (ibid.).

Chowdhury et al. (2021) and Khalil et al. (2018) report that the transformation strategy aims to restructure the health field to create a comprehensive and integrated system whilst improving the quality of healthcare services and expanding privatisation of public healthcare services. The program emphasises bringing complementary and modern medicine together in a harmonised system of healthcare that can foster healthy lives and promote wellbeing for all ages (ibid.). Khalil et al. (2018) note that this integrative medicine approach focuses on the whole person's complete physical, mental, and social wellbeing, aligning with WHO encouragement for implementation of complementary health approaches in national healthcare systems. The transformation program's decision to include integrative models represents recognition that traditional healing practices and cultural approaches to health may have continued relevance alongside modern medical interventions (MOH, 2018).

Chowdhury et al. (2021) report that the new MOC has been established to advocate public health approaches that concentrate on prevention and health awareness of society, representing a shift from previous curative-focused approaches towards more comprehensive prevention and health promotion strategies. The MOC is also designed to ensure access to health services through optimal coverage, equitable geographical distribution, and comprehensive and expanded e-health services and digital solutions (ibid.). Additionally, the MOC framework aims to achieve continuous improvement of health services by focusing on beneficiaries' experiences and satisfaction in accordance with international standards and best practices (ibid.). The transformation involves several leading institutions including the MOH, Saudi Health Council, and Ministry of Education, reflecting recognition that health improvement requires coordinated action across multiple sectors (ibid.).

2.4.6 International Frameworks and Postcolonial Influences

The healthcare transformation program demonstrates significant alignment with international frameworks (Alharthi et al., 2019), reflecting complex patterns of global influence on national policy development that require critical examination through a postcolonial lens. This contemporary reliance on global north frameworks represents a form of epistemological dependency that echoes colonial patterns of knowledge transfer, where external expertise and models are privileged over indigenous approaches to health and development (Said, 1978). Alharthi et al. (2019) report that this reflects ongoing global north influence on national policy development whilst also illustrating how Saudi Arabia strategically engages with global health governance to advance national development objectives. However, this strategic engagement operates within structures of global health governance that were established primarily by former colonial powers and continue to privilege global north biomedical paradigms over alternative approaches to health and wellbeing (Santos, 2015).

This contemporary pattern of external influence echoes the historical precedent established by foreign oil companies in the kingdom's early healthcare development. International frameworks such as health policies and initiatives have had significant impact on the country's health system (Alharthi et al., 2019). One of the key aspects of the Saudi transformation program is its explicit alignment with the United Nations Sustainable Development Goals (SDGs), which were developed primarily by global north countries and international organisations (ibid.). Saudi Arabia's commitment to achieving SDG 3, which focuses on ensuring healthy lives and promoting wellbeing for all at all ages, illustrates the integration of global health priorities into national planning (ibid.).

The transformation program has received substantial support from international organisations including the World Bank and the WHO (MOH, 2019). The new MOC was designed to support individuals' physical wellbeing, mental wellbeing, and social wellbeing, aligning with principles mentioned in the WHO constitution that define health as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (World Health Organization, 2006). Saudi Arabia's adoption of the WHO's Healthy Cities Program represents another example of how international frameworks influence national health policy. MOH (2019) reports that this program was adopted because it aligns with different perspectives of Vision 2030, particularly the quality of life initiative. The Healthy Cities Program is designed to increase community

participation by engaging community members, non-governmental organisations, and private sectors in local decision-making to optimise city resources for health promotion.

Additionally, MOH (2019) reports that the country also adopted the Oxford Higher Value Healthcare framework. The Oxford Higher Value Healthcare framework was developed to address healthcare systems that are fully committed to the health and healthcare of their entire population, emphasising that personal value must be complemented by allocative efficiency and active identification of underserved populations who may derive greater benefit from treatment than those currently receiving care (ibid.). The framework defines three types of value: allocative value (how well resources are shared between different groups), utilisation value (how efficiently resources are used to help people who need care), and personalised value (how much benefit patients get compared to the cost of their treatment) (ibid.). The Oxford framework helped Saudi Arabia distinguish three distinct system levels at which value can be secured: national level, sub-population level defined by need and geography, and individual level (ibid.).

The literature indicates that adopting and maintaining alignment with international frameworks has helped the country achieve development in the health field whilst also creating dependencies on external expertise (MOH, 2019, Alharthi et al., 2019). This pattern reflects broader postcolonial dynamics where former colonial subjects adopt metropolitan knowledge systems as markers of modernity whilst potentially marginalising alternative approaches that might be more culturally appropriate or sustainable within local contexts (Mignolo, 2011).

2.4.7 Saudi Specific Gender Dynamics

Saudi Arabia presents a unique case study for understanding gender and health promotion due to its distinctive social, cultural, and political context, having experienced rapid social transformation. The Kingdom has undergone significant social transformation in recent years, particularly regarding women's rights and participation in public life, whilst maintaining its commitment to Islamic values and traditions. These changes have created new opportunities and challenges for gender-sensitive health promotion approaches. Research indicates significant gender differences in healthcare access, with studies finding significant difference in healthcare access across the gender categories of respondents (Habib et al., 2022).

Historically, Saudi Arabia's interpretation of Islamic law and cultural traditions resulted in significant restrictions on women's mobility, employment, and social participation

(Walker, 2014). The male guardianship system, though recently reformed, previously required women to obtain permission from male guardians for various activities including travel, medical procedures, and employment (Mobaraki and Söderfeldt, 2010). These restrictions had profound implications for women's health, limiting their access to healthcare services and their ability to make autonomous health decisions (Walker, 2014, Alyaemni et al., 2013). The Saudi context reveals complex gender dynamics in health-related behaviours. Studies on physical activity demonstrate that male participants reported walking more frequently than female participants (Sabei et al., 2024). These findings highlight how traditional gender roles continue to influence health behaviours even as society undergoes transformation.

However, Saudi Arabia's Vision 2030 has catalysed substantial changes in gender relations and women's participation in society. The initiative explicitly aims to increase women's workforce participation from 22% to 30% and has introduced numerous reforms including allowing women to drive, attend sporting events, and travel abroad without guardian permission (Vision2030, 2016). Research examining women's empowerment in the Saudi health sector found substantial progress in empowering female healthcare workers, evidenced by increased participation in leadership roles, higher enrolment in medical education, and the implementation of workplace policies promoting gender equity (Alzaaqui et al., 2025). These changes have created new opportunities for women's engagement in health promotion activities and community development initiatives.

Despite these progressive reforms, significant gender-based challenges remain in Saudi society, with studies revealing that persistent challenges such as traditional gender norms, workplace biases, and limited access to mentorship and leadership opportunities were identified as barriers to further progress (Alzaaqui et al., 2025). Traditional gender roles continue to influence health behaviours and healthcare utilisation patterns, with cultural expectations around women's primary responsibility for family care potentially limiting their ability to prioritise their own health needs (Alyaemni et al., 2013, Bin Shalhoub and Hammad, 2021, Walker, 2014). The tension between traditional expectations and modern opportunities creates what researchers describe as women being torn between traditionalism and modernity (Alraddadi et al., 2024). The healthcare system itself reflects these gendered dynamics, with sex-segregated facilities and predominantly male medical professionals in many specialties. Whilst this segregation addresses cultural sensitivities around modesty and privacy, it can also create barriers to care, particularly in rural areas where specialist services may be limited (Albejaidi, 2010). Understanding these dynamics

is crucial for designing asset-based health promotion approaches that can navigate cultural sensitivities whilst promoting gender equity. Saudi women's traditional roles as family health managers and community caretakers represent significant assets that can be mobilised for health promotion, with research demonstrating that Saudi women often serve as health gatekeepers for their families, making decisions about when to seek care and managing household health practices (Al-Ahmadi and Roland, 2005)

Studies from Saudi Arabia reveal similar complexities. Research on women's empowerment found that whilst there has been substantial progress in empowering female healthcare workers, challenges remain due to traditional gender norms, workplace biases, and limited access to mentorship and leadership opportunities (Alzaaqui et al., 2025). This suggests that transformative approaches must be implemented gradually and sensitively to be effective in conservative contexts.

2.4.8 Cultural and Religious Consideration in Saudi Health

Islamic teachings and cultural traditions profoundly influence health behaviours and health promotion approaches in Saudi Arabia, and understanding these religious and cultural frameworks is essential for developing culturally appropriate and effective health interventions. These Islamic foundations demonstrate alignment with asset-based approaches, as both emphasise mobilising existing community resources and recognising the inherent strengths within communities rather than focusing solely on deficits or external solutions. Research from various Islamic societies demonstrates how religious identity can both constrain and empower women, depending on how Islamic principles are interpreted and applied (Siddiq et al., 2023, Alomair et al., 2023). Islamic principles provide a comprehensive framework for understanding health and well-being in Muslim societies. Research demonstrates that health promotion through Islam represents a key theme in health interventions among Muslim populations (Siddiq et al., 2023). Islam places significant emphasis on health preservation as both a religious duty and a social responsibility, providing a strong foundation for health promotion activities that align with religious values. The concept of health preservation (*hifz al-siha*) in Islamic jurisprudence emphasises the importance of maintaining physical and mental well-being as a religious obligation.

Studies examining Islamic approaches to health promotion highlight the importance of integrating religious values into health interventions, with research on Islamic persuasive communication suggesting that the use of Islamic values and elements in developing a strategy for communicating health promotion can enhance intervention effectiveness

(Ahmad et al., 2008). This approach recognises that Muslim beliefs predominantly structure every aspect of life, including ways of dealing with pathology and stress (Mou and Albagmi, 2023). Research from Saudi Arabia reveals that women experience more difficulties in talking about sexual matters generally, and specifically those that related to sexual intercourse due to cultural norms (Alzahrani, 2011). Similarly, studies on breast health awareness found that social barriers, cultural taboos, misconceptions, and myths significantly impact women's health-seeking behaviours (Madkhali et al., 2019).

However, cultural factors can also serve as facilitators for health promotion. Research demonstrates that the centrality of family and faith-based and family-centred approaches can enhance the effectiveness of health interventions (Siddiq et al., 2023). Cultural concepts of honour (karama) and reputation (sum'a) significantly influence health behaviours and help-seeking patterns in Saudi society, with mental health issues, in particular, potentially being stigmatised due to concerns about family honour and marriageability (Al-Subaie and Alhamad, 2000). Asset-based approaches that build upon existing cultural strengths and address health issues within culturally appropriate frameworks may be more successful in overcoming these barriers. The extended family structure prevalent in Saudi society represents both an asset and a potential constraint for health promotion, with strong family networks providing significant social support and resources for health management, but potentially perpetuating traditional gender roles and limiting individual autonomy in health decision-making (Long, 2005).

Developing culturally sensitive health interventions requires deep understanding of local contexts and values. Research on diabetes education programmes in Saudi Arabia found that interventions based on international standards and adapted to their cultural and religious contexts produced significant improvements in health outcomes (Al-Bannay et al., 2015). Similarly, studies on topical bleaching agents revealed that Islamic values increased women respect and esteem in this society and influenced cosmetic practices (Alanzi et al., 2018). The importance of cultural adaptation extends to intervention delivery methods, with research demonstrating that health interventions should consider social and cultural contexts and faith-based and family-centred approaches to be effective (Siddiq et al., 2023). This requires moving beyond simple translation to fundamental reconceptualisation of interventions within cultural frameworks. Traditional healing practices and folk medicine remain influential in Saudi healthcare, particularly in rural areas, representing important cultural assets that can be incorporated into contemporary health promotion approaches. Rather than dismissing traditional practices, asset-based

approaches can explore how to integrate beneficial traditional knowledge with modern health promotion strategies.

2.5 Conclusion

The literature review reveals significant theoretical and empirical foundations across multiple domains whilst highlighting critical gaps that this research addresses. The synthesis of asset-based community development theory, implementation science frameworks, realistic evaluation methodology, and analysis of Saudi cultural and health system contexts creates a comprehensive theoretical foundation for understanding the complex dynamics that influence feasibility of community-led health interventions in conservative contexts. The convergence of these literature streams demonstrates the need for sophisticated understanding of how asset-based approaches might operate within hierarchical governance structures and conservative cultural contexts, whilst the Saudi Arabian context provides a valuable case study for examining these dynamics given the country's ongoing health system transformation and distinctive cultural characteristics. Understanding these implementation challenges and opportunities requires detailed empirical investigation using methodological approaches capable of capturing the complexity and context-sensitivity of asset-based implementation processes. The evidence on asset-based approaches in conservative contexts remains limited, with most studies conducted in global north contexts (Bortel et al., 2019, Cassetti et al., 2020), creating challenges for understanding how these approaches might be adapted for conservative settings in the global south. These challenges constitute the empirical ground which this study explores. How the study was operationalised in terms of research design and methods is the focus of the next chapter.

Chapter 3 Research Methodology – Weaving Methods, Voices, and Contexts

This chapter presents the methodological framework that guided my research into the feasibility of implementing asset-based approaches to health in Saudi communities, situating my approach within broader methodological traditions whilst explaining the evolution of my research design. The study of health systems and the implementation of new health approaches demands methodological frameworks that can navigate complex social, cultural, and institutional landscapes (Sheikh et al., 2011). This is particularly true when examining global north-originated concepts like asset-based approaches to health within global south contexts such as Saudi Arabia, where post-colonial research considerations become paramount (Tuhiwai Smith, 2012).

3.1 The Methodological Landscape in Health Systems Research

Health systems research has traditionally employed methodological approaches ranging from positivist quantitative methods to interpretive qualitative inquiries. In the field of implementation science specifically, researchers have utilised structured frameworks such as the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009), Normalisation Process Theory (May and Finch, 2009), and Realist Evaluation (Pawson and Tilley, 1997) to understand how interventions function in complex health systems. These approaches provide valuable structure; however, they have been critiqued for viewing interventions as fixed and standardised entities rather than as dynamic events that interact with local systems in unpredictable ways (Hawe et al., 2009). The challenge of cultural translation in health systems research has prompted increased attention to methodological flexibility. This is especially important when examining how global north-originated health concepts are implemented in global south settings. As Sheikh et al. (2011) point out, navigating the complex social, cultural, and institutional landscapes of health systems requires research approaches that go beyond rigid frameworks. Scholars like Denzin and Lincoln (2011) have emphasised the need for methodologies that respond to the situated nature of knowledge and practice, recognising that the straightforward application of established methodological frameworks may prove insufficient in such contexts. This argument for methodological flexibility resonated strongly with my early fieldwork experiences, where I found that rigid adherence to predetermined procedures would have prevented me from accessing the rich cultural knowledge that ultimately became central to my findings.

These methodological concerns have intersected with broader debates around decolonised research. Post-colonial perspectives, as articulated by Tuhiwai Smith (2012), highlight how

conventional global north research approaches may inadvertently reproduce power imbalances and marginalise local ways of knowing—particularly when studying the implementation of global north health concepts in global south contexts. This became increasingly relevant to my research as I began to understand how asset-based approaches, despite their emphasis on community strengths, still carried assumptions about what constitutes legitimate knowledge and acceptable forms of community organisation. Extending these critiques, Denscombe (2025) argues that decolonised research approaches are not just about adapting existing methods—they call for a fundamental transformation in how knowledge is produced. These approaches place value on indigenous and community-based perspectives, support collaborative and participatory research relationships, and seek to generate knowledge that is meaningful and relevant to the communities involved—rather than simply reinforcing dominant academic or institutional priorities.

Asset-based approaches to health present a particular methodological challenge, as they inherently emphasise contextual understanding and community engagement (Morgan and Ziglio, 2007). Traditional methodologies grounded in positivist ontological orientations that position the researcher as epistemologically detached from the research context may fail to capture the relational and participatory aspects central to asset-based work. These approaches fundamentally challenge conventional researcher-participant relationships by requiring methodological orientations that can capture not just community resources but participants' lived experiences and interpretations of the contexts in which they find themselves. As Foot and Hopkins (2010) note, asset-based approaches require methods that privilege community perspectives and local knowledge systems—a stance that must be reflected in the methodological approach itself rather than simply the research focus.

The specific context of Saudi Arabia adds further complexity to those methodological considerations. Research by Alkhamis et al. (2014) on health system reforms in Saudi Arabia highlights the tension between imported health policy models and the country's unique cultural norms, religious framework, centralised governance, and hierarchical structures, suggesting the need for more contextually grounded approaches. These tensions manifest in multiple ways: conflicts between individualistic global north health promotion models and collectivist Saudi cultural values, challenges in adapting participatory approaches within hierarchical social structures, and difficulties in implementing community-based interventions within centralised health governance systems.

During my initial literature review, I discovered that the limited research on qualitative health research in rural Saudi settings further underscored the methodological innovation required in this context. Due to the lack of studies examining health systems implementation in rural Saudi Arabia, there were few methodological blueprints available to guide this research, necessitating an original contribution to methodological approaches that could navigate both the post-colonial dimensions of applying global north health concepts and the specific cultural complexities of the Saudi context. This realisation both excited and intimidated me; I was entering relatively uncharted methodological territory, which offered opportunities for innovation but also meant I would need to develop approaches without established precedents to follow.

3.2 From Structured Methodology to Bricolage

It is within this methodological landscape that the concept of bricolage emerged as particularly relevant to my research. Kincheloe (2001) describes methodological bricolage as an approach that allows researchers to employ diverse strategies as they are needed in the unfolding context of the research situation. This approach acknowledges that methodological choices must remain responsive to the research context rather than being predetermined. The concept originates with (Levi-Strauss, 1966), who used the term bricolage to describe the process of using available tools and materials to create something new. In research contexts, bricolage involves drawing on multiple methods, perspectives, and theoretical frameworks to develop a rich, complex understanding of a phenomenon. As Denzin and Lincoln (2011) note, the bricoleur is a maker of quilts, piecing together different elements to create a coherent whole.

When I first encountered bricolage in the methodological literature, I was initially sceptical. My training had emphasised the importance of methodological consistency and predetermined procedures. The idea of adapting methods in response to field realities seemed to compromise the rigour I had been taught to value. However, as I began to engage with the practical realities of cross-cultural research, I started to understand that methodological flexibility might actually enhance rather than diminish research quality when studying complex social phenomena across cultural boundaries.

Work on epistemological bricolage in policy contexts further illuminates how this approach allows researchers to navigate between different forms of knowledge—formal and informal, explicit and tacit—when studying complex social systems (Freeman (2007)). This ability to integrate different types of knowledge is particularly valuable when studying health systems, which encompass both technical-scientific and social-cultural

dimensions. Freeman's insights about how practitioners make sense of learning through bricolage resonated with my understanding of how health systems actually function—not as rational, technical systems but as complex webs of relationships, cultural practices, and institutional arrangements.

The decision to adopt a bricolage approach was not my initial methodological stance but emerged from engaging with the realities of my research context. This evolution represents what I now understand as a crucial learning process—moving from abstract methodological planning to contextually grounded practice. The journey taught me that methodological rigour is not about rigid adherence to predetermined procedures but about thoughtful responsiveness to research contexts whilst maintaining analytical integrity.

The sections that follow detail how this bricolage approach was implemented across all phases of the research process, from initial design through data collection, analysis, and interpretation. Section two outlines my research design, explaining the evolution from conventional approaches to a more adaptive methodology whilst maintaining the Realist Evaluation framework. Section three describes the data collection process, highlighting how field realities necessitated methodological adaptations. Section four explains my approach to data analysis, emphasising how bricolage informed the integration of different data types. Section five addresses ethical challenges encountered during the research and the strategies employed to navigate these complexities. The chapter concludes with reflections on the strengths and limitations of bricolage as a methodological approach for studying health systems in culturally distinct contexts.

Throughout this chapter, I employ a storytelling approach that mirrors the bricolage methodology itself, weaving together theoretical discussions, methodological decisions, and reflexive insights. This approach aligns with Flyvbjerg's (2001) argument that context-dependent knowledge is crucial for understanding social phenomena, particularly when studying complex interventions across cultural boundaries. By presenting my methodology as a journey rather than a predetermined framework, I aim to illuminate not only the methods used but also the methodological learning that emerged through the research process.

3.3 My Journey into the Field: Initial Plan and Early Realities

My research journey began with a structured methodological framework that reflected conventional approaches to health systems research. I had developed what I thought was a comprehensive plan based on asset mapping and systematic qualitative inquiry. The

original research design was organised around two distinct phases: asset mapping followed by feasibility assessment across multiple participant groups. This plan reflected methodological approaches commonly used in health systems research (Sheikh et al., 2011, Damschroder et al., 2009, May and Finch, 2009), with clearly defined stages, methods, and analytical procedures.

I remember discussing this first plan with my supervisors, reviewing the methodological framework with its neat stages and clear timelines. The plan looked impressive on paper; a systematic approach that would first identify community assets through structured interviews and observations, then assess the feasibility of asset-based approaches through focus groups and stakeholder interviews. I had allocated specific timeframes for each phase, identified target numbers of participants for each method, and developed detailed interview guides that would ensure consistent data collection across all encounters.

However, upon entering the field, I discovered that the reality of conducting research in Saudi rural/peri-urban communities was far more complex and nuanced than my methodological plans had anticipated. Most notably, engaging with people in small rural villages revealed complex cultural dynamics, social networks, and communication patterns that offered valuable learning opportunities but challenged my assumptions about how research should proceed. The cultural nuances, community relationships, and local knowledge systems I encountered highlighted the need for a more responsive and adaptive methodological approach that could better capture these insights and engage more meaningfully with the research context.

3.3.1 First Encounters with Al-Zaimah and Ain-Shams Villages

My initial fieldwork took place in Al-Zaimah and Ain-Shams, two small rural villages in western Saudi Arabia, areas I had selected because they represented traditional community structures that I thought would be ideal for studying asset-based approaches and were easy to access as they were close to the city where I live. I had imagined that these communities would have strong social networks and informal support systems that could provide rich examples of community assets in action. What I discovered was both more complex and more challenging than I had anticipated.

Early in my fieldwork, I recorded video footage of Al-Zaimah, as shown in Video 1. This footage served a specific methodological purpose—providing my supervisory team with visual context to understand the environmental and geographical setting that influenced my methodological decisions. The terrain was more challenging than I had expected, with

narrow roads that made access difficult and scattered housing that meant significant travel time between potential participants. More importantly, the social dynamics proved far more complex than my preliminary research had suggested.



Video 1: Video documentation of the Al-Zaimah, illustrating geographical and environmental challenges that necessitated the methodological transition to Al-Jumum. This visual record was created to provide my supervisors with contextual understanding of the research environment and demonstrates the reflexive documentation practices employed throughout the work. Click the picture to watch the video.

During my first attempt at community engagement in Al-Zaimah village, I went to the primary care centre in the morning, accompanied by my brother. This visit was to conduct interviews with patients after my efforts to meet people in the community had been unsuccessful, as documented in the video footage I recorded. The rural setting of Al-Zaimah presented immediate challenges – the scattered housing and limited public gathering spaces made it difficult to encounter potential participants through informal community engagement.

When I approached the centre manager for assistance in recruiting participants, he kindly offered to ask patients to volunteer for interviews. However, this approach proved problematic in multiple ways. When the manager directly asked patients in the Al-Zaimah

health centre waiting area to participate in my research, most refused to engage. I could sense their discomfort with being approached by a stranger conducting academic research, particularly when the request came through the authority figure of the centre manager. The few patients present seemed wary of discussing community matters with someone they did not know, and the formal clinical setting created an atmosphere that felt inappropriate for the kind of community-focused conversations I was hoping to facilitate. Additionally, the patient volume was much lower than I had anticipated, limiting the pool of potential participants even if they had been willing to engage.

My subsequent visit to Ain-Shams village, again accompanied by my brother, presented similar challenges, reinforcing the patterns I had begun to observe in Al-Zaimah. This time we went directly to the primary care centre in the afternoon, hoping that a different village and time of day might improve access to potential participants. However, the centre was nearly empty, with no patients available for interviews. I was able to speak with the centre manager and two other health providers, but they confirmed what I was beginning to understand about the rhythms of rural community life. The manager explained that it would be particularly difficult to meet community members at that time, as people in these villages rarely went outside during certain periods, preferring to remain within their family compounds. This insight highlighted another dimension of the access challenges I was facing, not only were the villages geographically dispersed and difficult to navigate, but the social patterns of daily life meant that potential participants were often not present in the few public spaces available. The conversation with the health providers reinforced my growing recognition that successful community engagement in these rural settings would require much longer relationship-building periods than my time constraints would permit.

The challenges I encountered in Al-Zaimah and Ain-Shams were compounded by significant time constraints. My doctoral funding body had allocated only three months for what they termed an educational trip to collect data, a timeframe that was proving inadequate for the kind of relationship-building and trust-development that rural community research required. Recognising that I needed a Plan B approach, I realised that continuing with rural village research would not be feasible within these temporal limitations. Fortunately, my sponsor agreed to allow me to use my annual leave allocation of 90 days to extend the data collection period, but this extension reinforced the need to adapt my methodological approach to work within more accessible community settings.

This experience in these villages taught me important lessons about the inadequacy of institutional approaches to community engagement and the particular challenges of

conducting research in rural settings where social networks and trust-building processes operate differently than in more populated areas. The combination of cultural barriers, institutional recruitment problems, and time constraints led me to recognise that I needed to fundamentally reconsider my research approach and setting.

3.3.2 The Shift to Al-Jumum: Recognising Methodological Adaptation

After several weeks of challenging attempts to establish meaningful research relationships in rural villages, I found myself questioning whether my research was feasible at all. The time required for relationship-building far exceeded my planned timeline, and I was concerned that the cultural protocols necessary for gaining trust might compromise the systematic data collection I had planned. It was during this period of methodological uncertainty that I began to consider shifting my focus to Al-Jumum, a small city that serves rural communities and offers different possibilities for research engagement. Figure 3.1 illustrates the geographical location of Al-Jumum city, showing its position within the western region of Saudi Arabia and its proximity to major urban centres including Jeddah and Makkah.



Figure 3.1 Map showing the location of Al-Jumum city in western Saudi Arabia and its proximity to other major cities (Google Map, n.d).

Al-Jumum represents a small city that has evolved from a rural village and now serves as the administrative centre of Al-Jumum Governorate. The city itself has a current population of approximately 41,000, whilst the broader Al-Jumum Governorate, which encompasses surrounding rural villages throughout the region, has a total population of 89,575 residents (City Population, 2023). The governorate was named after Al-Jumum city due to its historical importance and strategic location compared to other surrounding villages (Makkah Province Government, n.d.), figure 3.2 shows the map for Al-Jumum Governorate (City Population, 2023). This administrative structure makes Al-Jumum particularly valuable for understanding health promotion in semi-rural contexts, where a formerly rural settlement now serves as a hub for surrounding rural communities whilst maintaining many traditional community characteristics. The community's mixed demographic, including residents who had migrated from rural areas, others who had always lived in semi-urban settings, and some with experiences in larger cities (The third stage interviews, local policymaker, I1), provided opportunities to understand how different perspectives on community health and asset mobilisation might coexist within a single community context. Al-Jumum's position as both an administrative centre and a community with strong rural roots made it an ideal setting for examining how asset-based approaches might function at the interface between traditional community practices and modernising health systems. This combination of accessibility for sustained fieldwork and diverse community characteristics enhanced rather than compromised my ability to address the research questions about asset-based implementation feasibility in Saudi communities.

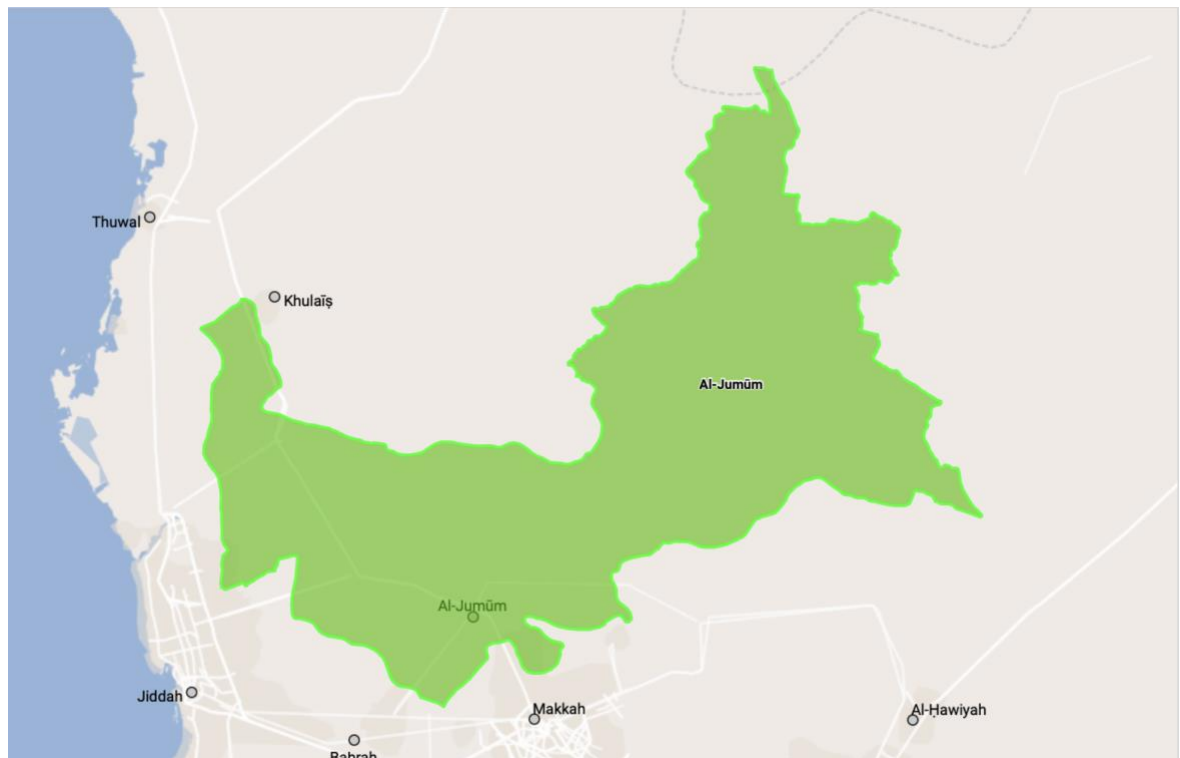


Figure 3.2 Map showing the location of Al-Jumum Governorate in western Saudi Arabia (City Population, 2023).

In methodological terms, I therefore approached Al-Jumum as a rural/peri-urban Saudi context rather than as a straightforwardly rural or urban site. This framing built on the contested understanding of rurality discussed in Chapter 2 and reflected the socio-cultural history of Al-Jumum as a place that has moved from a rural village towards a small city and governorate centre. During fieldwork, it became clear that rurality in Al-Jumum was not only an administrative or demographic issue, but was also connected to residents' memories, social relationships, family and tribal networks, links with surrounding villages, and patterns of access to health and community services. Some participants continued to describe or experience Al-Jumum through rural characteristics despite its urban and infrastructural development. This made rurality methodologically useful as a contextual lens for understanding community assets, local identity, social relationships, and implementation possibilities.

As I made the strategic decision to focus my investigation in Al-Jumum, I began to appreciate the unique opportunities this setting provided. The decision to focus on Al-Jumum rather than rural villages represented my first major methodological adaptation, and it required me to reconceptualise what this change meant for my research. Initially, I worried that this shift represented a compromise, a retreat from the authentic rural communities I had originally intended to study to a more accessible but potentially less

interesting urban setting. However, as I began to engage with Al-Jumum as a research site, I started to understand that this adaptation might enhance rather than diminish my research.

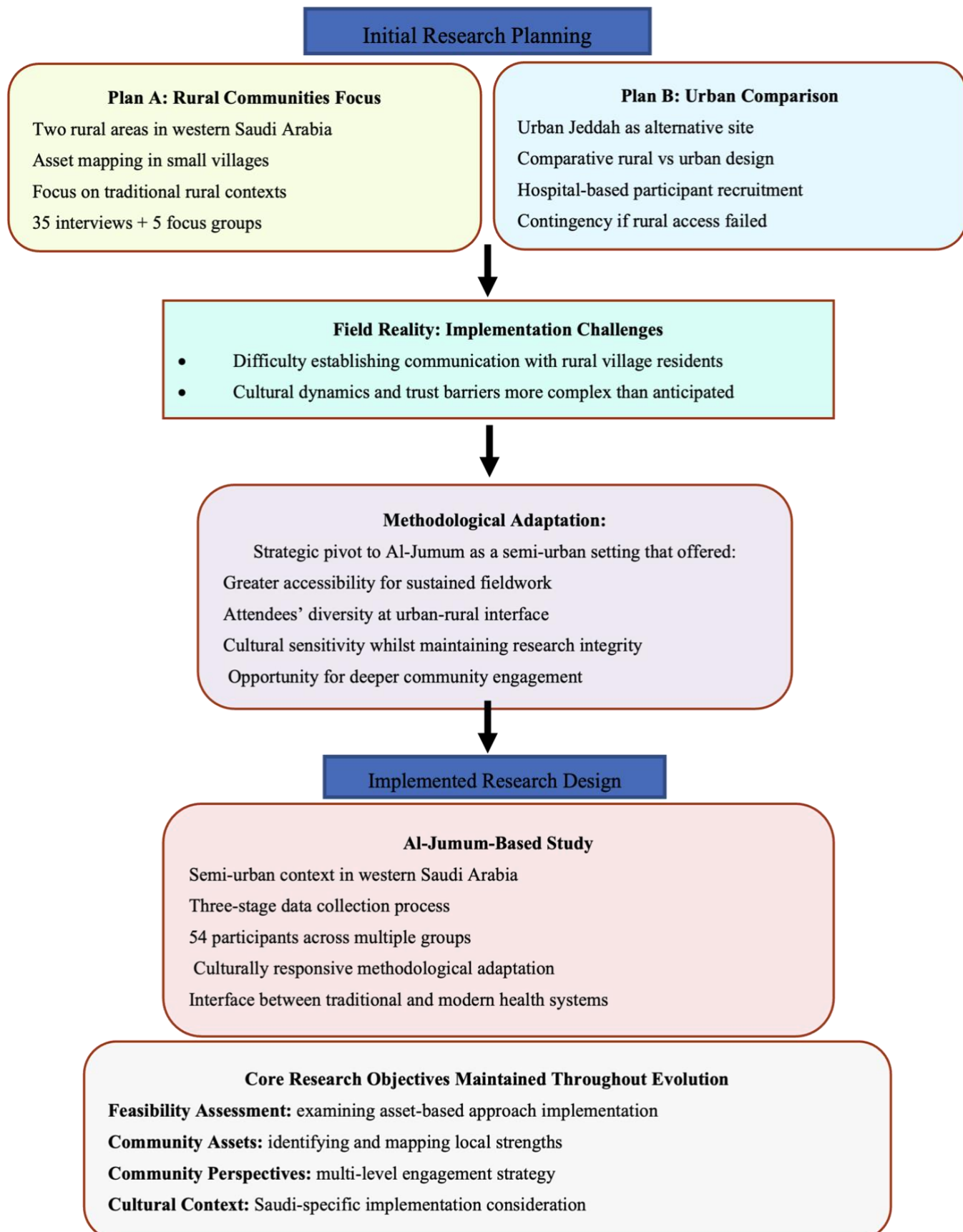


Figure 3.3 This flowchart illustrates the evolution from the original rural focus to Al-Jumum based study, showing how the research design adapted whilst maintaining core objectives.

The evolution of my research design from the original villages focus to the Al-Jumum setting illustrated what Hammersley and Atkinson (2019) describe as the progressive focusing that characterises thoughtful qualitative research. Rather than representing a compromise, this focusing enhanced the research by creating opportunities for deeper engagement with a specific community context that was more conducive to the systematic data collection required within my temporal constraints.

3.3.3 Developing Relationships in Al-Jumum

My approach to community engagement in Al-Jumum differed significantly from my earlier rural attempts, partly because I had learned from those experiences and partly because the community dynamics were different. Having learned from the challenges in Al-Zaimah and Ain-Shams, I decided to begin with a more strategic institutional approach that could provide legitimate introductions to community networks.

I started by meeting with the manager of the primary care centre in Al-Jumum, who proved to be an invaluable gatekeeper for accessing the community. Unlike my experience in the two rural villages, the centre manager in Al-Jumum had extensive knowledge of community activities and strong relationships with various community groups. He was particularly helpful in connecting me with key individuals who were involved in different types of community activities.

Through the centre manager's introductions, I was able to connect with the leaders of the local volunteering work, who became central to my understanding of grassroots community asset mobilisation. He also facilitated my connection with one of the individuals responsible for implementing the healthy city initiative in Al-Jumum, providing crucial access to formal institutional perspectives on community health promotion. These initial institutional connections proved essential for establishing my credibility within the community and opening doors to broader community engagement.

Once I had established these initial formal connections, I began spending time observing community life, particularly in the central park area which served as an important social gathering space. The park provided an ideal location for understanding informal community dynamics and social interactions. I would often sit in the park with my brother during different times of day, observing how community members used the space, who gathered together, and how informal conversations and support networks functioned in practice.

Through my time in the park, I gradually began building relationships with community members and conducting informal interviews. These conversations often emerged naturally from shared experiences—commenting on children playing, discussing the weather, or observing community activities. I found that people were more comfortable sharing their perspectives about community life and health experiences when these conversations developed organically rather than through formal interview arrangements. Then, I started to introduce myself and talking about my research, ask them about the city, and writing notes.

The park setting proved particularly valuable for accessing perspectives from community members who might not be involved in formal community organisations or healthcare activities. Residents who came to the park for social interaction, mothers who brought children to play, people who gathered in the evenings, and a police officer who was doing his job in keeping watch over the area all provided different insights into community assets and informal support systems that were not captured through institutional interviews.

This dual approach, beginning with institutional gatekeepers to establish credibility and access, then developing grassroots relationships through informal community engagement—proved much more effective than my earlier attempts at direct community approach in Al-Zaimah and Ain-Shams. The institutional introductions provided legitimacy and trust that enabled more authentic informal conversations, while the park-based observations revealed community dynamics that might not have emerged through formal interview settings alone.

3.4 Ontological and Epistemological Foundations: Finding My Philosophical Grounding

As my fieldwork experiences accumulated, I found myself needing to articulate more clearly the philosophical foundations that underpinned my evolving methodological approach. My early training had emphasised the importance of establishing clear ontological and epistemological positions before beginning research, but my field experiences taught me that these philosophical commitments might also evolve through engagement with research realities.

My research became grounded in a critical realist ontology and interpretivist epistemology, which proved particularly appropriate for studying asset-based approaches in the Saudi context. Critical realism, as articulated by Bhaskar (2013), posits that reality exists independently of our knowledge of it but acknowledges that our understanding of reality is

always partial and culturally mediated. This perspective was valuable for my research because it allowed me to recognise that community assets and health needs exist as real phenomena whilst acknowledging that how these are understood and experienced varies across cultural contexts.

The critical realist position helped me navigate one of the central challenges of my research—how to study asset-based approaches as real interventions when they did not exist as formal programmes within the Saudi health system. Critical realism's emphasis on underlying mechanisms and structures enabled me to look for asset-based principles within existing initiatives rather than searching for asset-based approaches as discrete, identifiable interventions. This philosophical position provided the foundation for my later methodological innovation of studying proxy interventions that embodied asset-based principles within Saudi contexts.

The interpretivist epistemological stance enabled me to focus on understanding how participants made sense of their own experiences and contexts rather than imposing external frameworks of understanding. This approach was essential when studying asset-based approaches, which fundamentally depend on how communities understand and define their own strengths and resources (Morgan and Ziglio, 2007, Foot and Hopkins, 2010). During my fieldwork, I found that community members had sophisticated understandings of community assets and health resources, but these understandings were articulated through cultural concepts and frameworks that differed significantly from academic asset-based literature. For example, when I asked participants about community strengths and resources, they often responded by discussing (*takaful ijtima'i* which means social solidarity) and (*ta'awun* which means mutual cooperation)—concepts that encompassed asset-based principles but were embedded within religious and cultural frameworks that gave them meanings beyond simple community resource identification. An interpretivist epistemological approach enabled me to understand these concepts within their cultural contexts rather than translating them immediately into global north academic frameworks.

As someone positioned between Saudi and global north academic contexts, I found this philosophical stance allowed me to navigate between different knowledge systems whilst maintaining analytical rigour. My dual positioning created both opportunities and challenges for understanding. On one hand, my cultural familiarity enabled me to grasp nuances and cultural meanings that might have been missed by outside researchers. On the

other hand, my global north academic training sometimes led me to approach community practices with analytical frameworks that did not fully capture their cultural significance.

The combination of critical realist ontology and interpretivist epistemology provided a framework for managing these tensions. Critical realism enabled me to acknowledge that community practices and health experiences existed as real phenomena that could be studied systematically, while interpretivism reminded me that understanding these phenomena required attention to how participants themselves made sense of their experiences within their cultural contexts.

3.5 Conceptual Foundations and the Challenge of Studying Non-Existent Interventions

My research design was conceptually anchored in two complementary yet distinct frameworks—asset-based approaches to health research and realist evaluation. These frameworks served different but interconnected purposes: asset-based approaches provided general methodological orientations and data collection methods, while realist evaluation offered the analytical framework for understanding how and why asset-based interventions might work in specific contexts.

The asset-based research approach, as elaborated in the previous chapter and conceptually grounded in the work of Morgan and Ziglio (2007), emphasises research methods that identify and engage with community strengths rather than focusing on deficits or problems. This perspective informed not only what I studied but fundamentally shaped how I approached the research process, encouraging methodological choices that could recognise, document, and meaningfully engage with existing community assets. Asset-based research approaches require methodological adaptations that can capture informal knowledge systems, community-defined priorities, and grassroots innovations that might be overlooked by conventional health services research methods (Hopkins and Rippon, 2015).

The realist evaluation framework (Pawson and Tilley, 1997) provided the analytical structure for my inquiry. As mentioned earlier in chapter 2, this framework examines interventions through the lens of context-mechanism-outcome configurations, asking not simply whether an intervention works but how it works, for whom, and under what circumstances. As Greenhalgh et al. (2015) note, realist evaluation is particularly valuable for studying complex health interventions in diverse contexts, as it accommodates the contextual specificity that shapes implementation processes. I chose this analytical

approach because it would enable me to examine not just whether asset-based principles were present in Saudi contexts, but to understand how they operated within specific cultural, institutional, and community settings—a crucial consideration given the contextual specificity of asset-based approaches.

However, as I began my fieldwork, a significant methodological challenge emerged that would test these theoretical frameworks in practice: asset-based approaches are not formally recognised or implemented as a coherent intervention within the Saudi health system or Saudi communities. This reality necessitated a crucial methodological innovation that would become one of the most important contributions of my research – the identification and study of proxy interventions that embodied asset-based principles within the existing Saudi context. The challenge of studying interventions that do not formally exist is not uncommon in implementation research (Hawe et al., 2009), but it requires methodological creativity and theoretical sophistication. I could not simply evaluate an asset-based programme because no such programme existed. Instead, I needed to identify existing initiatives and practices within the Saudi system that embodied asset-based principles, even if they were not explicitly framed in asset-based terms. This challenge highlighted the importance of the asset-based research methodologies I had adopted, as they were specifically designed to recognise community assets and strengths that might not be formally acknowledged or systematically documented.

This methodological challenge led me to spend considerable time during my early fieldwork identifying what my supervisory team and I came to call proxy interventions—existing initiatives that demonstrated asset-based thinking and practice within the Saudi contexts. Through my initial interviews with health system actors and community members, combined with document analysis of health policies and programme descriptions, I identified three key areas that demonstrated asset-based principles: the Healthy City concept, health coaching initiatives, and volunteering programmes.

3.5.1 Discovering the Healthy City Initiative

My discovery of the Healthy City initiative as a proxy for asset-based approaches occurred through a combination of formal document analysis and conversations with healthcare workers, local stakeholder, and citizens. During an interview with a primary care physician, she mentioned that Al-Jumum had been designated as a healthy city and that this designation involved community engagement activities that differed from traditional healthcare delivery approaches.

Following that, many people mentioned the healthy city initiative as a strength for Al-Jumum. I asked for more information and requested access to the official Healthy City documentation for Al-Jumum. The document I eventually obtained revealed a comprehensive approach to community health that emphasised community participation, environmental improvements, and intersectoral collaboration. The framework was built upon the WHO Eastern Mediterranean Regional Office (WHO/EMRO) guidelines for Healthy Cities Programme implementation, which were specifically developed to address health determinants through innovative community-based actions. The document incorporated the WHO/EMRO's comprehensive framework of 80 indicators organised across 9 key domains that align with both social determinants of health and Sustainable Development Goals. These domains encompassed community organisation and mobilisation for health development, intersectoral collaboration, information availability, environmental health, health development, education and literacy, skill development and capacity building, microcredit activities, and emergency preparedness and response.

I noticed that most of these indicators were fundamentally aligned with principles central to asset-based approaches, particularly those emphasising community mobilisation, capacity building, and intersectoral collaboration. However, the document framed these activities within national health policy language and WHO standardised terminology rather than explicitly adopting asset-based frameworks or vocabulary. This observation highlighted an interesting tension between the practical implementation of asset-based principles and the formal policy discourse used to describe and legitimise these activities within the Saudi health system context.

What made this particularly interesting from a methodological perspective was that the Healthy City initiative provided a formal institutional framework that embodied asset-based principles without explicitly referencing asset-based approaches. This meant I could study how asset-based principles functioned within Saudi institutional contexts whilst examining an initiative that had official legitimacy and practical implementation experience. However, it is important to acknowledge that Healthy Cities initiatives have been subject to substantial critique regarding their potentially top-down nature and limited authentic community participation. As Stern and Green (2008) demonstrate in their analysis of community participation in Healthy Cities projects, while such initiatives may offer communities "a seat at the table" (p.391), statutory authorities often control the form and content of meetings in ways that can elide the structural imbalance between contributing participants. This tension between formal community engagement

mechanisms and genuine grassroots empowerment represents a critical methodological consideration when studying asset-based approaches through institutional proxies.

My analysis of the Healthy City documentation revealed several elements that aligned closely with asset-based approaches: emphasis on community participation in health planning, attention to social determinants of health, integration of community resources into health promotion activities, and recognition of community knowledge and expertise. However, these elements were embedded within a framework that emphasised government leadership and institutional coordination rather than community empowerment and asset mobilisation. This institutional framing raised important questions about whether formally structured initiatives could genuinely embody asset-based principles or whether governmental oversight inherently constrained the community-driven nature that is central to asset-based approaches.

This discovery was methodologically significant because it demonstrated that asset-based principles could exist within Saudi contexts even when they were not explicitly recognised as such, while simultaneously revealing the complex negotiations between institutional control and community agency that characterise formally mandated participation initiatives. It also suggested that studying ABA feasibility might require looking for these principles within existing initiatives rather than attempting to introduce asset-based approaches as entirely new interventions, whilst remaining critically aware of the limitations and power dynamics inherent in institutionally mediated community engagement processes.

Thus, the choice of the healthy cities' initiative as a proxy intervention also proved methodologically sound despite the apparent mismatch between studying "cities" in research concerned with rural/peri-urban community health contexts. As discussed earlier, Al-Jumum represents a small city that evolved from a rural town, and it is now a governorate serving surrounding rural villages, fitting within the diverse range of settlement types included in WHO Healthy Cities networks globally. The WHO framework's flexibility in application across different demographic contexts (World Health Organization, 2010, Flynn, 1996), made it particularly relevant for understanding how international health promotion frameworks operate in settings that bridge rural and urban characteristics. Furthermore, the healthy cities initiative in Al-Jumum explicitly aimed to address health challenges common to rural and semi-rural contexts, including limited healthcare infrastructure, reliance on traditional health practices, and the need for community-based health promotion approaches (The third stage interviews, local

policymaker, I1). This alignment between the initiative's objectives and the health promotion challenges characteristic of rural Saudi communities reinforced the methodological appropriateness of using this proxy to understand asset-based implementation feasibility in contexts similar to those originally targeted in my research design.

3.5.2 Identifying Volunteering as Community Asset Mobilisation

The second proxy intervention, volunteering programmes, emerged through my community-level fieldwork and my connections with local community groups. During my early observations in Al-Jumum, I learned about various community activities that were organised by volunteer groups working within formal regulatory frameworks. When I began asking about these volunteer activities, I discovered a network of community engagement that embodied many asset-based principles while operating under governmental oversight.

My most significant insight into volunteering as asset mobilisation came through my connection with a women's volunteering group that became central to my research. I learned about this group from two local stakeholders, and one of them helped me establish connections with the group by adding me to their WhatsApp group. The group organised a wide range of activities including health education sessions, community clean-up initiatives, support for elderly residents, and educational programmes for children.

What made this group particularly interesting from an asset-based perspective was how they identified and mobilised community resources to address community needs within the formal regulatory framework governing volunteer work in Saudi Arabia. Volunteer activities are monitored by governmental entities, and groups must obtain approval from higher authorities and register through the National Platform for Volunteer Work (المنصة الوطنية للعمل التطوعي) before organising activities. Rather than this regulatory requirement constraining asset mobilisation, the group had learned to work within this system, using the formal approval process to legitimise their identification and mobilisation of community assets.

During my fieldwork, I observed volunteering activities that demonstrated asset-based principles operating within formal governance structures. Through observations and focus group sessions with a volunteering group, I learnt that participants had organised diabetes and obesity awareness sessions and coordinated community initiatives to clean the local park and plant trees after obtaining necessary approvals through the formal volunteer

registration system. These activities demonstrated key asset-based elements: identifying community priorities (health awareness, environmental improvement), mobilising available resources (volunteer time, community spaces, local knowledge), and building on community strengths and social networks to implement activities.

The volunteering activities represented a form of structured asset mobilisation that operated within Saudi Arabia's formal civic engagement framework. This regulatory context created an interesting dynamic where grassroots asset mobilisation operated through formal state structures rather than independently of them. During my interactions with the volunteering group, I observed how they navigated this tension by framing their community-driven priorities in ways that aligned with formal health promotion goals, suggesting adaptive strategies that maintained community ownership whilst satisfying regulatory requirements. The WhatsApp group that facilitated my connection with the volunteers also revealed the importance of digital networks in contemporary community organising, demonstrating how asset-based approaches might evolve within modern communication contexts.

What made volunteering particularly significant as a proxy intervention was its demonstration that community capacity for asset-based approaches existed within the Saudi context, even when operating under formal regulatory frameworks. The volunteers' ability to identify community priorities, mobilise resources, and implement activities showed that the foundational elements of asset-based community development were present and active. This suggested that more systematic integration of asset-based approaches into health promotion might be feasible, provided that implementation strategies could work constructively with existing regulatory structures rather than bypassing them.

The volunteering activities also highlighted the gendered nature of community asset mobilisation in the Saudi context. The women's volunteering group operated within cultural frameworks that shaped both the types of activities they could undertake and the spaces in which they could operate. Understanding these cultural dimensions became crucial for appreciating how asset-based approaches might need to be adapted to local contexts, recognising that community assets include not only material resources and skills but also cultural knowledge about appropriate forms of engagement (Liamputtong, 2011, Kretzmann and McKnight, 1993, Cornwall, 2003).

3.5.3 Uncovering Health Coaching as Asset-Based Practice

The identification of health coaching as a third proxy intervention emerged through my interviews with a national stakeholder who mentioned participating in training programmes that emphasised patient empowerment and behaviour change support. Initially, I was sceptical about whether health coaching would qualify as an asset-based approach, since coaching interventions often focus on individual behaviour change rather than community asset mobilisation (Olsen, 2014, Wolever et al., 2013). However, as I obtained documentation about the health coaching programme and conducted interviews with one health coach, I began to understand how coaching approaches in the Saudi context incorporated asset-based principles. The coaching curriculum, developed by the Makkah Healthcare Cluster for their six-month interprofessional training programme,

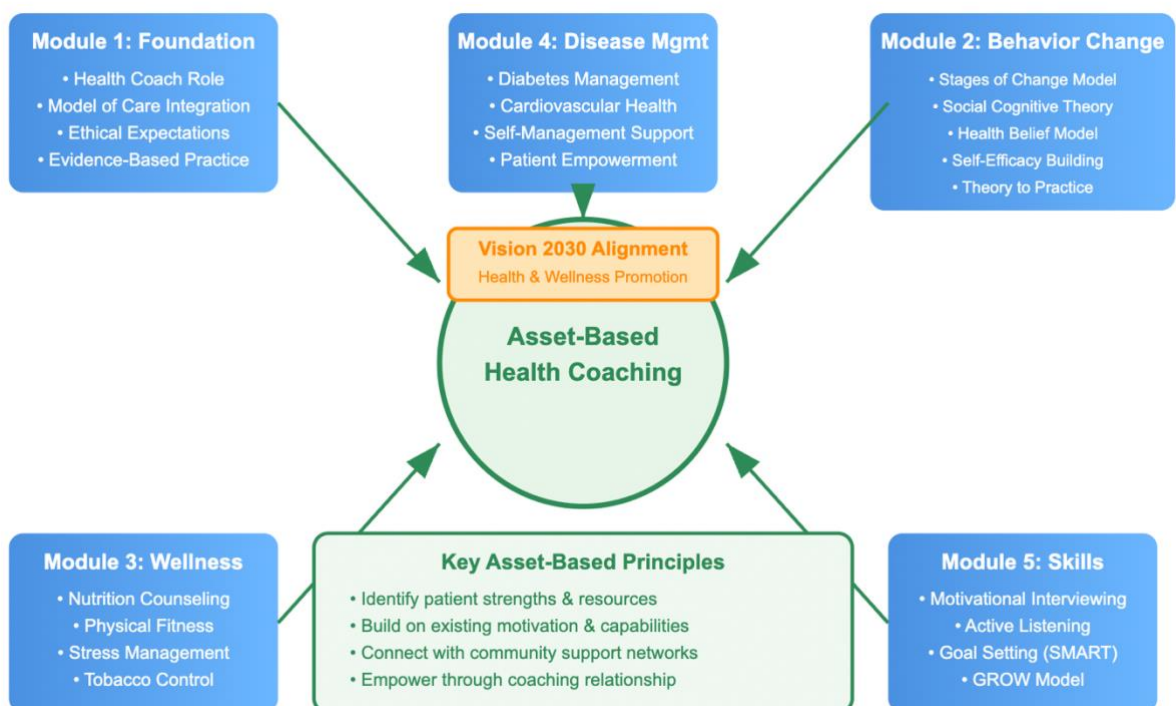


Figure 3.4 Health Coaching Program: Asset-Based Principles Integration in the Saudi Healthcare Context. Source: Author's analysis based on Makkah Healthcare Cluster Interprofessional Training Administration curriculum documents (2023-2024) and interview data.

The curriculum emphasised identifying patient strengths and resources through motivational interviewing techniques, building on existing motivation and capabilities using established behaviour change theories like the Transtheoretical Model and Social Cognitive Theory, and connecting patients with community support networks. Module 5 specifically trained coaches in the GROW model (Goals, Reality, Options, Way forward) and SMART goal setting, both of which focus on leveraging client assets rather than

addressing deficits. The programme's explicit integration with Saudi Arabia's Vision 2030 health transformation agenda further reinforced its asset-based orientation, positioning health coaches as facilitators who empower individuals through guidance rather than as traditional service providers who address health problems directly.

These elements aligned closely with asset-based approaches to individual health promotion, demonstrating how traditional health coaching methodologies had been adapted to incorporate community-oriented principles within the Saudi healthcare context. What made health coaching particularly interesting as a proxy intervention was that it represented a formal attempt to shift from deficit-based healthcare delivery (focusing on problems and pathology) toward strength-based approaches (identifying and building on patient assets). The health coach I interviewed described how coaching training had changed the current approach to patient interactions, moving from telling patients what they needed to do differently toward helping patients identify their own resources and motivations for health improvement.

The health coach I interviewed, who was also a care nurse, described this shift in approach. Before the coaching training, she had focused on what patients were doing wrong—not taking medications, not following diet recommendations, not exercising enough. After the training, she learned to ask patients about what was already working for them, what motivated them to be healthy, and what support they had available. She found that this approach worked better, and patients responded more positively.

This perspective suggested that health coaching represented a grassroots shift toward asset-based thinking within healthcare delivery, even though it was not explicitly framed in asset-based terms. The coaching approach provided a concrete example of how asset-based principles might be operationalised within existing healthcare structures, bridging the gap between individual-focused interventions and community asset mobilisation through its emphasis on identifying and strengthening patient networks and support systems.

Each of these three proxy interventions, the Healthy City concept, health coaching initiatives, and volunteering programmes, will be examined in detail in subsequent chapters, where I analyse how they function as pathways for asset-based approaches within the Saudi context, exploring their specific mechanisms, contextual factors, and implementation possibilities through the realist evaluation framework.

3.6 Research Design: Building a Flexible Framework

The identification of these three proxy interventions provided the foundation for developing a flexible research framework that could study ABA feasibility through existing initiatives rather than attempting to implement new programmes. This framework needed to accommodate both the formal institutional aspects of the Healthy City and health coaching initiatives and the informal community dynamics of volunteering activities.

My research design evolved to focus on understanding how each of these proxy interventions functioned within Al-Jumum context, what mechanisms they activated for community health improvement. Rather than studying a single asset-based intervention, I would examine three different pathways through which asset-based principles might be operationalised within Saudi health contexts.

The realist evaluation framework provided the analytical structure for this investigation, directing attention to the relationships between contexts, mechanisms, and outcomes for each proxy intervention. However, the bricolage methodology enabled me to adapt data collection methods to the specific characteristics of each intervention type. Studying the formal Healthy City initiative required different approaches than studying informal volunteering networks, but both could contribute to understanding asset-based approach feasibility.

This methodological framework represented a significant evolution from my original plan. Instead of implementing predetermined procedures across all research encounters, I developed a flexible approach that could accommodate the different dynamics associated with formal institutional initiatives and informal community practices. This flexibility proved essential for generating meaningful insights about how asset-based approaches might function within Saudi cultural and institutional contexts.

The framework also enabled me to examine potential synergies and tensions between different approaches to asset-based health promotion. The formal Healthy City initiative operated through institutional mechanisms and government coordination, while volunteering activities relied on community initiative and informal networks. Health coaching represented a middle ground—formally supported training that enabled individual healthcare providers to adopt asset-based approaches within their professional practice.

3.7 Sampling Strategy and Participant Recruitment

My approach to identifying and engaging participants evolved significantly through fieldwork experience, teaching me important lessons about the inadequacy of predetermined sampling strategies for cross-cultural research. My initial sampling plan had focused on identifying participants through formal healthcare institutions and community organisations, but I discovered that this approach would miss crucial perspectives and might inadvertently bias my findings toward formally recognised activities and mainstream viewpoints.

The combination of purposive and snowball sampling techniques that I ultimately employed emerged through practical experience with community dynamics rather than methodological textbook recommendations. I learned that effective sampling in the Al-Jumum context required understanding and working with existing social networks rather than attempting to create artificial research relationships. This adaptive sampling approach ultimately yielded 54 participants across three distinct stages of data collection (Table 3.1), demonstrating how relationship-building and network connections could generate rich and diverse perspectives that formal sampling procedures alone could not have accessed.

Table 3-1 Participant types and numbers

	Type of Participants	Number of Participants
Stage 1: Semi-structured interviews	Primary care workers	11
	A police officer	1
	Local citizens	22
Stage 2: Focus Groups	FG1: Male and female health care workers	6
	FG 2: Male local citizens	5
	FG3: Females from a local volunteers' group	2
Stage 3: Semi-structured interviews with key stakeholders	Local stakeholders	4
	National stakeholders	3
TOTAL		54

My sampling approach began with practical entry points - approaching the primary healthcare centre to connect with healthcare workers and seeking introductions to community members through local contacts. Rather than working from predetermined

categories, I allowed my understanding of relevant participants to develop through fieldwork experience and community recommendations.

3.7.1 Building Research Networks Through Relationship Development

Learning to work effectively with gatekeepers became one of my most significant methodological challenges, involving complex cultural and social dynamics that required careful navigation beyond simply obtaining formal permissions. Gatekeepers play crucial roles in qualitative research access, but their involvement can create power dynamics that potentially compromise participant autonomy and data authenticity (Hammersley and Atkinson, 2019). The challenge is particularly acute in hierarchical institutional settings where gatekeepers' endorsement of research participation may be perceived as implicit pressure by potential participants (Miller and Rollnick, 2012). My first major gatekeeping experience occurred when I approached the primary healthcare centre in Al-Jumum to request interviews with healthcare providers. The centre director was very helpful and immediately offered to identify staff members who could participate in my research. However, I quickly realised that this well-intentioned assistance created potential coercion issues. When the director personally asked specific staff members to participate in my research, they might have felt unable to decline without appearing uncooperative or uncommitted to their professional responsibilities. This situation exemplifies what Crowhurst and Kennedy-Macfoy (2013) describe as institutional pressure, where workplace hierarchies can compromise the voluntary nature of research participation.

To address this concern, I developed a more careful approach to institutional gatekeeping that ultimately proved more productive for building genuine research relationships. Instead of asking directors to identify specific participants, I requested opportunities to present my research to staff groups and invite voluntary participation, following recommendations by Feldman et al. (2004) for minimising gatekeeper influence on participant recruitment. I emphasised that participation was entirely voluntary and that individual decisions about participation would not be shared with supervisors. This approach took more time but resulted in 17 healthcare worker participants who seemed more genuinely interested in sharing their perspectives rather than fulfilling perceived obligations. However, the manager of the primary care centre also introduced me to local male citizens in the community, which led to a male focus group with 5 local residents who provided valuable community perspectives beyond the healthcare system.

A different type of gatekeeping challenge emerged when I attempted to access community volunteers through formal community organisations. The president of the women's

volunteering group initially offered to arrange interviews with group members, but I sensed that this arrangement might influence which members were selected and how they presented their perspectives. Instead, I requested permission to be added to their WhatsApp group as an observer, introducing myself and my research informally and inviting individual members to contact me if they were interested in participating. This approach aligns with what Sixsmith et al. (2003) describe as indirect recruitment strategies that reduce gatekeeper influence on participant selection and consent processes. This approach proved much more effective for building genuine research relationships, eventually leading to two volunteers participating in my female focus group. Group members had opportunities to observe me in social settings, ask questions about my research, and make independent decisions about participation without feeling pressure from group leadership. Several participants later commented that they appreciated having time to get to know me before deciding whether to share their perspectives through formal interviews.

3.7.2 Discovering and Leveraging Informal Networks

Some of my most valuable participants were identified through informal networks rather than formal sampling procedures, demonstrating how snowball sampling could access community knowledge that institutional approaches might miss entirely. These connections often emerged through casual conversations, chance encounters, and social introductions that could not have been planned through systematic sampling strategies, yet they provided crucial insights that enriched my understanding of community assets and health practices.

One particularly valuable participant relationship developed through a conversation I had with a police officer in a public park. My brother and I were walking in the park trying to discover the area and talk to as many people as we could, but not everyone accepted to talk to us. When this police officer approached and asked what we were doing in the area, our conversation about my research led to a discussion of his experiences as a long-term Al-Jumum resident and his observations about community changes over time. He shared insights about informal community support networks, traditional healing practices, and community resource-sharing arrangements that had not emerged in my formal interviews. This police officer refused to have the conversation recorded but allowed me to take some notes during our discussion. While he did not introduce me to other community members, his perspectives provided crucial insights about traditional community assets and informal health support systems.

Another example of network-building attempts occurred when I talked to two sisters in the same park. Our initial conversation about the area and community life gradually evolved into discussions about their experiences living in Al-Jumum. One of them mentioned that she was a teacher and offered to ask her colleagues to participate in my focus group, so we exchanged numbers. However, she later contacted me to explain that none of her colleagues accepted to participate because of their job time and family responsibilities, making it difficult for them to meet in person to do the focus group. While this connection did not lead to additional participants, the conversation with the sisters provided insights into the challenges of recruiting participants and the practical barriers that potential participants faced in balancing research participation with their professional and family obligations.

The most successful snowball sampling occurred through the 22 local citizens I eventually interviewed, many of whom were connected through family, neighbourhood, and social networks. Early participants often suggested other community members who they felt had relevant experiences or perspectives to share. This organic referral process was particularly effective because recommendations came from trusted community members rather than external researchers, lending credibility to the research and reducing suspicion about my motives. These referral chains also helped me understand the structure of social networks within Al-Jumum, revealing how information, support, and resources typically flowed through community relationships.

3.7.3 Adapting to Local Cultural Norms

My sampling and participant engagement approaches needed to accommodate cultural communication patterns that differed significantly from global north research contexts, requiring substantial adaptation of standard research protocols to build the trust necessary for meaningful participation. I learned that effective engagement required understanding and respecting cultural protocols around social interaction, gender dynamics, and authority relationships that shaped how community members were willing and able to participate in research.

One important cultural pattern I needed to navigate involved the importance of social introductions and relationship-building before engaging in substantive conversations about research topics. Community members expected and needed opportunities to understand who I was as a person before they would be comfortable sharing their perspectives about community life and health experiences. This relationship-building process involved sharing information about my family background, my education and work experiences, my

reasons for interest in community health, and my connections to the local area. They asked about my job, scholarship, home city, and other personal details that helped them place me within familiar social and cultural frameworks. Rather than viewing these conversations as peripheral to research, I came to understand them as essential foundations for meaningful data collection that enabled the eventual participation of 54 individuals across different community groups.

Gender dynamics presented particular challenges for sampling and engagement that required careful adaptation of my approaches. Cultural norms about cross-gender interaction meant that I needed to develop different strategies for engaging male and female participants. For female participants, I could conduct interviews independently and in various settings. For male participants, I needed to arrange interviews in more formal settings and sometimes with colleagues present, particularly when meeting participants individually. In the individual male interviews, I took my brother with me as it was much safer to drive with him and I felt more comfortable in his presence in new settings. However, my brother did not participate in the interviews. He was only sitting with me in the same room, and his presence was only after taking approval from the interviewee.

For the male focus group, I was accompanied by a female colleague who had completed her PhD and was familiar with research processes. I introduced her to the participants and got their approval before starting the interview. The main reason for bringing her was because the interview was scheduled late, between 8 and 9 pm, and I did not want to drive alone to the public meeting room we had booked for this interview. However, her presence during the interview proved valuable beyond safety considerations, as she helped me clarify some points and questions I posed to the participants and encouraged them to share more detailed information. Later on, when I started conducting interviews with stakeholders, especially the national stakeholders, I conducted the interviews by myself without the company of anyone, as these formal institutional settings provided different safety and cultural considerations.

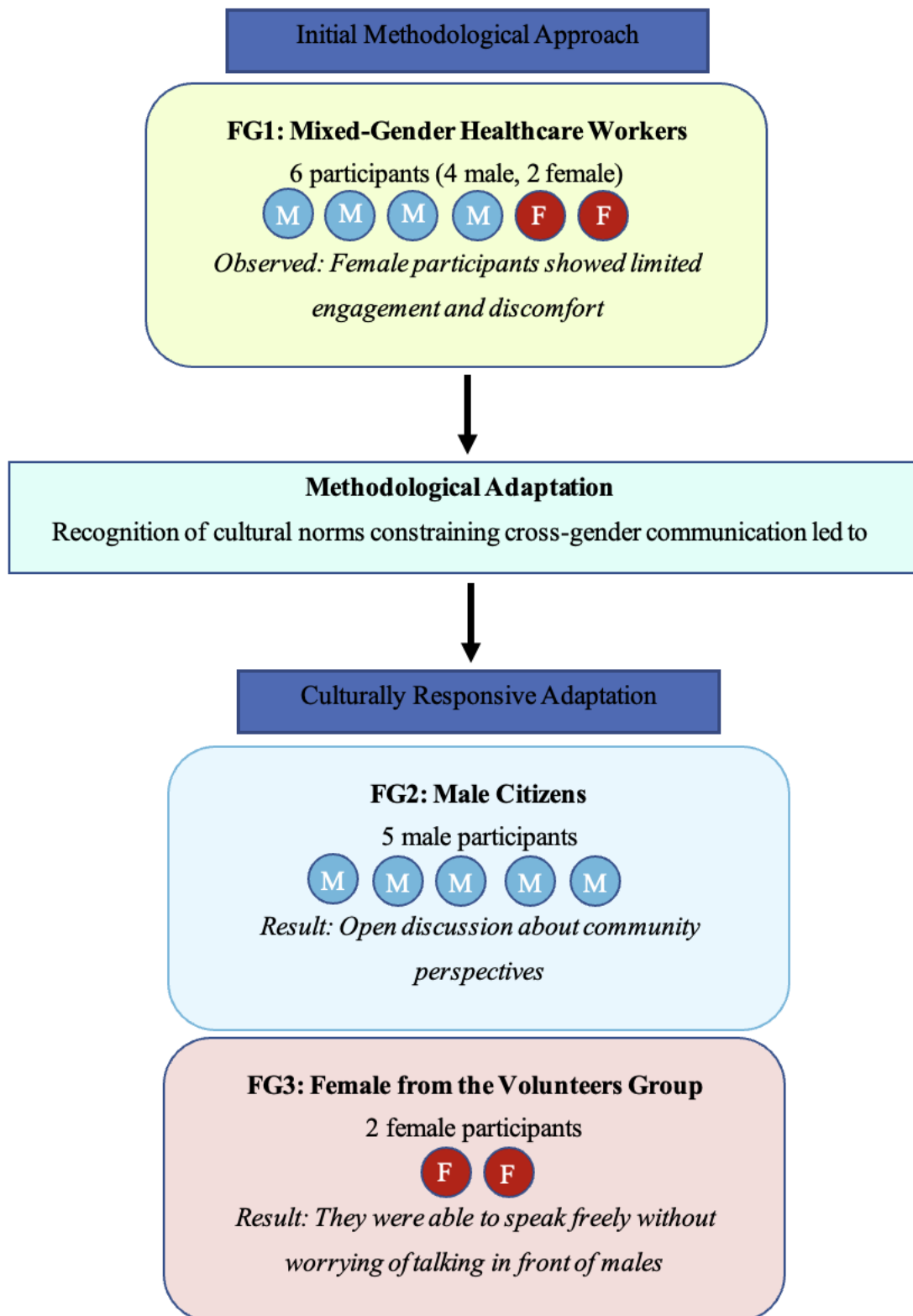


Figure 3.5 Focus group configuration adaptation. This diagram shows the evolution from mixed-gender to culturally appropriate single-gender focus groups, illustrating methodology responsiveness to cultural contexts.

These gender considerations influenced not only how I conducted interviews but also how I identified potential participants and ultimately shaped my decision to conduct separate male and female focus groups rather than mixed-gender sessions. Some community

activities were primarily organised by women, others primarily by men, and still others involved mixed-gender participation with specific cultural protocols. Understanding these dynamics was crucial for identifying the full range of community assets and avoiding bias toward activities that were most visible or accessible to female researchers. As shown in figure 3.5, the final composition of three focus groups reflected these cultural considerations: one mixed-gender healthcare worker group (6 participants), one male local citizens group (5 participants), and one female volunteer group (2 participants), each designed to create culturally appropriate spaces for open discussion whilst respecting local social norms.

3.8 Data Collection: Fieldwork Adaptation and Cultural Learning

My data collection approach evolved organically through fieldwork experience, exemplifying the bricolage methodology's emphasis on responsiveness to research contexts whilst maintaining analytical coherence. The systematic documentation of these adaptations became an important methodological contribution, demonstrating how cultural responsiveness can enhance rather than compromise research rigour.

Rurality was also used methodologically as a context for discussion rather than as a fixed category imposed on participants. Across interviews, focus groups, informal conversations, and observations, participants were invited to describe Al-Jumum, its community boundaries, its relationship with surrounding villages, its available assets, and its health-related challenges. This enabled participants to explain how they understood the place themselves, including whether they saw Al-Jumum as rural, urban, or occupying a position between the two. Asking about community assets, services, relationships, and local identity allowed rurality to emerge through participants' own accounts rather than being treated as a predetermined classification. This was particularly important because Al-Jumum's rurality appeared to be partly socio-cultural and relational, connected to history, family networks, community practices, and service access, rather than only to population size or formal administrative status.

3.8.1 Stage 1: Community Asset Discovery Through Multiple Methods

The first stage of data collection focused on discovering and mapping the assets present in Al-Jumum through multiple complementary methods. Rather than relying on single data collection approaches, I employed what emerged as a triangulated strategy combining formal interviews, informal conversations, observational methods, and document analysis.

I conducted eleven formal semi-structured interviews with healthcare providers working in Al-Jumum's primary healthcare centre. These interviews followed a semi-structured format with predetermined questions about community health needs, existing resources, collaboration patterns, and perspectives on community engagement approaches. The formal nature of these interviews was appropriate given the professional context and the participants' familiarity with research activities.

In addition, I conducted twenty-three informal interviews with community members encountered in various public settings—the public park, the local shops, and neighbourhood gathering places. These conversations were not recorded but were documented through detailed field notes written immediately after each encounter. The informal nature of these conversations enabled access to perspectives that might not have emerged through formal interview settings. Community members seemed more comfortable sharing their observations about community dynamics, local activities, and informal support systems when conversations emerged naturally from social interactions rather than formal research appointments. These informal support systems represented significant community assets, but they operated largely outside formal recognition and would not have been identified through interviews with healthcare providers or community leaders.

Throughout the first stage of my fieldwork, I maintained observational notes focused on how people used public community spaces, particularly the main park in Al-Jumum, and how informal social interactions unfolded in those settings. These observations took place in an open public space, where my presence was unobtrusive and did not require formal permissions. I visited the park with my brother, often sitting or walking around to get a sense of the atmosphere, the diversity of people, and the kinds of interactions taking place. These park-based observations provided valuable context for understanding the demographic composition of Al-Jumum and the informal social dynamics that shaped daily community life.

3.8.2 Stage 2: Deep Exploration Through Focus Groups

The second stage of data collection employed focus groups to explore collective perspectives on asset-based approaches and to verify insights gathered during the first stage. However, my experience with focus groups became one of my most significant methodological learning experiences, teaching me crucial lessons about cultural dynamics and gender considerations in research.

My first focus group was organised with six healthcare workers from the primary healthcare centre—four men and two women who worked together professionally and seemed comfortable with mixed-gender professional interaction. I had assumed that their professional relationships would enable open discussion regardless of gender composition. The focus group was held in a meeting room at the primary care centre, and I began with standard focus group protocols—introductions, explanation of discussion guidelines, and opening questions about community health resources.

However, during the mixed-gender focus group, I observed that the female participants were less talkative than their male colleagues. While the male participants readily shared their perspectives and engaged in discussions about health promotion activities and community assets, the female participants contributed less frequently to the conversation, often responding briefly when directly asked questions but rarely initiating new topics or elaborating extensively on their viewpoints. This observation highlighted important gender dynamics in professional healthcare settings that influenced research participation patterns.

This experience provided a crucial methodological insight about how cultural and professional dynamics might shape focus group participation. Despite being healthcare professionals working in the same environment, the mixed-gender setting appeared to influence communication patterns in ways that potentially limited the diversity of perspectives being expressed. The contrast between male and female participation levels suggested that single-gender focus groups might provide different insights and allow for more balanced contribution from all participants.

Based on this learning, I reconfigured my focus group approach to accommodate cultural communication patterns. I arranged a single-gender male focus group with five male participants, where I was accompanied by a colleague, as I mentioned earlier. I also organised a single-gender female focus group with women from the local volunteering group, which I facilitated independently.

Both single-gender focus groups included participatory mapping exercises where participants collaboratively identified community resources, strengths, and potential health assets. These activities produced visual representations of community assets that complemented verbal discussions and revealed spatial and relational aspects of community resource networks. I brought an initial asset map that I had developed based on the first stage interviews to serve as a starting point for these discussions.

3.8.3 Stage 3: Stakeholder Perspectives and Policy Context

The third stage of data collection focused on understanding institutional perspectives and policy contexts that would influence asset-based approach implementation. This stage required different interviewing approaches given the formal positions and institutional expertise of participants. I conducted seven interviews with stakeholders at both local and national levels, each bringing different institutional perspectives and policy insights to my understanding of community health promotion contexts. During this stage, I also gained access to key documents that provided formal documentation of community health initiatives and asset-based activities. These documents included official Healthy City Initiative documentation for Al-Jumum, health coaching programme materials, and volunteering activity reports.

The local stakeholder interviews provided crucial insights into how national policies were being implemented at the community level and the challenges involved in community engagement processes. These participants helped me understand how local authorities were working to achieve Vision 2030 goals, particularly around community empowerment. One local stakeholder explained that in order to achieve community empowerment objectives, they had to establish formal processes to encourage local people to adapt to new changes and accept them. This required guiding people through change processes and building trust channels between institutions and community members. This perspective revealed the complexity of implementing policy changes that required active community participation and highlighted the importance of trust-building and gradual adaptation processes in community health promotion initiatives.

The national level stakeholder interviews provided crucial insights into policy frameworks and institutional constraints that would influence asset-based approach implementation at scale. These participants explained the challenges of implementing community-based health promotion within a healthcare system structured around clinical service delivery, noting that infrastructure, funding mechanisms, and professional training were all designed for clinical care rather than community engagement. However, they also described growing recognition within the ministry that community engagement was essential for addressing chronic disease prevention and health behaviour change, particularly in relation to Vision 2030 objectives that emphasise community participation and preventive care.

Interviewing stakeholders in positions of authority required significant adaptations of my usual interview approaches. These participants expected more formal interaction protocols and often positioned themselves as providing expert information rather than sharing

personal perspectives. I learned to begin these interviews by explicitly acknowledging participants' expertise and positioning myself as seeking to learn from their knowledge rather than evaluating their practices. I also discovered that authority figures sometimes provided official responses that reflected policy positions rather than personal observations. To access more candid perspectives, I learned to ask about specific examples and practical challenges rather than general policy questions, finding that questions about obstacles encountered when implementing new programmes often elicited more detailed and honest responses than questions about official policies and procedures.

Figure 3.6 provides a visual representation of how these three stages progressed sequentially, showing the methodological flow that characterised the data collection process. As illustrated in the figure, the data collection process demonstrated the systematic yet flexible nature of the bricolage approach. Each stage built upon insights from the previous stage whilst engaging different stakeholder groups, creating a comprehensive understanding of asset-based approach feasibility. The progression from community-level asset identification through focus group discussions to policy-level stakeholder perspectives enabled triangulation across different levels of the health system.

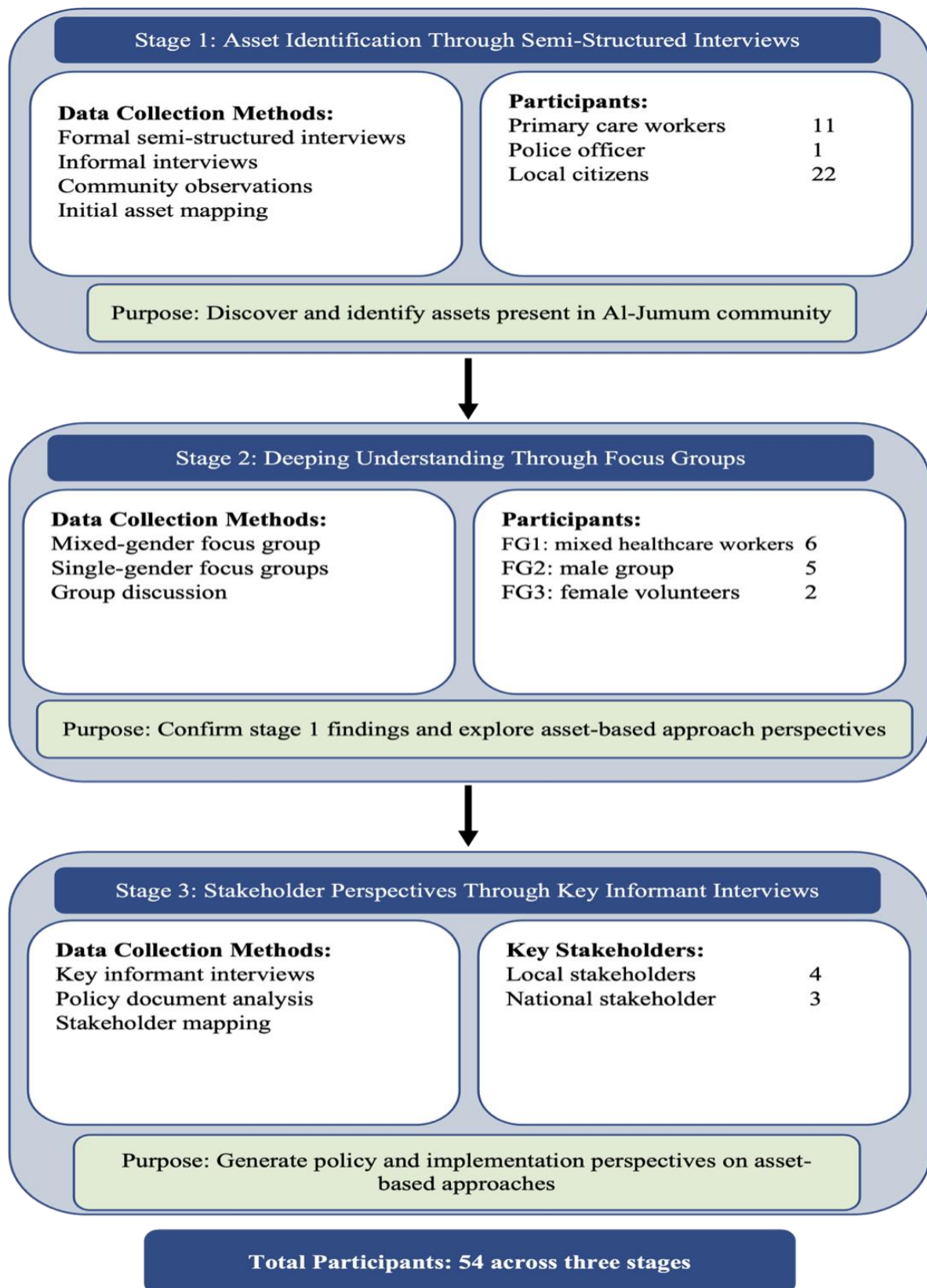


Figure 3.6 Three-stage data collection process. Visual representation of the data collection stages, showing the progression from asset identification (stage 1) through focus group discussion (stage 2) to stakeholder interviews (stage 3), with participant numbers

3.9 Data Analysis: Weaving Together Multiple Voices and Perspectives

The analytical process represented one of the most intellectually challenging aspects of my research, requiring integration of diverse data types whilst maintaining coherence through the realist evaluation framework. The analysis needed to honour the cultural specificity of Saudi contexts whilst generating insights relevant to broader understanding of ABA implementation.

3.9.1 Preparing and Organising the Data Corpus

The first analytical stage involved preparing the diverse data collection for systematic analysis. This process was more complex than standard qualitative analysis procedures because of the variety of data types and the need to maintain cultural authenticity whilst ensuring participant anonymity. All data collection was conducted in Arabic, including interview and focus group recordings that totalled approximately forty hours of conversation, field notes of handwritten and typed observations, and the key documents related to the healthy city initiative, volunteer work, and health coaching.

The organisation process proved particularly challenging given the volume of Arabic materials and the need to protect participant identities. I organised all materials into digital files on my laptop, creating three main folders titled Stage 1, Stage 2, and Stage 3 to reflect the chronological progression of my fieldwork. I maintained separate folders for interviews, focus groups, observational notes, and the collected documents. Most of my field notes were taken in Arabic to preserve the natural flow of observations and cultural expressions as they occurred.

A critical aspect of this preparation involved developing strategies for maintaining participant anonymity whilst preserving the contextual richness necessary for analysis. I listened to interviews multiple times, taking detailed notes in Arabic about key themes and perspectives whilst carefully removing identifying information. This process required particular attention to cultural markers that might inadvertently reveal participant identities, such as specific tribal affiliations, family connections, or professional roles that might be easily recognisable within the local community context.

The documents collected during fieldwork presented different organisational challenges. The volunteer work report proved particularly complex as it was a large, unorganised document covering the entire country. I had to systematically organise this material using Excel, creating categories to extract relevant information, and focusing specifically on the Al-Jumum context whilst comparing it to national-level data. This process required careful

analysis to identify local patterns within the broader national framework and to understand how volunteering activities in Al-Jumum compared to other regions across the country.

This systematic organisation enabled me to maintain comprehensive records whilst ensuring ethical protection of all participants. The chronological organisation by stages also proved valuable for tracking how my understanding evolved throughout the fieldwork process and how different phases of data collection built upon previous insights.

Following the organisation of the collected materials, I began a continuous process of familiarisation and analytical reflection across all collected materials. The interviews and focus groups were conducted in Arabic, and while not all recordings were fully transcribed word-for-word, I listened to the recordings multiple times and produced detailed summaries and notes in Arabic using notes cards and handwritten reflections. This process enabled me to remain close to the original language, cultural expressions, and meanings embedded within participants' narratives before translating selected extracts into English for use within the thesis. Maintaining the analysis in Arabic during the early stages proved particularly important for preserving culturally grounded concepts and expressions that did not always translate directly into English.

Rather than using qualitative software or line-by-line coding procedures, I adopted a more flexible and ongoing topic-based analytical process that aligned with the bricolage methodology underpinning this research. After interviews and observations, I regularly reviewed recordings, notes, and reflections whilst identifying recurring topics, issues, and ideas emerging from participants' accounts. These analytical reflections were documented through handwritten notes and reflective memos written throughout the fieldwork period. The analytical process remained closely connected to ongoing field experiences, allowing new insights emerging from interviews and observations to shape subsequent data collection decisions and areas of inquiry.

Field notes formed an important part of the analytical process from the beginning of the fieldwork. Notes were written during interviews, observations, and informal community encounters to capture contextual details, reflections, participant interactions, emotional responses, and observations about the research environment. These notes were not treated as separate supplementary materials but were continuously revisited alongside interview recordings and summaries to support interpretation and contextual understanding. The field notes also contributed to the development of subsequent interview questions by highlighting emerging topics and issues that required further exploration during later stages

of the fieldwork. For example, when participants repeatedly mentioned the Healthy City initiative during the early interview stages, I explored this issue further in later focus groups and stakeholders' interviews to better understand its role within community health promotion activities.

The analytical process developed collaboratively through regular supervisory meetings, where I discussed interview content, emerging observations, recurring topics, and reflections from the field. During these discussions, my supervisors and I gradually identified patterns and recurring areas that appeared significant in relation to asset-based approaches within the Saudi context. Through this continuous dialogue between fieldwork experiences, interview discussions, observations, and supervisory reflection, the three focal areas of healthy cities, volunteering, and health coaching gradually emerged as the most significant domains through which asset-based principles appeared to operate within the Saudi health and community context. These focal areas were therefore not predetermined categories but emerged progressively through ongoing engagement with the data and field experiences.

Documentary materials entered the analysis after the interview stages, when participants and stakeholders shared reports, policy documents, volunteering records, and health coaching materials that were considered relevant to understanding community health initiatives and institutional practices. These documents contributed significantly to the identification and understanding of the three proxy interventions. Because some of these materials were large and organisationally complex, particularly the national volunteering reports, I used Excel spreadsheets to organise and categorise the information in relation to Al-Jumum and broader national activities. The documents were analysed alongside interview reflections and field notes, enabling comparison between institutional narratives, community experiences, and observational findings.

Analysis remained ongoing throughout the study rather than occurring as a separate stage after data collection had ended. Early interviews shaped later interview questions, emerging themes influenced the direction of subsequent observations and focus groups, and earlier recordings and notes were revisited repeatedly as my understanding developed. For example, volunteering initially emerged as only one aspect of community activity but became increasingly significant as participants repeatedly referred to its importance during interviews and focus groups. This led me to conduct additional exploration into volunteering structures, activities, and community engagement processes. The focus groups also helped deepen and verify many of the issues that had emerged during the

earlier interview stages, particularly regarding community participation, informal support systems, and culturally embedded forms of cooperation. Through this continuous movement between data collection, reflection, discussion, and interpretation, broader analytical themes gradually developed and later informed the realist evaluation analysis presented in the following sections.

3.9.2 Collaborative Analysis and Identifying Focal Areas

One of the most valuable aspects of my analytical process was the collaborative engagement with my supervisory team, who brought diverse academic backgrounds to the interpretation process. Regular supervisory meetings provided opportunities to discuss emerging themes, test analytical interpretations, and challenge assumptions that might have been influenced by my cultural positioning, as discussed in chapter 7, or theoretical commitments. This collaborative analytical process proved essential for maintaining analytical rigour whilst avoiding the insularity that can develop when single researchers work alone with their data. I kept meeting with my supervisors on a regular basis, sharing what I had discovered in my data, and they consistently asked probing questions that helped me think more deeply about my findings. The supervisory discussions often revealed interpretive possibilities that I had not considered and challenged me to provide stronger evidence for analytical claims that I had accepted too readily.

Through this ongoing collaborative questioning process, the identification of the three focal areas, healthy cities, volunteering, and health coaching, emerged through iterative analysis of interview data, document content, and observational findings. These were not predetermined research categories but emerged inductively through the supervisory dialogue as the most significant domains where asset-based principles were already embedded within Saudi health contexts. This inductive emergence of focal areas created an interesting methodological tension with the more deductive nature of the realist evaluation framework's Context-Mechanism-Outcome (C-M-O) analytical structure that I subsequently applied to each domain. While the realist evaluation approach provided a systematic deductive framework for analysing how interventions work, the identification of what to analyse emerged through inductive processes of pattern recognition and theme development. This tension between inductive discovery and deductive analysis reflects the complexity inherent in studying social phenomena that do not conform neatly to predetermined theoretical categories (Danermark, 2002). Rather than viewing this as a methodological inconsistency, I came to understand it as a productive analytical dynamic

where emergent themes could be subjected to systematic theoretical examination, enabling both discovery and rigorous analysis within the same research process.

3.9.3 Applying Realist Evaluation Framework

Once the three focal areas were identified, I applied realist evaluation analysis to understand how each functioned within the Saudi context. The realist framework was particularly suited to this research because it enabled systematic examination of complex interventions within their specific cultural and institutional contexts, moving beyond simple questions of what works to explore what works, for whom, in what circumstances, and why. Figure 3.7 illustrates how the realist evaluation framework was applied to analyse asset-based approaches in the Saudi context, showing the relationship between contextual factors, activation mechanisms, and feasibility outcomes across the three proxy interventions.

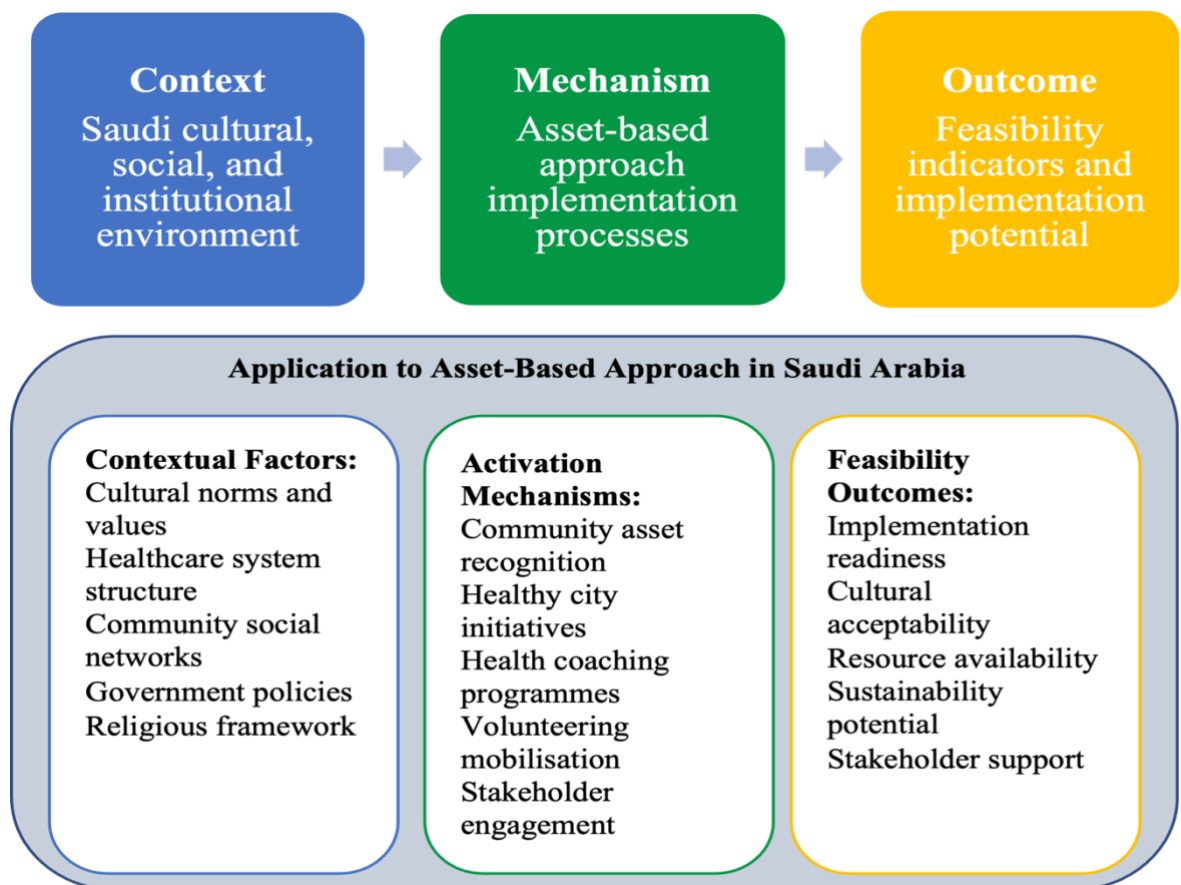


Figure 3.7 Analytical framework application. Visual representation of how the realist evaluation framework (Context-Mechanism-Outcome) was applied to analyse asset-based approaches in the Saudi context, showing the relationship between contextual factors, activation mechanisms, and feasibility outcomes

The realist evaluation framework directed analytical attention to three interconnected dimensions: contexts (social, cultural, institutional conditions), mechanisms (processes through which interventions activated change), and outcomes (results and consequences) for each focal area. This analytical structure proved invaluable for understanding how interventions with asset-based principles functioned within Saudi contexts and why similar principles might manifest differently across various settings. The framework's emphasis on contextual sensitivity aligned well with my bricolage methodology and cultural responsiveness commitments, enabling analysis that honoured local specificity whilst generating insights about the potential feasibility of asset-based approaches in Saudi contexts.

For each of the three proxy interventions, I systematically applied the context-mechanism-outcome analysis to understand implementation dynamics and identify asset-based principles embedded within existing practices. Contextual analysis involved examining the social, cultural, political, and institutional environments within which each intervention operated, drawing on interview data about participant experiences, observational insights about community dynamics, and document analysis of policy frameworks and organisational structures. This contextual analysis proved essential for understanding how interventions that contained asset-based principles functioned within Saudi cultural and institutional frameworks, and what contextual factors supported or hindered the activation of these principles.

Mechanism analysis focused on identifying and understanding the processes through which each intervention activated change, particularly examining how asset-based principles were embedded within or could be enhanced through existing practices. This involved careful examination of how participants described their experiences of engagement with each intervention, what motivated their participation, what barriers they encountered, and what factors supported or hindered their continued involvement. The mechanism analysis drew heavily on participant perspectives captured through interviews and focus groups, as these provided insights into the often-invisible processes that determined intervention success or failure. This analytical focus on mechanisms proved particularly valuable for understanding how existing Saudi interventions already embodied asset-based principles and what adaptations might be necessary for more systematic implementation of asset-based approaches.

Outcome analysis examined both intended and unintended consequences of each intervention, with particular attention to outcomes that reflected asset-based principles

such as community empowerment, resource mobilisation, and capacity building. Rather than focusing primarily on quantitative measures of success, the realist approach encouraged attention to the diversity of outcomes experienced by different participants and the contextual factors that influenced outcome variation. This analytical approach proved essential for understanding the potential for asset-based approaches within Saudi contexts and identifying factors that might support or challenge their future implementation.

3.9.4 Language, Translation and Cultural Methodological Considerations

As mentioned earlier, throughout all stages of data collection and analysis, I conducted interviews and focus groups in Arabic, which proved essential for cultural credibility and participant comfort. Speaking Arabic enabled access to cultural concepts and expressions that did not have direct English equivalents and facilitated more natural conversation flow. However, conducting research in Arabic while writing for English-speaking academic audiences created complex translation challenges that extended throughout the analytical process.

A particular challenge emerged during the preparation phase when I had to translate my interview questions from English to Arabic. The interview questions had been developed in English as part of my research proposal but conducting interviews in Arabic required careful consideration of how concepts would translate and be understood by participants. For example, one of my interview questions asked, what are the boundaries of your community? When translating (boundaries) to Arabic, the most direct translation would be (hudud حدود), which carries connotations of limitations or restrictions rather than the geographic or social delineation I intended to explore. This translation challenge required me to rephrase questions in ways that would capture the intended meaning whilst using Arabic concepts that participants would understand naturally. Instead of asking about boundaries, I learned to ask about the extent or reach of their community (nitaq al-mujtama نطاق المجتمع) or how they defined who belonged to their community, which elicited more meaningful responses about community conceptualisation.

Perhaps the most significant translation challenge involved the central concept of my research: asset-based approaches. The English word asset does not have a direct equivalent in Arabic that captures the same meaning within health promotion contexts. The most literal translation would be (osool أصول) or (mumtalakat ممتلكات), both of which refer primarily to financial assets or property ownership. However, these translations completely miss the concept of community strengths, resources, skills, and capacities that define asset-based approaches in health promotion. After extensive consideration and discussion with

bilingual colleagues, I developed several strategies to convey this concept. I used phrases like (al-qudurat wa al-mawarid al-mujtama'iyyah) (القدرات والموارد المجتمعية) meaning (community capacities and resources), or (nuqat al-quwwah fil-mujtama) (نقاط القوة في المجتمع) meaning (strengths within the community). During interviews, I consistently provided explanations and examples to ensure participants understood that I was referring to existing community strengths, skills, networks, knowledge, and resources rather than financial assets or deficits that needed to be addressed. This translation challenge was crucial because asset-based approaches represent a fundamental shift from deficit-based thinking, and ensuring participants understood this distinction was essential for meaningful data collection.

Many concepts central to my research carried cultural meanings that required careful translation throughout the analysis process. This challenge reflects what Temple and Young (2004) describe as the fundamental epistemological questions that arise when researchers attempt to represent one cultural worldview through the linguistic and conceptual frameworks of another. The translation difficulties I encountered align with broader discussions in decolonial scholarship about how linguistic translation intersects with power dynamics and knowledge production across cultural boundaries (Chambers and Demir, 2024). These challenges also illuminate what Bortel et al. (2019) identify in their systematic review of health assets literature: "the skew in terms of geography may also be due to the fact the term 'asset' does not translate sufficiently well to be used in some sociocultural and political contexts" (p. 8). Their finding that health assets research has been conducted predominantly in global north countries, with limited representation from other regions, partly reflects the linguistic and conceptual challenges of translating key terms like assets across different cultural contexts. This highlights how global north public health concepts may lack direct equivalents in global south linguistic frameworks, creating barriers to implementing and studying such approaches in diverse cultural settings. The difficulty of translating asset-based approaches into Arabic exemplifies how conceptual frameworks developed within specific cultural and linguistic contexts may not transfer seamlessly across cultural boundaries, requiring researchers to develop innovative strategies for cross-cultural knowledge representation that respect both the integrity of local concepts and the communicative requirements of academic discourse.

For example, the Arabic concept of (mas'uliyah mujtama'iyyah which means community responsibility) encompasses not only individual obligation to community but also collective accountability that includes religious, social, and cultural dimensions. Direct

translation as community responsibility loses these cultural nuances and fails to convey the depth of meaning that influenced participant perspectives. The concept of (*takaful ijtimai*) social solidarity) illustrates these challenges further. Participants frequently referenced this concept when discussing community support networks, but (*takaful ijtimai*) encompasses religious obligations, cultural traditions, historical practices, and contemporary social expectations that extend far beyond English concepts of social solidarity. When participants described (*takaful ijtimai*) as motivation for volunteering activities, they were referencing Islamic teachings, historical traditions, cultural expectations, and contemporary practices that influenced how they understood and practiced community asset mobilisation. These translation challenges reveal what Niranjana (2023) describes as the complex power relations embedded in translation practices, where the act of translation itself becomes a site where colonial and postcolonial dynamics are negotiated and contested. The process requires acknowledging that certain concepts resist translation precisely because they embody worldviews and epistemologies that cannot be easily accommodated within global north academic frameworks without significant conceptual violence.

To address these translation challenges, I developed several strategies. For key documents, I utilised the services of a certified translation office in Saudi Arabia to ensure professional accuracy. For interview transcripts and cultural concepts, I asked for help from a bilingual colleague who studied with me in America to verify that translations preserved conceptual meanings rather than just linguistic equivalence. She has a PhD and master's degree in English language with a focus on linguistics. In my analysis and writing, I maintained important Arabic terms when direct translation risked conceptual loss and provided contextual explanations alongside translations.

Beyond translation challenges, the research process required fundamental reconsideration of how knowledge is produced and validated within different cultural contexts. Cultural responsiveness in methodology required more than simply accommodating local customs—it demanded epistemological humility and willingness to learn from cultural contexts rather than imposing predetermined research frameworks. The adaptation to single-gender focus groups, for example, was not simply a procedural adjustment but represented recognition that meaningful participation might require different social arrangements than those assumed in global north research traditions.

Similarly, the emphasis on relationship-building and social introductions was not merely cultural politeness but reflected different epistemological assumptions about how trust and credibility are established. In the Saudi context, personal credibility established through

cultural protocols and social relationships proved more important than formal qualifications or institutional affiliations. Participants needed to understand not only my research credentials but also my family connections, social positioning, and cultural competence before they felt comfortable sharing their perspectives. This process of establishing trust through social relationships required significant time investment and cultural sensitivity, but it proved essential for accessing authentic participant perspectives. The relationship-building process was not simply a prerequisite for data collection but became an integral part of understanding how knowledge is constructed and validated within Saudi cultural contexts. This experience highlighted the importance of recognising that different cultural contexts may require fundamentally different approaches to establishing researcher credibility and participant trust.

These insights revealed that bricolage methodology involves more than methodological flexibility—it requires genuine openness to learning from participants and adapting research approaches based on cultural contexts and participant needs (Kincheloe, 2001). The methodological adaptations that emerged through my fieldwork were not deviations from proper procedure but essential components of culturally grounded research that could access meaningful local knowledge whilst maintaining analytical integrity. This experience demonstrated that effective cross-cultural research requires researchers to remain flexible and responsive to local contexts whilst maintaining rigorous analytical standards.

3.9.5 Maintaining Analytical Rigour and Integration

Throughout the analytical process, I maintained reflexive attention to how my cultural positioning and theoretical commitments might influence interpretation. As a Saudi researcher educated in global north contexts (see section 3.10.1), I occupied a unique position that enabled cultural understanding but also created risks of imposing analytical frameworks that might not fully capture participant perspectives. My reflexive notes documented instances where my initial interpretations were challenged by deeper engagement with participant perspectives. For example, I initially interpreted women's volunteering activities through frameworks that emphasised empowerment and agency. However, participants themselves framed their activities through religious and cultural concepts that emphasised duty and community obligation rather than individual empowerment. This analytical tension required careful navigation between respecting participant perspectives and maintaining critical analytical insight. I learned to present participant framings authentically while also offering analytical interpretations that might reveal patterns or implications that participants themselves might not explicitly articulate. I

developed the practice of writing separate reflexive memos (see box 3.1) that documented my emotional responses and personal reactions alongside analytical memos that focused on theoretical interpretations and research implications. This dual documentation system enabled me to acknowledge the human dimensions of my research whilst maintaining analytical rigour.

Box 3.1: Reflexive Note – Personal Reflections on Analysis

- Caught myself interpreting women’s volunteering through “empowerment” lens – feels very Western.
- Participants spoke more about duty, religion, and family expectations—not individual agency.
- Realised I might be over-reading based on my academic background.
- Felt torn—how to honour their views but still analyse critically?
- Need to stay grounded in what participants actually mean, not what I expect to find.

The final stage of analysis involved integrating insights from interviews, focus groups, documents, and observations to develop comprehensive understanding of each focal area. This integration process required careful attention to how different data sources might provide different perspectives on the same phenomena. For example, document analysis of healthy cities policies revealed comprehensive frameworks for community engagement and asset mobilisation. However, interview data with community participants provided more complex perspectives on how these policies functioned in practice. Some participants described meaningful involvement in community health planning, while others felt that their participation was largely symbolic or that their perspectives were not genuinely incorporated into planning processes. Rather than treating these different perspectives as contradictory, I interpreted them as revealing the complexity of policy implementation and the variable experiences that might result from the same policy framework. This analytical approach enabled nuanced understanding of implementation challenges and opportunities that would not have emerged from single data source analysis. Similarly, observational data about informal community support networks revealed sophisticated asset mobilisation practices that were not captured in formal documents or interview discussions about official programmes. Women's informal support networks had developed systematic approaches to identifying community needs, mobilising resources, and coordinating assistance that embodied asset-based principles but were not recognised in formal health system planning.

The integration of multiple data sources revealed both convergences and divergences that enriched analytical understanding. Convergences provided confidence in analytical

interpretations and revealed patterns that appeared across different contexts and data types. Divergences revealed complexity and highlighted the importance of attending to multiple perspectives rather than seeking simple consensus. Table 3.2 demonstrates how each data source contributed to understanding the three proxy interventions, showing the specific insights gained from interviews, focus groups, documents, and observations across the different thematic areas. The matrix illustrates the triangulation achieved through the bricolage approach, with colour coding indicating the relative contribution level of each data source to theme development. This systematic integration ensured that no single data source dominated the analysis whilst enabling comprehensive understanding of how interventions with asset-based principles functioned within Saudi contexts. This comprehensive integration process ensured that the final analysis captured the full complexity of how these proxy interventions operated within Saudi contexts whilst maintaining analytical coherence through the realist evaluation framework.

Table 3-2 Data Source Integration Matrix

-  *Highly contribution*
 *Medium contribution*
 *Supporting contribution*

Data Source	Emergent Themes		
	Healthy City	Health Coaching	Volunteering Work
Semi-Structured Interviews (n=41: 11 formal + 22 informal + 7 stakeholder + 1 police officer)	Policy implementation perspectives • Local government views on healthy city initiatives • Healthcare worker experiences with community programmes • Stakeholder opinions on feasibility and challenges	Professional and personal experiences • Healthcare providers' views on coaching approaches • Individual behaviour change perspectives • Training needs and capacity requirements	Community participation insights • Personal volunteering experiences • Motivations and barriers to participation • Cultural factors influencing engagement

Focus Group Discussions (n=3: Mixed healthcare workers, Male healthcare workers, Female volunteers)	Collective professional perspectives • Team-based views on healthy city integration • Workplace culture and implementation • Collaborative planning discussions	Peer learning and training insights • Group discussions on coaching effectiveness • Shared experiences and best practices • Professional development needs	Community mobilisation dynamics • Group volunteering experiences and networks • Gender-specific participation patterns • Social support and community connections
Documentary Sources (Healthy City documents, Health coaching materials, Volunteering data)	Official policy framework • Al-Jumum Healthy City Initiative documentation • Strategic plans and implementation guidelines • Formal asset-based approach alignment	Programme structure and content • Health coaching syllabus and curriculum • Training materials and methodologies • Institutional support frameworks	Participation data and trends • Volunteering statistics and demographics • Activity types and frequency patterns • Organisational structures and support
Field Observations (Community spaces, Health facilities, social interactions)	Physical infrastructure context • Community spaces and facilities • Environmental health assets • Municipal development indicators	Interaction patterns • Healthcare provider-patient dynamics • Communication styles and approaches • Cultural considerations in service delivery	Community engagement practices • Observed volunteering activities • Social networks and informal support • Cultural practices

			and community events
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Note: Matrix showing how different data sources (interviews, focus groups, documents, observations) contributed to understanding each of the three main proxies. The colour coding indicates the relative contribution level of each data source to theme development, demonstrating the triangulation achieved through the bricolage approach.

3.10 Ethical Considerations and Methodological Reflections

The ethical dimensions of this research extended far beyond formal approval processes to encompass ongoing ethical decision-making throughout fieldwork, analysis, and representation. While I received formal ethical approval from both the University of Glasgow Ethics Committee and the Saudi Ministry of Health, the reality of conducting research across cultural contexts presented complex ethical considerations that required continuous attention and adaptive responses.

3.10.1 Formal Ethics and Cultural Responsiveness

The research received formal ethical approval through established institutional processes, ensuring compliance with both UK and Saudi ethical standards. The main ethical risks identified at the approval stage included several key concerns that would require ongoing attention throughout the research process. Beneficence concerns focused on ensuring that the research would benefit rather than harm participants and communities. Given that I was studying community assets and health promotion approaches, there was potential for my research to contribute positively to community health planning. However, I also needed to ensure that research participation did not create unrealistic expectations about immediate improvements or that my presence did not disrupt existing community dynamics. Non-maleficence considerations centred on protecting participant confidentiality in a context where criticism of health services could have professional or social consequences. Healthcare providers who shared concerns about institutional practices needed assurance that their perspectives would not be attributed to them in ways that could affect their professional standing. Community members who discussed informal support networks needed confidence that their activities would not be misrepresented or subjected to unwanted official attention.

Autonomy issues related to voluntary participation within hierarchical cultural structures where direct refusal might be culturally inappropriate or professionally risky. Saudi cultural contexts emphasise respect for authority and collective decision-making (Al-

Rasheed, 2010) that could complicate individual autonomous choice about research participation. I needed to develop approaches that genuinely supported voluntary participation whilst respecting cultural communication patterns. Justice concerns focused on ensuring that diverse voices were heard despite cultural barriers to participation. Gender dynamics, generational differences, socioeconomic variations, and educational background could all influence whose perspectives were included in the research. I needed to actively work to include perspectives from community members who might not typically participate in formal research or community consultation processes.

My positioning as a Saudi researcher educated in global north contexts created unique ethical considerations about representation, cultural interpretation, and research responsibility. This positioning enabled cultural understanding that might not be accessible to outside researchers, but it also created responsibilities for accurate and respectful representation of Saudi community perspectives. My Saudi background provided cultural credibility that facilitated research access and participant trust. Community members often commented positively on my ability to understand cultural references, communicate in appropriate cultural styles, and respect cultural protocols. However, this cultural credibility also created ethical responsibilities for representing community perspectives accurately and avoiding misrepresentation that might reinforce stereotypes or misconceptions about Saudi communities. During interviews, participants sometimes made comments like "you understand how our culture works" or "you know what I mean" that assumed shared cultural understanding. While these comments reflected positive rapport, they also created risks that I might assume understanding without adequate exploration or that participants might not provide full explanations because they assumed I already understood their perspectives. I addressed this challenge by explicitly asking for clarification even when I thought I understood cultural references, developing the practice of saying things like "I want to make sure I understand your perspective correctly" or "can you explain what you mean by that?"

3.10.2 Power Dynamics and Research Relationships

One of the most significant ongoing ethical challenges involved navigating power dynamics within Saudi society's hierarchical structures, which manifested not only in research relationships but also in institutional access processes that could limit research scope. These dynamics became apparent early in my fieldwork when I sought to interview the mayor of Al-Jumum as a key community stakeholder who could provide valuable insights into community health planning and resource allocation. However, accessing this

level of government official required navigating complex bureaucratic power structures that extended beyond my initial ethical approval processes. To conduct interviews with municipal officials, I would have needed to obtain additional ethical approval from the Ministry of Municipal and Rural Affairs and Housing, which oversees local government operations and community development initiatives. This requirement reflected the hierarchical nature of Saudi institutional structures, where different ministries maintain distinct approval processes for research access to their personnel. While my existing ethical approval from the Ministry of Health covered healthcare providers and community health-related activities, municipal officials fell under different institutional authority that required separate approval processes.

The time constraints of my fieldwork period made pursuing this additional approval process impractical, as ministerial approval procedures typically require several months of processing time, document review, and institutional coordination. This institutional barrier highlighted how power dynamics within government structures can inadvertently limit research access and potentially skew research findings toward perspectives that are more easily accessible through existing approval channels. The inability to include municipal perspectives meant that my research captured community and healthcare provider viewpoints but lacked insights from local government officials who play crucial roles in community development and resource allocation decisions that influence health outcomes.

This experience illustrated how hierarchical power structures can create systematic exclusions in research participation that extend beyond individual choice or researcher bias to encompass institutional barriers that determine whose voices can be included in academic research. While I adapted my research approach to maximise insights from accessible participants, the structural limitation of ministerial approval processes represented an institutional power dynamic that shaped research boundaries in ways that could not be overcome through methodological adaptation alone.

Gender dynamics intersected with cultural authority in ways that required ongoing ethical reflection about research design and representation. Continuing with mixed-gender research approaches would have been ethically problematic because it would have systematically excluded female perspectives despite female presence in research activities. The adaptation to single-gender focus groups represented an ethical response to cultural norms that enabled more authentic participation from both male and female participants. However, this adaptation also required careful consideration of how to present research findings without reinforcing gender stereotypes or suggesting that gender-segregated

research approaches were inherently superior to integrated approaches. I documented these gender dynamics carefully in my reflexive notes, see box 3.2, paying attention to how cultural accommodation might interact with feminist research principles. While I respected cultural preferences for single-gender research settings, I also maintained analytical attention to how gender dynamics influenced community asset mobilisation and health promotion activities. This required balancing cultural responsiveness with critical analytical awareness, ensuring that methodological adaptations enhanced rather than compromised the research's ability to capture diverse perspectives on community health approaches.

Box 3.2: Reflexive Note – Gender Dynamics in Fieldwork

- One of the ladies did not speak at all and was shy when I sked her (her voice was hard to hear)
- I think I will need to do something about this (maybe talk to her after we finish)?
- She was holding her pen and looking at the notebook in her hand
- The other lady received a phone call and went out to answer it
- She was looking at her phone a lot; I felt that she was checking the time.

Through extended fieldwork, I developed genuine personal connections with several participants that extended beyond formal research relationships. Some participants offered assistance with practical needs during my fieldwork and several expressed interest in maintaining contact beyond the research period. These developing relationships created ethical questions about appropriate boundaries and ongoing obligations. While these personal connections enriched my cultural understanding and enabled deeper research insights, they also created responsibilities for maintaining respectful relationships and avoiding exploitation of personal trust for research purposes. I navigated these considerations by being transparent about my research role whilst honouring the personal connections that had developed. I maintained contact with participants who expressed interest in ongoing relationship, sharing research progress and outcomes when appropriate. However, I also maintained clear boundaries about using personal relationships to access additional research information without explicit consent.

3.10.3 Representation, Translation and Community Benefit

The process of representing participants' perspectives within English academic discourse raised fundamental ethical questions about cultural integrity and meaning preservation. The challenge extended beyond linguistic translation to encompass how cultural

knowledge could be shared across academic boundaries while maintaining respect for participant worldviews and avoiding misrepresentation.

A primary ethical concern involved the risk of cultural stereotyping or orientalist interpretations that might exoticise or misrepresent Saudi community practices. As Said (1978) demonstrates in his foundational work *Orientalism*, global north academic discourse has historically constructed knowledge about Middle Eastern societies in ways that serve imperial interests rather than representing authentic cultural realities. Global north academic audiences might approach research findings with preconceptions about Saudi society that could distort understanding of participant perspectives. This created an ethical responsibility to present community practices in ways that challenged rather than reinforced stereotypes. For instance, when representing women's community organising activities, I needed to ensure these were understood as sophisticated social coordination rather than merely traditional gender roles. Similarly, when religious frameworks influenced health approaches, the ethical imperative was to present religious motivation as thoughtful ethical commitment rather than uncritical traditionalism.

The question of community benefit versus academic extraction represented another central ethical tension. Academic research traditionally prioritises knowledge generation for scholarly audiences, potentially creating extractive relationships where communities provide data but receive limited benefit from research outcomes (Smith, 2021). This raised ethical questions about research reciprocity and the distribution of research benefits. The challenge was particularly acute in cross-cultural research where academic outputs might be less accessible to participating communities due to language barriers and academic formatting.

The dominance of English in academic publishing created ethical concerns about equitable access to research findings. While research outputs would be available to international academic audiences, the primary beneficiaries of research insights—the Saudi communities that participated—might have limited access to findings presented in English academic formats. This highlighted questions about whose knowledge was being served by the research and whether academic conventions might inadvertently marginalise the very communities whose perspectives were being studied.

These ethical considerations required ongoing attention throughout the research process, as decisions about representation, dissemination, and community engagement carried

implications for cultural respect, participant dignity, and research equity that extended far beyond methodological concerns.

3.10.4 Methodological Limitations and Ongoing Reflexivity

While this methodological approach proved valuable for addressing my research questions, it also presented limitations that must be acknowledged and that provide insights for future research development. The bricolage approach that enabled responsiveness to Saudi cultural contexts created challenges for transferability to other research settings and for replication by other researchers. The methodological adaptations that emerged through my fieldwork were context-specific and reflected particular cultural encounters, community dynamics, and researcher positioning that might not be present in other research contexts. Transferability should therefore be understood analytically rather than statistically.

Because rurality is contested and context-dependent, Al-Jumum should not be treated as representative of all rural communities in Saudi Arabia, the Middle East, or the wider Global South. Instead, the findings may be transferable to contexts that share similar characteristics, such as recent rural histories, rural/peri-urban transformation, strong family and social networks, links to larger urban centres, uneven access to services, and health system reforms that emphasise community participation. The purpose of providing detailed contextual and methodological description is therefore to allow readers to judge whether the findings are relevant to other rural/peri-urban settings, rather than to claim direct generalisability to all rural communities. The adaptation to single-gender focus groups, for example, emerged from specific observations of gender dynamics in Al-Jumum that might not characterise other Saudi communities or other Arab contexts. While the principle of attending to gender dynamics in research design has broader relevance, the specific adaptation might not be appropriate or necessary in different cultural contexts. Similarly, the identification of healthy cities, health coaching, and volunteering as proxy interventions for asset-based approaches reflected specific institutional and community characteristics of the Saudi health system and Al-Jumum's community context.

The reliance on a single researcher for data collection, while providing consistency and continuity, created potential limitations in perspective and interpretation. Alternative viewpoints and interpretations might have been missed due to individual researcher assumptions, cultural positioning, or theoretical commitments that influenced observation and analysis. The researcher's positioning as a Saudi national educated in global north contexts provided particular advantages for cultural understanding and participant access, but it also created specific limitations. Participants might have made assumptions about

shared cultural understanding that limited explanation of cultural practices and perspectives. The requirement for formal ethical approval from Saudi institutions, while essential for legitimate research access, might have influenced how participants perceived the research and what perspectives they felt comfortable sharing. Some participants might have been concerned about potential consequences of criticising health system practices or discussing informal community activities that operated outside official recognition.

Throughout my research, I kept regular reflexive notes where I recorded ethical concerns, decisions I made during fieldwork, and what I was learning about being culturally sensitive and responsible. These notes helped me reflect on the real ethical challenges I faced in the field—challenges that were often more complex than what was covered by the official ethical approval. Rather than treating ethics as just my own responsibility, I often discussed issues with participants, my supervisors, and local colleagues. Their input helped me see things from different perspectives and sometimes made me aware of concerns I would not have recognised on my own. As the research progressed, I realised that being ethical in a cross-cultural setting meant being flexible and responsive to the local context. I had to adapt my approach based on what was happening in real time, rather than relying on a strict set of predefined rules. While the formal ethics approval provided a useful foundation, the real ethical work happened during ongoing interactions in the field. This adaptive approach allowed me to stay true to both the values of the community and the principles of high-quality academic research.

3.11 Conclusion

This methodology chapter has documented the evolution from a structured methodological framework to a culturally responsive bricolage approach that maintained analytical rigour whilst accommodating the complexities of studying asset-based approaches in Saudi communities. The methodological approach that emerged represents a significant contribution to cross-cultural health research, demonstrating how the integration of bricolage methodology with realist evaluation principles can create new forms of methodological rigour through responsive adaptation (Kincheloe, 2001). This combination enabled the integration of global north theoretical frameworks with Saudi cultural knowledge whilst honouring both academic analytical traditions and community expertise, addressing the fundamental challenge of how knowledge is produced and validated across cultural boundaries.

The identification and study of proxy interventions—healthy city initiatives, health coaching, and volunteering programmes—represents an original methodological

contribution to implementation research that addresses a common challenge where global north-developed interventions may not exist as formal programmes in target contexts. This approach enabled study of asset-based approach feasibility through existing Saudi practices rather than imposing external intervention models, while the critical realist ontological foundation allowed examination of underlying mechanisms and structures that might not be immediately visible but were essential for understanding how asset-based principles operated within Saudi cultural and institutional contexts. The proxy intervention methodology provides a template for studying complex health interventions across cultural boundaries where direct translation of global north concepts proves problematic.

The translation challenges encountered highlighted both the complexity of representing cultural knowledge within global north academic discourse and the inherent tensions in applying global north public health concepts such as asset-based approaches to global south contexts. The development of strategies for preserving cultural meaning whilst making findings accessible to English-speaking audiences demonstrates how methodological adaptations can enhance rather than compromise research quality. This responsive methodology provides a framework for conducting culturally grounded research that serves both scholarly and community needs whilst maintaining analytical integrity. The systematic documentation of adaptive processes offers a model for methodological accountability that future cross-cultural health researchers can adapt to their own contexts.

Building upon this methodological foundation, the following three chapters present detailed empirical analysis of these proxy interventions as case studies. Chapters 4, 5, and 6 examine how existing health initiatives in Al-Jumum demonstrate asset-based potential when viewed through realistic evaluation and asset-based community development theoretical frameworks. Each case study applies Context-Mechanism-Outcome configurations to understand how these interventions operate and what they reveal about asset-based implementation feasibility within the Saudi context. These empirical chapters integrate the multiple data sources and adaptive methodological strategies described in this chapter to build comprehensive understanding of each intervention's asset-based potential. This methodological framing also clarifies that Al-Jumum is treated in this thesis as a rural/peri-urban context, not as a representative example of all Saudi rural communities, and that claims of transferability are limited to settings with comparable socio-cultural, institutional, and rural-urban characteristics.

Chapter 4 Al-Jumum's Healthy Cities Network

4.1 Introduction

In recent decades, there has been a growing recognition of the need to empower communities and leverage their inherent strengths and assets to address complex health and social challenges. This recognition builds upon the foundational principles established by the Ottawa Charter for health promotion (World Health Organization, 1986), which emphasised the importance of creating supportive environments and strengthening community action as fundamental strategies for health improvement. The World Health Organization's Healthy Cities Approach emerged from this broader 'settings approach' to public health, which recognises that health is created and lived within the ordinary settings of people's daily lives - where they learn, work, play, and love. The Healthy Cities Approach aligns closely with both the Ottawa Charter's vision and asset-based principles, emphasising the importance of community participation, empowerment, and capacity building as key strategies for promoting sustainable health and well-being. By engaging local stakeholders and harnessing community resources, the Healthy Cities Approach aims to create healthier and more equitable urban environments (Davies and Kelly, 2014).

As discussed in Chapters 1–3, Al-Jumum is treated in this thesis as a rural/peri-urban Saudi context rather than as a fixed or uncontested rural community. This framing is important for interpreting the Healthy Cities initiative because although the city has experienced significant urban and infrastructural development, it retains strong social, cultural, and economic connections with surrounding villages and rural communities. Participants frequently described local life through reference to community cohesion, family and tribal networks, volunteering practices, and collective forms of support that they associated with rural living. Consequently, the Healthy Cities initiative is examined within a rural/peri-urban context, recognising that the relevance of the findings lies not in representing all rural communities, but in understanding how asset-based principles operate within a setting characterised by overlapping rural and urban features.

“Although Al-Jumum has developed significantly in recent years, many people still know each other in the neighbourhoods and maintain the same relationships that existed when it was a small village. We still depend on family, neighbours, and relatives when help is needed.” (The first stage interviews, Local Citizen, I7).

“We have hospitals, schools, and government services now, but the social life is still similar to old days. People cooperate, volunteer, and support one another,

especially during community events and when families need help.” The first stage interviews, A Police Officer, I5).

“Al-Jumum has changed a lot in recent years. Anyone who visited five years ago would notice major improvements in the roads and services. Still, many residents, especially older people, value the simpler days and continue to preserve traditions such as sharing homemade Ramadan breakfasts at the mosque and decorating their neighborhoods for Eid.” ” The third stage interviews, A Local Policymaker, I6).

This chapter addresses the central research question - what factors influence the feasibility of implementing asset-based approaches to health in Saudi rural/peri-urban communities? - by examining Al-Jumum's participation in the WHO Healthy Cities Network as a proxy intervention. The analysis investigates community assets mobilised through Healthy Cities initiatives (Research Sub-Question 1), identifies barriers that hinder adequate health service provision through top-down policy implementation (Research Sub-Question 2), explores factors affecting implementation decisions within formal policy frameworks (Research Sub-Question 3), and examines how current health policies create both opportunities and constraints for asset-based approaches (Research Sub-Question 4). Additionally, it demonstrates how decision makers and community members differently influence implementation possibilities through their varying levels of engagement with international health promotion frameworks (Research Sub-Question 5).

The chapter evaluates the implementation of the healthy cities approach in Al-Jumum, Saudi Arabia, to assess to assess how asset-based principles may operate within a Saudi rural/peri-urban context. The analysis utilises a realistic evaluation framework to examine the contextual factors, mechanisms, and outcomes associated with the Healthy Cities Approach, exploring how this programme's experiences can inform the potential adoption of asset-based strategies in Saudi communities.

4.2 Background

4.2.1 The Healthy Cities Network (HCN) versus the Healthy Cities Approach

The Healthy Cities Approach was initiated by the World Health Organisation (WHO) in 1986 as a comprehensive response to urban health challenges, building upon the foundations established by the Ottawa Charter and the broader settings approach to public health. This approach must be contextualised within the historical development of 'settings' as a public health strategy, which emerged from recognition that health is created and lived within the ordinary settings of people's daily lives - where they learn, work, play, and love.

The settings approach, rooted in the principles of the Ottawa Charter for Health Promotion, emphasises the importance of creating supportive environments and strengthening community action (Davies and Kelly, 2014), principles that directly inform the Healthy Cities methodology and align closely with asset-based approaches in their shared focus on community empowerment and local capacity building

A crucial distinction must be established between the Healthy Cities Approach and the Healthy Cities Network, as these terms represent different conceptual frameworks that reflect an underlying tension in implementation (De Leeuw, 2009; Dooris, 2009). The Healthy Cities Approach can be understood as both a fixed set of principles requiring cities to conform to established WHO criteria (World Health Organization, 2015b), and simultaneously as a looser collection of notions that allow for local flexibility in implementation (Heritage & Dooris, 2009). The Healthy Cities Network, conversely, represents the organisational structure through which these approaches are operationalised and coordinated across participating cities (De Leeuw, 2009; Flynn, 1996).

The WHO defines the Healthy Cities Approach as "the process that creates the possibility of health in people" (World Health Organization, 2015b), establishing it as an intersectoral platform for health and social development that should be integrated into the organisational structure of government offices, reflecting high-level official political commitment and ownership (Al-Fiqi, 2018). For its proponents, the Healthy Cities Approach uses community participation as a method to promote health equity, reduce inequalities, gain health benefits, and promote mental and social well-being in different communities worldwide (Davies and Kelly, 2014, World Health Organization, 2015b). It is seen as a means of supporting the process of community empowerment (Heritage and Dooris, 2009).

The WHO initiated the Healthy Cities Approach to create and improve physical and social environments and expand community resources that enable people to support each other in life (Heritage and Dooris, 2009). It first began in Canada and Europe, then expanded all over the world (Flynn, 1996). It started with the concept of establishing a network of cities committed to health and sustainable development (De Leeuw, 2009). The Healthy Cities Network operates based on a social model of health, aiming to address more distal determinants of health, including institutional change for health (ibid.). The network functions by developing and implementing city health development plans, forging effective partnerships with other city departments and sectors, and addressing equity (ibid.). It also works by influencing policies, adhering to principles, and involving various actors (ibid.).

The network's operations are inspired by ideological, theoretical, and evidence-based perspectives, resulting in a dynamic, complex, and diverse landscape of initiatives, plans, programmes, and actions (ibid.).

The Healthy Cities Network has achieved notable influence since its inception in the 1980s, affecting thousands of cities around the world and providing added value to urban performance, particularly in health and sustainable development arenas (De Leeuw, 2009). The network has been successful in forging partnerships with other city departments and sectors, addressing equity, and developing city health development plans (ibid.).

Critics of the Healthy Cities movement have maintained that little evidence of its success and effectiveness has been generated, with this critique finding its foundations in perceptions of evidence, the politics of science and urban governance, and perspectives on the preferred utilities of evidence-based health notions (De Leeuw, 2009). This critical perspective highlights the ongoing debate about whether Healthy Cities represents a meaningful intervention or merely a bureaucratic exercise in meeting predetermined criteria. The Healthy Cities Approach encompasses 11 key characteristics (World Health Organization, 2015b), including:

1. A high quality, clean and safe physical environment.
2. A long term stable and sustainable ecosystem.
3. A strong and supportive community.
4. A high degree of community participation in decisions affecting their lives, health, and well-being.
5. Meeting the basic needs for all citizens, such as food, water, shelter, and work.
6. Facilitate access to a wide variety of resources.
7. A diverse, vital, and innovative community economy.
8. Encourage connecting with cultural and biological heritage, and other individuals.
9. An optimum level of public health services accessible to all.
10. High health status; and
11. A city form that is compatible with and enhances the above 10 parameters and behaviours.

4.2.2 Alignment with Asset-Based Approaches

Asset-based approaches and the Healthy Cities Network share fundamental conceptual foundations that make this comparison particularly relevant for understanding

implementation feasibility in the Saudi context. Both approaches prioritise community participation, empowerment, and equity as key elements of their work (McLean et al., 2017, Heritage and Dooris, 2009), though the extent to which these principles are realised in practice varies considerably (De Leeuw, 2009). The theoretical alignment between these approaches provides a foundation for examining how Healthy Cities implementation might inform asset-based approach feasibility (Davies and Kelly, 2014), whilst acknowledging that such alignment does not guarantee practical compatibility. The following table (Table 4.1) shows the common key concepts associated with ABAs and HCN.

Table 4-1 The Key Concepts Associated with Asset-Based Approaches and the Healthy Cities Approach

The Key Concepts	ABAs	HCN
Strengths-Based and empowerment	This concept recognises and values the unique strengths, skills, resources, and successes of individuals and communities. It is about strengthening the factors that support health and well-being (McLean et al., 2017).	HCN aims to empower local people by developing strategies that include commitment, understanding, competencies, and resources (Heritage and Dooris, 2009).
Participatory	Participatory processes are central to asset-based approaches. Community members are encouraged to be involved in decision-making processes, and their knowledge, skills, and perspectives are valued and integrated into the development of strategies and initiatives (GCPH, 2012).	Participation is a core value underpinning the Healthy Cities movement. HCN supports public participation and involvement in decision-making, and encourages community representatives to participate in decision-making (Heritage and Dooris, 2009).
Collaboration	This concept is essential to asset-based approaches. It involves bringing together diverse stakeholders, such as community members, government agencies, non-profit organisations, and	HCN emphasises that key stakeholders and local citizens must collaborate to create the conditions necessary to make change possible (Heritage and Dooris, 2009).

	businesses, to work towards common goals (GCPH, 2012).	
Holistic	ABA is holistic and multidisciplinary. It recognises and builds on a combination of human, social, and physical assets that exist within the community (GCPH, 2012).	HCN recognizes that health is influenced by social, economic, and environmental factors. It adopts a holistic approach to address these factors comprehensively to improve health outcomes. It sustains intersectoral partnerships (de Leeuw, 2011).
Equity	This is another key concept in ABA. This approach is about mobilising assets, promoting equity, and increasing individuals' control over their lives and health. Applying this approach is the first step towards equity (Montañez, 2023).	The Healthy City emphasises the importance of equity in health promotion. It aims to promote equitable access to resources, opportunities, and services for all members of the community (World Health Organization, 2015b).
Long-term interventions	ABA is long-term. As it prioritises identifying and building on the strengths and assets of a community to promote sustainable development, it aims to create lasting change that will benefit the community over the long term (GCPH, 2011).	This programme is developed as an integral part of long-term strategic development (Heritage and Dooris, 2009).

4.2.3 The Healthy Cities Approach in the Saudi Context

The Healthy Cities Network was established in the Eastern Mediterranean region in 1990, first implemented in the Islamic Republic of Iran before expanding to Afghanistan, Bahrain, Iraq, Oman, Pakistan, Saudi Arabia, and Sudan (World Health Organization, 2010). Mainly, WHO selects cities that are committed to providing a safe and sustainable healthy environment for their citizens and that encourage adopting healthy and clean

lifestyles (Al-Fiqi, 2018). Through collaboration with local communities, the WHO helps implement programmes and projects aimed at promoting health, wellbeing, and public safety, including improving access to basic health services, disease prevention, healthy nutrition, and public hygiene and health education (ibid.).

To achieve Healthy Cities accreditation, candidate cities are assessed according to 80 indicators (World Health Organization, 2010). These indicators include asset-based approach-associated areas related to community organisation and mobilisation for health and development; intersectoral collaboration, partnership, and advocacy; microcredit activities; education and literacy; health development; water, sanitation, food safety, and air pollution; community-based information centres; skills development, vocational training, and capacity-building; and emergency preparedness and response (Al-Fiqi, 2018, World Health Organization, 2010). In Saudi Arabia, the Healthy Cities Approach was launched in 1998 (Alasqah et al., 2021). It has been expanding through different stages (ibid.). Currently, 30 cities have joined the programme, and nine of them have obtained the accreditation of healthy cities by the WHO (ibid.).

I noticed that most of these indicators were fundamentally aligned with principles central to asset-based approaches, particularly those emphasising community mobilisation, capacity building, and intersectoral collaboration. However, within the Saudi context, the document framed these activities within national health policy language and WHO standardised terminology rather than explicitly adopting asset-based frameworks or vocabulary. This observation highlighted an interesting tension between the practical implementation of asset-based principles and the formal policy discourse used to describe and legitimise these activities within the Saudi health system context.

The Healthy City initiative provided a formal institutional framework that embodied asset-based principles without explicitly referencing asset-based approaches. This meant I could study how asset-based principles functioned within Saudi institutional contexts whilst examining an initiative that had official legitimacy and practical implementation experience. However, it is important to acknowledge that Healthy Cities initiatives have been subject to substantial critique regarding their potentially top-down nature and limited authentic community participation. As Stern and Green (2008) demonstrate in their analysis of community participation in Healthy Cities projects, while such initiatives may offer communities "a seat at the table" (p.391), statutory authorities often control the form and content of meetings in ways that can elide the structural imbalance between contributing participants. This tension between formal community engagement

mechanisms and genuine grassroots empowerment represents a critical methodological consideration when studying asset-based approaches through institutional proxies.

My analysis of the Healthy City documentation revealed several elements that aligned closely with asset-based approaches: emphasis on community participation in health planning, attention to social determinants of health, integration of community resources into health promotion activities, and recognition of community knowledge and expertise. However, these elements were embedded within a framework that emphasised government leadership and institutional coordination rather than community empowerment and asset mobilisation. This institutional framing raised important questions about whether formally structured initiatives could genuinely embody asset-based principles or whether governmental oversight inherently constrained the community-driven nature that is central to asset-based approaches. This is particularly important in Al-Jumum because the Healthy Cities initiative operates in a context that is formally framed as a city but socially and historically connected to rural and village-based forms of community life. The use of the Healthy Cities initiative as a proxy intervention is therefore not intended to treat Al-Jumum as a conventional urban setting, but to examine how an international urban health promotion framework is adapted within a Saudi rural/peri-urban context.

4.3 Examining the Dynamics of the Healthy Cities Approach in Al-Jamoum: A Realistic Evaluation

To analyse the Healthy Cities Approach in Al-Jumum as a proxy intervention that can inform the feasibility of asset-based approaches in this Saudi rural/peri-urban context, the realistic evaluation framework, that was first introduced by Pawson and Tilly (1997), is used.

The purpose of this section is to assess the feasibility of implementing asset-based approaches in Al-Jumum as a Saudi rural/peri-urban community context (outcome) by analysing the Healthy Cities Approach as a proxy mechanism and identifying the contextual factors that shaped its implementation.

4.3.1 Contextual Factors in Al-Jumum

The key stakeholders in the Healthy Cities Approach included representatives from various ministries and sectors: municipality, education, environment, social affairs, health, police, emergency preparedness and response teams, media, civil society sponsors, and private sector organisations. Interviewing these stakeholders was essential to the research because their contributions helped uncover intervention mechanisms leading to outcomes in

specific contexts (Evans et al., 2020). Their involvement proved crucial for checking the feasibility of asset-based strategies, providing insight and suggesting methods for accessing target populations, and offering ongoing feedback and recommendations. The quality of stakeholder engagement was associated with their roles and positions in the implementation process and provided greater confidence in key findings connecting particular mechanisms in specific contexts with change, helping develop the programme theories underpinning this research.

In Al-Jumum case, the Healthy Cities Approach started more than 10 years ago (Al-Fiqi, 2018). The city participated in the WHO campaign (A Thousand Cities, a Thousand Lives) in 2010, aiming to take action that benefits the health of the city (ibid.). This work was run mainly by the Ministry of Health (MOH) and the Healthy Cities Coordination Office (ibid.). From March 10 to 12, 2018, a formal evaluation visit was made to evaluate the city and ensure that it met all 80 indicators (ibid.). The evaluation visit included a meeting with the Healthy Cities coordination team with representatives of various relevant sectors, such as the municipality, education, environment, social affairs, health, police, emergency preparedness and response team, the media, some sponsors of the Healthy Cities from civil society, and the private sectors, as well as conducting field visits to the municipality, schools, non-governmental organisations, a health centre, police stations, the Social Development Centre, Umm Al-Qura University, and the governor's office (ibid.). By the end of the visit, it was announced that the city had achieved all 80 of the WHO Healthy Cities Approach's indicators and had received accreditation (ibid.).

Since Al-Jumum achieved WHO accreditation as a Healthy City, understanding this context is important for assessing the potential feasibility of the asset-based approach. A range of contextual factors identified by interviewees have been recognised as supportive of achieving the desired research outcomes. These contextual factors include the establishment of supportive networks, the development of trusting relationships, and the identification and utilisation of local assets and opportunities. One significant contextual factor highlighted in the interviews was the necessity of providing support, advice, and connection within the community through local formal bodies that can help encourage positive thinking about new interventions. This foundation of institutional support creates an enabling environment for community engagement and participation. One interviewee suggested that these would be afforded by a local formal body, which can help encourage people to think positively about the new intervention.

“You have to find ways to increase people’s awareness about the approach you are introducing; you have to show them how this approach will benefit them by doing different public activities and workshops. You can also do this by seeking the help of formal bodies such as hospitals and schools. I believe that starting with them will encourage the rest of the community to participate. At least, this is what we did in the Healthy Cities Programme. Anyway, you have to show them your support for their interests” (The third stage interviews, local policymaker, I1).

The contextual significance of Al-Jumum extends beyond its administrative status as a city. Throughout the interviews, participants frequently referred to characteristics associated with rural living, including close social relationships, strong family and tribal networks, collective community action, and longstanding connections between the city and surrounding villages. These findings support the argument developed in Chapters 1 and 2 that Al-Jumum is best understood as a rural/peri-urban setting in which rural and urban characteristics coexist. This context is particularly important when examining asset-based approaches because many of the assets identified by participants were embedded within social relationships, community networks, and forms of collective support that have historically characterised rural communities.

Another fundamental contextual element emphasised throughout the interviews was the critical importance of establishing positive, trusting relationships between programme staff and local citizens. It was suggested that this positive relationship is the basis for engaging people and encouraging them to accept changes and new interventions. It was identified that this trusting relationship is important for local citizens to accept new programmes. It was also suggested that in order for a programme to work, it is important to allow the community to interact with someone they trust.

“If you want to implement the programme you are doing your research on successfully here, you have to have the trust of the people here. If they do not trust you, they will not accept anything you provide them. You can do that by starting with a key person in the community, contacting him or her, getting his or her trust, and asking him or her to help you with the rest of the individuals” (The third stage interviews, national policymaker, I3).

Additionally, the interviewees also emphasised the importance of accessing and utilising local opportunities and assets to enable citizens to develop their knowledge and skills and empower them to participate in improving their health and well-being. The city possesses

numerous local resources that could be leveraged to increase health awareness and improve health outcomes, representing a rich foundation of community assets that align with asset-based approaches. These resources demonstrate the community's existing capacity and infrastructure, which provides a strong foundation for future interventions.

Participants' accounts also showed that Al-Jumum's assets were not only physical or institutional, but also social and relational. As noted earlier in this chapter, participants continued to describe community life through relationships, familiarity, cooperation, and family-based support that they associated with its earlier village history. These accounts support the rural/peri-urban framing used in this thesis, because they show how urban development and rural social characteristics coexist in Al-Jumum.

These accounts demonstrate that rurality in Al-Jumum was experienced less as a fixed administrative classification and more as a socio-cultural condition connected to memory, social networks, mutual support, and continuing community relationships. Multiple interviewees also highlighted the physical and institutional assets available in Al-Jumum:

“The city includes different resources. For example, it has public parks that contain all services where people can walk, do exercises, and attend public activities that are organised by the ministry of health and other bodies.” (The first stage interviews, Health Professional, I4).

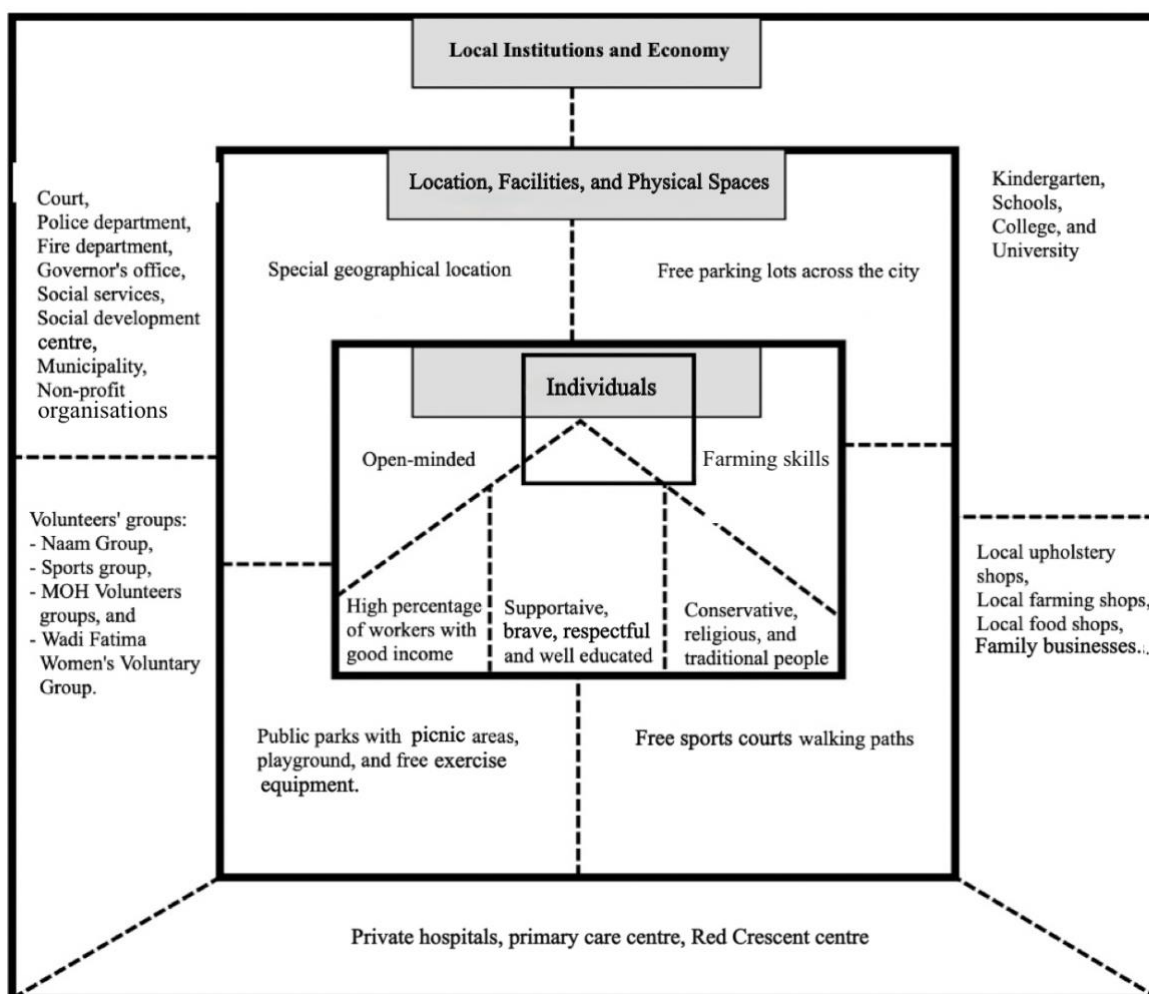
“We have a social security centre and a social development centre, as well as summer centres to hold some community events. There are also health clubs and parks where awareness programmes are conducted with the support of the Ministry of Health. Al-Jumum community is active. Public places such as the health walkway and free sports equipment are available to encourage people to exercise. People here are receptive to any new health-related events. They are a supportive community, active in community service events, and generally participate in collaborative community events” (The first stage interviews, A Police officer, I5).

A comprehensive assessment of Al-Jumum's assets reveals a diverse range of resources spanning cultural, social, economic, and infrastructural domains. These assets represent the cultural, regional, social, and economic contexts that contributed to the Healthy Cities Approach's success. The community demonstrates considerable potential for development, though this must be approached strategically to ensure acceptance and engagement. One health professional observed:

“I can say that people in Al-Jumum are open-minded and have the potential to change, but you have to know the first key step to encourage them. Any mistake you make, may affect you negatively and make people turn away from what you are trying to offer them. It took many years for the different bodies involved in implementing the Healthy City Initiative here to succeed and encourage people to accept this big change. We have many useful resources that can be used in achieving your goal, such as the parks and the natural sources of water and food. Al-Jumum is known for its agriculture, the volunteer programmes we have here, and many other” (The first stage interviews, Health Professional, I6).

Following comprehensive interviews with diverse community members, the following assets, in figure 4.1, were identified: natural resources including agricultural land and water sources; social infrastructure comprising volunteer groups, community centres, and religious institutions; physical infrastructure including parks, walking paths, sports facilities, and healthcare centres; institutional resources including schools, social development centres, and government offices; economic assets including local businesses

and agricultural enterprises; and human resources including skilled professionals, community leaders, and active volunteers.



In the city, the stakeholder cooperation that enabled programme establishment and successful accreditation represents another crucial contextual element. According to the head of the Healthy Cities coordination team, implementation involved multiple strategic steps: assessing the environment, facilitating planning, setting priorities, implementing targeted interventions, monitoring, evaluating, documenting, and following up on intervention implementation across different sectors. This systematic approach demonstrates the comprehensive nature of the programme's implementation strategy. As the coordinator explained:

"We initially had to put together a plan. It all began with a visit from the health ministry. We held a meeting to go over everything we need to do to make the necessary modifications. It was at this point that we realised we needed help from other organisations, so we organised another meeting and invited various ministries. We agreed upon a time and day, and then the process began. We got the

support, and we all cooperated together to get the job done.” (The third stage interviews, local policymaker, I1).

4.3.2 Mechanism in Al-Jumum's Healthy Cities Implementation.

The Healthy Cities network represents a comprehensive approach to improving health and well-being in urban areas. The approach emphasises collaboration across different sectors, including government, civil society, the private sector, and community members. This mechanism was selected because it aligns with the principles of the asset-based approach and was expected to function effectively within the community context, though the quality of available evidence must be acknowledged as primarily consisting of self-congratulatory accounts from policymakers rather than independent evaluation. During the interviews with the head of the Healthy Cities Approach coordination team, he described the work that has been done to implement the programme, and he provided a document including all the work steps that they have followed to successfully implement the programme and gain the accreditation.

The implementation work encompassed various strategic phases. Initially, a higher committee was established under the Governor of Al-Jumum's leadership, with membership from all concerned sector heads forming a support group. The Healthy Cities office then established programme subcommittees aligned with the main WHO Healthy Cities Approach indicator sets health, education, environment, and social development. Furthermore, it jointly planned necessary activities with different sectors related to the eighty standards, built communication channels and networks with sponsors, volunteers, and private sector stakeholders concerned with health development. This systematic approach demonstrates the programme's comprehensive scope while raising questions about the extent of genuine community engagement versus institutional coordination.

The programme facilitated the establishment of an intersectoral platform for health and social development, with intersectoral action reflected in organised work across all city sectors aimed at improving health and influencing its determinants. Under the Governor of Al-Jumum's leadership, general intersectoral actions that integrate health considerations into other sectors' policy processes, embodying a (Health in All Policies) approach (Al-Fiqi, 2018). This comprehensive approach to addressing social determinants of health represents a key mechanism through which the programme operated, recognising that health outcomes are shaped by factors beyond healthcare services, including education, environment, housing, employment, and social conditions. The programme's systematic attention to these broader determinants aligns theoretically with asset-based approaches,

which similarly emphasise addressing root causes rather than merely treating symptoms. However, this top-down approach raises questions about the extent to which this represents genuine intersectoral collaboration versus administrative coordination mandated from above.

The programme's actions included establishing family parks, walking paths, and sports parks; prohibiting tobacco sales within the city and smoking in indoor and recreational spaces; taking volunteering seriously, particularly among youth and women's groups to encourage local participation, ensuring community ownership and empowerment; encouraging schools to implement WHO health promotion activities including healthy foods and activities; and complementing Al-Jumum's health services with wide coverage through well-equipped mobile clinics in cooperation with civil society institutions, provided free of charge. These actions can be located within the broader 'settings' approach to public health, representing environmental and policy interventions designed to create healthier contexts for daily life.

The evidence available from interviews and documentation reveals limited detailed information about specific community engagement mechanisms beyond the establishment of volunteer groups, particularly amongst women and youth. Whilst the programme claimed to incorporate community participation, the data collected provides insufficient detail about formal platforms for community input or the processes through which residents could influence decision-making. This represents a significant limitation in assessing the extent of genuine bottom-up engagement versus top-down coordination with community participation elements. However, within these constraints, the programme did achieve some notable coordinated actions across sectors, though the nature of this coordination appears more administrative than transformational.

Implementation faced significant challenges, particularly regarding community acceptance. The coordination team head acknowledged:

“We faced refusals and denials from the people in the community; we had to work hard to start encouraging specific individuals in different sectors and increase awareness among them through workshops, social media, and formal events” (The third stage interviews, local policymaker, I1).

This resistance highlights the gap between institutional enthusiasm and community readiness for change, suggesting that initial implementation relied heavily on institutional

coordination rather than community-driven engagement. He noted that after a while, people became encouraged when they started to see some difference:

“It requires us to take many small steps until we reach the great success. It is a work that has been carried over the years” (The third stage interviews, local policymaker, I1).

While these accounts suggest eventual community acceptance, they must be balanced against the acknowledgement that initial community response was characterised by resistance and denial, raising questions about the depth and authenticity of subsequent engagement.

Contemporary community response is described positively by programme leaders:

“Today, the local citizens are happy and satisfied with the changes that this programme has made. Their awareness has increased. The programme has been met with enthusiasm and support, with residents taking an active role, and this is because of the encouragement of the volunteers’ groups. Many residents have expressed appreciation for the programme’s efforts to address local health and environmental issues, and there has been increased participation in community events and initiatives” (The third stage interviews, local policymaker, I2).

However, the limitations of accessing only positive accounts from programme implementers must be acknowledged, as these perspectives may not fully represent the diversity of community experiences and opinions.

4.3.3 The Observed Outcomes of Healthy Cities Implementation in Al-Jumum

The effects of the Healthy Cities mechanism on the community context were analysed for consistency with asset-based approaches, though any claims to outcomes must be made cautiously given the quality of available evidence and the difficulties inherent in generating robust evidence for Healthy Cities and broader settings approaches (De Leeuw, 2009; Dooris, 2009). The programme appears to have encouraged collaboration between different organisations in Al-Jumum, though evidence for deep community engagement with the general public remains limited and requires careful interpretation.

Some community members did report positive changes:

“I can see how things have changed over time. Five years ago, this was not the situation. You would not see people go around, do exercises, walk, and adopt a

healthier lifestyle. I can see how things changed here, and the city developed from a rural, quiet area to a more open area where people like to live” (The first stage interviews, Local Citizen, I7).

This quotation is important because it shows that rurality was also present in participants’ own accounts of Al-Jumum’s change over time. The participant did not describe Al-Jumum as purely rural or purely urban, but as a place that had developed from a rural and quieter setting into a more open and developed community. This account suggests that observable behaviour change has occurred, though the extent to which this represents deep cultural transformation versus surface-level compliance remains unclear.

Additionally, the programme's focus on addressing social determinants of health aligns with the principles of asset-based approaches, though the top-down nature of implementation raises questions about the authenticity of community empowerment. Through the interviews, some community members reported feeling empowered and recognised for their assets, leading to increased community ownership and involvement in health-related activities, though these accounts came primarily from programme participants rather than the broader community. The programme's focus on promoting health equity and addressing the root causes of health disparities demonstrated a commitment to improving the overall health and well-being of the community, though the extent to which this translated into measurable equity improvements requires further investigation.

Some participants, particularly the volunteers’ groups, noted that they had formed new social connections and experiencing greater sense of community cohesion.

“After starting this group, we felt that we are more connected to our community, especially with all the programmes we joined and the activities we did. We started to recognise what we have in our environment and what we have to do to make it a better place to live. We used to visit schools, hospitals, and some association centres in the city to increase awareness and get more participants. It feels like we all share the same goal, and we all work together to achieve it” (The second stage interviews, female volunteer, FG3).

This account suggests that programme participation facilitated social capital development among engaged community members, though it represents the experiences of active participants rather than the broader community.

Moreover, participants expressed expectations that implementing approaches such as asset-based approaches would help in achieving the country's new vision 2030 and lead to increased community engagement and empowerment, improved social connections and cohesion, and better health outcomes.

“It sounds promising and goes well with our new vision and plans. I believe this is a very good intervention that can help us improve health in the rural communities. I have to say it will not be an easy thing to do, but if we do it, we will be able to take all the possible benefits from those isolated areas” (The third stage interviews, national policymaker, I3).

Although this participant referred to “rural communities” and “isolated areas”, this thesis interprets such claims cautiously. The findings from Al-Jumum cannot be generalised to all rural communities, but they can provide insights into how asset-based approaches may be considered in rural/peri-urban contexts where service access, community relationships, and institutional reform intersect.

However, while the Healthy City network in Al-Jumum demonstrates promising results and interviewees express confidence in the potential success of the asset-based approach, it is important to underscore that the unique challenges and dynamics observed during the interviews introduce some factors. These factors may impact the extent to which the asset-based approaches can be effectively realised. The successful operation of one approach does not automatically ensure the seamless integration of asset-based principles. The following section will provide an in-depth critical analysis of these factors.

4.4 Discussion and Critical Analysis

4.4.1 The Tension Between Top-Down and Bottom-Up Dynamics

The analysis of the Healthy Cities programme in Al-Jumum reveals integration of both top-down and bottom-up approaches while highlighting significant tensions in their alignment with Asset-Based Approach (ABA) principles. As discussed in chapter 2, Asset-based interventions exist on a spectrum between bottom-up and top-down initiation, though the idealised view of ABA is often equated with community-driven, bottom-up development. This tension reflects broader debates within the settings literature about whether health-promoting settings should conform to standardised criteria and awards or develop health initiatives according to local priorities and capacities. Löffler (2001) highlights how quality awards in public sector contexts can become focused on meeting predetermined benchmarks rather than fostering genuine improvement, whilst Rosenblatt

(2011) demonstrates how innovation awards may prioritise recognition over authentic innovation when poorly administered

The Healthy City Network in Al-Jumum demonstrates a dual approach, intertwining top-down and bottom-up mechanisms to achieve its goals. On the one hand, the programme employs top-down elements, notably through the establishment of a higher committee. This committee played a pivotal role in overseeing decisions, policies, and strategies related to Healthy City Network initiatives, comprising representatives from various sectors to ensure streamlined decision-making and swift implementation of health-related actions. The top-down approach is mainly characterised by centralised decision-making (Sabatier, 1986). It starts with policy decisions by governmental officials at lower levels (ibid.). It involves making decisions at a higher, more general level before moving to more specific considerations (Frei et al., 2003). It refers to aspects of the programme that are guided, initiated, or controlled by higher authorities or central entities (ibid.). It is seen as more conventional and is often associated with government legitimacy (Carey and Braunack-Mayer, 2009). As mentioned previously in the chapter, a higher committee was established, headed by the Governor of Al-Jumum, to monitor the work of the HCN in Al-Jumum. This committee played a pivotal role in overseeing decisions, policies, and strategies related to the Healthy City Network initiatives within the city representatives from various sectors, this centralised structure was created to ensure streamlined decision-making and swift implementation of health-related actions, though it potentially limits community agency and self-determination.

The reliance on higher authority support is evident in the interviews, as one of the interviewees mentioned, they wanted to make sure that they would succeed in achieving the goal of obtaining the WHO certificate.

“When we first decided to start the Healthy City Network, it was hard to make this huge change in the community without the influence of higher bodies. For this, we decided to start with establishing a higher committee and get in touch with individuals who have authority from different sectors to ask for their support. This is when the whole thing started.” (The third stage interviews, local policymaker, I1).

This account reveals the programme's dependence on institutional authority rather than community-driven momentum, suggesting limited potential for organic, grassroots development characteristic of asset-based approaches.

Conversely, the programme also incorporates bottom-up dynamics that emphasise community participation and empowerment, though these appear more limited in scope and influence. The bottom-up approach is seen as more radical and community-centred (Carey and Braunack-Mayer, 2009). It involves actions initiated by individuals or groups within the community (Cheney et al., 2023). It is considered a social movement of self-selecting health care service users' activities (Boswell et al., 2015). However, in this study, the evidence for genuine bottom-up engagement mechanisms is limited. The primary evidence of community-level engagement comes from volunteer participation, particularly among women and youth. For instance, one female volunteer noted:

"We started as a small group of women interested in local activities, and gradually more women joined us when they saw the positive impact of our work in the community" (The second stage interviews, female volunteer, FG3).

Whilst the programme claimed to facilitate community participation, the available data provides insufficient detail about formal platforms for community input or processes through which residents could meaningfully influence programme decisions. The primary evidence of community-level engagement comes from the establishment of volunteer groups, particularly among women and youth, though these emerged within and were constrained by the overarching institutional framework rather than representing autonomous community initiatives.

During the data collection and observation stages, it was evident that elements of both top-down and bottom-up approaches existed in the process of implementing the Healthy City Network in Al-Jumum. This is important because some previous studies show that both top-down and bottom-up approaches are necessary to create a cultural shift towards health as a shared value and to build healthier communities (Cheney et al., 2023). It has been highlighted that there is a need for more complementary ways in which such top-down and bottom-up efforts are coordinated (Boswell et al., 2015).

4.4.2 Alignment and Divergence with Asset-Based Principles

The data collection process provided valuable insights into the mechanisms underlying the implementation of the Healthy Cities Approach in Al-Jumum city, revealing both promising alignments and significant divergences from asset-based approach principles. The findings indicate that the implementation of the Healthy Cities Approach in Al-Jumum city has achieved some progress in fostering community participation, empowerment, and capacity building - principles that are central to asset-based approaches as well.

One of the key shared concepts between asset-based approaches and the Healthy Cities Approach is the emphasis on strengths-based and empowerment-focused strategies (GCPH, 2012, Heritage and Dooris, 2009). The evidence from interviews revealed that the Healthy Cities Approach in Al-Jumum has succeeded in increasing community members' sense of empowerment and recognition of their individual and collective assets. As one local policymaker emphasised, residents reported enhanced feelings of being able to contribute to improving their community's health and well-being, as noted in a previous mentioned quote from I2:

"Today, the local citizens are happy and satisfied with the changes that this programme has made. Their awareness has increased. The programme has been met with enthusiasm and support, with residents taking an active role" (The third stage interviews, local policymaker, I2).

This aligns with the asset-based principle of valuing, and mobilising local strengths (McLean et al., 2017). However, a closer examination reveals that the implementation of the Healthy Cities Approach in this context tends to adopt a more top-down approach rather than fully embracing the community-driven development advocated by asset-based approaches.

The requirement for accreditation and approval from higher authorities underscores the presence of centralised decision-making processes (Sabatier, 1986). This dynamic contrasts with the participatory and collaborative essence of asset-based approaches, which emphasize bottom-up community engagement and local ownership (GCPH, 2012). As one local policymaker mentioned,

"When we first decided to start the Healthy City Network, it was hard to make this huge change in the community without the influence of higher bodies. For this, we decided to start with establishing a higher committee and get in touch with individuals who have authority from different sectors to ask for their support." (The third stage interviews, local policymaker, I1)

The observed challenges in obtaining approvals for interviews across different ministries also highlight the potential barriers to effective cross-sectoral collaboration, despite the Healthy Cities Approach's emphasis on this principle (Heritage and Dooris, 2009, de Leeuw, 2011). This finding suggests that while the Healthy Cities Approach aims to foster intersectoral action, the implementation in Al-Jumum may not have fully realised the potential for true collaborative partnerships envisioned by asset-based approaches. Instead,

the evidence points toward a more bureaucratic process focused on meeting predetermined WHO criteria rather than fostering organic intersectoral collaboration. As one participant noted:

"We initially had to put together a plan. It all began with a visit from the health ministry. We held a meeting to go over everything we need to do to make the necessary modifications. It was at this point that we realised we needed help from other organisations, so we organized another meeting and invited various ministries." (The third stage interviews, local policymaker, I1).

This account reveals the programme's instrumental approach to collaboration - seeking organisational participation primarily to fulfil accreditation requirements rather than to harness genuine intersectoral synergies.

The reliance on awards and accreditation schemes represents a specific manifestation, reflecting broader criticisms within the settings literature about the tension between standardised certification processes and authentic community-driven development (Dooris, 2009). The WHO's 80-indicator assessment framework, whilst providing clear benchmarks, may inadvertently encourage superficial compliance over substantive transformation. This bureaucratic focus on meeting external validation criteria potentially undermines the community empowerment and organic collaboration that both Healthy Cities and asset-based approaches purport to champion, reducing complex social change processes to measurable targets that can be achieved through administrative coordination rather than genuine community engagement.

Furthermore, the data collection process revealed nuanced dynamics related to community trust and open dialogue. Participants' hesitation to share negative experiences or concerns raises questions about the extent to which the Healthy Cities Approach has been able to facilitate the holistic and inclusive community engagement advocated by asset-based approaches (GCPH, 2012). Building trust and encouraging candid discussions are essential for leveraging community assets and fostering genuine empowerment (Baron et al., 2019). As one interviewee highlighted:

"If you want to implement the programme you are doing your research on successfully here, you have to have the trust of the people here. If they do not trust you, they will not accept anything you provide them." (The third stage interviews, national policymaker, I3)

Similarly, the principle of collaboration is central to both asset-based approaches and the Healthy Cities Approach (GCPH, 2012, Heritage and Dooris, 2009). This was evident in bringing together diverse stakeholders including community members, government agencies, non-profit organisations, and businesses. In the case of Al-Jumum, the Healthy Cities Approach involved the establishment of a higher committee comprising representatives from various sectors, including the municipality, education, environment, social affairs, health, police, and emergency preparedness. This collaborative structure aimed to ensure streamlined decision-making and swift implementation of health-related actions. However, evidence suggests this collaboration occurred primarily among powerful organisations with less meaningful collaboration with the general public, limiting the community empowerment potential of the approach. One health professional noted the challenges in achieving genuine community-level collaboration:

"It took many years for the different bodies involved in implementing the Healthy City Initiative here to succeed and encourage people to accept this big change"
(The first stage interviews, health professional, I6).

The holistic and multidisciplinary nature of both asset-based approaches and the Healthy Cities Approach is another key commonality (GCPH, 2012, de Leeuw, 2011). These approaches recognise that health is influenced by a combination of social, economic, and environmental factors, and they adopt a comprehensive approach to address these factors. In Al-Jumum, the Healthy Cities Approach encompassed a range of interventions, from establishing family parks and walking paths to prohibiting the sale of tobacco and encouraging healthy activities in schools. However, while this demonstrates comprehensive scope, the extent to which these interventions emerged from community priorities versus institutional mandates remains unclear. The programme coordinator described their systematic approach:

"We initially had to put together a plan... We agreed upon a time and day, and then the process began. We got the support, and we all cooperated together to get the job done" (The third stage interviews, local policymaker, I1).

Lastly, the principles of equity and long-term interventions are shared between asset-based approaches and the Healthy Cities Approach (Montañez, 2023, Heritage and Dooris, 2009). The Healthy Cities Approach in Al-Jumum aimed to promote equitable access to resources and services, while the asset-based approaches prioritise mobilising assets and increasing individuals' control over their lives and health. Additionally, both approaches

emphasise the importance of long-term, sustainable development that can benefit the community over the long term. However, the programme's reliance on institutional coordination and external validation through WHO accreditation raises questions about long-term sustainability and community ownership once external support diminishes. As one national policymaker reflected on the broader potential:

"It sounds promising and goes well with our new vision and plans. I believe this is a very good intervention that can help us improve health in the rural communities. I have to say it will not be an easy thing to do, but if we do it, we will be able to take all the possible benefits from those isolated areas" (The thirds stage interviews, national policymaker, I3).

Despite positive outcomes observed in implementation, the critical analysis underscores complexities involved in aligning this mechanism with core asset-based approach principles. The data suggest that while the Healthy Cities Approach demonstrated progress in fostering some forms of community engagement and empowerment, certain aspects do not fully conform to fundamental asset-based tenets, including the persistence of top-down decision-making, barriers to effective collaboration with broader communities, and challenges in ensuring equitable participation. These findings highlight the importance of carefully navigating contextual nuances and adapting asset-based approaches to the specific dynamics of Al-Jumum as a Saudi rural/peri-urban context. They also suggest that any wider application to other Saudi communities should be considered cautiously and only in relation to settings with comparable socio-cultural, institutional, and rural-urban characteristics.

4.5 Conclusion

This chapter assessed how the implementation of the Healthy Cities Approach in Al-Jumum can inform understanding of the feasibility of asset-based approaches in a Saudi rural/peri-urban community context. The analysis reveals that the Healthy Cities Approach achieved progress in several areas aligned with asset-based approaches, including fostering some forms of community participation, empowerment, and capacity building among programme participants. Residents expressed heightened senses of ownership and recognition of individual and collective strengths, representing core elements of asset-based thinking. Furthermore, the approach demonstrated focus on collaborative, intersectoral action bringing together diverse stakeholders from various governmental and community sectors, aligning with asset-based emphasis on leveraging partnerships and shared ownership to address complex community challenges.

However, the critical analysis also revealed significant areas of potential divergence between the Healthy Cities Approach and fundamental asset-based approach principles. The persistence of top-down decision-making processes, with requirements for accreditation and approval from higher authorities, suggests a more centralised approach that may limit communities' genuine agency and self-determination. Challenges in obtaining cross-sectoral collaboration and building trust within broader communities present barriers to fully realising the participatory and empowering nature of asset-based approaches. Additionally, observed dynamics around gender participation and community engagement highlight the need to address entrenched cultural and traditional norms that can hinder equitable engagement.

These findings underscore complexities involved in aligning the Healthy Cities Approach implementation with core asset-based approach tenets within the Saudi Arabian context. While the approach demonstrated promising outcomes among engaged participants, the data suggests that contextual factors and systemic dynamics may constrain full realisation of asset-based principles. Nevertheless, the Al-Jumum experience provides valuable insights and foundations for further exploration and adaptation of asset-based approaches in similar Saudi rural/peri-urban communities. By acknowledging unique challenges and leveraging strengths observed in the Healthy Cities Approach, there is potential to develop contextualised strategies that can more effectively integrate asset-based principles and foster sustainable, community-driven development. The next chapter examines a contrasting approach by investigating grassroots volunteering programmes in Al-Jumum, exploring how community members independently organise and implement health-related activities within regulatory frameworks. This shift from institutionally driven to community-initiated asset mobilisation provides important insights into how different forms of community engagement might support or constrain asset-based implementation in conservative cultural contexts.

Chapter 5 Al-Jumum's Volunteers Groups

5.1 Introduction

The primary objective of this chapter is to critically examine the potential connections and tensions between volunteer groups and asset-based approaches for community development. As mentioned in chapter 2, asset-based approaches emphasise identifying and mobilising local assets as catalysts for development, rather than focusing on deficiencies that need external resources. The choice to explore volunteerism carries profound significance in the context of Saudi Arabia's Vision 2030, which prominently features volunteerism as part of the nation's developmental plans.

As discussed in previous chapters, Al-Jumum is treated in this thesis as a rural/peri-urban Saudi context rather than as a fixed rural community. This framing is important for interpreting volunteering because volunteer practices in Al-Jumum are shaped by both contemporary state-regulated civic participation and older forms of community cooperation, family support, religious duty, neighbourhood familiarity, and village-like social relationships. Therefore, this chapter does not treat volunteering in Al-Jumum as representative of all rural Saudi communities, but as a case through which to examine how asset-based principles may operate in a rural/peri-urban context shaped by recent development, social continuity, and formal regulation.

This chapter specifically addresses the central research question - what factors influence the feasibility of implementing asset-based approaches to health in Saudi rural/peri-urban communities? - by examining volunteer groups as another proxy intervention. The analysis investigates community assets mobilised through volunteering activities (Research Sub-Question 1), identifies barriers that constrain grassroots health initiatives (Research Sub-Question 2), explores factors affecting implementation decisions within regulatory frameworks (Research Sub-Question 3), and examines how current policies on volunteerism impact asset-based possibilities (Research Sub-Question 4). Additionally, it demonstrates how both decision makers and community members influence implementation through their roles in shaping volunteer programmes (Research Sub-Question 5).

This chapter explores whether volunteer groups in Al-Jumum align with asset-based approaches' principles of identifying and mobilising local assets for development. Volunteerism has the potential to build social capital—connections, relationships, trust, and reciprocity within a community—which is often viewed as a key local asset. However, social capital building through volunteering also has complexities that warrant

examination, such as exclusivity or maintenance of power hierarchies. The analysis will examine how women's involvement in volunteer groups contributes to individual and community empowerment, while also assessing the feasibility and potential limitations of volunteerism in shaping a more resilient and empowered community.

5.2 Background

5.2.1 Global Perspective on Volunteering

Volunteerism has witnessed world-wide growth, with its concepts and scope varying significantly across studies (Jiang et al., 2018, Butcher and Einolf, 2017). Butcher and Einolf (2017) identify four dimensions where definitions diverge: the element of free choice, material rewards, institutional context, and nonmaterial benefits. Consequently, there are differing perspectives on the scope of volunteering, which may be limited to entirely voluntary acts of assistance or may encompass obligatory services (Butcher and Einolf, 2017). Additionally, volunteer work may be considered entirely unpaid or may include small stipends or salaries below the market rate (ibid.). Lastly, there is debate on whether volunteering should solely focus on aiding others or if work that benefited friends, family, or an institution to which the volunteer belonged could also be classified as volunteering (ibid.).

The United Nations Volunteers (UNV) definition provides one framework, characterised by three key features. First, the activity should not be primarily motivated by financial gain, although expenses may be reimbursed and token payment may be accepted (Giesing et al., 2011). Second, the activity must be done voluntarily, and carried out of the individual's free will. However, there are grey areas here, such as school programs that encourage and require students to do voluntary work (ibid.). Third, the volunteer work must benefit someone other than the volunteer, or benefit the society, although volunteering is recognised to provide benefits to the volunteers themselves (ibid.).

5.2.1.1 Social Capital in Volunteering. Different types of volunteering can result in various forms of social capital, as collaborative activities extend interpersonal bonds of trust and cooperation into the broader community (Putnam, 2001, Stukas et al., 2005). It refers to the networks, norms, and trust that facilitate coordination and cooperation between people and groups (Wilson and Musick, 1998). When utilised positively, social capital can serve as the social glue that brings volunteers together and enhances their impact, making it easier for people to link their own identity and interests with those of their community (ibid.). Social capital plays a vital role in promoting social cohesion, resilience, and collective action (Boneham and Sixsmith, 2003). When individuals engage

in volunteer activities, they not only contribute their time and skills but also invest in building social capital (ibid.), which can be categorised into three types, as shown in table 5.1 below:

Table 5-1 Distinctions Between Bonding, Bridging, and Linking Social Capital

Dimensions	Bonding Social Capital	Bridging Social Capital	Linking Social Capital
Nature of ties	Horizontal; with similar groups (Bhandari and Yasunobu, 2009).	Horizontal; across different groups (Claridge, 2018, Woolcock, 2001).	Vertical; cross power and status levels (Bhandari and Yasunobu, 2009).
Homogeneity	Homogenous groups (Södergren, 2017).	Heterogeneous groups (Södergren, 2017).	Connects heterogeneous actors (Claridge, 2018).
Orientation	Inward facing (Södergren, 2017)	Outward facing (Södergren, 2017)	Leveraging resources and influence top-down or bottom-up (Marais, 2012).
Primary function	Reinforce exclusive identities; promote in-group loyalty (Woolcock, 2001).	Promote inclusive identities by bridging divides (Woolcock, 2001).	Gain access to resources and information; voice needs (Woolcock, 2001).
Levels of analysis	Primarily micro (intra-community) (Woolcock, 2001, Södergren, 2017).	Primarily meso (inter-community) (Woolcock, 2001, Södergren, 2017).	Micro and macro (Woolcock, 2001).
Risks	Can promote intolerance, create bonded labour and	Can create tensions from clashing norms,	Can reinforce inequalities if only accessible to

	captive organizations (Claridge, 2018).	goals, statuses (Claridge, 2018).	certain groups (Claridge, 2018).
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The role of participation in voluntary organisations is crucial in the development of social capital for some community members (Boneham and Sixsmith, 2003). However, such participation risks excluding marginalised groups and reinforcing inequality across age, ethnicity, gender and other differences (Southby et al., 2019). Furthermore, Baycan and Öner (2023) point out the complexities around social capital and cautioned about its potentially problematic aspects, including promoting unhealthy behaviours, increasing inequality, enabling corruption and organised crime, hindering innovation, and decreasing political/social tolerance.

5.2.1.2 Theoretical Perspectives on Volunteering. Theoretical perspectives connect volunteering to concepts like social capital, sense of community, and civic participation, which align with principles of asset-based approaches. Additionally, individuals volunteering in community work exhibit higher belonging, commitment, and local knowledge (Zanbar, 2019). Communitarian values linked to community participation and belonging also motivate volunteering (Paton and McMenemy, 2024).

Communitarianism refers to the idea that individuals derive aspects of their identity and purpose from participating in a community, and that strong communities are essential for human well-being (Etzioni, 2014). These values emphasise civic participation, mutual responsibility, and contribution to the community (ibid), aligning closely with and motivating volunteering aimed at community betterment. A sense of community belonging can inspire volunteerism by connecting individuals to a larger cause and obligation to support it (Wilson and Son, 2018, Vannier et al., 2021, Omoto et al., 2000, Stukas et al., 2015).

Volunteering may take different political valences – it can be a predominantly conservative activity aimed at maintaining the status quo, or one involved in more radical social transformations (Evers and von Essen, 2019). The conservative critique suggests that volunteering may inadvertently maintain the status quo by providing services that could be seen as the responsibility of the state or by reinforcing traditional power structures (ibid.). More radical forms of volunteering could address systemic issues and advocate for social change, challenging existing power dynamics and potentially being seen as a threat to the established order (ibid.). The distinction between conservative and radical forms of volunteering is not always clear-cut, as the meaning and perception of volunteering and

civic action can change over time and across different contexts (Evers and von Essen, 2019). Actions that are considered politically significant at one point can become trivial and apolitical at another, and vice versa (ibid.). The boundaries between civic action and volunteering can blur, making it difficult to uphold an initial will to avoid politics (ibid.).

Volunteering can serve as a vital act of compassion and a catalyst for societal and political improvement (Talaue et al., 2018). It is a significant force in social and economic development, appealing to those motivated by interest, passion, or a sense of duty rather than financial rewards (Jiang et al., 2018). Participation varies across demographics, with higher rates among those with more education, higher incomes, older individuals, and notably more women than men (Bussell and Forbes, 2002). Additionally, people with greater social capital, through their connections and networks, tend to engage more in volunteering activities. (Boneham and Sixsmith, 2003).

Although engaging in volunteer activities can positively impact community mental well-being and cohesion (Alshammari et al., 2023), it also has implications for the political and civic participation of young people, encompassing involvement in initiatives, decision-making, and interactions between the government and its citizens (Talaue et al., 2018). For example, youth may become involved with local government boards or community organisations that make decisions impacting schools, infrastructure, public services, and other areas relevant to young people. It integrates critical thinking while fostering youth participation tailored to local contexts (ibid.). However, the extent of its impact may vary depending on the specific characteristics and context of each community (ibid.).

Volunteering embodies compassion whilst also being a potent catalyst for driving positive social and political transformations (Talaue et al., 2018). For example, grassroots volunteer groups addressing systemic inequalities may be viewed as politically radical in some contexts but not others (Evers and von Essen, 2019). The boundaries between volunteering and activism blur as well, with civic participation taking on different meanings and levels of political significance across contexts (ibid.), suggesting that volunteerism's impacts are multifaceted, situated within societal power dynamics that shape whether activities challenge or uphold existing systems.

5.2.2 Critical Perspectives on Volunteering

Whilst volunteering offers benefits to both volunteers and the communities they serve, it also comes with criticisms and difficulties. Major criticisms revolve around the limited impact of volunteering efforts, lack of expertise from volunteers, issues of safety, problems related to volunteer management and high volunteer turnover rates (Lough et al., 2018,

Robinson, 2016, Erasmus and Morey, 2016). Common difficulties faced by volunteers include lack of resources, communication barriers, lack of role clarity, lack of support and feedback as well as personal struggles like insufficient time or lack of recognition (McAllum, 2014, Lough et al., 2018, Wilson, 2012). A key concern centres on doubts over volunteers' ability to create meaningful change, especially for complex, large-scale socioeconomic issues tied to poverty, inequality and marginalisation (Robinson, 2016). Reliance on volunteers' localised efforts focused on symptoms rather than systems is viewed as an individualised, sentimental approach unable to address the full scale of injustice nationally and globally (ibid.).

Moreover, organisations, especially in the non-profit sector, encounter a significant challenge in the form of high volunteer turnover rates (Erasmus and Morey, 2016). This issue impacts the ability to retain their volunteers, with far-reaching consequences for the organisations' capacity to meet the ever-growing social service needs (ibid.). As volunteers depart, non-profits continuously invest time and resources in recruiting and training new individuals to fill the gaps left by departing volunteers (ibid.). This continuous cycle of recruitment and turnover not only strains organisational resources but also disrupts the continuity and effectiveness of programs and services (ibid.). Consequently, addressing volunteer turnover is paramount for non-profits to maintain their vital roles in addressing societal needs effectively (ibid.).

Burnout was more likely among volunteers who felt they were wasting their time and less likely among those who felt appreciated (Wilson, 2012). Communication barriers create issues as well, especially for volunteers working in low-income countries (Lough et al., 2018). They have been perceived as too junior, inexperienced and ill-prepared and more likely to experience difficulties with cultural and language barriers, and with differences in norms and values, resulting from insufficient cultural sensitivity and awareness (ibid.). While volunteering offers essential community-building functions, implementing it thoughtfully requires acknowledging both its benefits and the multifaceted criticisms and difficulties it encompasses, necessitating a balanced approach that harnesses positive aspects of volunteering while addressing these shortcomings.

5.2.3 Alignment with Asset-Based Approaches

While not positioned as central in Kretzmann and McKnight's original conception of asset-based community development (Kretzmann and McKnight, 1993), many scholars and practitioners note the alignment between volunteering and core principles of asset-based approaches (Benenson & Stagg, 2016; Brennan, 2007). Both emphasise strengths and

capacities existing within communities rather than focusing on deficiencies. Volunteering manifests this approach by showcasing abundant local skills, passions, and collective determination (Brennan, 2007). Additionally, synergies exist between volunteering and asset-based approaches. Volunteering enables individuals to leverage personal assets in service of their communities (Benenson & Stagg, 2016), moving beyond perceived lacks by mobilising innate resources in community members whilst building the mutual reliance and trust reinforced in asset-based community development (ABCD) (Badawi, 2020). Thus, while volunteerism itself may not be intrinsic to asset-based community development, the two share foundational principles and can powerfully reinforce each other.

From another perspective, volunteers embody local assets, contributing their time, expertise, and passion to drive positive change at multiple levels—from individual to community to the broader political context (Brennan, 2007). They shape communication channels and, more crucially, facilitate engagement that may cross class and other divides, thereby connecting local citizens across differences and resulting in the formation of an inclusive community (ibid.). Accordingly, the very essence of volunteerism aligns with the core principles of asset-based community development, which prioritize identifying and mobilizing local strengths and resources. The following table 5.2 displays the alignment between volunteering and asset-based approaches.

Table 5-2 Alignment of Volunteering and Asset-Based Approaches

The Key Concepts	Volunteering	Asset-Based Approaches
Strength Focused	Focuses on individual/community strengths and resources. Provide opportunities to develop and apply skills and knowledge (Benenson and Stagg, 2016).	Focuses on the individual's abilities, resources, and resilience (Baron et al., 2019). Client-led, strengths-based approach (ibid.).
Community Engagement	Create individual commitment and decision making toward common causes (Butcher and Einolf, 2017).	Recognises communities assets and resources (Baron et al., 2019). Highlights importance of social networks and community connections (ibid.).

		Encourages social action (ibid.).
Relationship-Building	Fosters and strengthens relationships among individuals and within communities (Benenson & Stagg, 2016; Butcher & Einolf, 2017). Builds bonding and bridging social capital (Putnam, 2000).	Develops strong and supportive relations and social network (GCPH, 2011). Allows people to connect and communicate with each other because they have common goals (ibid.).
Empowerment	Can empower individuals and communities, giving them a political voice (Butcher and Einolf, 2017). Encourages social change and problem solving (ibid.).	One of the key features of asset-based approaches is community empowerment (GCPH, 2011). ABA Encourages community and individual empowerment (ibid.).
Collaboration	Brings together diverse individuals around shared goals (Butcher & Einolf, 2017). Builds partnerships between organisations (Alshammari et al., 2023).	Involves working with community groups and organisations to utilise strengths and resources (Baron et al., 2019).
Top-Down vs Bottom-up	Can emerge from top-down and bottom-up initiatives (Butcher & Einolf, 2017).	Emphasises bottom-up, community-driven efforts using local asset (Baron et al., 2019).

5.3 Examining the Dynamics of Volunteering in Al-Jumum: A Realistic Evaluation Approach

In applying the Realistic Evaluation framework to Al-Jumum, this analysis scrutinises the multifaceted aspects of volunteering, considering the interplay of contextual factors, mechanisms, and potential outcomes. Understanding the dynamics of volunteering in this rural/peri-urban Saudi context sheds light on how asset-based principles may be mobilised through existing community practices and formal volunteer structures. The analysis examines volunteering as a proxy intervention for asset-based approaches, investigating

how national policies, local circumstances, cultural norms, and implementation mechanisms interact to produce particular outcomes in Al-Jumum.

5.3.1 Contextual Factors in Al-Jumum

This section examines the process of volunteering in Saudi Arabia and, more specifically, in Al-Jumum by scrutinising its historical, cultural, institutional, and regulatory underpinnings. It first considers the impact of national policies, particularly Vision 2030, on volunteering dynamics before examining how these directives are interpreted and enacted at the local level. The objective is not to assess the feasibility of asset-based approaches across Saudi Arabia as a whole, but to understand how volunteering informs the feasibility of asset-based approaches in Al-Jumum as a rural/peri-urban Saudi community. This examination provides a critical lens through which to consider how historical roots, cultural norms, community relationships, and national policy frameworks shape the possibilities and constraints of asset-based implementation.

5.3.1.1 National Contexts: Volunteering in Saudi Arabia. Volunteering provides a structured framework for organising community participation and civic engagement within Saudi Arabia (Badawi, 2020). It brings individuals together and offers them opportunities for effective and goal-oriented participation in social initiatives and volunteer projects (ibid.). However, the highly structured and regulated nature of the state-driven volunteering ecosystem may create tensions with the more locally driven emphasis of asset-based approaches. This structured framework represents a key insight, as the volunteering domain is clearly highly regulated and 'shaped' by the state, with relevance for discussions of whether such structured underpinnings align with asset-based approaches. The alignment and potential tensions between top-down state-managed versus bottom-up locally driven development require careful analysis throughout this examination.

Volunteering has become a fundamental cornerstone in building the Saudi community and promoting social cohesion among Saudis (Badawi, 2020). Yet the aim of social cohesion must be critically examined in terms of who is included or excluded from such visions. Policy attention on volunteer work in Saudi Arabia increased following the establishment of the Ministry of Labour and Social Development in (1960-1961), where a social care department was set up within the ministry to oversee all volunteer activities in the country (Badawi, 2020). Following that, the Ministry of Labour and Social Development established the Agency for Social Care Affairs, which began issuing regulations to organise volunteer work by formalising the establishment of charitable organisations and

specifying the acceptable types of activities, beneficiary groups, and nature of assistance (ibid.).

These regulations required organisations to focus on providing skills training, education programs, and capacity building to vulnerable individuals to enable self-reliance, rather than broader efforts at societal change (Badawi, 2020). This led to the proliferation of associations predominantly providing direct services to approved groups through government-sanctioned programs. Additionally, these associations assisted individuals in becoming self-reliant through the development of economically productive skills via vocational training programs, enabling them to contribute to their communities (ibid.). The ministry is committed to encouraging citizens to establish and engage with volunteer work only as permitted by these regulatory boundaries (ibid.). Furthermore, the Kingdom has prioritised promoting volunteerism in all its developmental plans, including Vision 2030 (ibid.).

"Volunteer work is a national duty, an ethical and societal commitment, and a human right to solidarity and communication" (Vision2030, 2020).

Generally, volunteer work encompasses various fields in the country, including educational, social, and cultural aspects, with suggestions that volunteer work contributes to the development of a stronger and more prosperous community (Vision2030, 2020). The ministry's name has now changed to the Ministry of Human Resources and Social development (HRSD), with its website establishing different sections defining the ministry's initiatives in all sectors including volunteer work. A document called 'executive regulations for volunteer work in the Kingdom of Saudi Arabia' has been posted on the website, including information about the volunteer work in the country (HRSD, 2020). The major goals of these regulations include promoting and fostering a culture of volunteer work and activating it amongst individuals and institutions in all sectors of society; regulating relationships between parties involved in volunteer work and specifying their rights and responsibilities; enhancing values of national belonging, humanitarian work, and social responsibility amongst individuals and institutions in all sectors; developing capacities of sectors, entities, and volunteer leaders whilst guiding them towards national priorities; and advancing the volunteer work system to expand activation of volunteer work in achieving societal developmental goals (HRSD, 2020).

These major goals, with their emphasis on promoting a culture of volunteerism, regulating relationships, enhancing values of belonging, developing capacities, and advancing the

volunteer system, largely reflect a conservative approach to volunteering focused on normalization and entrenchment within existing societal structures and systems. However, given the dynamic nature of civic action, the politicization of volunteerism over time means these same goals and activities may later shift toward more radical social change as societal norms change and volunteering takes on more controversial and courageous functions in challenging established power structures. For now, though, these goals mainly serve to solidify volunteerism's standing as an accepted and regulated institution in society.

In 2020, the launch of the National Volunteer Work Platform marked a key advancement, providing a centralised hub for volunteering opportunities, facilitating engagement that matches personal interests and goals, and ensuring high standards for volunteer and societal safety (Vision2030, 2022b). This platform epitomises the structural and strategic frameworks supporting volunteerism in Saudi Arabia (ibid.). Volunteerism in Saudi Arabia aims to raise employees' awareness of societal issues, special needs groups, environmental concerns, and community service, seeking to accelerate social development and national progress (Talaue et al., 2018). The country has launched volunteering initiatives to encourage sustainability of volunteer programmes over time, with volunteer activities across the country covering endeavours like cleanliness campaigns, visiting patients and the elderly, maintaining mosques, organising events, distributing gifts, enhancing language skills of non-native speakers, food preservation, and community service projects (ibid.).

Saudi Arabia's national policies, notably Vision 2030, are pivotal in reshaping its socio-economic landscape, emphasizing social development, economic diversification, and enhanced social cohesion (Vision2030, 2022a, Vision2030, 2022b). Vision 2030 particularly highlights volunteerism as a crucial element, aiming to foster a sense of community and societal well-being through civic engagement (HRSD, 2020). This policy framework sets the backdrop for community initiatives and influences public participation dynamics (Vision2030, 2022a). One goal of vision 2030 is to use volunteering curricula to foster a culture of civic engagement and sustainable development (Alshammari et al., 2023). Another goal is to enhance and increase the number of volunteers (Talaue et al., 2018). In 2022, the total number of volunteers was 658,000 male and female, and it is expected to reach 1 million by 2030 (Hameed, 2021, Arab News, 2023). These days, all individuals above 18 years old are encouraged to volunteer. According to the HRSD (2020), voluntary activities must:

- 1- Adhere to Islamic, societal, and ethical values, as well as the ethical code of volunteer work, regulations, instructions, and guidelines specific to the beneficiary entity.
- 2- Accomplish the assigned volunteer work with integrity, trustworthiness, and transparency, in line with the requirements, principles, and objectives of volunteer work.
- 3- Maintain the commitment to the received task and show respect.
- 4- Safeguard the confidentiality of private information related to the beneficiary entity or the volunteer opportunity, especially if volunteering is done in some situations such as the health field.
- 5- Disclose to the relevant parties any conflicts of interest that may arise from their volunteer work, whether before their participation or if such conflicts become apparent.
- 6- Adhere to all security and safety instructions and measures when carrying out volunteer opportunities, especially those of a field nature, and disclosing the volunteer's health condition if he or she requires special care.
- 7- Not collect or receive funds or donations in any way, whether personally or on behalf of the beneficiary organization. There are official organisations responsible for collecting donations. (HRSD, 2020)

An underlying tension emerges between grassroots, community-driven volunteer initiatives and the centralised, top-down nationwide volunteer policies and codes of conduct put forth in Vision 2030. While Vision 2030 aims to foster more civic participation, national guidelines may enforce a one-size-fits-all model that may not account for unique circumstances and diversity of individuals and communities (Stathi et al., 2021). This could constrain the flexibility of grassroots efforts tailored to local contexts. While Saudi Arabia encourages all adults over 18 to volunteer, the mandated code of conduct requiring adherence to governmental regulations and values represents a top-down imposition. This approach contradicts notions of bottom-up participation arising more organically from civil society. The emphasis on meeting institutional objectives and respecting beneficiary entities reflects a state-driven volunteering paradigm rather than one grounded in altruistic motivations of active citizenship.

The formation of the National Committee for Volunteering in 2019, led by the Minister of Labour and Social Development and comprising representatives from various sectors (BOE, 2019), represents a significant milestone. This committee plays a central role in

shaping volunteer work strategies, supervising volunteer databases, and supporting volunteerism through organisational and developmental mechanisms. Since then, volunteer work has been organised under supervision of three main sectors: government, for-profit, and non-profit. In the government sector, governmental entities can establish administrative bodies responsible for overseeing, organising, and developing volunteer work within government entities and subsidiaries, following regulations issued by the Ministry of Human Resources and Social Development. In the for-profit sector, organisations are committed to promoting a culture of volunteerism and activating it amongst community members in line with their roles and objectives. Private sector entities are allowed to participate in volunteer work and implement volunteer initiatives after registering with governmental or non-profit organisations to ensure integrity of practices and avoid receiving any form of financial gain.

The level of volunteerism in Saudi Arabia is significantly impacted by its conservative culture (Talaue et al., 2018). Participation in volunteer activities is strongly shaped by traditional norms and core values (ibid.). This conservative cultural ground has relevance for both accessing opportunities to volunteer and the actual work undertaken, which could range in community development terms from conservative service provision to more radical advocacy modes. Formerly, women in some Saudi communities faced more difficulties engaging in volunteering, especially in small communities and when their families were worried about potential gender interactions (Jiang et al., 2018). Saudi Arabia is renowned for its conservative cultural norms, which, in many instances, restrict women's participation in community activities (Talaue et al., 2018). Hence, male Saudi volunteers tend to dominate the volunteer landscape in comparison to many other countries, largely influenced by tradition and culture (ibid.). These days, with the establishment of the new 2030 vision, volunteer work is more encouraged, especially among youth groups and women's groups, which expands community ownership and empowerment.

Saudi Arabia has extensive datasets profiling volunteers in the country (Open Data, 2023). This state-coordinated data collection reflects the highly structured system mandating all volunteers to register with relevant authorities through the national volunteer portal website, which explains the existence of this dataset. The following figures show data segmented by key demographics and participation areas, including age, gender, education level, and fields of engagement. Overall, the data provides a detailed overview of who is volunteering in Saudi Arabia and the types of roles they are involved in. Specifically, the following figures shows the number of female and male volunteers in Saudi Arabia across

various age groups, spanning from 16-20 years old to over 60 years old. The data shows that the highest number of female and male volunteers are aged 41-45. When looking at the overall volunteer numbers across the age ranges, there are more male than female volunteers in aggregate - with 144,277 male volunteers compared to 137,361 female volunteers. While women participate very actively in the 41-45 age range, men tend to volunteer more overall across age groups in Saudi Arabia. In terms of education level, most volunteers have a bachelor's degree (108,867 volunteers). Finally, looking at volunteering fields, the highest number of volunteers are in technical roles (50,322 volunteers) followed by social volunteering (37,351 volunteers) and organizational roles (37,895 volunteers). Other fields with high representation include general volunteering, administrative roles, and media.

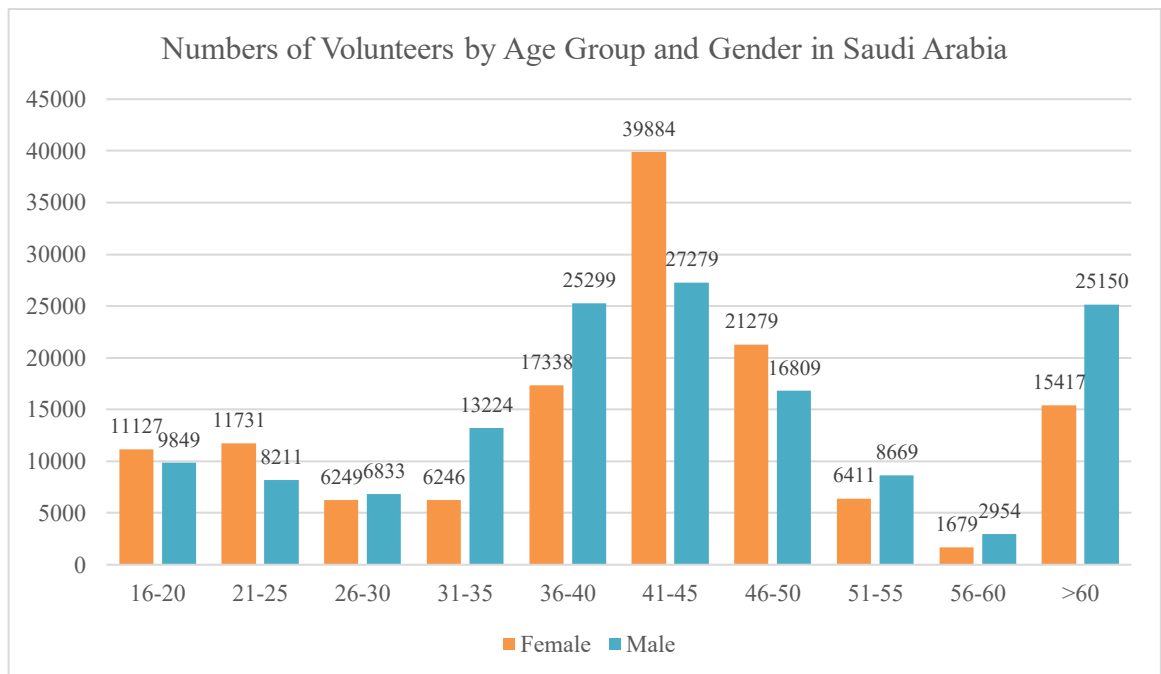


Figure 5.1 The Number of Volunteers by Age Group and Gender in Saudi Arabia (Open Data, 2023).

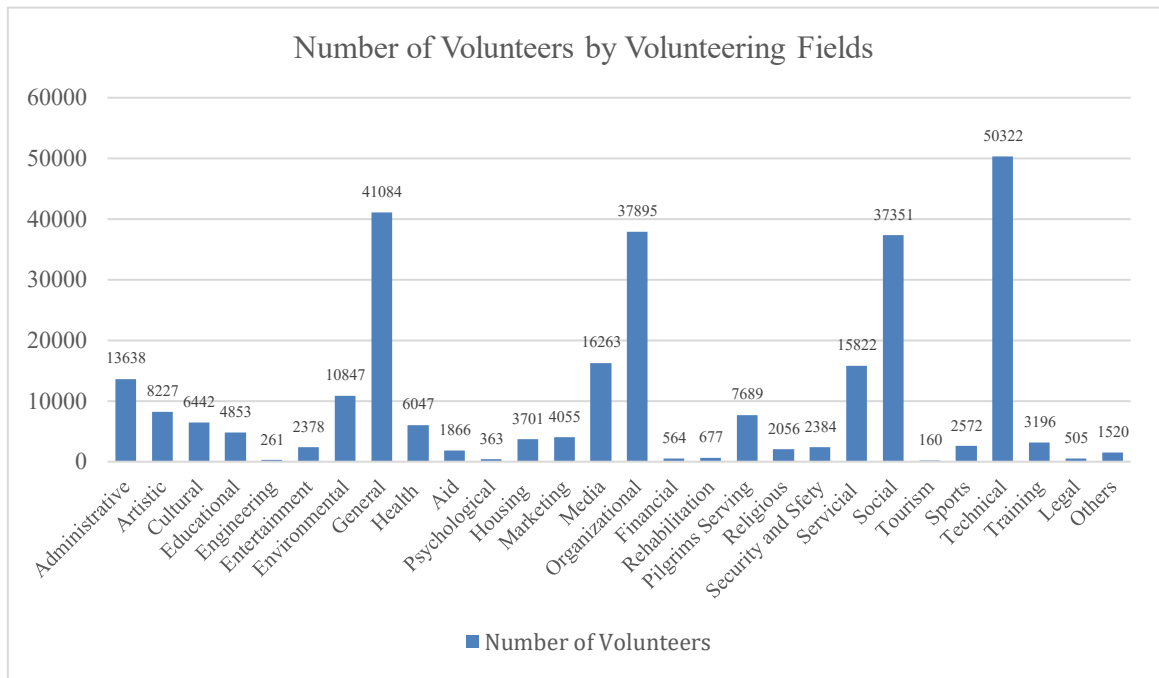


Figure 5.2 The Number of Volunteers by Volunteering Fields in Saudi Arabia (Open Data, 2023).

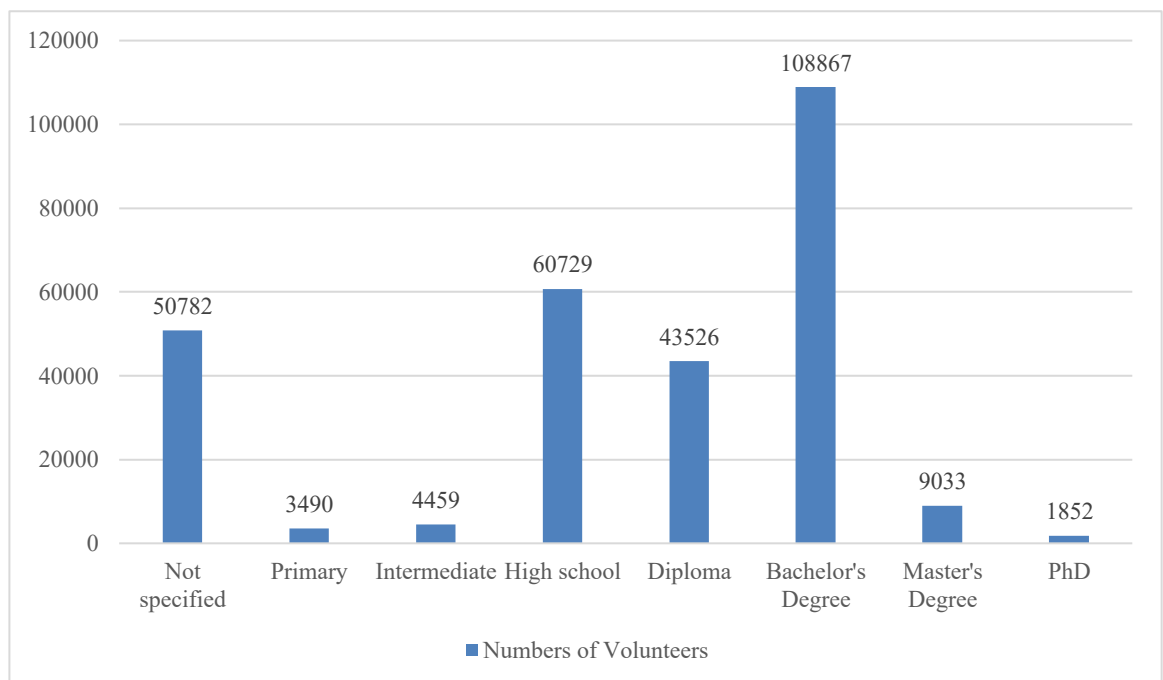


Figure 5.3 The Number of Volunteers by Education Level in Saudi Arabia (Open Data, 2023).

5.3.1.2 Local Contexts: Volunteering in Al-Jumum. Building on the previous broader discussion of Saudi national contextual factors, the analysis will now proceed to examine the specifics circumstances relating to volunteering participation within Al-

Jumum. In the case of Al-Jumum, the overarching goal of volunteer work is to enhance the well-being and development of the community, promote unity, and create a better place to live for the residents. These volunteering practices should be understood within Al-Jumum's rural/peri-urban character. Although Al-Jumum has developed administratively and infrastructurally as a small city and governorate centre, volunteering continues to draw on forms of social familiarity, family connection, neighbourhood cooperation, religious obligation, and local trust that participants associated with older village-based community life. In this sense, volunteering functioned as a bridge between traditional forms of mutual aid and newer formalised structures of civic participation promoted through Vision 2030 and the National Volunteer Work Platform.

In the city, the main purpose for people to participate in volunteering is to engage in community service projects, such as cleaning campaigns, neighbourhood beautification, and local infrastructure improvement. Sometimes, they also participate in environmental initiatives, such as tree planting, recycling programs, and awareness campaigns to protect and preserve the natural surroundings. In addition, Al-Jumum, like many Saudi cities, may have volunteers engaged in charitable and religious activities, such as organising events at local mosques or assisting with charitable endeavours. Another field where volunteers may participate in is engaging in educational programs, language teaching, or cultural preservation efforts to celebrate and pass down the rich heritage of the region.

“Another key area where we mobilize volunteers is in celebrating and spreading knowledge of the rich cultural heritage here, especially to visitors during times like Ramadan or Hajj pilgrimages. Volunteers engage in activities like educational programs teaching regional languages, serving as tour guides to share cultural background, and preservation efforts. It's crucial that younger generations gain exposure to these traditions, while also educating those outside the region about our unique local community.” (The third stage interviews, local policymaker, I2).

A dataset of 157 volunteer opportunities in Al-Jumum, from the Saudi Open Data Portal, was analysed. The volunteer demographic presents a diverse and interesting landscape. In terms of gender, there is a slightly higher participation from females, with 85 female volunteers compared to 72 male volunteers. This contrasts with the previous overall national data which shows more aggregate male volunteers than female. The higher proportion of female volunteers engaged in Al-Jumum community may indicate more localised acceptance and opportunity structures enabling women's participation, despite national trends reflecting remaining barriers. The educational background of the volunteers

is predominantly at the bachelor's level, with 77 individuals holding a bachelor's degree, indicating a well-educated volunteer base. High school graduates and those with a diploma also contribute significantly, with 35 and 17 volunteers respectively. When it comes to the fields of volunteering, technical roles are the most common, attracting 58 volunteers. This is followed by recreational activities, with 31 volunteers. These numbers indicate a preference or need in the community towards technical and recreational volunteering opportunities. Other fields like Cultural, General, Educational, and Social had fewer volunteers, indicating a diverse range of interests but with clear preferences towards certain fields. The following figures shows the number of volunteers by age group, gender, and volunteering fields (Open Data, 2023).

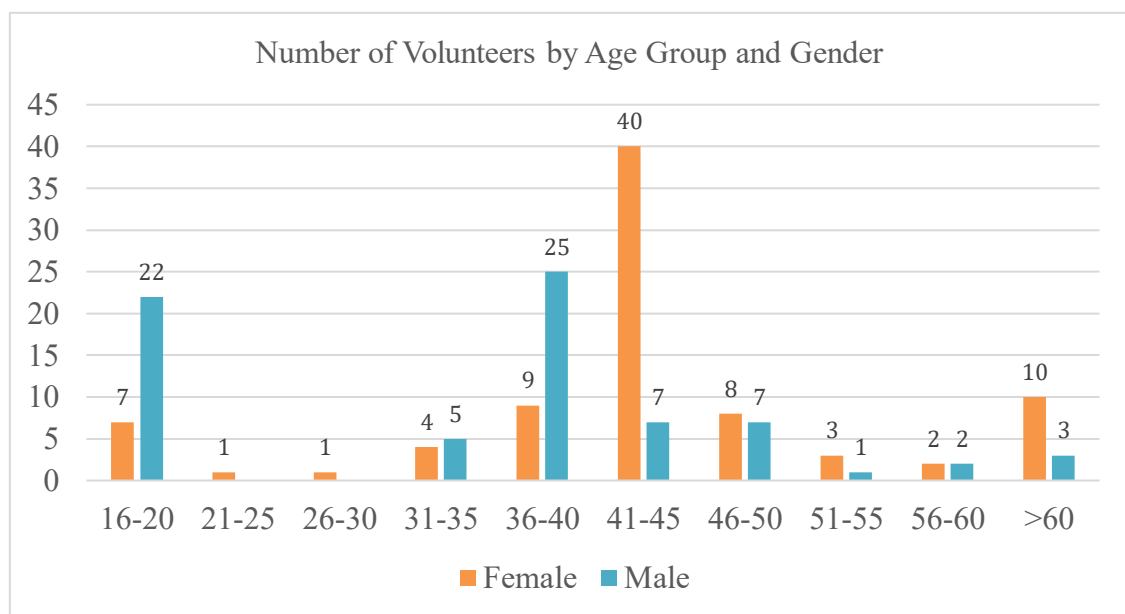


Figure 5.4 The Number of Volunteers by Age Group and Gender (Open Data, 2023).

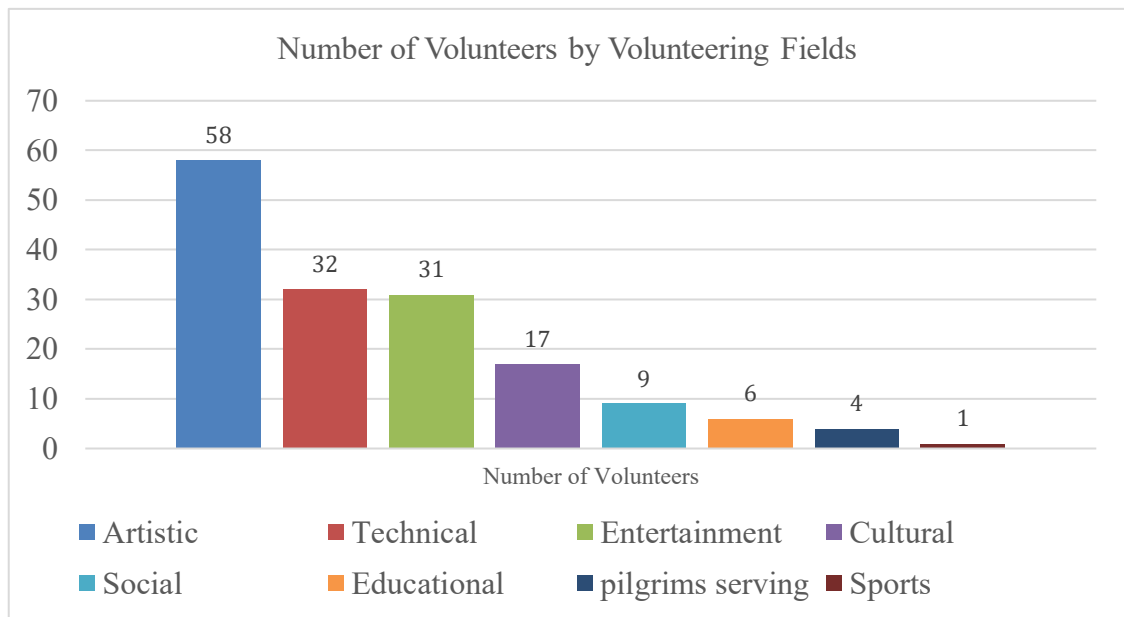


Figure 5.5 The Number of Volunteers by Volunteering Fields (Open Data, 2023).

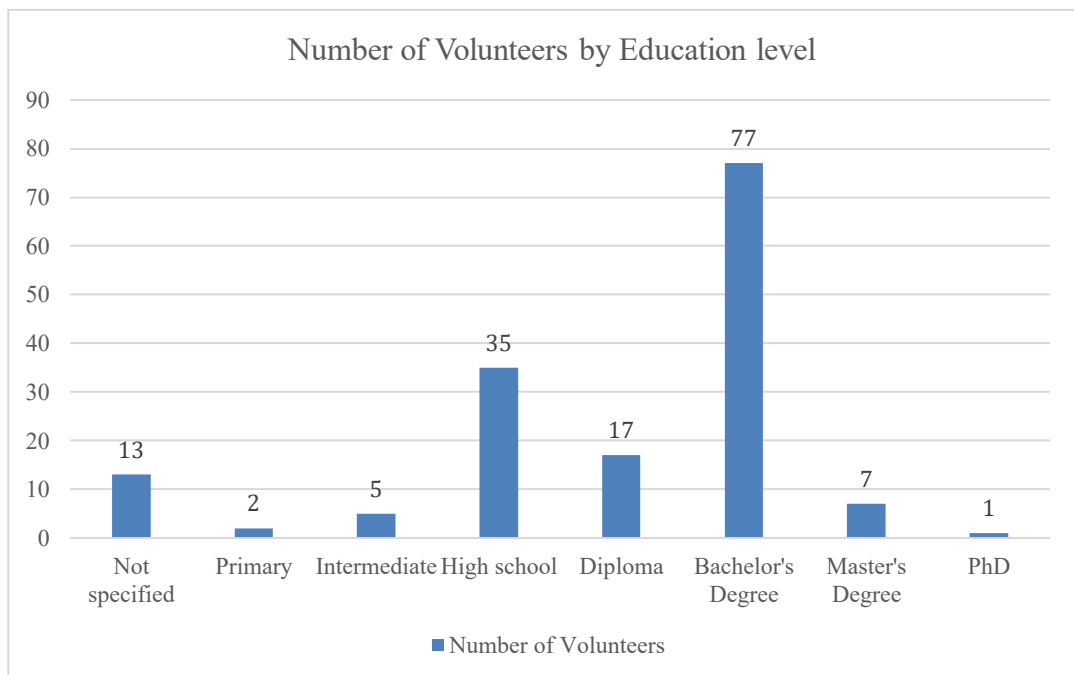


Figure 5.6 The Number of Volunteers by Education Level (Open Data, 2023).

As another part of the contextual factors in the RE framework, the specific historical and cultural underpinnings of volunteering provide crucial background. The deeply rooted cultural and historical underpinnings of volunteering in Saudi Arabia have been previously discussed. Within this broader context, the specific case of Al-Jumum stands out due to its historical and geographical location.

“Al-Jumum has an important location as it connects three big cities together. In ancient times, the generosity of the citizens, with pilgrims coming for Hajj in Mecca, was seen when they stopped to rest in the middle of the road. Even now, you can see this even with other people and travelers. Therefore, the love of helping others has been present among the people of the city. They did these things because of the traditions they grew up with. You also know that our religion urges us to do so. However, the volunteering work in its new shape has been recently developed in the city.” (The third stage interviews, local policymaker, I2).

This account is important because it connects contemporary volunteering with older practices of hospitality, religious duty, and mutual assistance. It also reflects Al-Jumum's position as a rural/peri-urban place located between larger urban centres while retaining social practices associated with village-based community life. The participant's distinction between older traditions of helping and the “new shape” of volunteering illustrates how asset mobilisation in Al-Jumum is not entirely new, but is being formalised through contemporary policy and institutional frameworks.

Also, the historical practice of helping pilgrims on their way to Mecca reflects a deeply ingrained cultural ethos of hospitality. This concept of hospitality carries deeper connotations beyond mere accommodation, tying to traditions of diversity, inclusion, and bridges between different groups. Also, the interviewee's mention of the city's residents acting out of both tradition and religious teachings underscores the intertwined nature of cultural heritage and Islamic principles in shaping altruistic behaviour. The cultural traditions passed down through generations serve as a foundation for the community's commitment to helping others. Furthermore, the acknowledgment that contemporary forms of organised volunteering have only recently emerged in Al-Jumum is noteworthy. As elaborated in earlier sections, modern civic participation encompasses formal structures and dedicated roles - qualities beginning to manifest in Al-Jumum's volunteer landscape.

However, data documenting perspectives and attitudes towards this societal shift is confined to one interviewee who conveyed an openness and enthusiasm to personally adopt these modernised practices, while retaining core values of compassion. She described her efforts to actively participate in various new structured volunteer programmes. This limitation inevitably characterises case study approaches which must rely on particular perspectives, though this represents a methodological constraint rather than a fundamental flaw. Even for those embracing the transition, deeper insights into rationales, hesitations and priorities would provide greater nuance around the pace and

growing pains guiding the movement from traditional charity to formalised, contemporary volunteering.

In addition, the same interviewee expresses a strong sense of duty as a community member. This reflects a cultural value of communal responsibility where individuals feel a moral obligation to contribute to the betterment of their community. The interviewee's response reflects a cultural backdrop that places a high value on community engagement, individual responsibility, and the belief that positive change is a collective endeavour. The cultural underpinnings influence the interviewee's perception of their role within the community and shape their understanding of how resources, particularly the citizens themselves, can be leveraged for the greater good.

On the other hand, introducing female volunteers in Al-Jumum initially encountered cultural challenges deeply rooted in traditional norms and societal expectations. The conservative cultural context posed obstacles to the active participation of women in volunteer activities, reflecting historical gender roles and perceptions. In the past, prevailing cultural factors limited the visibility and involvement of female volunteers in public spaces. However, over time, the landscape has witnessed a transformative shift. Evolving social dynamics, educational advancements, and a broader discourse on women's roles in society have contributed to changing perceptions (Hamdan, 2005). The gradual acceptance of the notion that women can play a crucial role in community development has paved the way for an increased presence of female volunteers in Al-Jumum. This transformation not only signifies a departure from entrenched gender norms but also underscores the resilience of cultural values in adapting to contemporary societal needs.

The founding of the Wadi Fatima Women's Group, which is a female volunteering group based in Al-Jumum, entirely spearheaded and comprised of female volunteers, epitomises this driving force of women's leadership diversifying community action's focus. The group participated in organising several volunteer events in the city, including an event targeting children aged 6 years and above to help discover and develop their talents and encourage them to be part of the volunteering work, in addition to many other activities such as city cleaning, tree planting, and so on. The journey of integrating female volunteers into the fabric of community engagement in Al-Jumum reflects a nuanced interplay between cultural evolution and the collective recognition of the untapped potential that women bring to the realm of volunteering.

"If you visited us a few years ago, you would not have found any women volunteer groups. This idea started when [name of individual] decided to do something for the community. I am a teacher, and I remember when he first contacted our school manager to ask her for support and to encourage us to participate and be part of his group. At first, the individuals in the volunteer group were all male. That is why he decided to make a move and start at girls' schools to gain more female participants. We were only two girls at the beginning. Now, the group has more than 90 female participants, which is a huge improvement given the restrictions that existed in our community." (The second stage interviews, Participant 1, Females from a local volunteers' group, FG3).

Moreover, the participant begins by acknowledging restrictive cultural norms regarding gender roles that have historically presented obstacles for women wishing to engage in civic activities. There is discussion of the challenges these traditions posed to women's confidence and ability to participate publicly.

"It was difficult for us to participate in these kinds of activities. I believe you have an understanding of what the situation was like in small communities here, and the importance of gender segregation due to traditions. So, it was challenging for us to participate in public activities that involved the presence of individuals from the opposite gender. Even if we wanted to, we felt shy and lacked confidence." (The second stage interviews, Participant 1, Females from a local volunteers' group, FG3).

Additionally, one of the participants discussed an evolution in mindsets enabling bolder participation. There is a notable transition towards increased confidence and focus on goals over restrictive norms when it comes to engagement.

"Now, everything has changed. We are more confident, and it is easier for us to participate more in public activities. We focus on our goals more than our traditions, as long as we do not do something wrong." (The second stage interviews, Participant 1, Females from a local volunteers' group, FG3).

While substantial progress has occurred, the integration of female volunteers continues to face some lingering resistance rooted in conservative gender norms. However, the broader community displays increasing openness to women's public participation, evident through evolving compromises to enable engagement while addressing families' concerns. As one female volunteer described:

“Until now, there are still some families that refuse to allow their women to work in mixed-gender environments. However, their numbers have started to decline. Even if there is resistance from some community members due to excessive caution and fear of deviating from traditions, they have begun to send their women with a male family member to ensure their safety. In general, there is an increase in awareness and knowledge among the people of the region, especially regarding volunteering and community contribution. They are becoming more inclined to allow their sons and daughters to participate in such activities to enhance their roles in society.” (The second stage interviews, Participant 2, Females from a local volunteers’ group, FG3).

This illuminates lingering reluctance of some conservative families to endorse women entering public, mixed-gender spaces independently. Yet it also captures nascent adaptations enabling engagement under supervision, signalling small steps towards openness. Promisingly, the participant perceives broader increases in awareness, suggesting societal evolution more receptive to women's visibility through volunteering. In examining responses from members of local volunteer groups, it is evident that cultural dynamics have played pivotal roles in shaping female participation in volunteering activities in Al-Jumum. The initial absence of women in volunteer groups, as recalled by interviewees, highlights historical challenges rooted in gender segregation traditions. The transformative journey, catalysed by community leaders, symbolises significant shifts in attitudes and opportunities for women. From hesitancy expressed by participants in the past due to societal norms, there emerges a narrative of empowerment and increased confidence amongst female volunteers. The progression from only two female participants to a thriving group of over 90 represents remarkable strides forward, showcasing cultural evolution where goals take precedence over restrictive traditions. They were working on increasing awareness amongst different age groups in the city, and the team also played important roles during implementation stages towards obtaining Healthy City accreditation. Due to the team's contributions, it has received numerous local awards and certificates of appreciation, in addition to its contribution to increasing the number of female volunteers in the city. This shift indicates growing awareness and knowledge within the community, emphasising willingness to adapt cultural practices in favour of broader community contributions. As cultural perceptions evolve, the inclination to involve both sons and daughters in volunteer activities reflects positive trajectories toward enhanced roles for women in societal development.

5.3.2 Mechanisms in Al-Jumum's Volunteering Implementation

Mechanisms are operationalised through community-based initiatives that leverage the traditional values, encouraging individuals to engage in volunteer activities as a manifestation of their societal duty. Numerous government-led initiatives have been launched to encourage participation in community service and philanthropy. These initiatives span various sectors, including education, healthcare, and social welfare. In this section, examples of established volunteering initiatives and key stakeholder interaction in Al-Jumum will be mentioned to provide a nuanced understanding of the processes and dynamics that lead to success or challenges for volunteer initiatives in Saudi Arabia.

In Al-Jumum, local volunteer programs often align with cultural festivities and religious occasions, integrating cultural heritage into their activities. During Ramadan, there is a surge in community-driven volunteer initiatives focused on providing iftar meals to the less fortunate. These daily community meal services embody the cultural values of charity, goodwill, and unity integral to Ramadan traditions. Specific initiatives include the (Feeding the Fasting) campaign, which mobilises youth volunteers across neighbourhoods to distribute hundreds of meals prepared by local groups. As described by one policymaker driving this annual initiative:

“One of the initiatives that I always strive to implement annually is the "Feeding the Fasting" initiative. I always encourage young people to volunteer in this initiative, targeting the younger age group to instil in them the spirit of initiative and a love for helping others. I also believe that this makes them feel the extent of their importance and increases their connection to the community.” (The third stage interviews, local policymaker, I2).

Additionally, in this interviews, the policymaker noted, “The locations of its implementation and the distribution of meals vary from year to year and from day to day, including neighborhoods, roads at traffic lights, mosques, etc.” This exemplifies the strategic use of religious spaces and underscores the community's innovative engagement. This initiative not only showcases the alignment of volunteer efforts with cultural and religious values but also illustrates the community's capacity to mobilise resources. The adaptability and inclusiveness of these efforts, across various locations, affirm the community's ability to leverage its cultural heritage and religious practices as essential assets, setting a model for utilising religious institutions in fostering community solidarity and development.

Also, some volunteer initiatives in Saudi Arabia have witnessed collaboration among various government and private entities, contributing to the widespread dissemination of a volunteer culture among different segments of society. The interplay between the state and voluntary initiatives presents a complex dynamic, with the domestic voluntary sector playing a significant role in civil society through traditional forms of social interaction and serving as an alternative channel for socio-political dialogue and social reform (Montagu, 2010). This involvement signifies a structured approach to fostering civic engagement, with government bodies like municipalities and governorates establishing advisory councils for development and volunteering, composed of government personnel and individuals from various sectors (Thompson, 2018). Additionally, organisations such as the Saudi Red Crescent Authority have institutionalized volunteer efforts by registering volunteer groups (*ibid.*). Also, the active participation of young people, through university programs and clubs, highlights the promotion of a volunteer culture among the youth (*ibid.*).

Despite restrictions on formal opposition, civil society engages through voluntary sector activities, including advocacy for social causes and promotion of dialogue on issues like women's participation in municipal elections and countering extremism (Montagu, 2010). The government's interest in developing the voluntary sector, evidenced by the establishment of organisations like the National Association for Human Rights, shows a nuanced relationship between state support and the voluntary sector's independence (*ibid.*). However, while the state's involvement provides structure and resources, it also imposes limitations on volunteer groups' scope and autonomy, with selective approval for associations that can hinder the organic growth of an independent civil society (Thompson, 2018). Professional associations, registered and financially supported by the government, are strictly monitored and unlikely to challenge government policies, raising questions about their independence and ability to represent their members' interests without government influence (*ibid.*). Therefore, the balance between state support and the independence of civil society in Saudi Arabia is delicate, requiring careful consideration to ensure volunteer efforts genuinely reflect the people's needs and aspirations (*ibid.*).

The extensive involvement of state actors risks over-structuring grassroots civic action in a top-down manner potentially at odds with bottom-up, community-driven ideals of volunteering (Claridge, 2018). As such, while collaboration enhances reach, the power dynamics shaping such cooperation warrant examination through critical civil society perspectives. For example, one local policymaker described coordinated efforts between

ministries and organisations to provide volunteering opportunities and instil nationalistic values, stating:

"Through collaboration with various entities, we endeavored to promote a culture of volunteering...These initiatives aimed to contribute to instilling a spirit of volunteering in the community, acquiring experiences, investing time and abilities, and enhancing a sense of national belonging." (The third stage interviews, local policymaker, I1).

Similarly, cross-sector partnerships between government agencies, police and private businesses focused public health volunteer campaigns on implementing state-defined safety protocols, as this quote illustrates:

"Another campaign we conducted in 2020 focused on health awareness...in collaboration with the municipality and the police. The campaign's objective was to implement precautionary measures in commercial establishments and raise health awareness among market visitors and workers." (The third stage interviews, local policymaker, I2).

While likely benefiting communities, critics contend that government-led volunteering of this nature can restrict autonomous civic action (Claridge, 2018). As such, analysing who directs priorities in state-sponsored initiatives and whether alternative avenues exist for citizen-led agendas merits exploration. There are more than 24 approved volunteer initiatives, at the level of the Ministry of Human Resources and Social Development which has been implemented in the city.

"All volunteer initiatives are conducted under the supervision of relevant authorities, whether governmental or private, to ensure compliance with instructions and the implementation of regulations and specific rules pertaining to volunteer work in the country" (The third stage interviews, local policymaker, I2).

Indeed, an alternative mechanism led by citizens themselves involves the Wadi Fatimah group focused on women's volunteering and empowerment. As mentioned earlier, this group is encouraging women citizens to volunteer and participate in different social activities and be active in their community. By creating a platform that focuses on the unique challenges encountered by women in mixed environments, this volunteer group serves as a catalyst for positive change. Through empowerment, community building, and skill development, the group endeavours to uplift women, providing them with the tools

and support needed to navigate and overcome obstacles. Furthermore, the Wadi Fatimah group plays a pivotal role in advocacy and awareness, shedding light on the issues at hand and fostering understanding within the broader community. This initiative not only addresses immediate concerns but also contributes to the long-term goal of creating a more inclusive and supportive mixed-gender environment, where women can thrive and actively participate in various facets of life.

"We have always and continue to emphasize the importance of encouraging the establishment of such initiatives and volunteer teams to enhance the role and strengthen the individual in society, especially women." (The third stage interviews, local policymaker, I1).

Additionally, one of the interviewees mentioned that he was keen on increasing the number of female volunteers to achieve balance. He noted that in some initiatives, the presence of the female element was essential due to the importance of the role they play in attracting a larger audience and achieving the initiative's goals. An example is an afforestation initiative conducted in the area to increase green spaces, where the presence of women was crucial in attracting a broader range of people and achieving the initiative's objectives.

"To get more women volunteers, I approached family first then worked with a principal who motivated teachers and students, making volunteering part of the curriculum. This prompted initial participation for grades, but many kept engaging afterward without rewards. The numbers grew over 100, so I established 'Nabd Al-Jumum Volunteer Team'. Women were essential for the afforestation initiative's success in increasing green spaces." (The third stage interviews, local policymaker, I2).

Regulatory Navigation and Digital Coordination emerged as significant mechanisms observed through direct engagement with volunteer groups. During observations and focus group sessions with volunteering groups in Al-Jumum, participants described activities they had organised through the formal volunteer registration system. After obtaining the necessary approvals, they had organised diabetes and obesity awareness sessions and coordinated a community initiative to clean the local park and plant trees. These examples demonstrated asset-based principles operating within formal governance structures: identifying community priorities (health awareness, environmental improvement), mobilising available resources (volunteer time, community spaces, local knowledge), and

building on community strengths and social networks to implement activities, all while adhering to regulatory requirements.

This regulatory context created an interesting dynamic where grassroots asset mobilisation operated through formal state structures rather than independently of them, raising important questions about how governmental oversight might shape the nature and effectiveness of community-driven asset-based approaches. The volunteering activities observed represented a form of structured asset mobilisation that operated within Saudi Arabia's formal civic engagement framework, creating both opportunities and constraints for community-driven health promotion.

The formal registration process provided legitimacy and potentially resources for volunteer activities, while also ensuring coordination with broader governmental health initiatives. The National Platform for Volunteer Work served as a mechanism for connecting community assets with identified needs across different localities, potentially scaling up effective asset-based approaches. However, the regulatory requirements also raised questions about the authenticity and sustainability of community asset mobilisation when it operates under formal oversight.

During interactions with the volunteering group, there was evidence of how they navigated this tension by framing their community-driven priorities in ways that aligned with formal health promotion goals, suggesting a form of adaptive strategy that maintained community ownership while satisfying regulatory requirements. Digital Network Facilitation emerged as a contemporary mechanism for community organising, with WhatsApp groups serving as crucial coordination platforms. The digital network used by the volunteers facilitated not only coordination and planning but also sharing of health information, celebrating successes, and maintaining social connections between formal activities. This digital dimension of community asset mobilisation represented a contemporary adaptation of traditional social networks, demonstrating how asset-based approaches might evolve within modern communication contexts while maintaining the social capital and relationship-building essential to community development.

5.3.3 The Observed Outcomes of Volunteering Implementation in Al-Jumum

As part of the analytical framework, investigating outcomes comprises assessing results of volunteering work in Al-Jumum, specifically tracing links back to contextual factors and employed mechanisms. In the context of the local volunteering initiatives in Al-Jumum, this section delves into the results of the volunteering work in Saudi Arabia and Al-

Jumum, specifically. Through an examination of the observed and anticipated outcomes, from the lens of the key concepts mentioned previously in table 2, this section seeks to illuminate the changes that have emerged as a direct consequence of the implemented strategies and mechanisms. The outcomes outlined here encapsulate the dynamic interplay between the contextual factors, and the mechanisms employed.

Community engagement manifests in volunteer work conducted in Al-Jumum to encourage women to participate in different activities. Additionally, aligning volunteer efforts with cultural and religious events not only reflects community engagement but also enhances the overall impact and relevance of volunteer programs. It creates opportunities for community members to actively participate in initiatives that hold cultural significance, reinforcing a shared commitment to social responsibility and collective well-being.

The previous mechanisms reveal collaboration and relationship-building outcomes manifesting across individual, community, and societal levels, reflecting the multi-dimensional impacts outlined earlier regarding volunteering's potential benefits. The initiatives demonstrate a shared commitment to societal well-being, safety, and health through coordinated efforts and partnerships. Collaboration is reflected in the coordination of different ministries, as well as the facilitation of over 500 volunteer opportunities. Such collaboration not only provides diverse volunteering chances but also plays a pivotal role in "fostering a collective understanding of the importance of volunteerism," as one local policymaker expressed (I1). This sentiment was echoed by a community organiser, who stated that "bringing together different stakeholders has been key in raising awareness and enthusiasm for volunteering among residents" (I2). A representative from the private sector also emphasised the collaborative spirit, noting that "government, companies, and local groups have worked hand-in-hand to promote opportunities for people to give back" (I3). For example, anti-smoking campaigns had high turnout, with many signing up for quitting support associations (I2). Consequently, as the policymaker noted, "Al-Jumum earned the title of a smoke-free city" given the almost non-existent prevalence of smokers after the awareness drives (I1).

This reflects a strong relationship built among governmental, private, and community entities, working together to instil a spirit of volunteering in society and aligned around the goal of "doing our best to achieve the 2030 vision and increase awareness in our city," as one policymaker stated in the interview (I1). Drawing from multiple perspectives reinforces the theme of partnerships across sectors working collectively to spread the impact of volunteerism. Also, this collaborative approach between ministries demonstrates

the building of relationships to address health concerns collectively and disseminate information widely to the public. Drawing perspectives from policymakers and health officials reinforces the theme of impactful coordination across governmental entities for health promotion.

Additionally, collaboration for health awareness campaigns, conducted with multiple sectors, including the health volunteering department, the health sector, the municipality, and the police has made a positive change by implementing precautionary measures and raise health awareness. This is noticeable now in the community according to one local policymaker (I2). This policy maker mentioned that "you can notice how the level of knowledge and awareness among community citizens has increased," aided by coordinated media efforts to disseminate the message widely (I2). He also stated, "over time, even our efforts to raise awareness have diminished" as the campaigns have taken hold, reflecting increased public knowledge (I3). By coordinating with various entities, the campaign contributes to the overall well-being of the community. This reflects a collaborative approach that involves different community levels, emphasizing the importance of shared responsibility and coordinated efforts for the benefit of public health.

The establishment of Wadi Fatimah group has been instrumental in empowering women within the community of Al-Jumum. This group has provided a nurturing environment for personal growth, allowing women to explore and develop their individual strengths and capabilities. The group has become a dynamic force in promoting women's empowerment and contributing to positive social change within Al-Jumum. Moreover, the group has won the second prize in the 'Hayak Initiative' competition, thanks to their role in empowering the community as a whole, and empowering women in particular. This competition was launched by the Civil Defense Administration in Al-Jumum to initiate volunteer programs in civil defense, aiming to promote a culture of public and private safety and enhance the services provided by the Civil Defense to the residents of the region (The third stage interviews, local policymaker, I1; (Al-Fiqi, 2018).

A critical outcome of volunteer work is the potential for more sustainable development, encompassing economic, social, and environmental dimensions. By building on local assets and capacities, people's efforts in Al-Jumum work towards long-term and self-sustaining solutions to their challenges.

"We can see the potential in our resources, the strengths in our people, and the benefits we can gain by focusing our efforts on the inside. This can help us, in the

long term, develop our community at all levels. I believe the volunteer work here is helping us in this manner. People are getting more involved, and their knowledge about what is happening in the community is increasing.” (The third stage interviews, local policymaker, I2).

5.4 Discussion and Critical Analysis

This chapter explored connections between volunteer efforts and asset-based approaches for community development. The analysis now examines findings, assessing alignments and tensions around key themes: integration of volunteerism with asset-based principles; limitations posed by hierarchical structures; and considerations around empowerment and gender dynamics.

The findings also contribute to the discussion of rurality developed in Chapters 1–3. Although Al-Jumum is formally classified as a city, participants frequently described volunteering through social relationships, local identity, community cohesion, and traditions of mutual support that reflected their understanding of the area's rural heritage. Volunteering therefore emerged not only as a mechanism for service delivery but also as a means of maintaining and strengthening social connections that many participants associated with rural community life. This finding reinforces the argument that rurality is best understood as a socio-cultural and relational concept rather than solely an administrative classification.

The volunteer work observed in Al-Jumum aligns with the key aspects of the UNV definition of volunteerism adopted earlier in the chapter. First, the volunteering activities in Al-Jumum are primarily motivated by a desire to help others. The essence of the work is voluntary service to the community. Second, participation is freely chosen. Residents decide for themselves to contribute their time and skills where needed. However, student participation tied to academic credits reveals elements of external obligation rather than purely voluntary engagement. Finally, the efforts ultimately aim to benefit the broader community, such as through health campaigns and Iftar meal activities. This type of voluntary civic participation reflects an asset-based approach by utilising existing human and social resources within Al-Jumum. Volunteer initiatives in Al-Jumum activate local capabilities and strengthen communal ties.

The volunteer work in Al-Jumum exhibits some alignment with asset-based principles but also key differences. A core aspect of asset-based approaches is enabling bottom-up, community-driven development grounded in residents' strengths and priorities (Marais,

2012; McLean et al., 2017). However, volunteering remains largely top-down and government-directed in Al-Jumum, requiring state approval as standardized by national regulations (BOE, 2019; HRSD, 2020). This conflicts with the community empowerment vision of asset-based models (McEwan, 2008; Rans et al., 2002). Nonetheless, the work does activate localised resources, seen in rising volunteer numbers (Open Data, 2023) and growing female participation despite patriarchal norms (Hamdan, 2005). This reflects strengthening communal ties and social capital essential to sustainability in asset-based approaches (Boneham & Sixsmith, 2003; Woolcock, 2001). Further, increased inter-ministerial collaboration (Vision2030, 2022b) indicates some shift from siloed bureaucracies toward the partnership model (Sutton, 2018). These partnerships forged between sectors, however narrow currently, signal openings for collaborative governance models that draw together diverse stakeholders (Evers & von Essen, 2019). Extending such cooperation more locally could address complex communal needs holistically.

As noted in the chapter, the outcomes of volunteer work may unequivocally demonstrate success in amplifying key aspects of community development, including heightened levels of community engagement, relationship-building, empowerment, and collaboration. The surge in community engagement is evident through increased participation in various initiatives and activities, as presented in the analysed data from the Saudi Open Data Portal, fostering a sense of belonging and shared responsibility. Relationship-building flourishes as volunteers establish meaningful connections within the community, creating a network of support and collaboration.

"I feel that we are one family with a common goal that we strive to achieve. I have gained many friends through volunteering. We now communicate and meet regularly." (The second stage interviews, Participant 2, Females from a local volunteers' group, FG3).

The sense of empowerment among community members is obvious, as individuals report a greater understanding of their strengths and capabilities, translating into increased confidence and initiative. This was especially obvious in the women's volunteer work. Moreover, the collaborative spirit fostered by volunteer efforts strengthens social ties and facilitates joint problem-solving. The participants, in the interviews, were focusing on achieving the goals of the 2030 vision, one of which is increasing the empowerment of Saudi communities and people's participation.

However, gender-based segmentation of roles and resources significantly influences asset mobilisation (Hamdan 2005; Jiang et al. 2018). For instance, Community Midwives (CMWs) in Pakistan encounter challenges such as lack of trust, affordability concerns, and gendered mobility constraints (Mumtaz et al., 2015). Patriarchy also impedes inclusive communications (Underwood et al. 2011), crucial for asset-based approaches. In Al-Jumum, gender norms affected information sharing and participation, sometimes creating separate communication channels for men and women. This may cause information gaps (Underwood et al., 2011). In other words, these norms can determine the roles and expectations for men and women in sharing and receiving information, potentially limiting the participation of one gender in certain discussions or decision-making processes and leading to situations where women and men have separate communication channels that may cause information gaps or misunderstandings. Asset-based approaches aim to leverage diverse resources (GCPH, 2012), and if there are gender-based imbalances, it can hinder the full utilisation of available strengths.

Even if the government's Vision 2030 and volunteering laws promote community participation and empowerment (BOE, 2019), putting these policies into practice at the local level may face difficulties. In Al-Jumum, many approvals were required before residents could volunteer, blocking engagement (HRSD, 2020). While the achievements of Vision 2030 in relationship-building and engagement are commendable, the influence of the centralised state merits critique through an asset-based lens prioritising community authority and bottom-up solutions. As known, asset-based approaches emphasise enabling bottom-up, community-led development tailored to residents' strengths and priorities (GCPH, 2012). However, the gap between Vision 2030's policy aims, and localised capacity can block this grassroots empowerment. Government control in Al-Jumum conflicted with key principles of asset-based models upholding localised voice (McEwan, 2008; Vaughn & Jacquez, 2020).

Additionally, the dominance of bonding over bridging social capital also aligns with asset-based principles prioritizing communal solidarity (Claridge, 2018; Jiang et al., 2018). Most volunteering in Al-Jumum involves people with similar identities working together, like all men or all women's groups. This kind of bonding within groups creates community belonging (Woolcock, 2001), but it also makes connecting across differences harder. Vision 2030 wants to include everyone. However, rules keeping some people apart are still strong locally. Thus, while joining together people alike gives solidarity, rules dividing

groups and limiting change diverge from asset-based approaches empowering all residents equally from the bottom-up (GCPH, 2011, Baron et al., 2019).

Moreover, the findings of this chapter encourage reflection on the integration of religion-cultural activities with community-driven initiatives. This highlights the potential for religious institutions in an asset-based approach, in contrast to the wider literature's perspectives, which view religious institutions as under-utilised in community development (Lightfoot et al., 2016, Rans et al., 2002). Lightfoot et al. (2016) highlight those places of worship possess considerable untapped resources, advocating for their greater inclusion in ABCD strategies. This discussion aligns with the observations in Al-Jumum, where mosques serve not just as places of worship but as dynamic centers for volunteer activities, particularly during Ramadan.

There are cultural factors hindering full adoption of asset-based approaches, including traditions and reservations about change. Most Al-Jumum volunteering focuses more on service delivery than questioning existing systems, reinforcing Saudi Arabia's communitarianism. As Evers and von Essen (2019) discuss, conservative forms of volunteering can inadvertently maintain the status quos by not addressing root causes. This risks sustaining hierarchies and inequalities through supporting establishment-aligned activities. Indeed, the interviewee noted resistance to embracing new visions that disrupt traditions.

“You know, we are individuals who resist change. I do not mean everyone, but generally, especially in small communities, people tend to resist change and reject any new ideas. This was the case in Al-Jumum. It took us a long time to convince people to embrace new ideas and services, whether in health, social, or educational aspects.” (The third stage interviews, local policymaker, I1).

This quote does not define Al-Jumum as simply rural, but it shows how participants associated Al-Jumum with characteristics often linked to smaller communities, including caution towards change, strong traditions, and the importance of gradual trust-building. This supports the interpretation of rurality in this thesis as a socio-cultural and relational feature rather than only an administrative classification. Additionally, there might be challenges in identifying and comprehensively incorporating all available assets, leading to insufficient knowledge or resources to achieve this. As evidenced during initial asset mapping, confusion around the term "assets" posed difficulties despite extensive explanation. As one interviewee expressed, "I did not fully grasp what you meant by

'assets' at first when you described it." (The first stage interviews, Health Professional, I4). This gap in perceiving inherent capacities risks hindering asset mobilization (McLean et al., 2017). Understanding these challenging factors is crucial for assessing the feasibility of implementing asset-based approaches in Al-Jumum and in similar Saudi rural/peri-urban contexts.

In light of the findings, the examination of volunteering dynamics in this community has uncovered a diverse range of practices. These practices exhibit a dual nature, simultaneously aligning and diverging from the principles of the asset-based approach. On one hand, certain volunteering practices resonate with the core tenets of asset-based methodologies, emphasizing the utilization and enhancement of community strengths and resources. On the other hand, there are instances where the observed practices deviate, perhaps reflecting the influence of pre-existing structures or external factors that introduce variations in the alignment with asset-based principles. This nuanced coexistence of alignment and divergence underscores the complexity of integrating asset-based approaches within the volunteering landscape of the community, prompting a deeper examination of the factors that contribute to this dual dynamic.

The findings also have implications for how the transferability of volunteering-based asset mobilisation should be understood. While these findings provide evidence of the potential contribution of volunteering to asset mobilisation and community development, they should not be interpreted as representative of all rural communities in Saudi Arabia or the wider Global South. Rather, the transferability of the findings lies in settings characterised by similar patterns of social cohesion, community interconnectedness, local identity, and relationships between formal institutions and community action. In particular, the findings are most applicable to rural and peri-urban contexts where volunteering is shaped by strong social networks, cultural traditions, and ongoing interactions between community members and governmental institutions.

5.5 Conclusion

This chapter examined the potential of asset-based approaches within Al-Jumum as a Saudi rural/peri-urban community context, focusing on local volunteer groups as a proxy intervention. The analysis highlighted a dynamic relationship between the theoretical benefits of volunteering as an asset-based practice and the practical challenges posed by existing structural hierarchies, regulatory frameworks, and cultural norms. Although volunteering in Al-Jumum demonstrated important strengths, including social connection, local commitment, women's participation, and intersectoral collaboration, it was also

shaped by national policies and approval systems that may limit community autonomy and constrain more bottom-up forms of community-led development.

The emergence of strong community bonds and intersectoral partnerships through volunteering offers important insights into how asset-based principles may operate in Al-Jumum. Volunteering mobilised local knowledge, social relationships, religious and cultural values, and residents' willingness to contribute to community well-being. At the same time, achieving closer alignment with asset-based approaches requires careful attention to local customs, gender roles, regulatory processes, and the balance between formal state coordination and community initiative. These issues are further discussed in Chapter 7.

This chapter therefore sheds light on Al-Jumum's specific rural/peri-urban community rather than claiming to represent all rural Saudi communities. The findings suggest that volunteering can support asset-based implementation where community relationships, religious and cultural values, local trust, and formal policy frameworks can be productively aligned. However, the Al-Jumum case also shows that asset-based approaches may be constrained when volunteering is strongly shaped by centralised regulation, gender norms, and institutional approval processes. These findings may be relevant to similar Saudi rural/peri-urban settings, but they should not be generalised to all rural communities without attention to local histories, governance structures, and community relationships.

However, this community-focused approach represents only one level of asset-based implementation. To develop a fuller understanding of asset-based feasibility in Al-Jumum, it is also necessary to examine how asset-based principles might function at the individual level within formal healthcare settings. The next chapter investigates health coaching initiatives as a third proxy intervention, exploring how healthcare professionals incorporate asset-based approaches in clinical practice and individual patient interactions. This shift from community volunteering to individual health coaching provides insights into how asset-based principles translate across different scales of implementation—from collective community action to personalised healthcare delivery.

Chapter 6 Health Coaching

6.1 Introduction

Health coaching has emerged as a promising approach to promote health and well-being in various settings, including community health (Edwards et al., 2018). This chapter explores the feasibility of implementing asset-based approach in the Saudi community through analysing the work of health coaching in the country, specifically in the city of Al-Jumum. Asset-based approaches focus on identifying and leveraging the strengths, resources, and capacities within individuals and communities to promote health and well-being, rather than solely focusing on deficits or problems (GCPH, 2011)

The Kingdom of Saudi Arabia has been facing significant public health challenges, including high rates of non-communicable diseases such as obesity, diabetes, and cardiovascular diseases (AlQuaiz et al., 2014). These challenges have prompted the need for innovative and culturally relevant approaches to health promotion and disease prevention. Health coaching, with its emphasis on empowerment, collaboration, and self-management, has the potential to address these challenges and contribute to the achievement of Saudi Arabia's Vision 2030 goals related to health and quality of life (Vision2030, 2022b). However, the translation of health coaching concepts, which originated in global north contexts such as the UK and US, into the Saudi context raises important questions about cultural adaptation and the alignment with local values and practices. This translation process represents more than mere linguistic conversion; it involves the complex negotiation of culturally and politically sensitive principles that underpin health coaching approaches.

As established in the previous chapters, Al-Jumum is treated in this thesis as a rural/peri-urban Saudi context rather than as a fixed or uncontested rural community. This framing is important for interpreting health coaching because individual health behaviours, service access, trust in healthcare professionals, family influence, gender norms, and patient engagement are shaped by Al-Jumum's position between rural social traditions and expanding urban infrastructure. Therefore, this chapter does not treat health coaching in Al-Jumum as representative of all rural Saudi communities, but as a case through which to examine how asset-based principles may operate at the individual and healthcare-service level within a rural/peri-urban context.

This chapter specifically addresses multiple aspects of the central research question - *what factors influence the feasibility of implementing asset-based approaches to health in Saudi rural/peri-urban communities?* - by examining health coaching as a proxy intervention.

The analysis investigates individual and community assets that can be mobilised through health coaching practices (Research sub-Question 1), identifies factors that influence implementation decisions in conservative cultural contexts (Research Sub-Question 3), and explores how both policymakers and community members shape the possibilities for asset-based approaches through their engagement with health coaching services (Research Sub-Question 5). While health coaching operates primarily at the individual level, this examination provides insights into broader implementation dynamics that affect asset-based feasibility in Al-Jumum.

The realistic evaluation framework (Pawson and Tilley, 1997) is employed to analyse the data and understand the context, mechanisms, and outcomes of health coaching in this setting. The chapter begins by providing a background of health coaching and its alignment with asset-based approaches, followed by a description of the work in the Saudi context. The findings are then presented and discussed by applying the realistic evaluation framework, highlighting the key contextual factors, mechanisms, and outcomes that influence the feasibility of health coaching in Al-Jumum.

6.2 Background

6.2.1 Global Perspectives on Health Coaching

Healthcare systems worldwide face growing strain from rising rates of chronic conditions and decreasing financial resources (Edwards et al., 2018). Health coaching is one strategy that has gained recognition as a way to support patients in taking a more active role in managing their health (Olsen, 2014). The concept emerged in the context of a wider public health movement towards preventive care and lifestyle medicine (ibid.). While definitions vary, health coaching generally refers to a patient-centred process that empowers individuals to set health goals, make sustainable behaviour changes, and engage in informed self-care practices (Kivelä et al., 2014).

When implemented broadly, health coaching has the potential to ease the resource burden on strained healthcare systems by facilitating patient self-management of chronic conditions at home (Boehmer et al., 2016). This aligns with the shift towards preventive and community-based care in response to the global rise in chronic diseases and simultaneous shrinking of healthcare funding (Edwards et al., 2018). This development represents part of healthcare's neo-liberal turn, which emphasises individual responsibility for health outcomes whilst potentially reducing state expenditure on health services through the promotion of self-management strategies.

The concept of health coaching, as we understand it today, began to take shape in the late 20th century, particularly in the 1990s (Perlman and Abu Dabrh, 2020), primarily in global north healthcare contexts such as the United States and United Kingdom. The practice of health coaching emerged as a possible intervention to help patients adopt health-supportive behaviours that improve quality of life and health outcomes (Conn & Curtain, 2019). It was influenced by various psychological theories and models, such as motivational interviewing, which was introduced almost 30 years ago by William Miller and Stephen Rollnick and has since been supported by numerous studies demonstrating its effectiveness in health coaching. It also has drawn from various disciplines, including psychology, nursing, nutrition, fitness, and health education, to develop a holistic and patient-centred approach (Conn & Curtain, 2019; Perlman & Abu Dabrh, 2020).

In the United States, the rise of health coaching can be traced back to the increasing prevalence of chronic diseases and the need for more effective strategies to promote lifestyle changes and self-management (Olsen and Nesbitt, 2010). In the United Kingdom, the NHS Expert Patient Programme, launched in 2002, aimed to empower patients with chronic conditions to manage their health more effectively, which aligned with the principles of health coaching (Rogers et al., 2008). The publication of the NHS Health Trainer Handbook in 2006 further supported the integration of health coaching into primary care settings (Michie et al., 2008). This period marked a shift in healthcare towards a more patient-centred approach, recognising the importance of behaviour change and self-management, especially in the context of chronic disease prevention and management (Perlman and Abu Dabrh, 2020, Conn and Curtain, 2019). The development of health coaching in these contexts was driven by the need to address the growing burden of chronic diseases and the desire to empower patients to take a more active role in their health and well-being.

Health coaching has evolved as a response to the growing need for more comprehensive approaches to healthcare that address both illness and wellness within and outside of traditional healthcare settings (Perlman and Abu Dabrh, 2020). The history of health coaching is intertwined with the recognition that chronic diseases, which are often lifestyle-related, require ongoing management that extends beyond the scope of episodic medical treatments (CADTH rapid response service, 2016). The concept of health coaching emerged to empower individuals to take ownership of their well-being, focusing on facilitating behavior change and improving quality of life (Conn and Curtain, 2019). However, it is important to acknowledge the potential hidden power dynamics that may be

involved in these types of relationships, where the coach's agenda may sometimes overshadow the client's autonomy (Mold & Forbes, 2013). As health coaching continues to evolve, it is crucial to critically examine these dynamics and ensure that the practice genuinely empowers patients to make positive lifestyle changes aligned with their personal values and goals (Edwards et al., 2018, Howard et al., 2023).

Among the definitions provided, the one by Palmer et al. (2003) was the most commonly cited, defining health coaching as "the practice of health education and health promotion within a coaching context, to enhance the well-being of individuals and to facilitate the achievement of their health-related goals". This definition highlights a potential tension between two contrasting approaches: health education and health promotion. Health education focuses on providing information and increasing knowledge about health, while health promotion takes a more comprehensive approach, emphasizing the empowerment of individuals and communities to take control of their health (Whitehead, 2004). As discussed in more depth in chapter 7, health promotion aligns more closely with the principles of asset-based approaches, as it recognises the importance of building on individuals' and communities' strengths and resources to achieve better health outcomes (ibid.). This distinction is particularly relevant when considering the alignment between health coaching and asset-based approaches, as health promotion orientations may be more compatible with community empowerment principles whilst health education approaches may be more hierarchical and directive.

Olsen proposed an operational definition that emphasizes the empowering nature of health coaching, describing it as "a goal-oriented, client-centered, and partnership that is health-focused and occurs through a process of client enlightenment and empowerment" (Olsen, 2014). This definition covers the main themes or attributes of health coaching: goal-oriented approaches using SMART goals determined by the client; client-centred tailoring to individual needs whilst respecting autonomy; partnership fostering collaborative relationships based on mutual respect; health-focused concentration on promoting healthier lifestyles; process engagement in dynamic, ongoing journeys involving assessment, planning, intervention, and evaluation; enlightening facilitation of education and reflective inquiry to help clients gain insights; and empowering fostering of self-confidence, autonomy, and self-efficacy to enable clients to take charge of their health (Olsen, 2014). These attributes work together to define the essence of health coaching and guide its practice across various disciplines and settings (ibid.).

These roles require health coaches to be trained in various health coaching techniques and to possess skills such as active listening, empathy, effective communication, and the ability to motivate and support behaviour change (Anstiss and Passmore, 2020, Gierisch et al., 2018). Overall, health coaches play a vital role in empowering individuals to make long-term, self-directed changes consistent with their values and goals, ultimately enhancing their health and well-being (Conn and Curtain, 2019, Gierisch et al., 2018, Perlman and Abu Dabrh, 2020). However, this emphasis on individual empowerment raises important questions about the tension between individual behaviour change and community development approaches, which potentially challenges the implementation of asset-based approaches that prioritise collective action and community assets over individual interventions.

To better understand the position of health coaching within the broader landscape of health promotion interventions, it is useful to consider Beattie's framework (Beattie, 1991). This framework categorises health promotion interventions along two dimensions: the mode of intervention (authoritative vs. negotiated) and the focus of intervention (individual vs. collective) (ibid.). Health coaching, with its emphasis on collaboration, empowerment, and individual goal-setting, can be positioned within the individual-negotiated quadrant of Beattie's framework. This quadrant includes interventions that aim to empower individuals to make informed choices about their health through a process of negotiation and partnership with health professionals (Beattie, 1991). However, it is important to recognise that health coaching does not operate in isolation and can be integrated with other health promotion approaches (Lawson et al., 2013). The differentiation between individualistic and collectivist approaches represents a significant consideration when evaluating the compatibility of health coaching with asset-based community development principles.

Health coaching can be delivered in various formats, including individual and group settings, as well as online or face-to-face modalities (Anstiss & Passmore, 2020; Gierisch et al., 2018). Individual coaching involves one-on-one sessions between the health coach and the client, allowing for personalised attention and tailored guidance to the specific needs and goals of the individual. Group coaching involves a health coach working with multiple clients simultaneously, often fostering a sense of community and allowing for shared experiences and support amongst group members. This format can be cost-effective and may provide different dynamics compared to individual coaching, though it remains essentially grouped individual interventions rather than truly collectivist approaches. Online coaching is conducted remotely through video calls, phone calls, emails, discussion

forums, or messaging platforms, offering flexibility and convenience whilst allowing clients to engage with their health coach from any location. Face-to-face coaching involves in-person sessions between the health coach and the client, allowing for more personal connection and immediate feedback. These different formats cater to diverse preferences and needs, and the choice between them depends on factors such as individual preferences, accessibility, and the nature of the coaching relationship.

To facilitate a comprehensive understanding, the following table elucidates key distinctions between the traditional approach to health and the innovative coaching approach in primary care (Conn and Curtain, 2019).

Table 6-1 The Key Differences Between the Traditional Approach and Coaching Approach in Primary Care (Conn & Curtain, 2019).

The Key Differences	Traditional Approach	Coaching Approach
Expertise	The practitioner is viewed as the health expert.	Patients are respected as experts in their own lives.
Advice and Solutions	The practitioners are providing advice and solutions.	Based on the patient's needs, the practitioner provides information
Health Priorities	Within the traditional approach, the practitioners decide the health priority.	It is the patient who decides what health goals to pursue, what strategies to use, and what targets to set.
Focus on Change	In the traditional approach, clinicians often assume that the client is ready to change and look for reasons why they have not.	As opposed to other approaches, the coaching approach focuses on the strengths of each client, and practitioners identify their readiness and offer strategies to help them become more confident and effective.

Globally, key drivers of health coaching include rising awareness of behavioural and mental health, growing demand from corporations hiring health coaches for employee wellness programs, and increased mental health issues (Precedence Research, 2022). The health coaching industry is rapidly growing, fuelled by rising wellness awareness and

demand, and expected to exceed \$29 billion globally by 2032 (ibid.). A growing number of employers, insurance companies, and communities are investing in health coaching initiatives, and educational programs are being developed to train professionals in this field all over the world (Olsen, 2014). While health coaching has common principles globally, its implementation is tailored to the specific needs, healthcare infrastructure, and cultural contexts of each region (Olsen, 2014), raising important questions about the principles of asset-based approaches and the potential relationships between different contextual implementations.

6.2.2 Alignment with Asset-Based Approaches

As mentioned earlier, health coaching aims to empower individuals to make positive changes to improve their wellbeing. Similarly, asset-based approaches in healthcare focus on leveraging a person's strengths and resources to enable health. Though emerging from different backgrounds, health coaching and asset-based care share important principles and benefits. Understanding these commonalities lays the foundation for assessing the feasibility of implementing asset-based approaches in Al-Jumum's rural/peri-urban community, whilst recognising that the individual focus of health coaching may create tensions with the more collective orientations of asset-based community development. Table 6.2 outlines key parallels between health coaching and asset-based care models in their aims, processes, and outcomes.

Table 6-2 Alignment of Health Coaching and Asset-Based Approaches.

The Key Aspects	Health Coaching	Asset-Based Approaches
Person-Centric Focus	Focuses on the individual's strengths, capabilities, and aspirations to set health goals (Wolever et al., 2013).	Identifies and builds on a person or community's strengths and assets rather than just focusing on deficits or problems (Foot and Hopkins, 2010).
Relationship-Building	Collaborative partnership between coach and client aimed at eliciting client self-discovery and learning (Palmer et al., 2003)	Aim to promote participatory relationships that value and appreciate community assets and strengths (Foot and Hopkins, 2010)
Empowerment & Motivation	Encourages intrinsic motivation and autonomy to	Seeks to support and mobilise community strengths,

	drive sustainable behaviour change (Wolever et al., 2013); and empowers individuals to take control of their health and well-being (Quronfulah et al., 2023).	capacities and assets to promote change from within (GCPH, 2011); and empowers communities by recognising and leveraging existing assets (ibid.).
Collaborative Partnership	Establishes a collaborative relationship between coach, client, professionals, and the health care system (Quronfulah et al., 2023, NHS, 2020). The collaborative nature of health coaching is also reflected in its role in bridging the gap between the clinician and patient, helping patients navigate the healthcare system, and providing emotional support (ibid.).	Encourages collaboration and partnerships within communities (Baron et al., 2019). It is the key to maximising the strength and resources available in the community (ibid.).
Long-Lasting Outcomes	Aims to build self-efficacy, empowerment, knowledge, skills and confidence to achieve health goals (Wolever et al., 2013).	Seeks individual and collective empowerment along with community-driven solutions and outcomes (Foot and Hopkins, 2010).

The table 6.2 illustrates the strong alignment between the key aspects of health coaching and asset-based approaches. However, it is crucial to acknowledge potential tensions within the health coaching concept. As discussed earlier, there is a distinction between health education and health promotion approaches (Whitehead, 2004). Conceptually, health education tends to be more hierarchical and focused on imparting knowledge, while health promotion emphasizes collaboration and empowerment (ibid.). Similarly, the way health coaching is implemented in practice can influence its alignment with asset-based approaches. For example, if health coaching is delivered in a more directive, educational manner, it may not fully embody the collaborative spirit of asset-based approaches. On the

other hand, if health coaching is implemented with a strong emphasis on partnership, empowerment, and building on individuals' strengths and resources, it will be more closely aligned with asset-based principles.

6.2.3 Health Coaching in the Saudi Context

To address the growing burden of chronic diseases on the healthcare system and support the health objectives of Saudi Vision 2030, in 2019 the Ministry of Health (MOH) in Saudi Arabia launched a health coaching program (Quronfulah et al., 2023). As mentioned in chapter 2, one of the three main pillars of Saudi Arabia's ambitious Vision 2030 is building a vibrant society (MOH, 2018). To achieve this vision, numerous vision realisation programs were instituted, including the Health Sector Transformation Program implemented by the MOH (ibid). This program stresses preventive health measures and improved health awareness using a new model of care (Quronfulah et al., 2023, MOH, 2019). The critical question emerges whether this represents the basis of an idealised asset-based approach or reflects more traditional top-down health system interventions.

The MOH integrated this model into health clusters across Saudi Arabia's regions (Quronfulah et al., 2023). There are five key health clusters in the country created to deliver timely, appropriate care through the right team in the right place for the right patient, as shown in figure 6.1 (MOH, 2018). For this to be achieved, in late 2019 a nationwide primary care-based health coaching program was introduced (Aldhamin et al., 2023). It was implemented first in the Eastern Province then expanded to the other regions (ibid.). It is also called the health trainer program in some areas; it is part of the preventive care system under modern healthcare models seeking to improve lifestyles (MOH, 2018, Saudi Press Agency, 2023, MOH, 2019). In general, the program aims to assist individuals in better controlling their health, following treatment plans, maintaining healthy diets, and staying physically active, playing a vital role in addressing physical, mental and social well-being (Saudi Press Agency, 2023).

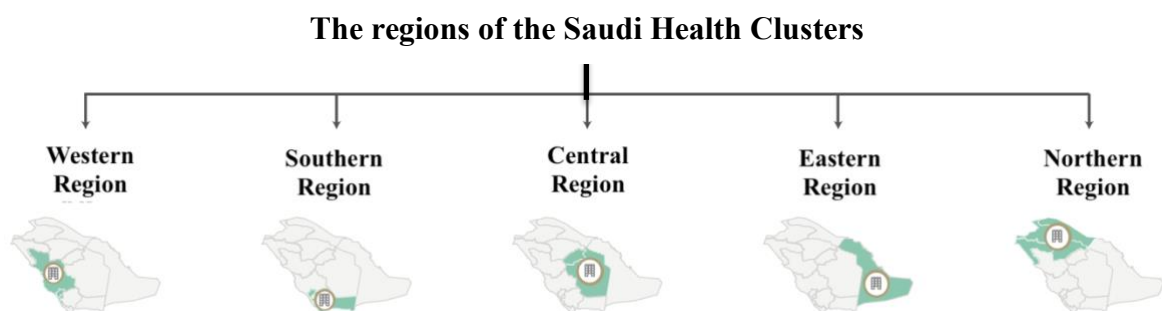


Figure 6.1 The Five Main Regions for the Saudi Health Clusters. (MOH, 2018)

The program targets various behaviour-related issues like smoking, anxiety, poor nutrition and physical inactivity (Aldhamin et al., 2023). The main goal is helping chronically ill individuals adopt healthier lifestyles (MOH, 2022). To enhance this, over 230 primary care centres across the country now have health coach clinics, also called Health Education Clinics (*ibid.*). The nomenclature as Health Education Clinics is significant as it suggests a health education rather than health promotion orientation, potentially creating tensions with asset-based approaches that align more closely with health promotion principles emphasising empowerment and community participation. This is a key primary care development project of the Assistant Agency for Primary Health Care (Saudi Press Agency, 2023). Educational sessions are held at these clinics for each outpatient according to their condition to manage their health, evaluate progress, and improve their quality of life (*ibid.*). The emphasis on monitoring and evaluation elements of health coaching raises questions about empowerment versus more top-down approaches to health management.

The clinics are open and accessible to all citizens (Aldhamin et al., 2023). Based on one of the interviews conducted with a key stakeholder, clients can self-refer or be referred by a provider (The third stage interviews, National policymaker, I3). Appointments can be booked through mobile applications including virtual coaching. Sessions use the five A's approach: Ask, Assess, Advise, Assist and Arrange (*ibid.*). The process involves assessing needs, setting goals, monitoring, and providing feedback (*ibid.*). For example, initially the coach evaluates the client's requirements, readiness to change and sets a SMART (specific, measurable, achievable, relevant, and time-bound) goal and action plan (*ibid.*). In follow-ups, they measure progress towards goals and decide whether to continue or modify (*ibid.*). Program length and frequency varies based on needs (*ibid.*).

Health coaches have at least a 2-year post-high school degree in a health field like nursing or nutrition with one year of experience (Aldhamin et al., 2023). They complete a 4 to 6 months training program on coaching skills, behaviour change theories and techniques, evidence-based practice, nutrition, physical activity, smoking cessation, mental wellness, sleep hygiene and disease management (*ibid.*). They must then pass an exam to become certified (*ibid.*). The curriculum for the health coaching training program in Saudi Arabia provides further insights into the content and structure of the training, though critical examination of this curriculum reveals important tensions with asset-based approaches.

The program is divided into five modules, including foundational topics such as health coaching fundamentals, theories, and models of behaviour change, as well as more specialised modules focusing on wellness, prevention, and disease management. The

curriculum also includes a module dedicated to developing health coaching skills, such as communication techniques, goal setting, and motivational interviewing. This comprehensive curriculum aims to equip health coaches with the necessary knowledge and skills to effectively support clients in achieving their health goals. The table below shows the program blocks and modules.

Table 6-3 Health Coach Program Curriculum.

Block	Module
Foundation Block	Health coaching fundamentals
	Theories and models of behaviour change
Progressive Block	Wellness and prevention
Intensive Block	Diseases management
Skills Block	Health coaching skills
Practicum Block	Clinical practice

In the Western region, this initiative is new (The third stage interviews, National policymaker, I3). In October 2023, the health cluster of Mecca graduated 51 health directors representing the first batch of the health coach program (Saudi Press Agency, 2023). They are the first 51 persons who got the certificate of health coaching (ibid.). The program, spanning 6 months and supervised by 33 doctors across 16 health centers in the region, equipped these graduates with the necessary skills to guide and counsel members of the community (ibid.). According to the Saudi Press Agency (2023), the program reported positive results during the training period. Approximately 39% of participants managed to reduce their weight, while 40% reduced the risk of heart diseases (ibid). Furthermore, over 51% succeeded in lowering their glycated hemoglobin levels within the 6-month duration (ibid).

In Al-Jumum city, which is under the health cluster of Mecca, there is one health trainer clinic in the main primary care center in the city (The third stage interviews, National policymaker, I3). The initiative is new, and it is still under process. According to one policymaker, the initiative has achieved great success and received significant response from residents of the region, though these policymaker narratives represent only one perspective which may be challenged by other stakeholders in this local context. (The third stage interviews, National policymaker, I3).

“We were afraid of people’s response, especially in these smaller areas, but we were impressed by the results as we noticed that people in the villages and smaller

cities were more accepting of this program than people in big cities, such as Mecca" (The third stage interviews, National policymaker, I3).

This quotation is important because it shows how policymakers themselves distinguished between large urban centres and smaller localities such as Al-Jumum and surrounding villages. However, this should not be read as evidence that Al-Jumum is simply rural. Rather, it supports the rural/peri-urban framing used in this thesis: Al-Jumum was understood by participants and stakeholders as a smaller, socially connected locality positioned between village-based social relations and expanding formal health infrastructure.

As the focus turns to Al-Jumum, examining the dynamics of a localised health coaching programme through a realist evaluation approach allows the generation of contextualised knowledge about how health coaching operates within a Saudi rural/peri-urban healthcare setting. The principles of realistic evaluation emphasise understanding how mechanisms of health coaching initiatives are activated within the realities of Al-Jumum's setting to produce certain outcomes whilst maintaining alignment with the tensions that exist between top-down and bottom-up models and their different aims, tasks, and expectations.

6.3 Examining the Dynamics of Health Coaching in Al-Jumum: A Realistic Evaluation Approach

The potential of health coaching as a catalyst for individual and community well-being is a dynamic and multifaceted process, particularly when applied to Al-Jumum's rural/peri-urban community. In this section, I analyse the data using a realist evaluation framework to examine the dynamics shaping the implementation and outcomes of health coaching in this specific setting. The aim is not to treat Al-Jumum as a representative rural Saudi community, but to identify how contextual factors, mechanisms, and outcomes interact in a locality shaped by smaller-community social relationships, formal healthcare expansion, service-access issues, gender norms, and links to surrounding villages.

6.3.1 Contextual Factors in Al-Jumum

The realist evaluation framework prompts examination of how contextual elements shape the implementation process and influence the outcomes of health coaching interventions. In Al-Jumum, these contextual elements included cultural traditions, communal identity, patterns of trust, access to healthcare, gender norms, and the gradual expansion of formal health services within a rural/peri-urban setting. After conducting the interviews, the following contextual factors were observed. Cultural Traditions and Communal Identity

represent significant influences, with Al-Jumum holding deep-rooted cultural traditions and a strong sense of communal identity. Limited access to healthcare characterises the local infrastructure, with limited health care facilities and shortages of providers, especially specialist services, which can pose challenges for population-wide reach. Some older people still do not prefer modern medical facilities, often relying on traditional healing methods passed down through generations.

The context within which health coaching was introduced in Al-Jumum reflects the complexity of defining rurality discussed in earlier chapters. Participants often described a community that had experienced significant social and physical development while continuing to retain strong traditions of social connectedness and mutual support. These characteristics shaped community responses to health coaching and influenced the mechanisms through which the programme generated outcomes. Consequently, the local context provides an important lens for understanding how health coaching may operate within settings characterised by overlapping rural and urban features.

Respected community leaders constitute a notable contextual factor, with community leaders holding significant sway over residents' opinions and decisions. Recognising this, the analysis explores how involving these leaders in health coaching initiatives may act as mechanisms to enhance acceptance and effectiveness, discovering whether social capital held by these figures can contribute to legitimacy and credibility of health coaching within the community. As one policymaker noted:

“Focusing on improving the work of health system in rural areas, and increasing people health there, we had to make some visits, discover the areas to make the best decisions. We noticed that people there are more connected to their traditions and have more trust in their community leaders.” (The third stage interviews, National policymaker, I3).

Although this stakeholder referred to “rural areas,” the analysis interprets this cautiously in relation to Al-Jumum’s rural/peri-urban character. The quotation highlights features that participants associated with smaller communities, including attachment to tradition, reliance on trusted local figures, and the importance of social legitimacy. These factors are relevant to health coaching because they shape whether residents accept new health services, trust health coaches, and engage with behaviour-change support. Technological infrastructure represents another contextual element, with integration of technological tools, particularly smartphone applications, into healthcare practices in Al-Jumum

signifying growing trends towards digital solutions. Smartphones serve as primary gateways to digital information, communication, and, increasingly, healthcare services. The penetration rate of smartphones provides insights into potential reach and accessibility of health coaching apps.

We also noticed that we could take benefits of the technology to access these areas, as some of them was hard to access.” (The third stage interviews, National policymaker, I3).

Gender dynamics constituted important contextual considerations in Al-Jumum’s rural/peri-urban community, where traditional gender roles and expectations around gender segregation continued to shape interactions between men and women. This segregation is deeply rooted in cultural and religious practices, influencing daily life, public spaces, and community engagements.

“Also, we take into consideration the gender segregation and how they see it. We wanted to implement services that make them feel more comfortable and help us achieve our goals. ” (The third stage interviews, National policymaker, I3).

These contextual factors had direct implications for health coaching. Trust in community leaders could support the acceptance of new services, gender norms shaped preferences for male or female coaches, and service-access issues created opportunities for digital coaching. At the same time, these factors also complicated the alignment between health coaching and asset-based approaches, because the programme remained largely professionally designed and institutionally implemented rather than community-led.

6.3.2 Mechanisms in Al-Jumum’s Health Coaching Implementation

After conducting in-depth interviews with key local and national policymakers, as well as two health coaches in Al-Jumum, several key mechanisms emerged that promote increased access, acceptance, and engagement with health coaching in this Saudi Arabian context. While I attempted to interview recipients of health coaching to gain patient perspectives, recruitment challenges prevented access to this stakeholder group. By the time I sought to interview patients, I had returned to Glasgow and was attempting remote recruitment via email and WhatsApp. However, participants were reluctant to engage in online interviews, and the UK-Saudi time difference created scheduling difficulties that made recruitment unsuccessful. Nevertheless, the mechanisms identified through interviews with health coaches and policymakers align with the principles of both health coaching and asset-based approaches, as outlined in Table 6.2.

Health coach clinic integration represents the first significant mechanism, with establishment of the health coach clinic in the primary care centre in Al-Jumum serving as a physical anchor, offering recognisable and accessible space for community members to seek health coaching services. This mechanism aligns with the person-centric focus and collaborative partnership aspects of both health coaching and asset-based approaches (Wolever et al., 2013, Foot and Hopkins, 2010). The clinic relies on one-on-one coach-client sessions, allowing for personalised assessment, goal setting, and planning, which empowers individuals to take control of their health and well-being (Quronfulah et al., 2023). However, questions arise about integration of services and the extent of partnership and dialogue between health coaches and other professionals in the healthcare system, as this was not mentioned in the interviews.

“We established the health coaching clinic in Al-Jumum’s primary care centers, for personal visits. This allows our coaches to work closely with clients, understanding their unique needs and strengths, and developing tailored plans to support their health goals.” (The third stage interviews, national policymaker, I3).

Digital access through mobile applications represents the second mechanism, with introduction of online apps for health coaching registration, access, and appointment scheduling representing technological mechanisms. These apps act as gateways, providing on-demand access to health coaching services via smartphones, thereby increasing accessibility and convenience for the community.

“We had to take advantage of the application created by the Ministry of Health, include the health coaching programs to them, and encourage people in Al-Jumum to register and benefit from them. This digital approach has helped us reach more people and empower them to take charge of their health.” (The third stage interviews, national policymaker, I3).

Community leaders as advocates constitute the third mechanism, with involvement of respected community leaders through training and workshops in health coaching initiatives serving to enhance acceptance, effectiveness and promote awareness. Community leaders act as advocates, endorsing and promoting health coaching services within communities, leveraging their social capital to foster trust and credibility. However, advocacy in health promotion and asset-based approaches has deeper meanings, involving people with power acting on behalf of expressed needs of people who do not have voice, raising questions about the nature of this advocacy relationship.

"We contacted some community leaders such as the mayor, explained the health coaching program to him, and asked for his help. We know that people in small cities like Al-Jumum would trust their leaders more than us. By involving these leaders, we aim to build strong, participatory relationships that value community assets and strengths." (The third stage interviews, national policymaker, I3).

Public awareness campaigns represent the fourth mechanism, with implementation of short courses in public parks, primary care centres, and schools acting as mechanisms to raise public awareness about health coaching services. These courses introduce the community to the benefits and principles of health coaching.

"As part of the health system work, we conducted some educational workshops in the primary care center and other places such as schools and public parks to introduce the new health coaching service, explain how it can be used, where it can be used, and kind of services it provides. By raising awareness, we aim to empower the community to make informed decisions about their health and well-being."
(The third stage interviews, local policymaker, I6).

Professional Practice Transformation represents a fifth significant mechanism, evidenced through changes in healthcare provider approaches following health coaching training. The health coach interviewed, who was also a care nurse, described a fundamental shift in her practice approach following the coaching training programme. Before the training, her interactions with patients focused primarily on identifying deficits and non-compliance:

"Before the coaching training, I focused on what patients were doing wrong—not taking medications, not following diet recommendations, not exercising enough. I would tell them what they needed to do differently to improve their health" (Health coach interview) (The third stage interviews, health coach, I8).

However, the coaching training transformed her approach toward asset-based principles, emphasising patient strengths and existing resources:

"After the training, I learned to ask patients about what was already working for them, what motivated them to be healthy, and what support they had available. Instead of telling them what to do, I help them identify their own resources and motivations for health improvement" (The third stage interviews, health coach, I8).

This professional transformation represents a significant mechanism for implementing asset-based approaches, as it demonstrates how health coaching training can shift

healthcare providers from deficit-focused to strengths-based practice. The health coach reported that this approach was more effective and generated more positive patient responses, suggesting that asset-based principles can be successfully integrated into existing healthcare delivery systems when supported by appropriate training and professional development.

Whilst these mechanisms demonstrate some alignment with principles of health coaching, this alignment with asset-based approaches requires more critical examination. The top-down approach in setting up the health coaching programme may not fully align with the community-driven ethos of asset-based approaches. It is crucial to ensure that predetermined expectations and structure of the programme do not overshadow the importance of empowering individuals and communities to identify and mobilise their own assets. As one local policymaker observed:

"I appreciate the effort put into establishing the health coaching program, but I sometimes feel like our voices and unique strengths are not fully considered. It would be better if the community was more involved in shaping the program to fit the community's specific needs and resources." (The third stage interviews, local policymaker, I8).

6.3.3 The Observed Outcomes of Health Coaching Implementation in Al-Jumum

The implementation of health coaching interventions in Al-Jumum, integrating various mechanisms and strategies, has shown a range of outcomes. This section explores the noticed outcomes based on the collected data. Establishing dedicated health coaching clinics within the primary care centre in Al-Jumum enhanced convenience and service availability. This infrastructure supports in-person consultations and ongoing relationships between coaches and community members. By embedding health coaching within the primary care system, the intervention aligns with existing healthcare norms and enhances the legitimacy of health coaching as a valuable and integral component of overall health care.

"Having the health coaching clinics in the primary care centres have made it much easier for us to get in touch with our patients. For me as a health coach, I would prefer this more than the online sessions because I feel that the patient can be more comfortable knowing that he/she can discuss any health concerns with me in a familiar setting." (The third stage interviews, health coach, I8).

This patient-centred approach elicits self-determined incremental changes aligned with individual priorities through motivational interviewing. There are male and female coaches in the clinic to help clients feel more comfortable, aligning with the cultural norms of gender segregation in the country.

"In a small city like Al-Jumum, it is important to have male and female coaches. It makes the patients feel more at ease discussing personal health matters with someone of the same gender. Even in the online sessions, patients can choose the gender of the coach." (The third stage interviews, local policymaker, I8).

Introducing user-friendly smartphone apps expanded the accessibility of services, enabled self-monitoring, provided appointment features, and matched prevalent use of technology. Reducing friction to interact with coaches remotely can facilitate participation. These apps are used all over the country, and policymakers are now trying to expand their use into the rural cities. Also, digital access addresses the challenge of limited healthcare facilities and the influence of traditional healing methods. By offering a convenient and private channel for health coaching interactions, the APPs cater to the community's technological trends while respecting privacy concerns associated with traditional healthcare preferences. Thus, the establishment of a health coach clinic within the primary care centre, coupled with the accessibility provided through mobile applications, has increased the utilization of health coaching services.

"The health coaching app has been a game-changer for my practice. It allows me to easily manage my appointments, monitor my clients' progress, and communicate with them remotely. It's a convenient and private way to support my clients in achieving their health goals, especially for those who may face barriers to accessing in-person services. The app has greatly enhanced my ability to provide personalized, continuous care to the community members." (The third stage interviews, health coach, I8).

Harnessing influence of community leaders aligns with deep-rooted cultural traditions and strong communal identity of Al-Jumum. This mechanism recognises social capital held by these figures, fostering trust and credibility in health coaching interventions. By leveraging existing community structures, health information is disseminated more effectively, though critical questions arise about the nature of agenda setting and who sets the agenda in these relationships. Asset-based approaches and collective community development would place agenda-setting in the hands of communities rather than professionals.

“As health coaches, we understand the importance of trust and credibility in our work. Having the support of respected community figures helped us build stronger connections with the people of Al-Jumum. It opened doors for us to engage with more individuals and families, as they felt more confident in the potential of health coaching to improve their well-being. This endorsement has been crucial in establishing our role as trusted partners in the community's health journey.” (The third stage interviews, local policymaker, I8).

Conducting public outreach courses in different places have helped in raising general understanding of health coaching for Al-Jumum citizens.

“I can say that we noticed changes in behaviors. People now prefer to take control over their health, especially people who have chronic diseases such as diabetes. Today, people are using health coaching services more than before.” (The third stage interviews, local policymaker, I6).

While these outcomes demonstrate the positive impact of health coaching interventions in Al-Jumum, it is essential to acknowledge the potential tensions arising from the top-down approach in implementation, which may not fully align with the organic ethos of asset-based approaches. As mentioned earlier, it is important to critically examine the implementation process and ensuring that the principles of asset-based approaches, such as community empowerment and bottom-up decision-making, are not overshadowed by the formal accreditation and implementation procedures.

“We are taking a step-by-step process. Implementing health coaching in the smaller cities was not easy. However, we were able to do so. Now, health coaching programs are implemented in different small cities. It was not hard that much to establish it in Al-Jumum, but it took some time due to the accreditations and formal implementation process.” (The third stage interviews, national policymaker, I3).

By presenting perspectives from both policymakers and service providers, this analysis offers insights into outcomes of health coaching interventions in Al-Jumum. While overall impact appears positive based on available data, it is important to acknowledge the limitation of not having conducted interviews with service users. This gap in data collection may result in lack of comprehensive understanding of community experiences, perceptions, and priorities regarding health coaching initiatives. The absence of service user voices highlights the need for future research to include their perspectives, as they are primary beneficiaries of health coaching programmes. Incorporating service user

experiences and feedback would provide more balanced and nuanced understanding of outcomes and potential areas for improvement. The tension between top-down implementation approaches and principles of asset-based approaches remains a crucial consideration point.

6.4 Discussion and Critical Analysis

The analysis of health coaching dynamics in Al-Jumum within the Realistic Evaluation framework provides valuable insights into the feasibility of implementing asset-based approaches in this Saudi rural/peri-urban community. By examining contextual intricacies, surfacing key mechanisms, and assessing noticeable outcomes, this analysis explores the nature of potential relationships between health coaching and asset-based approaches via health promotion and health education orientations rather than attempting to force compatibility where it may not naturally exist.

The rural/peri-urban framing is particularly important in this chapter because health coaching operates at the level of individual behaviour change, but individual behaviour in Al-Jumum is embedded within family routines, gendered expectations, social trust, transport and service access, and local understandings of health. Participants' accounts suggested that the acceptability of health coaching depended not only on the availability of trained coaches or digital applications, but also on whether the service could be made culturally familiar, socially trusted, and accessible within everyday community life. This means that health coaching cannot be assessed only as a clinical intervention; it must also be understood as a service introduced into a specific rural/peri-urban social context.

The alignment between health coaching and asset-based approaches across five key aspects - person-centric focus, relationship-building, empowerment and motivation, collaborative partnerships, and long-lasting outcomes - suggests potential for health coaching to serve as a mechanism for assessing feasibility of implementing asset-based approaches in Saudi rural/peri-urban communities. However, this alignment requires critical examination rather than assumption of compatibility.

Starting with the person-centric focus, the establishment of dedicated health coaching clinics within the primary care centres provides a strong foundation for personalized, one-on-one coaching sessions. These sessions allow health coaches to tailor their approach to each individual's unique strengths, capabilities, and aspirations, aligning with the core principles of both health coaching and asset-based approaches (Wolever et al., 2013, Foot and Hopkins, 2010). However, this raises critical questions about the collectivist and

communitarian underpinnings of asset-based approaches. The individualistic focus of health coaching, whilst potentially valuable, contrasts sharply with asset-based approaches that emphasise community assets, collective action, and communal empowerment. The one-to-one coaching model, whilst providing personalised attention, may inadvertently reinforce individualised approaches to health improvement rather than fostering collective community development that asset-based approaches prioritise.

The training materials for health coaches in Al-Jumum require critical examination regarding their incorporation of asset-based community development principles. The 4 to 6-month training programme covering coaching skills, behaviour change theories, and techniques (Aldhamin et al., 2023) serves as a critical foundation for the health coaching initiative. However, ensuring alignment with asset-based approaches requires examination of content, focus, and delivery of training programmes. The curriculum's inclusion of modules on (Theories and Models of Behaviour Change) (Module 2) demonstrates understanding of behaviour change importance in promoting health and well-being, though it is important to note the individualistic basis of much behaviour change theory and related tensions between individual and collective orientations in asset-based approaches.

The curriculum's inclusion of modules on (Wellness and Prevention) (Module 3) and (Diseases Management) (Module 4) indicating combined focus on promoting health and managing chronic conditions. Additionally, the (Health Coaching Skills) module (Module 5) is another essential component of the training program, covering various coaching skills such as goal setting, motivational interviewing, problem-solving, and communication techniques. However, these modules are presented from a 'deficits and barriers' perspective. One of the main outcomes of this training program is to assess an individual's need for health. This does not align with the principles of asset-based approaches which focus on strengths. To better align with asset-based principles, the modules should emphasize the importance of recognising and leveraging individuals' and communities' strengths, capacities, and resources in the behaviour change process. They should further incorporate content and activities that train health coaches to identify, appreciate, and build upon the unique assets and strengths that individuals and communities bring to the coaching process.

This tension between health education and health promotion orientations becomes particularly relevant when examining the Saudi health coaching programme. The programme's designation as Health Education Clinics rather than health promotion initiatives suggests more didactic, top-down approaches to health improvement. Health

education focuses on information provision and knowledge transfer, often maintaining professional expertise and authority, whilst health promotion emphasises empowerment, participation, and community control over health determinants (Whitehead, 2004). The Saudi programme's emphasis on monitoring, evaluation, and compliance with predetermined protocols aligns more closely with health education orientations that may conflict with asset-based approaches' emphasis on community empowerment and self-determination.

Moving to empowerment and motivation aspects, the introduction of user-friendly smartphone apps for health coaching registration, access, and appointment scheduling demonstrates commitment to empowering individuals to take control of their health and well-being. By providing convenient and accessible platforms for engagement, these apps support intrinsic motivation and autonomy central to both health coaching and asset-based approaches (Wolever et al., 2013, GCPH, 2011). However, the emphasis on monitoring clients' progress, as evidenced in health coach testimonials, reveals more hierarchical approaches that may be less empowering and more aligned with surveillance than genuine empowerment.

The involvement of respected community leaders in promoting health coaching initiatives in Al-Jumum (The third stage interviews, national policymaker, I3) is a promising example of the relationship-building and collaborative partnership aspects of health coaching and asset-based approaches. By engaging these leaders as advocates, the health coaching program taps into existing social networks and community structures to build trust, credibility, and support for the initiative. However, it is essential to critically examine the nature and depth of community leader involvement in health coaching programmes. The evidence suggests that engagement of community leaders is limited to superficial endorsement or promotion of initiatives, rather than genuine partnerships in shaping programme design, implementation, and evaluation, which may fall short of authentic asset-based community development. True collaborative partnerships in asset-based approaches require community leaders to be actively involved in decision-making processes, with their input valued and incorporated into programme development rather than merely serving as conduits for professionally-determined interventions.

Moreover, the top-down approach in setting up the health coaching program, as evidenced by the formal accreditation and implementation processes (The third stage interviews, national policymaker, I3), poses significant challenges to full realisation of asset-based community development principles. Whilst structured implementation processes may have

facilitated programme establishment, they may also have limited opportunities for community members to take ownership and drive initiatives based on their unique strengths, assets, and priorities. The requirement for formal accreditation and adherence to predetermined protocols reflects more traditional healthcare approaches that prioritise professional expertise and institutional control over community empowerment and local decision-making.

The distinction between individualistic and collectivist approaches represents a fundamental tension requiring examination. Health coaching's emphasis on individual behaviour change and personal goal-setting contrasts with asset-based approaches' focus on collective action, community assets, and social determinants of health. While individual empowerment may contribute to community well-being, the extent to which individualised interventions can foster collective community development remains questionable. Asset-based approaches emphasise community ownership, collective problem-solving, and mobilisation of community resources, which may be incompatible with health coaching's person-centred, individualised methodology.

Furthermore, the delivery format of health coaching raises questions about collective versus individual orientations. While group coaching exists as a format, it essentially represents grouped individual interventions rather than truly collectivist approaches that characterise asset-based community development. The focus remains on individual participants' goals, behaviour changes, and outcomes rather than collective community assets, shared problem-solving, and community-wide empowerment that asset-based approaches prioritise.

The integration of health coaching within existing healthcare systems also presents challenges for asset-based implementation. The embedding of health coaching within primary care centres, whilst providing legitimacy and accessibility, may reinforce medical model approaches that focus on individual pathology and professional intervention rather than community assets and collective action. This medicalisation of health coaching may conflict with asset-based approaches' emphasis on community control, social determinants of health, and non-medical community resources.

To enhance alignment between health coaching work and asset-based approaches in Al-Jumum, it would be crucial to create more spaces for community members to actively participate in shaping programme design, implementation, and evaluation in ways that reflect the locality's rural/peri-urban characteristics, including family influence, trust

relationships, gender norms, service-access patterns, and connections with surrounding villages. This could involve establishing community advisory boards, conducting participatory action research, or implementing feedback mechanisms that allow community members to share experiences, insights, and suggestions for improvement. By shifting towards more bottom-up, community-driven approaches, health coaching programmes could better harness the power of local assets and strengths, leading to more sustainable and impactful outcomes. However, such shifts would require fundamental reconceptualisation of health coaching from individual behaviour change interventions to community development approaches, potentially transforming the intervention beyond recognition as health coaching per se.

6.5 Conclusion

This chapter examined health coaching in Al-Jumum as an individual-level proxy intervention through which to explore the feasibility of asset-based principles in a Saudi rural/peri-urban community context. Through the lens of realist evaluation, the chapter analysed the interaction between contextual factors, implementation mechanisms, and observed outcomes, highlighting both opportunities and limitations for integrating asset-based principles into localised health coaching initiatives.

The analysis identified several promising mechanisms, including the integration of health coaching clinics within primary care, digital access through mobile applications, involvement of community leaders, public awareness campaigns, and professional practice transformation among trained health coaches. These mechanisms suggest that health coaching may support some asset-based principles, particularly when coaches focus on patients' strengths, motivations, existing support systems, and capacity for self-management. In Al-Jumum's rural/peri-urban context, these mechanisms were shaped by trust relationships, gender norms, family and community influence, service-access issues, and the gradual expansion of formal healthcare infrastructure.

However, the chapter also identified significant limitations. Health coaching in Saudi Arabia remains largely structured through top-down implementation, formal accreditation processes, professional expertise, and individual behaviour-change models. These characteristics create tensions with asset-based approaches, which place greater emphasis on collective action, community control, and the mobilisation of community-defined assets. The distinction between health education and health promotion is particularly important here: if health coaching is implemented primarily as advice-giving, monitoring, or compliance support, its alignment with asset-based approaches remains limited. If it is

implemented through collaborative goal-setting, attention to patient strengths, and recognition of family and community resources, its compatibility with asset-based principles becomes stronger, although still largely individual rather than collective.

The absence of service user voices is an important limitation of this chapter. The available data came primarily from policymakers and health coaches, meaning that the experiences, priorities, and interpretations of patients themselves could not be fully examined. Future research should include service users in order to understand how health coaching is experienced by residents and whether it is perceived as empowering, accessible, and culturally appropriate.

Overall, the health coaching programme in Al-Jumum demonstrates partial but limited alignment with asset-based approaches. It provides useful insight into how individual-level strengths-based practice may be introduced within a Saudi rural/peri-urban healthcare context, but it does not by itself represent a fully asset-based community development approach. The findings should therefore be understood as context-specific to Al-Jumum and potentially relevant to similar rural/peri-urban Saudi settings, rather than generalisable to all rural communities in Saudi Arabia.

Chapter 7 Discussion and Conclusion - Analysing Asset-Based Approaches in Public Health Initiatives

7.1 Introduction

This discussion chapter integrates the key findings from the empirical focal points presented in Chapters 4, 5, and 6, directly addressing the central research question: *What factors influence the feasibility of implementing asset-based approach to health in Saudi rural/peri-urban communities?* The analysis draws upon evidence from three initiatives in Al-Jumum—the WHO Healthy Cities programme, health coaching services, and community volunteering initiatives. These initiatives function as proxy interventions that embody core asset-based principles such as community participation, capacity building, and resource mobilisation. They enable examination of the complex dynamics involved in translating asset-based approaches, largely developed in Global North contexts, into Al-Jumum as a Saudi rural/peri-urban context shaped by local social relationships, cultural norms, state-led development, and the broader framework of Saudi Arabia's health system transformation and Vision 2030 objectives.

The implementation of asset-based approaches in diverse settings remains a significant challenge, requiring substantial shifts in mindset, policy, and practice (Hopkins and Rippon, 2015). As discussed in chapter 2, the literature review, asset-based approaches have often been developed and theorised in Global North contexts, and their translation into different social, cultural, political, and institutional settings requires careful adaptation. This is particularly pronounced in rural/peri-urban communities where unique socio-economic, cultural, and environmental factors influence feasibility and effectiveness (Bourke et al., 2012). However, as also discussed in Chapter 2, rurality is not a fixed or universally agreed category. In this thesis, Al-Jumum is therefore not treated as a representative rural Saudi community, but as a rural/peri-urban case through which to examine the feasibility of asset-based approaches in a locality shaped by both recent development and continuing village-like social relationships.

Despite growing literature on asset-based approaches, there is limited research on implementation in rural settings (Blickem et al., 2018), especially within global South contexts where traditional governance structures and cultural norms may conflict with participatory empowerment principles central to asset-based practice. This research addresses this gap through a qualitative case study examining three pre-existing initiatives that share implicit features of asset-based approaches, providing insights into organisational, community, and systemic capacities necessary for successful

implementation whilst investigating how cultural and contextual factors influence feasibility.

The conducted analysis in this research reveals five key tensions that fundamentally shape implementation feasibility in Al-Jumum's rural/peri-urban context. First, the rural/peri-urban character of Al-Jumum affects how the findings should be interpreted and transferred to other settings, requiring careful attention to context rather than generalisation to all rural Saudi communities (Section 7.2). Second, governance structures create complex dynamics between hierarchical control and community empowerment, where traditional top-down approaches must navigate emerging bottom-up initiatives (Section 7.3). Third, gender dynamics present both barriers and opportunities for cultural adaptation, requiring careful balance between respecting traditional norms and fostering inclusive participation (Section 7.4). Fourth, the tension between individual versus collective approaches highlights challenges in balancing personal empowerment with community mobilisation within culturally appropriate frameworks (Section 7.5). Fifth, findings illuminate the conservative versus radical transformative potential of asset-based approaches, revealing how implementation strategies must negotiate between incremental change and systemic transformation (Section 7.6). Finally, stakeholder contributions demonstrate varying capacities and motivations that directly impact implementation feasibility across different community levels (Section 7.7).

This chapter makes three original contributions to asset-based implementation literature. First, it provides one of the first detailed examinations of the feasibility of asset-based approaches within a Saudi rural/peri-urban context situated within broader Global South debates concerning community development and health promotion. Second, it introduces a methodological approach to assessing feasibility through existing community initiatives rather than imposing external frameworks, offering a more contextually grounded evaluation method. Third, it develops a nuanced understanding of how traditional hierarchical governance structures can both constrain and enable asset-based implementation, challenging assumptions about participatory approaches in global south contexts. These findings have significant implications for policy makers and practitioners seeking to implement asset-based health interventions in similar rural/peri-urban, Saudi or regional contexts where traditional social relationships, rapid development, and state-led reform intersect.

7.2 Rurality, Context and Transferability: Al-Jumum as a Rural/Peri-Urban Case

A central analytical issue in this thesis concerns how rurality should be understood in relation to Al-Jumum and how this affects the interpretation and transferability of the findings. As discussed in Chapter 2, rurality is not a fixed or universally agreed category. Rural places can be defined administratively, geographically, demographically, economically, socially, culturally, and relationally. The rurality literature emphasises that rural areas should not be understood only through population size, distance from urban centres, or administrative classification, but also through social relations, local meanings, cultural practices, service-access patterns, and everyday relationships with place (Cloke, 2006, Philo et al., 2003, Woods, 2010, Halfacree, 1993). This is particularly important in Saudi Arabia, where many localities have experienced rapid infrastructural, administrative, and economic development while continuing to retain social relationships, family networks, cultural practices, and service-access patterns associated with rural or village-based life.

In light of this, Al-Jumum should not be understood as a straightforwardly rural community. It is formally a small city and governorate centre and has experienced significant development in services, infrastructure, and institutional presence. However, the findings across Chapters 4, 5, and 6 show that rurality remained analytically relevant because participants continued to describe Al-Jumum through features associated with smaller communities and village-like social life. These included familiarity between residents, family and tribal networks, neighbourhood cooperation, reliance on trusted community figures, gendered social expectations, traditions of hospitality and mutual aid, and continuing connections with surrounding villages. This supports understandings of rurality as relational and socio-cultural rather than purely geographical or administrative (Halfacree, 1993, Woods, 2010). It also aligns with rural health literature that highlights how health and health promotion in rural and rural/peri-urban settings are shaped by social connectedness, local trust, service access, distance, professional availability, and relationships between formal services and informal community support (Bourke et al., 2012, Farmer et al., 2012).

Therefore, this thesis treats Al-Jumum as a rural/peri-urban Saudi context. This framing avoids presenting Al-Jumum as representative of all rural Saudi communities while still recognising that rurality shaped the feasibility of asset-based approaches. Rurality in this study is understood less as a fixed administrative classification and more as a socio-cultural and relational context that influenced trust, participation, volunteering, healthcare

engagement, gender norms, and the mobilisation of community assets. This interpretation is also consistent with place-based approaches to health, which argue that health promotion must be understood in relation to the social, cultural, institutional, and material characteristics of particular localities rather than through universalised models alone (Bourke et al., 2012, Cummins et al., 2007, Macintyre et al., 2002).

Across the three proxy interventions examined in this thesis, Al-Jumum's rural/peri-urban character shaped implementation in different ways. In the Healthy Cities initiative, rural/peri-urban dynamics were visible in the importance of local trust, institutional gatekeeping, community relationships, and the adaptation of an international urban health framework to a smaller Saudi locality with village-like social characteristics. In the volunteering chapter, rural/peri-urban dynamics were evident in the coexistence of formal state-regulated volunteering with older forms of mutual aid, religious duty, family support, neighbourhood cooperation, and hospitality. In the health coaching chapter, rurality was less visible as a collective community category but remained important through family influence, gender norms, service access, trust in healthcare professionals and community leaders, and the need to make formal healthcare innovations culturally acceptable.

Together, these findings show that rurality shaped the feasibility of asset-based approaches not by defining Al-Jumum as an isolated rural village, but by influencing the social and institutional conditions through which assets could be identified, mobilised, and sustained.

This has important implications for transferability. The findings should not be read as generalisable to all rural communities in Saudi Arabia, the Middle East, or the wider Global South. Al-Jumum is not presented as a representative rural community. Instead, the study offers analytical transferability to contexts that share similar characteristics, including rural/peri-urban transformation, strong family and social networks, continuing links with surrounding villages, developing health and civic infrastructure, gendered participation norms, and policy reforms that emphasise community participation and preventive health. This follows qualitative research principles that emphasise the importance of thick description and contextual detail in enabling readers to judge whether findings may be transferable to other settings (Lincoln, 1985). Therefore, the relevance of this thesis beyond Al-Jumum depends on careful attention to local histories, governance arrangements, service infrastructure, community relationships, and the ways in which rurality is locally constructed and experienced.

7.3 Governance Structures and Community Assets: Navigating Top-Down Control and Bottom-Up Empowerment

Addressing Research Sub-Questions 1 and 4: What are the assets of Saudi rural/peri-urban communities that could have impacts on health? What is the impact of current health policies on the possibility of implementing asset-based approaches?

The analysis reveals substantial community assets across Al-Jumum whilst exposing how hierarchical governance structures fundamentally shape asset recognition and mobilisation possibilities. These findings resonate strongly with Labonte and Laverack's (2001) critical analysis of capacity building in health promotion and their identification of tensions between institutional control and community empowerment. The present examination addresses both the identification of community resources and the policy environments that enable or constrain their utilisation, demonstrating that asset-based implementation feasibility depends not merely on asset availability but on governance frameworks that support community empowerment and local innovation. The tension between centralised control and community autonomy emerges as perhaps the most significant structural factor influencing implementation feasibility in Al-Jumum, aligning with broader literature in implementation science that emphasises the crucial role of contextual factors in determining intervention success (Damschroder et al., 2009, Nilsen, 2015). This finding particularly supports Wallerstein's (2006a) argument that genuine community empowerment requires addressing structural power imbalances rather than simply encouraging participation within existing hierarchical frameworks.

This section examines Al-Jumum's diverse asset base through four key categories that emerged from the empirical analysis of interview data, focus group discussions, document analysis, and observational findings: human and social assets, institutional assets, physical and environmental assets, and cultural assets. Each category reveals both substantial community resources and complex governance dynamics that shape their utilisation for health promotion. The analysis then explores how hierarchical governance structures systematically constrain community autonomy in asset recognition and mobilisation, before examining the policy landscape that both enables and limits asset-based implementation.

7.3.1 Al-Jumum's Assets: A Typology

7.3.1.1 Human and Social Assets. Al-Jumum possesses extensive human assets including professional expertise, traditional knowledge systems, and indigenous leadership capabilities that could support comprehensive health promotion initiatives, findings that

align closely with Kretzmann and McKnight's (1993) foundational work on asset-based community development which emphasises the importance of recognising individual skills, talents, and knowledge as community resources. The community's healthcare workers, educators, and administrative personnel provide clinical competence and technical expertise relevant to health promotion, representing what GCPH (2011) categorises as formal human assets within community settings. However, my observations during fieldwork revealed a critical disconnect between available expertise and its utilisation for community empowerment. This disconnect manifested in several ways: health professionals operated within narrow clinical frameworks without engaging with broader community development opportunities, educational staff possessed valuable knowledge about environmental health and wellness promotion but lacked formal channels to contribute to health initiatives, and administrative personnel with organisational expertise remained disconnected from both health and educational sectors despite their potential to facilitate cross-sector collaboration. As I noted in my field diary:

Box 7.1: Field Notes

Despite having qualified professionals in various fields, there seems to be little cross-pollination of knowledge between sectors, with health professionals working in isolation from educators who could contribute valuable perspectives on environmental health and community wellness.

The empirical analysis conducted in Chapter 5 using Saudi Arabia volunteer datasets (Open Data, 2023) revealed an expansion of female volunteer participation from virtually none to over 90 active participants with female leaders demonstrates latent leadership capacity and organisational skills that had previously been constrained by cultural limitations rather than absent from the community. This finding strongly supports feminist community development literature emphasising women's substantial but often unrecognised contributions to community wellbeing (Kenny, 2011, Ledwith, 2016). Local female leaders demonstrated sophisticated skills in cultural navigation, relationship building, conflict resolution, and resource mobilisation that proved essential for successful programme implementation, reflecting what Nahapiet and Ghoshal (1998) describe as structural, relational, and cognitive social capital, which can be leveraged for collective action.

The establishment of the Nabd Al-Jumum Volunteer Team and the Wadi Fatimah Women's Group illustrated how indigenous leadership development could create sustainable community capacity whilst respecting cultural boundaries and traditional authority structures, aligning with Bang and colleagues' (2024) recent findings on gender-

transformative approaches that work within rather than against cultural frameworks. The Wadi Fatimah Women's Group exemplifies this innovative leadership through their strategic use of existing social networks and kinship ties to recruit participants, as documented in Chapter 5. Through their dedicated efforts in community mobilisation and women's empowerment initiatives, the group achieved success, ultimately winning second place in the Hayak Initiative competition. This achievement demonstrates how women's leadership, when provided with culturally appropriate frameworks, can not only drive local community development but also gain recognition at broader institutional levels, validating their contributions to both general community empowerment and women's empowerment specifically.

The volunteer coordinator's strategic approach to recruiting women volunteers demonstrated sophisticated cultural competence and leadership thinking that represents valuable assets for health promotion. The coordinator's methodology, detailed in Chapter 5 (section 5.3), involved building trust with families first, working through established authority figures like school principals, and ensuring that participation enhanced rather than threatened traditional values. This culturally grounded approach resulted in the establishment of the Nabd Al-Jumum Volunteer Team with over 100 participants. The strategy exemplifies what might be termed a conservative-radical transformation—achieving transformative participation outcomes through methods that work within, rather than against, existing cultural and social structures. This approach reflects what Minkler and Wallerstein (2011) describe as culturally grounded community organising that builds upon existing social structures rather than challenging them directly, demonstrating how indigenous leadership can navigate cultural boundaries while creating sustainable community capacity for health promotion.

One interview that particularly enriched my understanding was with a family medicine physician who had worked in Al-Jumum for over five years. She provided detailed perspectives on how community health patterns had evolved over time, describing changes in disease prevalence, health-seeking behaviours, and community resource utilisation. Her insights helped me understand how traditional community assets had adapted to modernisation pressures and how healthcare providers perceived their roles in community health promotion.

During this interview, the physician in the primary care centre described how the healthcare system was adapting to meet community needs through flexible service delivery

approaches. He provided an example of how staff had adapted standard procedures to better serve an elderly patient with transportation difficulties, arranging home healthcare services rather than requiring frequent clinic visits. This example illustrated the type of adaptive practices that suggested potential alignment with asset-based principles of working with existing community resources and constraints.

This example demonstrated how formal healthcare services were evolving to become more community-oriented and responsive to patient needs. The home healthcare programme represents a systematic approach to bringing health services to patients in their own environments, which aligns with asset-based principles of building on existing community resources—in this case, the patient's home and family support system. The physician explained that these services include chronic disease follow-up, medication provision, laboratory tests, and patient education, and are available not only for elderly patients but for all age groups including cancer patients, post-surgical patients, and those requiring rehabilitation services. However, the physician did not describe this as an asset-based approach.

Building upon these human assets, the community's social capital emerges as perhaps its strongest resource category. As demonstrated through the empirical analysis in Chapter 4 of Al-Jumum's healthy cities initiatives and further evidenced in the volunteering work examined in Chapter 5, social capital is manifested through extensive family networks, religious connections, and traditional mutual support systems that provide both immediate health promotion resources and foundations for sustainable development. These findings strongly support Coleman's (1988) seminal work on social capital as a resource for individual and community action. Extended family systems offer emotional support, resource sharing, caregiving assistance, and decision-making frameworks significantly influencing health behaviours and outcomes. Meanwhile, Islamic institutions provide community gathering spaces, spiritual leadership, trusted communication networks, and established charitable activities that correspond with health promotion goals. This aligns with literature emphasising the crucial role of faith-based organisations in community development, particularly in Muslim-majority societies (Ager and Ager, 2011, Tadros, 2010).

In an Islamic context, the annual (Feeding the Fasting) programme during Ramadan exemplifies how religious networks could be leveraged for health promotion whilst strengthening community bonds and reinforcing cultural values, bringing together

community members across different age groups, social positions, and economic backgrounds to address food insecurity during the holy month. The empirical analysis in Chapter 5 revealed the programme's sophisticated organisational structure and community-wide impact, demonstrating how different families take responsibility for various aspects—from food preparation to distribution routes—creating a complex web of interdependence that strengthens social bonds while addressing practical needs. This finding supports Putnam's (2000) argument about the multifaceted benefits of civic engagement, whilst also reflecting what Ager and Ager (2011) describe as faith-based social capital that can be mobilised for community development.

However, my observations also revealed how social hierarchies and traditional authority structures could constrain asset mobilisation, with family networks enforcing compliance with traditional gender roles and cultural expectations that limited full asset utilisation. During focus group discussions, I noted tension between younger and older women regarding participation boundaries:

Box 7.2: Field Notes

Whilst older women supported the activities, they often expressed concerns about maintaining 'proper' behaviour and not overstepping traditional boundaries, creating informal monitoring that could limit the full expression of women's capabilities.

This reflects broader literature on how social capital can be both empowering and constraining (Portes (2024), particularly for marginalised groups within traditional societies.

Furthermore, Al-Jumum's historical role as a stopping point for pilgrims travelling to Mecca had cultivated distinctive social assets including traditions of hospitality, interfaith cooperation, cultural bridge-building, and community service that provided strong foundations for inclusive health promotion, findings that resonate with historical literature on the role of pilgrimage routes in fostering intercultural exchange and community development (Schramm et al., 2004). As detailed in Chapter 4, local policymakers emphasised how the community's historical role in welcoming Hajj pilgrims had cultivated enduring traditions of generosity and hospitality that continue to characterise interactions with visitors and travellers today, demonstrating that the cultural value of helping others remains deeply embedded within the community. This reflects deep-rooted cultural assets around hospitality and mutual aid that aligned closely with asset-based principles.

One particularly insightful informal conversation occurred with a group of four women who were neighbours, sitting on the ground drinking coffee together in the park, watching their kids who were playing in the play area. I approached them, introduced myself, and explained my research, though mostly only one of them was willing to talk to me. Our conversation began with general observations about the community, but gradually evolved into detailed discussions about how mothers in the neighbourhood organised informal support networks for childcare and educational assistance. She told me that she does not work and usually waits for her son along with his friend, who was her neighbour's child. She prepares lunch for them, and the friend stays with them until his mother comes home from work, as his mother works in a private company from 8 to 5 pm and his father is a police officer with different shift work. This arrangement demonstrated how neighbourhood mothers developed informal systems of mutual support, with non-working mothers providing childcare assistance to working mothers in their community.

However, not everyone was willing to talk to me, which itself provided insights into community dynamics and the challenges of external engagement. In general, people were welcoming and willing to provide help when asked questions about directions or basic information about the area, demonstrating a baseline level of community hospitality and mutual support. This happened when my brother asked for directions of a cafe, one man even walked part of the way with us.

During these park visits, I observed notable cultural diversity within Al-Jumum community, with residents from different cultural backgrounds including an Indian family and individuals. The police officer I spoke with explained that some of these residents may work in other cities such as Mecca or Jeddah but choose to live in Al-Jumum because it is more affordable, suggesting that the area functions as a residential community for workers employed in the broader regional economy. This observation revealed an important community asset in the form of affordable housing that attracts a diverse population, though it also suggested potential challenges related to commuting and community cohesion when residents' work lives are geographically separated from their home community.

Whilst I was not able to observe the intensive community asset mobilisation that might occur in more concentrated social spaces like markets or community centres, the park interactions demonstrated basic patterns of community civility and helpfulness that formed a foundation for more substantial community support networks, see box 7.3 below.

Box 7.3: Field Notes Extract - Park Observations (August 2022 – January 2023)

- First visit (18 August 2022) - noticed diverse people, saw Indian family and several Indian individuals
- Families mostly near play area - ladies gathering while kids play, group of men sitting together, people walking around
- Approaching people challenging - not everyone accepted to talk. Some ignored me completely, others refused politely, some willing to chat
- Hard to get women to talk with my brother present - went alone to ladies' group to make them more comfortable
- First visit felt uncomfortable - people staring because I dressed differently. They wear black abayas, most cover faces. I had light grey abaya
- Second and third visits (29 November 2022 and 19 January 2023) wore black and dark blue abayas - felt more accepted
- Park busiest at sunset - weather much nicer then

7.3.1.2 Institutional Assets. Moving from human and social resources to formal structures, institutional assets include healthcare facilities, educational institutions, religious organisations, governmental structures, and emerging civil society organisations providing formal frameworks for health promotion activities, though analysis reveals complex relationships between institutional capacity and community empowerment requiring careful navigation.

The community's traditional healthcare infrastructure included primary healthcare centres, specialist clinics, and referral networks providing essential medical services that could serve as platforms for expanded health promotion activities, possessing clinical expertise, diagnostic capabilities, and community trust that represented important institutional assets for health improvement. The health coaching programme demonstrated how healthcare system assets could be leveraged for community-centred health promotion through professional development, service integration, and community engagement strategies, though the research also revealed how healthcare system culture and institutional priorities could constrain asset-based implementation by emphasising individual treatment over community empowerment and maintaining professional authority rather than promoting community autonomy.

Educational institutions, such as schools, represented crucial institutional assets providing access to diverse population segments, trusted community venues, and educational

expertise relevant to health promotion. As detailed in chapter 5, the integration of volunteer activities into school curricula demonstrated how educational institutions could serve broader community development purposes whilst maintaining their primary educational functions. Educational institutions possessed particular strengths in youth engagement, family outreach, and community communication that could be leveraged for health promotion, with teachers and educational administrators often holding respected community positions providing legitimacy and credibility for health-related programming. However, educational system constraints including curriculum requirements, administrative regulations, and resource limitations could restrict innovative health promotion approaches, suggesting significant potential for expanding educational institutions' role in community health promotion through curriculum integration, facility sharing, and teacher training in asset-based approaches. However, this expansion required policy support and institutional commitment extending beyond individual programme initiatives.

Complementing educational institutions, mosques and religious organisations provided essential institutional assets including community gathering spaces, spiritual leadership, trusted communication networks, and established patterns of charitable activity that aligned with health promotion goals. Religious institutions possessed particular credibility and influence within the community that could be leveraged for health improvement whilst respecting spiritual values and traditions. The successful integration of volunteer activities with religious observances demonstrated how religious institutional assets could support health promotion whilst maintaining spiritual authenticity, though the research also revealed potential constraints related to gender segregation requirements, traditional authority structures, and conservative interpretations of religious teachings that might limit participation opportunities or innovative approaches, requiring respectful engagement with religious leadership, careful attention to theological compatibility, and culturally appropriate adaptation of health promotion activities.

7.3.1.3 Physical and Environmental Assets. Physical and environmental assets including Al-Jumum's location, agricultural heritage, natural resources, and built environment represented important resources that could support environmental health initiatives whilst connecting health promotion with traditional livelihoods and cultural practices, see chapter 4. This finding aligns with rural and place-based health literature emphasising that environmental context, local landscapes, built environments, and everyday relationships with place can shape health promotion opportunities (Bourke et al.,

2012). The Healthy Cities programme specifically incorporated environmental quality indicators including air pollution monitoring and green space development as key components of its accreditation framework, recognising Al-Jumum's rural/peri-urban setting and its potential for environmental health improvements linked to green spaces, agricultural heritage, walking areas, and community relationships with place. The health coaching services utilised the community's access to natural walking paths and outdoor spaces for promoting physical activity, whilst coaches encouraged participants to engage with traditional agricultural practices as forms of therapeutic exercise. The volunteering initiatives most directly leveraged environmental assets through the women's groups' afforestation projects, which demonstrated how environmental improvement could serve health promotion goals whilst providing meaningful volunteer opportunities and strengthening community bonds.

However, this analysis raises critical questions about the relationship between rurality, peri-urban transformation, and asset-based approaches. Al-Jumum's case suggests that environmental assets should not be understood only through a rural/urban binary. Rather, they include agricultural heritage, green spaces, local walking environments, affordability, residential links with larger cities, and continuing connections with surrounding villages. This concern reflects broader critiques in rural geography literature about the urban bias in health promotion models and the need for place-sensitive approaches that recognise rural specificity (Cloke and Little, 2005, Philo et al., 2003). Research on environmental health promotion has increasingly recognised the importance of 'therapeutic landscapes' and the health benefits of human-nature connections, particularly in rural contexts where such relationships may be more pronounced and culturally embedded (Gesler, 1992, Bell et al., 2018). Furthermore, literature on traditional ecological knowledge emphasises how indigenous and local environmental practices can provide culturally appropriate pathways for health promotion that build upon existing community knowledge systems rather than imposing external frameworks (Berkes, 2012, Drew and Henne, 2006).

7.3.1.4 Cultural Assets. Finally, cultural assets—Islamic values, Arabian traditions, and local customs—emerged as foundational resources providing motivation, legitimacy, and sustainability frameworks for health promotion activities, representing perhaps the most important and complex category of community assets requiring sophisticated understanding and respectful engagement. This finding aligns with broader literature on faith-based community development, which emphasises how religious

frameworks can enhance rather than compete with secular health promotion approaches when appropriately integrated (Ager and Ager, 2011, Tadros, 2010).

Islamic principles of community service, mutual aid, social justice, and collective responsibility provided strong cultural foundations for asset-based health promotion that aligned closely with community empowerment principles. The Healthy Cities programme strategically incorporated Islamic concepts of community stewardship and collective responsibility into its environmental health initiatives, with stakeholders explicitly referencing religious obligations to care for the community and environment as motivation for participation. The health coaching services adapted their approach to align with Islamic concepts of holistic wellness and community care, with coaches reporting that participants responded more positively when health advice was framed within religious contexts of bodily stewardship and family responsibility. Most significantly, the volunteering initiatives demonstrated successful integration of religious observances with community action, particularly through the coordination of volunteer activities during Ramadan and the embedding of charitable giving principles within health promotion projects.

As documented in Chapter 5, the (Feeding the Fasting) programme during Ramadan exemplified how religious networks could be mobilised for health promotion whilst strengthening community bonds, with families taking responsibility for different aspects of food preparation and distribution, creating complex webs of interdependence that addressed both nutritional needs and social cohesion. Religious frameworks for understanding health, wellness, and community responsibility offered culturally authentic approaches to health promotion that proved more effective than secular health education models, supporting literature on culturally grounded health interventions that build upon rather than challenge existing belief systems (Kreuter et al., 2003).

7.3.2 Governance Constraints on Asset Mobilisation

However, the empirical insights suggest that the hierarchical governance structure governing these initiatives fundamentally constrains community autonomy in asset recognition and mobilisation despite substantial resources being available, a finding that strongly supports critical implementation science literature emphasising how power structures and institutional arrangements shape intervention outcomes (Hawe et al., 2009, May et al., 2016). This represents the most pervasive barrier identified across all initiatives, creating a structural framework that systematically undermines the community empowerment and local innovation essential for effective health promotion in Al-Jumum's rural/peri-urban community. All programmes operate within rigid institutional hierarchies

requiring multiple governmental approvals, standardised protocol compliance, and external evaluation adherence that limits community input and local adaptation essential for asset-based implementation.

As documented throughout my fieldwork, the Healthy Cities programme required adherence to strict WHO accreditation standards with limited flexibility for local cultural adaptation, whilst stakeholders reported in chapter 4 that programme success depended heavily on "support from the government and different ministries" (Local policymaker, I1) rather than community-driven initiatives. Moreover, the health coaching programme exemplifies this constraint through its standardised Ministry of Health curriculum that provided limited flexibility for local adaptation or community input, reflecting what street-level bureaucracy literature describes as the tension between standardisation and professional discretion (Lipsky, 2010). Similarly, the volunteering sector required that "all volunteer initiatives [are] conducted under the supervision of relevant authorities" (Local policymaker, I2), with every activity proposal requiring ministerial approval that often resulted in delays and modifications reducing local relevance. This finding aligns with Carey and Braunack-Mayer's (2009) analysis of how government funding can shift community organisations toward top-down approaches, reducing potential for bottom-up innovation. This centralised approach fails to utilise local knowledge whilst constraining community empowerment essential for asset-based implementation, supporting Freire's (1970/2020) critique of top-down educational approaches that ignore local knowledge and community expertise.

7.3.3 Paternalism and Community Autonomy

The tension between paternalism and autonomy represents a specific manifestation of broader top-down governance structures, operating through the actual dynamics and relational processes within hierarchical frameworks rather than simply structural arrangements, reflecting what Freire (1970/2020) described as the banking concept of development where experts deposit knowledge into passive communities rather than engaging in collaborative learning. Central authorities, particularly the Ministry of Health, directed implementation of public health programmes including the Healthy City initiative and health coaching programmes through approaches that reflected limited initial community engagement. The Healthy City Network particularly demonstrates this dominant approach, where initiatives required high-level governmental support to gain traction. As one stakeholder noted, the programme's success depended heavily on "support from the government and different ministries" (Local policymaker, I1), highlighting

centralised decision-making whilst stakeholders reported they "faced refusals and denials from the people in the community" initially.

This pattern extended to other initiatives, with the volunteering sector operating under strict oversight where "all volunteer initiatives conducted under the supervision of relevant authorities" (Local policymaker, I2), limiting community-driven innovation. After interviewing the volunteers, I noted:

Box 7.4: Field Notes

Every activity proposal must be submitted for approval through the related ministry, with officials who have never lived in the community making decisions about what activities are appropriate or needed, and as I have been told that this may take some time. This could create significant delays and often results in modifications that reduce local relevance.

This finding supports Laverack's (2006) argument that paternalistic approaches to health promotion often undermine community autonomy by stifling local innovation and self-determination.

During fieldwork observations, many community members were unwilling to express their true opinions about health initiatives, saying they were happy with programmes even when body language or tone suggested otherwise, a phenomenon that reflects what Scott (1990) describes as hidden transcripts - the critique of power that occurs outside the direct observation of authority. This dynamic presented methodological challenges for data collection, as participants may have been similarly constrained in expressing authentic views during research interactions. However, this reluctance itself provides important evidence of entrenched power structures and high levels of social control that constrain authentic community engagement essential for asset-based approaches. As I recorded in my field notes:

Box 7.5: Field Notes

I saw that many people in the community did not want to share their true thoughts about the health programs. When I asked them, many said they were happy with what was happening, but their body language or tone made me think they were not being completely honest. It seemed like they did not trust me because I'm an outsider, and they were afraid that if they criticised the programs, it might hurt their reputation or job. This shows that there are strong power structures and social rules in the community that make it hard for people to speak freely.

Box 7.6: Field Notes

I encountered difficulties when attempting to speak with some key stakeholders in the community. On multiple occasions, I was told that I needed formal approval from specific ministries before they would agree to meet with me. This added layer of bureaucracy further illustrated the top-down nature of governance in Al-Jumum, where community members and local leaders had little power to engage freely without oversight from higher authorities.

7.3.4 Accreditation and Regulation

Accreditation and regulation proved pivotal in shaping implementation whilst creating tensions between compliance requirements and local flexibility essential for asset-based approaches. While meeting WHO Healthy Cities accreditation standards represented a significant achievement, it required community compliance with strict, externally imposed guidelines. As one stakeholder explained, "we had to work with different ministries and follow specific protocols to meet the WHO standards," ensuring health programmes aligned with global standards but limiting flexibility needed to adapt programmes to local needs and cultural contexts. This tension was evident across multiple initiatives, with the health coaching programme heavily structured around ministry-approved curricula focusing on standardised health education modules, lifestyle modification strategies, and preventive care approaches. Health educators reported having to "take advantage of the application created by the Ministry of Health" (National policymaker, I3) and follow prescribed digital platforms, constraining their ability to address specific health challenges unique to Al-Jumum's community.

The pursuit of accreditation, particularly through the Healthy Cities designation, revealed what could be termed 'awardism', where focus shifts from genuine community development to achieving external recognition and meeting standardised benchmarks (Peters, 2009). This was evident in stakeholders' emphasis on obtaining Healthy Cities status rather than ensuring sustainable community health improvements. Whilst such recognition can provide motivation and validate efforts, it risks prioritising compliance with external metrics over meaningful local transformation (Dooris and Heritage, 2013).

Monitoring and evaluation processes in Al-Jumum were primarily focused on quantifiable outcomes determined by external authorities, leaving little room for communities to define success from their perspective. The national volunteering platform maintains extensive records documenting multiple aspects of volunteer participation, including detailed

demographic information, types of activities performed, hours logged, and participation rates across different programmes. While this systematic documentation demonstrates governmental commitment to volunteer engagement, it also reflects the highly regulated and centralised nature of civic participation. These metrics, whilst useful for assessing immediate success, do not capture qualitative outcomes essential to asset-based approaches such as increased community empowerment, social cohesion, and long-term sustainability (Foot and Hopkins, 2010, Morgan and Ziglio, 2007). Observations revealed that whilst health initiatives focused on counting sessions held or volunteers recruited, little attention was paid to actual impact on community. Volunteers shared that they felt their work had strengthened community bonds and increased trust among neighbours, yet none of this was recorded in formal evaluation processes. Instead, emphasis remained on easily quantifiable data points, failing to capture more profound effects of initiatives, and highlighting limitations of top-down evaluation approaches.

7.4 Gender Dynamics and Cultural Adaptation in Asset-Based Implementation

Addressing Research Sub-Questions 2 and 3: What are the barriers that hinder the provision of adequate health services? What factors could affect implementation decisions?

Gender dynamics emerged as crucial factors influencing asset-based implementation, demonstrating how traditional cultural norms create complex challenges requiring sophisticated navigation rather than simple accommodation. These findings align with extensive feminist development literature emphasising the centrality of gender relations in determining development outcomes (Moser, 2012, Kabeer, 2001, Cornwall, 2016). Asset-based approaches emphasise inclusive participation to fully mobilise local assets (Laverack, 2006), yet traditional gender norms can restrict participation, preventing communities from leveraging the full potential of their members, particularly women who often possess valuable insights into family health and caregiving that could significantly enhance programme effectiveness. The analysis of all three focal points reveals that gender-related constraints operate simultaneously as barriers limiting current service effectiveness and factors significantly influencing implementation feasibility, whilst also showing potential for transformation into assets through culturally competent adaptation strategies that respect traditional values whilst expanding empowerment opportunities.

The data, presented in chapter 5, from the Saudi Open Data Portal reveals interesting patterns regarding women's participation in Al-Jumum's volunteering activities, with the community demonstrating a higher proportion of female volunteers (85 female volunteers

compared to 72 male volunteers) despite national trends showing more male volunteers overall (144,277 male compared to 137,361 female volunteers nationally). This local variation suggests that contextual factors and specific community initiatives can successfully overcome some gender-based barriers to participation through culturally appropriate programming and strategic community engagement that respects traditional values whilst creating expanded opportunities for meaningful contribution.

The Healthy Cities programme illustrates how global north assumptions about universal participation clash with local cultural norms, creating implementation challenges requiring cultural competence rather than direct framework application (Mohan and Stokke, 2000, Hickey, 2004). These assumptions, often embedded in global health models, did not fully account for localised gender expectations, thus limiting inclusivity and programme effectiveness (Castro et al., 2010). Activities in mixed-gender public spaces such as health workshops experienced reduced female attendance, highlighting gaps between programme inclusivity goals and implementation realities within conservative cultural contexts. This finding aligns with broader literature on gender participation challenges in conservative settings (Khoja et al., 2017). This disconnect underscores challenges of balancing standardised healthcare delivery with local community assets and cultural requirements, demonstrating need for approaches that accommodate rather than confront cultural boundaries whilst maintaining programme effectiveness and community acceptance.

However, the research demonstrates that gender-based barriers can be transformed into assets through appropriate adaptation strategies that respect cultural boundaries whilst expanding participation opportunities, challenging assumptions about inevitable conflicts between traditional gender norms and progressive health promotion. The development of gender-sensitive service delivery options and women-only volunteers programming creates culturally acceptable pathways for expanded participation whilst maintaining cultural legitimacy and family support essential for sustainable engagement. Rather than representing insurmountable obstacles, gender dynamics reveal opportunities for culturally appropriate adaptation that could enhance rather than constrain community engagement when managed with cultural competence and respect for traditional frameworks that provide stability and meaning for community members.

The health coaching programme demonstrates successful cultural adaptation through gender-sensitive service delivery that respects local preferences whilst maintaining programme effectiveness and achieving health improvement outcomes, findings that align with literature on culturally responsive healthcare delivery (Beach et al., 2005, Wing Sue

and Sue, 2008). Recognising that participants felt more comfortable discussing personal health matters with someone of the same gender, programme organisers provided options for male or female coaches, consistent with literature recommending culturally sensitive adaptations to healthcare delivery, particularly in conservative settings where gender dynamics are prominent (Carey and Braunack-Mayer, 2009). However, due to the limited number of available coaches and the inherent difficulties of recruiting qualified health coaching professionals in rural areas, the programme innovatively established an online system with a mobile application that enables virtual sessions with coaches. As illustrated in chapter 6, participants can access gender-appropriate coaching services by booking appointments through the Mawid App or Sehhaty App, which expanded access whilst maintaining cultural sensitivity requirements essential for community acceptance.

Health coaching programme stakeholders described the importance of providing both male and female coaches to ensure cultural appropriateness, as detailed in Chapter 6. This gender-sensitive approach aligns with asset-based principles by fostering trust and strengthening connections between community members and health providers whilst demonstrating how respecting local cultural norms enhances rather than threatens programme effectiveness. The digital platform solution addresses practical implementation challenges whilst maintaining cultural appropriateness, allowing clients to choose their coach's gender through virtual consultations that overcome geographical and resource constraints common in rural settings. This reflects understanding that cultural sensitivity is essential for sustainability rather than a secondary consideration, with technology serving as an enabler for culturally appropriate service delivery rather than a replacement for community-responsive programming.

This approach represents what Kabeer (2005) describes as practical gender needs accommodation - addressing immediate access barriers without necessarily challenging underlying gender relations - whilst creating conditions for potential transformation through increased women's access to health services. Studies on community-based health interventions in conservative settings highlight that gender-sensitive adaptations that work within existing cultural frameworks rather than confronting them directly can enhance access and engagement whilst supporting sustainable impact of health initiatives (Wallerstein, 2006b, Moser, 2012), with Al-Jumum's experience demonstrating how innovative service delivery models can maintain cultural sensitivity whilst addressing practical implementation constraints through appropriate technology integration.

Traditional gender norms in Al-Jumum create significant barriers to equitable health service access through multiple mechanisms including family oversight requirements, gender segregation expectations, and traditional authority structures limiting women's autonomous decision-making about health and community participation, findings that resonate with broader literature on gender and health in conservative Muslim contexts (Al-Rasheed, 2013, Doumato, 2000). Gender-based social expectations played a significant role in Al-Jumum's rural/peri-urban community, where traditions of gender segregation and family oversight continued to affect participation levels, especially for women (Al-Rasheed, 2013). Early volunteer initiatives faced substantial resistance due to gender segregation expectations and family concerns about women's participation in public activities, with female participants describing feelings of shyness and lack of confidence when initially engaging in community activities, as detailed in Chapter 5.

During my focus group sessions with women, I observed how these cultural constraints manifested in subtle but powerful ways, as documented in chapter 5. The dynamics revealed complex negotiations between respect for traditional authority and women's autonomous participation, with younger women deferring speaking time to older participants whilst still demonstrating confident knowledge and articulate opinions when directly addressed. Most significantly, younger participants came accompanied by male family members who waited outside during discussions, and they mentioned needing to consult with family before committing to activities. These observations, detailed further in Chapter 5, demonstrate how women can participate actively in community discussions whilst still operating within cultural frameworks requiring male accompaniment and family consultation for public activities. These cultural constraints limited community asset mobilisation not by silencing women's voices, but by creating practical barriers and protocols that, whilst enabling participation within culturally acceptable boundaries, still restricted the full extent of women's autonomous engagement in community health initiatives, supporting broader literature on how cultural norms create complex participation patterns in development programmes (Minkler and Wallerstein, 2011, Moser, 2012).

As discussed in Chapter 5, the volunteer sector reveals the most dramatic transformation in gender participation, evolving from complete absence of women's groups to thriving female volunteer teams demonstrating significant empowerment and leadership development that challenges assumptions about fixed cultural constraints, findings that support recent literature on gender-transformative approaches that work within rather than

against cultural frameworks (Bang et al., 2024, Cornwall, 2016). This evolution demonstrates that asset-based approaches can facilitate radical incrementalism—a form of gradual cultural change that achieves substantial transformation through patient, strategic navigation working within traditional frameworks whilst creating expanded opportunities for meaningful participation (Bayat, 2013). This concept builds upon established literature on incremental institutional change (Van der Heijden and Kuhlmann, 2017) whilst extending it to community development contexts where cultural sensitivity is paramount for sustainability. The transformation required sophisticated understanding of family dynamics, community influence patterns, and appropriate engagement strategies that honoured cultural boundaries whilst building capacity for autonomous action and community leadership, exemplifying what Berman and Fox (2014) describe as the strategic value of gradual approaches in achieving meaningful change within resistant contexts.

The establishment of the Wadi Fatimah Women's Group exemplifies successful radical incrementalism through women-only programming that operates within cultural frameworks whilst achieving meaningful empowerment outcomes and community development goals, reflecting what Kabeer (2001) describes as strategic gender interests that challenge existing power relations whilst maintaining cultural legitimacy. This entirely female-led initiative became instrumental in various community health activities including environmental projects, awareness campaigns, and community education programmes, providing spaces where women could participate meaningfully without violating cultural expectations or threatening traditional authority structures. As documented in Chapter 5, founding members highlighted how creating appropriate spaces and opportunities demonstrated women's eagerness to contribute to their community, with participation growing to over 90 female participants. The group's success in organising events, conducting awareness campaigns, and implementing environmental improvement projects demonstrates how strategic incrementalism can unlock previously untapped community assets whilst maintaining cultural legitimacy and community acceptance essential for sustainable development, supporting literature on women's informal leadership roles in community development (Ledwith, 2016, Kenny, 2011).

In adapting to this shift, local organisers leveraged family networks and schools to foster environments where female participation was supported through culturally appropriate mechanisms that respected traditional authority whilst expanding empowerment opportunities. As detailed in Chapter 5, one organiser described strategic approaches that involved approaching families first, then working with school principals who motivated

teachers and students, ultimately leading to the establishment of the 'Nabd Al-Jumum Volunteer Team' with over 100 participants. This demonstrated sophisticated understanding of cultural dynamics and strategic thinking necessary for constructive incrementalism within conservative contexts—an approach that accepts both the potential and limitations of gradual change whilst recognising that patient, respectful engagement can achieve more substantial transformation than confrontational strategies that might provoke resistance and undermine sustainability. However, this research acknowledges the inherent limitations of incremental approaches, particularly regarding the depth and pace of change possible within existing power structures, reflecting broader critiques of incrementalism that highlight how gradual approaches may maintain rather than fundamentally challenge systemic inequalities (Lindblom, 1959). Women became instrumental in projects like the afforestation initiative aimed at increasing green spaces in Al-Jumum, demonstrating how gender-sensitive approaches can align with asset-based principles by engaging community strengths in ways that respect local gender norms whilst fostering both social cohesion and community health improvement, though the extent to which such approaches can address deeper structural inequalities remains constrained by their commitment to working within rather than challenging traditional authority structures (Morgan and Ziglio, 2007).

However, this transformation required patience and strategic engagement rather than confrontational approaches that might threaten cultural identity and social cohesion essential for community stability and programme sustainability, reflecting what Mohanty (2005) describes as the importance of understanding local contexts rather than imposing universal feminist frameworks. Female volunteers described substantial personal development through participation whilst maintaining cultural boundaries, as documented in Chapter 5. Participants reported increased confidence and greater ease in participating in public activities, whilst emphasizing their commitment to avoiding culturally inappropriate behaviour.^p This statement reveals successful cultural navigation that allows empowerment whilst maintaining respect for traditional values, suggesting that asset-based approaches can facilitate social change when implemented with cultural competence and patience rather than direct confrontation with existing authority structures.

My conversations with these women revealed the complexity of this transformation process, as detailed in my fieldwork notes in Chapter 5. Participants described how initial family concerns about women's participation in public activities gradually transformed into acceptance and even support as family members observed that other participants came

from respectable families and that the work genuinely benefited the community. This gradual acceptance process reflects what Kandiyoti (1988) describes as bargaining with patriarchy - strategic negotiations that expand women's agency whilst maintaining family and community relationships. The transformation required demonstrating that women's community engagement aligned with rather than threatened traditional values of family honour and community service, suggesting that sustainable empowerment occurred through careful navigation of existing social structures rather than direct confrontation with patriarchal norms.

During focus group discussions with two female volunteers, marked differences emerged in participation levels between older and younger women, with younger participants being more vocal about experiences and willing to challenge traditional limitations whilst older women, though supportive of activities, often deferred to male authority figures when discussing programme decisions and expressed concerns about maintaining appropriate boundaries in mixed-gender activities. As I observed

Box 7.7: Field Notes:

The generational divide was evident in group dynamics - younger women would propose ambitious projects and activities, whilst older women would immediately consider family and community acceptance. This tension was productive rather than divisive, with older women's caution helping to ensure cultural appropriateness whilst younger women's enthusiasm drove innovation.

This generational variation suggests that cultural adaptation processes operate differently across age groups and require nuanced understanding of how traditional authority intersects with emerging empowerment opportunities to create sustainable change that respects intergenerational relationships whilst expanding participation possibilities.

Challenges remain regarding full utilisation of women's potential contributions, with participation often contingent on family approval and male accompaniment creating ongoing constraints on autonomous decision-making and leadership development. As documented in Chapter 5, participants acknowledged that some families have begun allowing women to participate in mixed-gender environments when accompanied by male family members. This reveals ongoing negotiation processes rather than fixed constraints, suggesting continued potential for expansion whilst respecting cultural boundaries that provide stability and meaning for community members whilst gradually creating space for enhanced participation and empowerment.

The success of women-focused initiatives like the afforestation project demonstrates potential for asset-based approaches when adapted to local gender norms, with women's involvement in environmental projects aligning with traditional associations between women and care for the natural environment whilst contributing to broader community health goals. This suggests that asset-based approaches can be most effective when they work with rather than against existing cultural frameworks, identifying points of convergence between traditional values and contemporary health promotion goals rather than imposing external models that may threaten cultural identity or social cohesion.

However, gender dynamics also revealed persistent inequalities and reproduction of traditional power structures in new forms, with women gaining access to volunteer leadership roles that often remained segregated from male-dominated decision-making spaces. The Health Coaching programme, despite providing same-gender options, continued to operate within individualised therapeutic frameworks that potentially limited collective empowerment opportunities essential for comprehensive community development. The volunteer sector's success in expanding women's participation highlighted how asset-based approaches must navigate multiple, sometimes competing, community assets and values, with strong social capital within traditional family networks providing essential support for women's expanding participation whilst these same networks also enforcing compliance with gender norms that could limit full asset mobilisation.

The analysis reveals that gender dynamics significantly influence implementation decisions through community assessments of cultural compatibility and programme acceptability that determine sustainability and effectiveness of health promotion initiatives. Families' willingness to support women's participation depends on programming approaches that respect traditional authority whilst creating meaningful opportunities for contribution and development. Implementation decisions must consider not only current participation patterns but also the potential for gradual expansion through culturally appropriate strategies that build upon existing assets whilst respecting cultural boundaries. The research shows that gender-sensitive programming can enhance rather than constrain asset-based approaches by recognising women's substantial but often underutilised assets whilst working within cultural frameworks that provide stability and legitimacy for community development initiatives. These gender dynamics reflect broader tensions between individual empowerment and collective mobilisation that fundamentally shape

how asset-based approaches must navigate cultural expectations and community priorities in Al-Jumum's traditional context.

7.5 Navigating Conservative-Radical Tensions in Asset-Based Implementation: Individual Versus Collective Approaches

Addressing Research Sub-Questions 1 and 3: What are community assets and what factors affect implementation decisions?

The analysis reveals a fundamental tension between conservative approaches that maintain existing social structures and transformative potential that challenges established norms, demonstrating how asset-based approaches must navigate traditional frameworks whilst promoting beneficial change through patient, respectful engagement rather than confrontational strategies that might threaten cultural identity and social cohesion. This tension between radicalism and conservatism emerges as the key overarching dynamic that shapes all other implementation considerations, including the balance between individual versus collective approaches to asset identification and mobilisation, with important implications for implementation feasibility and cultural appropriateness in Al-Jumum's rural/peri-urban context, where family networks, community relationships, religious values, and smaller-community forms of trust shaped collective identity and mutual support. These findings align with Gramsci and his colleagues' (1971) concept of hegemony and the potential for gradual transformation through cultural work, as well as broader debates in community development literature, which have highlighted how global north models often overemphasise individual empowerment, overlooking the significance of communal relationships and collective agency (Labonte, 1997, Craig, 2007).

This conservative-radical tension manifests most clearly in the fundamental philosophical orientations underlying different approaches to health promotion, where individualistic models derived from global north therapeutic traditions conflict with collective approaches that better align with conservative cultural contexts characterised by strong family networks and community solidarity. However, it is crucial to recognise that communal relationships can be conservative in nature, as demonstrated in Al-Jumum where traditional social networks sometimes reinforced existing power structures and gender hierarchies whilst simultaneously providing essential support systems. This reflects Putnam's (2001) distinction between bonding and bridging social capital, where strong in-group bonds can maintain traditional norms and exclude outsiders, whilst bridging capital connects diverse groups and linking capital connects communities to formal institutions with potential for more transformative change. As Campbell and Jovchelovitch (2000)

argue, health and development interventions grounded in social participation must consider local understandings of identity and cooperation, especially in collectivist cultures where empowerment is embedded in social ties rather than individual autonomy, creating a complex dynamic where collective approaches can simultaneously preserve conservative structures and enable transformative change.

7.5.1 Conservative Elements: Maintaining Stability Through Institutional and Cultural Frameworks

Conservative elements dominate health programme implementation in Al-Jumum, operating within frameworks that reinforce existing social hierarchies whilst providing stability and legitimacy for community development initiatives that ensure programme acceptance and sustainability. Institutional conservatism manifests through requirements for all volunteer initiatives to operate "under supervision of relevant authorities" (Local policymaker, I2), ensuring state control over civil society activities rather than empowering communities for self-organisation and autonomous governance. This framework maintains traditional authority structures whilst limiting opportunities for genuine community empowerment and innovative approaches that might challenge existing power arrangements or decision-making processes. During my fieldwork observations, I witnessed how this conservatism operated in practice through rigid approval processes that constrained organic community development, yet simultaneously provided the legitimacy necessary for programme acceptance within existing institutional frameworks.

The health coaching programme exemplifies how institutional conservatism operates through individual-focused interventions that, whilst appearing to promote empowerment, actually reinforce traditional therapeutic relationships and personal responsibility frameworks that align with conservative governance structures. This programme predominantly embodies individualistic approaches through one-to-one relationships, personalised goal-setting, and individual behaviour change strategies that emphasise self-management and personal accountability for health maintenance and improvement, reflecting what Crawford (1980) critically identified as the ideology of victim blaming in health promotion. Health coaches work with clients to develop personal lifestyle modification strategies, conduct individual assessments, and create tailored action plans that draw heavily from motivational interviewing and behaviour change theories prioritising individual agency and personal responsibility for health outcomes (Miller and Rollnick, 2012), an approach that has been challenged by public health scholars who argue for more collective and structural approaches addressing social determinants rather than

focusing solely on individual behaviour change (Marmot and Wilkinson, 2005, Frohlich and Potvin, 2008).

The limitations of this individualistic approach became evident through the programme's design and implementation structure, which created a disconnect between intervention design and the collective nature of decision-making in rural Saudi contexts. As detailed in Chapter 6, health coaches explained their focus on individual patients and provision of confidential sessions, particularly virtual ones, for those who preferred privacy. While this individualistic, confidential approach may address privacy concerns, the programme structure did not provide tools for addressing collective influences on individual behaviour, creating a fundamental mismatch with community realities where health behaviours and outcomes are significantly influenced by family dynamics, community networks, and cultural practices requiring community-centred rather than individually focused intervention approaches. Training curricula focusing on individual assessment, personal goal setting, and behaviour change theories emphasising individual psychological processes rather than community dynamics, social determinants, or collective resources. This represents a missed opportunity for asset mobilisation that could enhance health outcomes through community empowerment.

Cultural conservatism appears through gender-segregated programming that, while necessary for ensuring women's participation within existing cultural frameworks, also reinforces traditional role expectations and authority patterns that may limit autonomous decision-making and full empowerment potential. The emphasis on family approval for women's participation in volunteering activities represents another form of cultural conservatism that successfully increased participation by working within existing family structures whilst also perpetuating patriarchal authority patterns that constrain women's independent decision-making about community engagement and personal development opportunities. Religious conservatism frames health initiatives within traditional obligations and duties, with the (Feeding the Fasting) initiative mobilising community action by connecting volunteering to religious requirements during Ramadan rather than promoting secular concepts of civic engagement or social justice that might challenge traditional authority structures.

7.5.2 Transformative Potential: Collective Approaches and Quiet Encroachment

Despite these conservative constraints, several initiatives demonstrate radical potential through their challenge to existing power relations and empowerment of marginalised community members, suggesting that transformative change can occur within conservative

frameworks when approached with cultural competence, patience, and strategic positioning that respects traditional values whilst creating expanded opportunities. These findings support literature on quiet encroachment and everyday forms of resistance (Bayat, 2013), where marginalised groups achieve incremental social change through silent, patient, and prolonged mobilisation that avoids direct confrontation with authority whilst gradually altering social arrangements through persistent everyday practices. This process involves non-confrontational but sustained actions where individual and family strategies collectively create broader social transformation over time, allowing groups to expand their social and political space without openly challenging dominant power structures.

In contrast to the individualistic health coaching programme, volunteer initiatives demonstrate more sophisticated collective approaches successfully mobilising diverse community assets through collaborative programming that leveraged both individual skills and community resources to achieve broad-based improvements. These findings align with Putnam's (2000) work on social capital and collective efficacy whilst demonstrating the activation of multiple forms of social capital simultaneously. The Nabd Al-Jumum Volunteer Team brought together community members across different age groups, social positions, and economic backgrounds to work on shared environmental and health promotion projects, revealing how collective approaches could simultaneously activate individual capabilities and community assets to create meaningful health promotion activities that addressed both individual empowerment and community development goals.

These initiatives demonstrated the mobilisation of bonding, bridging, and linking social capital as conceptualised by Putnam (2000), with bonding social capital evident through strengthening ties within existing family networks and religious communities, bridging social capital emerging as initiatives connected participants across different social and economic positions, and linking social capital developing through connections between community members and formal institutions. The volunteer initiatives achieved community-wide participation that recognised assets exist across all population segments, facilitated skill and resource sharing where participants contributed diverse capabilities including organisational abilities and local knowledge, built social capital through strengthened community bonds and new connections, and generated sustainable impact by building on existing cultural and religious practices to create lasting changes in community capacity for collective action.

The annual (Feeding the Fasting) campaign during Ramadan exemplifies effective collective asset mobilisation by combining religious observance traditions, community

solidarity practices, family networks, and youth energy to create meaningful health promotion activities that activated multiple asset categories simultaneously. As detailed in Chapter 5, local policymakers emphasised encouraging youth participation to instil community spirit whilst addressing food security, demonstrating how collective approaches activate cultural assets through religious traditions, social assets through community networks, human assets through volunteer skills, and institutional assets through local facilities in ways that are more comprehensive and sustainable than individual interventions.

Women's empowerment within traditional frameworks represents perhaps the most significant manifestation of transformative potential operating through conservative accommodation, exemplifying Bayat's (2013) concept of quiet encroachment. The development of volunteer groups fundamentally altered women's relationships to public space and community decision-making whilst operating within culturally acceptable boundaries that maintained family support and community acceptance. Rather than directly challenging traditional gender roles, women strategically expanded what those roles could encompass, gradually normalising their public participation through patient, incremental actions that avoided confrontation whilst achieving substantive change in their community engagement and leadership opportunities. The establishment of the Wadi Fatimah Women's Group exemplifies how women-only programming can create spaces for meaningful empowerment whilst operating within traditional gender role expectations, with this entirely female-led initiative becoming instrumental in environmental projects, community education, and health promotion activities that demonstrated women's capacity for autonomous organisation and community leadership.

7.5.3 Navigating Individual-Collective Tensions Within Conservative-Radical Dynamics

The fundamental tension between individual and collective approaches must be understood within this broader conservative-radical dynamic, where cultural contexts significantly influence the effectiveness of different empowerment strategies. Communities with strong social ties and collective identities, such as Al-Jumum, potentially benefit more from asset-based approaches that start with existing collective structures and gradually expand to include broader participation rather than beginning with individual behaviour change and hoping to build community connections. This finding supports the theoretical connection between social capital dimensions and asset-based implementation, with communities rich in what Nahapiet and Ghoshal (1998) describe as relational and cognitive social capital—characterised by trust, shared values, and collective identity—being particularly well-

suited to asset-based approaches that leverage these existing networks and shared understandings for health promotion.

However, as previously discussed regarding the conservative nature of communal relationships, even collective initiatives operated within constraints limiting their full asset mobilisation potential. Formal approval requirements and external regulation compliance created bureaucratic barriers constraining organic community development essential for authentic collective empowerment, reflecting broader tensions identified in literature on state-civil society relations (Edwards, 2009). During interviews with volunteers, they explained the regulatory framework governing their activities: volunteers must first register through the national volunteering platform, and any volunteer initiative requires prior approval “to make sure that the work is going within the rules and does not affect the community negatively” (The third stage interviews, local policymaker, I2), with all activities requiring comprehensive documentation. While these approval processes ensure regulatory compliance and community safety, they also create bureaucratic barriers that can constrain the flexibility and responsiveness essential for grassroots innovation and community-driven programming.

The Healthy Cities programme demonstrates hybrid approaches combining individual and collective elements within this conservative-radical tension, though with mixed success in comprehensive asset mobilisation. While the programme structure required extensive multi-sector collaboration and community engagement reflecting collective approaches, the top-down implementation framework limited opportunities for organic collective action that could emerge from community priorities and local innovation, reflecting what Cornwall and Brock (2005) describe as invited versus invented spaces for participation. The programme exemplified invited participation, where community members could engage within predetermined parameters set by WHO indicators and governmental requirements, representing what Arnstein (2019) characterises as consultation or placation levels rather than genuine citizen power where communities hold real decision-making authority.

7.5.4 Technology and the Conservative-Radical Spectrum

The integration of technology adds another dimension to these conservative-radical tensions, particularly through smartphone applications for health coaching and volunteer coordination, which create new complexities in individual-collective dynamics with implications for community empowerment and asset mobilisation. While digital platforms provided individual empowerment through convenient access and self-monitoring

capabilities, they also potentially reinforced individual rather than community-centred approaches to health improvement that could undermine collective support systems essential for sustainable change, reflecting broader concerns about technological solutions that ignore social contexts (Lupton, 2016). However, volunteer initiatives' use of digital platforms for coordination and communication demonstrated how technology could enhance rather than replace community connections when designed appropriately, with the national volunteering platform enabling individual registration and skill-sharing whilst facilitating group organisation and collective project development that built upon rather than replaced traditional community networks.

7.5.5 Strategic Navigation and Implementation Implications

The research demonstrates that successful navigation of conservative-radical tensions requires incremental transformation approaches that build upon small changes rather than dramatic confrontation with existing power structures that might provoke resistance and undermine sustainability. Cultural framing makes radical changes more acceptable when positioned within traditional values and existing cultural frameworks, whilst building from existing assets provides more sustainable foundations than imposing external models that may not align with local contexts and preferences. Creating safe spaces for experimentation within broader conservative contexts enables innovation whilst maintaining legitimacy and community acceptance, requiring long-term perspectives recognising that transformative change may require sustained engagement over extended periods rather than expecting immediate radical transformation that could threaten cultural identity and social cohesion.

This analysis reveals that stakeholders can influence implementation possibilities through sophisticated understanding of cultural dynamics and strategic positioning that respects traditional authority whilst creating expanded empowerment opportunities essential for sustainable community development and health improvement. The most successful initiatives were those that recognised and built upon existing community assets rather than attempting to import external solutions, with environmental initiatives that mobilised local environmental knowledge and traditional conservation practices building upon existing cultural values and traditional ecological knowledge rather than assuming communities lacked environmental awareness or capacity for environmental action.

Asset-based approaches contain inherent radical potential through their emphasis on community self-determination, challenge to deficit-based thinking, and recognition of community wisdom and capabilities that can contest traditional professional authority and

external expertise assumptions (Kretzmann and McKnight, 1993, Freire, 1970/2020, GCPH, 2011). However, the potential for addressing root causes exists through asset-based approaches that could challenge structural inequalities and power imbalances creating health inequities, though programmes examined did not explicitly address broader structural issues that might require more confrontational approaches. Instead, they created foundations for community organising that might eventually support more fundamental social change through capacity building, leadership development, and collective efficacy enhancement that could provide platforms for future advocacy and transformation efforts addressing underlying causes of health disparities and social inequalities.

The research suggests that this sophisticated navigation requires deep understanding of cultural dynamics, political constraints, and community assets that must be approached with cultural competence and respect for local contexts whilst maintaining commitment to evidence-based practice and sustainable community empowerment. Success depends on recognising that transformative change can emerge through what appears to be conservative accommodation, but actually represents strategic engagement with cultural constraints to achieve expanded empowerment over time, demonstrating how asset-based approaches can work within traditional frameworks whilst gradually expanding possibilities for individual and collective agency.

7.6 Stakeholder Contributions and Implementation Feasibility

Addressing Research Sub-Question 5: How can decision makers and community members influence implementation possibilities?

This section examines how different stakeholder groups can influence asset-based implementation possibilities by applying Greenhalgh et al.'s (2004) diffusion-dissemination-implementation continuum to understand the roles various actors play in moving asset-based approaches from passive spread to active mainstreaming within health systems. It is important to note that Al-Jumum currently remains in the early diffusion stage with no formal commitment to asset-based approaches, though this research demonstrates that more systematic dissemination and implementation are feasible given appropriate stakeholder coordination. The analysis reveals specific contributions that community members, healthcare professionals, local government officials, and national policymakers can make to enhance implementation feasibility whilst recognising the collaborative nature of community development requiring coordinated engagement across multiple levels and sectors. Building upon Marks and Hooghe's (2004) multi-level governance framework, this examination demonstrates how effective asset-based

implementation requires both vertical coordination across different governmental levels and horizontal coordination across different sectors and actors. The section first explores community-level contributions observed within the diffusion phase, then examines professional and administrative roles that could facilitate the dissemination phase, before analysing policy-level contributions necessary for systematic implementation, concluding with how these multi-level stakeholder contributions interact to create supportive environments for sustainable asset-based health promotion.

7.6.1 Community Contributions in the Diffusion Phase

Community members occupy a central position in what Greenhalgh et al. (2004) describe as the diffusion phase—the passive, unplanned spread of new practices through informal networks and peer influence. In Al-Jumum, community members possessed intimate knowledge of local resources, social networks, and cultural practices that external assessments frequently overlooked, with the research demonstrating that resident-led asset identification reveals capabilities not apparent through professional assessment including informal support systems, traditional knowledge systems, and innovative problem-solving strategies developed through local experience and cultural adaptation, findings that support participatory development literature emphasising the value of local knowledge (Chambers, 1994, Pretty, 1995). Chambers (1994) argues that local people are sophisticated analysts of their own conditions and possess detailed knowledge about local variations, seasonal changes, and social dynamics that outsiders often miss or misunderstand. He emphasises that "rural people's knowledge is often superior to that of outsiders" in understanding local contexts, resource availability, and appropriate solutions.

The volunteer initiatives' success stemmed from bottom-up approaches beginning with existing community strengths and gradually expanding asset recognition capacity through practical engagement, exemplifying what Greenhalgh et al. (2004) identify as the horizontal, peer-mediated spread characteristic of diffusion processes. Despite operating within formal regulatory frameworks requiring registration through the national volunteering platform, the initiatives maintained their community-driven character through recruitment processes that relied on personal networks and local knowledge rather than formal training or external assessment, as I wrote in my field notes:

Box 7.8: Field Notes:

I observed numerous examples of community members' sophisticated understanding of local assets that were not captured in formal assessments: Residents consistently demonstrated knowledge about informal helping networks, seasonal resource availability, traditional skill sets, and cultural practices that could support health promotion but were not recognised by official programmes. Their asset maps are far more nuanced and dynamic than any external assessment could capture

Residents serve as cultural interpreters and bridge-builders helping translate asset-based concepts into culturally appropriate language and frameworks that resonate with traditional understanding whilst maintaining conceptual integrity with evidence-based principles, addressing what Alcoff (1991) describes as the challenge of (speaking for) versus (speaking with) marginalised communities. Alcoff's distinction highlights a fundamental ethical and methodological concern in research and development contexts where the act of representation carries significant risks of misrepresentation, expansion of researchers' own authority and privilege, and perpetuation of what Alcoff calls imperialist speaking rituals – patterns of discourse that reproduce colonial power dynamics by privileging external voices over local knowledge whilst claiming to represent community interests without genuine participation or consent from those being represented. As Alcoff argues, "we should strive to create wherever possible the condition for dialogue and the practice of speaking with and to rather than speaking for others." (Alcoff, 1991).

In the Al-Jumum context, this distinction proved particularly relevant as I observed how official health programmes often operated through (speaking for) approaches, reflecting what decolonial scholars identify as colonial knowledge practices that privilege external expertise over indigenous knowledge systems (Santos, 2015, Mignolo, 2011). These approaches involved external assessments and standardised protocols that defined community assets and needs without meaningful community input into these definitional processes, exemplifying what Quijano and Ennis (2000) terms the (coloniality of knowledge) where global north-derived frameworks are imposed as universal truths whilst marginalising local ways of knowing. However, when residents were engaged, they demonstrated sophisticated understanding of local assets and innovative approaches to health promotion that challenged external assumptions whilst maintaining cultural authenticity and community ownership of development processes, illustrating the potential for what Santos (2015) describes as epistemologies of the South that recognise and value diverse knowledge systems.

The difference in data quality was dramatic. In the male-only focus group with male citizens from the city, participants were reluctant to discuss challenges or problems in their community. They kept focusing only on the strengths and assets in their city, consistently stating that everything in their community was good and that they were happy with what they had in the city so far. When I tried to explore potential areas for improvement or difficulties, they might have encountered in community health services or community life, they avoided discussing these topics and redirected the conversation back to positive aspects of their community and available services.

This experience highlighted important cultural considerations about how community members might present their community in research settings. The male participants seemed reluctant to acknowledge challenges or criticisms, possibly reflecting cultural values about presenting their community positively to outsiders, community pride, or concerns about how their responses might be used. This pattern made it difficult to gather nuanced data about implementation barriers or areas where asset-based approaches might address existing gaps in community health promotion.

The female-only focus group proved even more revealing. The two women participants, who were both from the female volunteer group, engaged in rich discussions about their volunteer work and the challenges they faced as females in the community. This adaptation proved particularly valuable for female participants, who demonstrated markedly increased engagement in the single-gender setting compared to my initial mixed-gender attempts. As one participant commented following the female-only focus group: "I can speak freely without worrying about what others might think" (Female Volunteer, FG3). Her observation captured a broader pattern I witnessed throughout the female focus group, where participants shared more openly about their experiences with family life, community changes, improvements they had noticed in the area, and their volunteer work activities.

The participants explained how volunteering had become much easier for them compared to the past, and how their families now supported and encouraged their volunteer activities. They spoke about how women in their group encouraged each other and worked together to overcome barriers they faced as female volunteers. Their conversation revealed how community attitudes toward women's participation in volunteer work had evolved, with families becoming more supportive and the community more accepting of women's active roles in community service.

In the male local citizens focus group, the mapping exercise focused on formal resources and institutional relationships. Participants reviewed and added to the initial map by identifying healthcare facilities, educational institutions, religious centres, government offices, and formal community organisations. Their contributions emphasised official resources and community networks that could be mobilised for health promotion activities, building upon the institutional assets I had already identified through individual interviews.

The female volunteers' mapping exercise revealed a different layer of community assets that had not been fully captured in my initial mapping. Their contributions to the map included formal institutions but gave equal emphasis to informal networks and social gathering places. They identified the park as an important social space where women gather whilst children play and mentioned that they sometimes conducted volunteer activities in this park. They also highlighted the local small mall as a significant community asset, recognising it as both a practical resource for accessing goods and services and a social space for community interaction. This mapping exercise demonstrated how the female volunteers understood community assets differently from other participants, recognising both formal services and informal social spaces as important resources for community engagement and health promotion activities.

7.6.2 Professional Roles in Active Dissemination

Healthcare professionals demonstrate crucial potential for advancing asset-based principles through their existing roles within health programmes. Healthcare professionals who embraced community engagement and participatory approaches within current health initiatives achieved better programme outcomes whilst building stronger community relationships, demonstrating potential for professional transformation that enhances both clinical effectiveness and community empowerment through approaches that honour both professional knowledge and community wisdom, findings that support literature on transformative professional education (Frenk et al., 2010).

Healthcare professionals positioned within formal health systems can influence implementation through practice reorientation integrating clinical competence with community development skills whilst maintaining professional credibility and service effectiveness. Their system knowledge and clinical authority position them to advocate for policy and practice changes supporting asset-based approaches whilst managing bureaucratic constraints and professional accountability requirements that ensure service quality and patient safety. Professional contributions include developing clinical practice

models that integrate asset-based principles with evidence-based clinical care through innovative service delivery approaches that enhance both clinical outcomes and community empowerment whilst maintaining professional standards and institutional accountability. This represents what Greenhalgh et al. (2004) identify as the planned, formal dissemination strategies that utilise professional authority and institutional channels to spread innovations.

Healthcare professionals participate in peer learning networks and professional communities supporting innovation and shared learning about asset-based practice whilst providing professional support and development opportunities that may not be available through formal continuing education programmes focused primarily on clinical competence rather than community engagement skills.

7.6.3 Administrative Facilitation and Coordination

Local government officials and administrators possess significant influence over implementation feasibility through control over regulatory requirements, approval processes, and administrative procedures that can enable or constrain community innovation and local adaptation essential for effective asset-based practice. Within Greenhalgh et al. (2004) framework, local administrators operate at the intersection of dissemination and implementation phases, facilitating the transition from active persuasion to systematic mainstreaming within organisational contexts.

Local government officials influence implementation through regulatory flexibility balancing quality assurance with community autonomy, creating supportive frameworks for community organising and asset mobilisation through simplified approval processes, technical assistance provision, and resource-sharing arrangements that enhance community capacity whilst maintaining administrative accountability. Administrative contributions include developing inter-sectoral coordination mechanisms bringing together health, education, social services, and other sectors for integrated programming that leverages multiple community assets whilst addressing complex health challenges requiring collaborative approaches and resource sharing across institutional boundaries.

Local government's convening power and coordination authority provide crucial capabilities for facilitating inter-sectoral collaboration essential for comprehensive asset-based health promotion addressing social determinants and mobilising diverse community resources for integrated programming that could be more effective than single-sector approaches. The Al-Jumum experience demonstrates how local administrative decisions

directly shape implementation possibilities, revealing both enabling and constraining aspects of oversight. As documented across the Healthy Cities programme and volunteering initiatives, administrative facilitation proved essential for programme legitimacy and resource access, with local administrators serving as crucial intermediaries between national standards and community implementation realities. However, the requirement for extensive governmental coordination and ministerial approval for all activities, whilst ensuring regulatory compliance and community safety, also created bureaucratic barriers that constrained the flexibility and responsiveness essential for grassroots innovation, highlighting the dual role of administrative oversight in both enabling and limiting asset-based implementation.

7.6.4 National Policy Framework for Implementation

National-level decision makers possess crucial influence over what Greenhalgh et al. (2004) define as the implementation phase—the systematic integration of innovations within organisational structures through formal policies, procedures, and institutional arrangements. National policymakers shape implementation possibilities through evolving frameworks that show potential for supporting asset-based approaches, though explicit ABA policy frameworks remain to be developed. Currently, Saudi Arabia lacks comprehensive policy frameworks explicitly supporting asset-based approaches as a defined health promotion strategy—indeed, the absence of formal asset-based policy frameworks necessitated this research’s innovative use of proxy initiatives to assess implementation feasibility. However, the 2030 Vision’s emphasis on community empowerment, citizen engagement, and participatory development creates emerging policy space that could support asset-based implementation when fully operationalised (National Transformation Program, 2020). The Vision’s goals related to enhancing community participation in national development, strengthening primary healthcare through community engagement, and building local capacity represent foundational elements that align with asset-based principles, though these remain aspirational objectives rather than implemented policy frameworks (Chowdhury et al., 2021, Vision2030, 2022b).

National policymakers contribute by developing comprehensive policy frameworks explicitly supporting asset-based approaches through legislative initiatives, regulatory reform, and institutional guidance creating supportive environments for community empowerment and participatory health promotion whilst maintaining quality standards and accountability requirements.

During my interviews with national policymakers, insights emerged about the perceived receptiveness of smaller and rural/peri-urban communities to programmes when local assets are recognised and valued. As detailed in chapter 4, one national policymaker reflected on how working with rural communities had fundamentally changed their understanding of health service delivery, emphasising that rural communities become more accepting of new health initiatives when approached with recognition that community knowledge about health and healing can complement clinical approaches. This policymaker noted that rural communities are often more receptive to new health programmes than urban populations when their assets and knowledge are valued rather than dismissed. This observation highlights how national policymakers can contribute to asset-based implementation by developing programme approaches that recognise and build upon community assets whilst providing clinical expertise and evidence-based intervention.

National stakeholders also provided insights into how international health promotion concepts were adapted for Saudi implementation, describing the complex process of translating frameworks like WHO healthy cities initiatives into policies acceptable within Saudi cultural and political contexts. These discussions revealed that asset-based principles might be more readily accepted if presented as extensions of existing community support traditions rather than as entirely new innovations. The importance of working through established community leadership and influence networks emerged as a crucial implementation consideration, with suggestions that initiatives should begin with trusted community members who could then influence broader community acceptance.

Interviewing stakeholders in positions of authority required significant adaptations of my usual interview approaches. These participants expected more formal interaction protocols and often positioned themselves as providing expert information rather than sharing personal perspectives. I learned to begin these interviews by explicitly acknowledging participants' expertise and positioning myself as seeking to learn from their knowledge rather than evaluating their practices. I also discovered that authority figures sometimes provided official responses that reflected policy positions rather than personal observations. To access more candid perspectives, I learned to ask about specific examples and practical challenges rather than general policy questions, finding that questions about obstacles encountered when implementing new programmes often elicited more detailed and honest responses than questions about official policies and procedures.

For example, when I asked one national stakeholder about the health coaching programme implementation process, they initially provided formal policy information. However, when I asked about specific challenges they had encountered, they shared more practical insights about their research approach in rural areas to understand how to implement new services effectively. They explained that people in small cities and rural areas were much easier to influence than people in larger cities but emphasised the crucial importance of knowing where to start and with whom. They noted that successful implementation required working with people that communities trusted, such as the mayor, highlighting how community influence networks and trusted leadership were essential considerations for any new health promotion initiative. This response revealed practical implementation wisdom that went beyond official policy guidelines and demonstrated the importance of understanding local social structures and trust relationships.

Policy contributions include reforming health sector policies to integrate community development principles with clinical service delivery through frameworks recognising and supporting asset-based practice as legitimate health system performance components. National educational and training policies significantly influence healthcare professionals' preparedness for asset-based practice through impact on professional curricula, continuing education requirements, and career development pathways shaping professional identity and practice orientation toward community-centred approaches. National policymakers contribute by mandating curriculum reform integrating community development skills with clinical competence requirements through medical education standards, professional certification processes, and continuing education frameworks ensuring healthcare professionals develop asset-based practice capabilities alongside technical skills.

National monitoring and evaluation requirements shape local programme priorities and implementation approaches through influence on institutional incentives, resource allocation, and performance assessment that can support or constrain asset-based implementation depending on indicator selection and evaluation framework design recognising or ignoring community empowerment outcomes. National policymakers contribute by developing evaluation frameworks recognising community empowerment and asset development outcomes alongside traditional clinical indicators through performance measurement systems capturing the full range of asset-based achievements whilst maintaining accountability for health improvement and service quality.

7.6.5 Multi-Level Coordination and Implementation Sustainability

The collaborative nature of these stakeholder contributions demonstrates that successful asset-based implementation requires coordinated engagement across Greenhalgh and colleagues' (2004) diffusion-dissemination-implementation continuum rather than isolated individual efforts. Each stakeholder group possesses unique capabilities and influence that must be mobilised collectively to create supportive environments for community empowerment and sustainable health improvement. This aligns with Marks and Hooghe (2004) multi-level governance framework, which emphasises that effective policy implementation requires both vertical coordination across different governmental levels (national, regional, local) and horizontal coordination across different sectors and actors within the same level.

The research reveals that stakeholder influence operates through complex interactions requiring sophisticated understanding of cultural dynamics, institutional constraints, and community assets that must be navigated with patience and respect for local contexts whilst maintaining commitment to evidence-based practice and health improvement outcomes. Community members provide the foundational diffusion mechanisms through informal networks and local knowledge, healthcare professionals facilitate active dissemination through professional channels and clinical credibility, local administrators enable coordination and resource mobilisation, whilst national policymakers create the institutional frameworks necessary for systematic implementation and sustainability.

This multi-level approach recognises that asset-based implementation cannot rely solely on grassroots enthusiasm or top-down mandate but requires strategic coordination across all levels of the health system and broader governance structures. The Al-Jumum experience demonstrates that when stakeholders understand their complementary roles within this continuum and work collaboratively to support asset-based approaches, sustainable implementation becomes feasible even within hierarchical governance contexts that might otherwise constrain community empowerment and local innovation.

7.7 Final Reflection: Original Contributions and Implications for Theory, Policy, and Practice

This research makes original contributions to understanding the implementation feasibility of asset-based approaches in Al-Jumum as a Saudi rural/peri-urban context, with possible relevance to similar Global South contexts where rapid development, traditional social relationships, and centralised governance intersect. Through examining Al-Jumum's experience with three health initiatives which function as proxies in the absence of explicit

commitments to ABA, this study reveals how traditional governance structures, cultural norms, and community assets interact to shape implementation feasibility in ways that challenge existing assumptions about participatory development approaches.

7.7.1 Conceptual and Theoretical Contributions

This research extends Nilsen's (2015) implementation science framework by demonstrating how characteristics of context, mechanisms, and implementation objects interact differently in conservative cultural settings compared to global north contexts where most implementation theories have been developed. Nilsen's framework categorises implementation theories into three main types: process models (describing steps in implementation), determinant frameworks (identifying factors that influence implementation outcomes), and evaluation frameworks (assessing implementation effectiveness). His taxonomy emphasises that implementation success depends on understanding how interventions interact with contextual factors, individual characteristics, and organisational processes to produce outcomes. Building upon this foundation, the analysis of this research reveals that traditional hierarchical governance structures and cultural deference to authority do not necessarily represent insurmountable barriers to community empowerment, but rather require sophisticated navigation strategies that work within rather than against existing cultural frameworks. This extends Nilsen's framework by demonstrating that determinant frameworks developed in global north contexts may inadequately capture how traditional authority structures can simultaneously constrain and enable implementation, requiring more nuanced understanding of how cultural hierarchies function as both barriers and assets for community-based interventions.

This research introduces the concept of radical incrementalism: a process whereby meaningful social change occurs through methods that respect rather than challenge traditional authority structures whilst gradually expanding empowerment opportunities. This concept builds upon established theoretical foundations, particularly Bayat's (2013) concept of quiet encroachment—the patient, non-confrontational mobilisation that gradually alters social arrangements whilst avoiding direct challenges to authority that characterises social change in Middle Eastern contexts. This finding significantly extends feminist development literature (Cornwall, 2016, Kabeer, 2001) by demonstrating that women's empowerment can occur within conservative frameworks when approaches build upon rather than confront traditional values. The evolution from minimal women's participation to thriving female leadership in Al-Jumum provides empirical evidence that challenges simplistic assumptions about necessary conflicts between traditional values and

progressive development, suggesting instead that cultural authenticity and transformative change can be mutually reinforcing when approached with patience and cultural competence.

Building upon Kretzmann and McKnight's (1993) foundational work, this research demonstrates that asset-based approaches require not simply asset identification but sophisticated cultural navigation capabilities that can mobilise community strengths whilst respecting traditional boundaries. The concept of cultural navigation emerges as a crucial implementation determinant that enables practitioners to work strategically within existing structures whilst gradually expanding empowerment opportunities. This extends beyond cultural competence to encompass dynamic understanding of how to leverage cultural assets for progressive change whilst maintaining community legitimacy and social cohesion. The volunteer coordinator's strategic approach to recruiting women volunteers exemplifies this cultural navigation, involving trust-building with families, working through established authority figures, and ensuring participation enhanced rather than threatened traditional values. This approach represents a significant advance over existing literature on community engagement, which often assumes universal applicability of participatory approaches without adequate attention to cultural adaptation requirements (Hickey, 2004, Mohan and Stokke, 2000).

This research also develops a framework for understanding how governance structures fundamentally shape asset recognition and mobilisation possibilities. The research reveals that hierarchical governance creates systematic constraints on community autonomy through multiple mechanisms: requirements for governmental approval, standardised protocol compliance, and external evaluation criteria that limit local innovation essential for asset-based implementation. However, the analysis also demonstrates that these constraints can be strategically navigated through what DiMaggio (1988) terms institutional entrepreneurship—creative approaches that achieve community empowerment goals whilst maintaining compliance with formal requirements. This research extends institutional entrepreneurship theory to community development contexts, demonstrating how local actors can work within systemic constraints to achieve culturally appropriate outcomes. For example, the health coaching programme's adaptation to provide gender-sensitive services through digital platforms whilst maintaining Ministry of Health compliance exemplifies how local actors can work within systemic constraints to achieve culturally appropriate outcomes.

7.7.2 Methodological Contributions

The methodological insights that emerged through my fieldwork revealed that bricolage methodology involves more than methodological flexibility—it requires genuine openness to learning from participants and adapting research approaches based on cultural contexts and participant needs (Kincheloe, 2001). The methodological adaptations that emerged through my fieldwork weren't deviations from proper procedure but essential components of culturally grounded research that could access meaningful local knowledge whilst maintaining analytical integrity. This experience demonstrated that effective cross-cultural research requires researchers to remain flexible and responsive to local contexts whilst maintaining rigorous analytical standards.

The evolution from my initial structured plan to a responsive bricolage approach represents a crucial methodological contribution. My original research design was organised around two distinct phases: asset mapping followed by feasibility assessment across multiple participant groups, reflecting conventional approaches to health systems research with clearly defined stages, methods, and analytical procedures. However, upon entering the field, I discovered that the reality of conducting research in Saudi communities was far more complex and nuanced than my methodological plans had anticipated, requiring significant adaptation to accommodate cultural dynamics, social networks, and communication patterns.

This research makes significant methodological contributions through its innovative approach to assessing implementation feasibility through existing community initiatives that share implicit features with asset-based approaches, rather than imposing external frameworks or conducting experimental interventions. This proxy methodology represents a significant methodological advance that enables feasibility assessment whilst respecting community autonomy and avoiding extractive research practices that have characterised much development research. The approach of examining the WHO Healthy Cities programme, health coaching services, and community volunteering initiatives as proxy indicators for asset-based implementation capacity provides a replicable methodology for similar contexts globally.

Building upon Greenhalgh et al.'s (2004) diffusion-dissemination-implementation continuum, this research demonstrates how implementation science can be applied prospectively to assess whether relevant determinants are in place before moving to active dissemination phases. The research positions itself within the diffusion phase of the continuum, examining how various ABA-related practices have developed within the

community, then prospectively assessing whether conditions exist for more active spread of asset-based approaches. This methodology provides practical guidance for similar assessments in diverse contexts whilst contributing to implementation science theory development by demonstrating how feasibility assessment can occur respectfully within existing community structures rather than through imposed experimental designs that may be culturally inappropriate or methodologically extractive. Furthermore, this approach has significant practical value by potentially reducing costly implementation failures, addressing what (Eccles et al., 2005) describe as the "expensive version of trial and error" that characterises traditional intervention testing. By conducting feasibility assessment through existing practices before costly programme deployment, this methodology provides the foundational understanding necessary for informed implementation decisions.

7.7.3 Empirical Contributions and Evidence Base

This research provides the first comprehensive empirical assessment of asset-based approach feasibility in a rural global south context, filling a significant gap in implementation literature that has been dominated by global north case studies (Blickem et al., 2018). The systematic analysis of Al-Jumum's human, social, institutional, physical, and cultural assets demonstrates that rural/per-urban community context possess substantial resources for health promotion when recognised and mobilised through culturally competent approaches. The documentation of Al-Jumum's extensive social capital - manifested through family networks, religious connections, historical traditions of hospitality, and sophisticated mutual support systems - provides empirical evidence that challenges deficit-based assumptions about rural community capacity. The annual (Feeding the Fasting) programme during Ramadan exemplifies how religious networks can be leveraged for health promotion whilst strengthening community bonds, demonstrating the potential for faith-based social capital mobilisation that builds upon rather than competes with secular health promotion approaches.

The empirical analysis of women's participation evolution from virtually zero to over 90 active participants with established female leadership provides unprecedented documentation of gender transformation within conservative cultural contexts. This finding significantly advances understanding of how traditional gender norms can be transformed into assets through patient, respectful engagement that creates expanded opportunities whilst maintaining cultural legitimacy. The establishment of the Wadi Fatimah Women's Group demonstrates how women, when provided with culturally appropriate frameworks, can drive local community development whilst gaining recognition at institutional levels.

This validates their contributions to both community empowerment and women's empowerment specifically, providing empirical evidence for gender-transformative approaches that work within rather than against cultural frameworks (Bang et al., 2024).

The research provides insights into how digital platforms can enhance rather than replace community connections when designed with collective goals in mind. The volunteer coordination platform enabled individual registration and skill-sharing whilst facilitating group organisation and collective project development, building upon traditional community structures through new coordination tools rather than fragmenting existing social networks. This finding contributes to understanding of how technology can support rather than undermine community empowerment when integrated thoughtfully with existing cultural practices and social structures, addressing concerns about digitalisation's potential to erode community cohesion (Putnam, 2000). The systematic documentation of governance constraints through empirical analysis of approval processes, standardised protocols, and evaluation requirements provides concrete evidence of how centralised control mechanisms systematically undermine community autonomy whilst revealing strategic opportunities for institutional entrepreneurship that maintains compliance whilst achieving empowerment goals.

7.7.4 Policy Implications and Strategic Recommendations

This research reveals substantial gaps between Saudi Arabia's 2030 Vision rhetoric supporting community participation and operational frameworks that maintain centralised control mechanisms constraining genuine community empowerment. The findings provide specific guidance for policy reform that could align implementation practices with stated national objectives whilst respecting cultural authenticity. The findings suggest that future health initiatives need to strike better balance between ensuring compliance with external standards and providing sufficient flexibility for local actors to innovate and lead, requiring movement beyond checkbox approaches to accreditation towards approaches that value and incorporate local knowledge and community-defined measures of success. The analysis demonstrates that policy reform requires systematic approaches addressing multiple levels simultaneously: regulatory frameworks that enable local innovation whilst maintaining appropriate oversight, professional development systems that build cultural navigation capabilities alongside clinical competencies, and evaluation frameworks that capture qualitative outcomes essential to asset-based approaches rather than focusing exclusively on easily quantifiable metrics.

Therefore, this research argues that asset-based approaches in Al-Jumum, and potentially in similar Saudi rural/peri-urban contexts, should be understood within wider critiques of ABCD to wider critiques of ABCD and asset-based approaches. As discussed in Chapter 2, critical scholars warn that asset-based approaches can be used to shift responsibility for health improvement onto communities without addressing the structural conditions that create health inequalities (Friedli, 2013, MacLeod and Emejulu, 2014). This concern is important in Al-Jumum, where community assets such as volunteering, family networks, religious institutions, and women's groups provide important resources for health promotion, but cannot replace adequate health services, sustainable funding, or supportive policy frameworks. Therefore, this research argues that asset-based approaches in Saudi rural/peri-urban communities should be understood as complementary to, rather than a substitute for, formal health system responsibilities and broader structural reform.

Policy recommendations emerging from this research include development of flexible accreditation standards that accommodate local cultural practices whilst maintaining evidence-based quality standards, moving beyond checkbox approaches toward recognition of community-defined success measures. The research provides evidence for establishing regional approval mechanisms that reduce bureaucratic delays whilst maintaining oversight, enabling more responsive adaptation to local needs and cultural contexts. Professional development reform should integrate asset-based practice capabilities and cultural navigation skills into health professional training, moving beyond deficit-based clinical models toward community development competencies that recognise and mobilise community assets. Systematic integration of culturally appropriate gender accommodations across health services, building upon successful adaptations demonstrated in Al-Jumum's health coaching programme, represents another crucial policy priority emerging from this research.

The research provides practical guidance for staged implementation approaches that respect cultural boundaries whilst building sustainable capacity for community empowerment. The implementation framework developed through this research offers systematic guidance for similar contexts, beginning with cultural asset mapping and relationship building through systematic identification of human, social, institutional, physical, and cultural assets, engagement with traditional authority structures to build trust and legitimacy, and assessment of governance constraints and opportunities for institutional entrepreneurship. Strategic pilot development follows, implementing culturally adapted programming that works within existing constraints whilst documenting

successful adaptation strategies and building the evidence base for expanded community engagement. Gradual empowerment expansion represents the final phase, involving progressive expansion of community decision-making opportunities, development of indigenous leadership capabilities, and integration of asset-based approaches with broader health system objectives.

The implications suggest that future asset-based implementation should explicitly design for both individual empowerment and collective development through programme models that begin with individual skill-building and confidence development whilst progressively creating opportunities for collective action and community asset mobilisation. This might involve developing approaches that start with existing community strengths and gradually expand asset recognition capacity through practical engagement, creating multiple participation pathways that accommodate different comfort levels and cultural preferences, and training practitioners in both individual support techniques and community development approaches enabling them to work effectively across individual and collective levels simultaneously.

The analysis reveals specific regulatory constraints that systematically undermine community autonomy. However, the findings also provide guidance for reform approaches that maintain appropriate oversight whilst enabling local innovation. Recommendations for regulatory framework reform include streamlined approval processes for community-led initiatives that reduce bureaucratic delays without compromising quality standards, flexibility provisions within standardised protocols that enable cultural adaptation whilst maintaining evidence-based foundations, and community-responsive evaluation frameworks that capture qualitative outcomes essential to asset-based approaches such as increased empowerment, social cohesion, and long-term sustainability rather than focusing exclusively on easily quantifiable metrics that may miss the most important outcomes.

7.7.5 Future Research Directions and Sustainable Development

This research's focus on a single rural/peri-urban case, while enabling deep contextual understanding, limits generalisability to other settings. The reliance on existing initiatives rather than designed interventions provides valuable insights into natural diffusion processes but constrains ability to assess controlled implementation outcomes. These limitations point to crucial future research priorities that could enhance both theoretical understanding and practical implementation guidance across diverse contexts.

Future research would examine long-term sustainability and impact of culturally adapted asset-based approaches through longitudinal studies that track community empowerment, health outcomes, and social change processes over extended periods. This research provides baseline understanding that enables future comparative analysis whilst the methodological framework developed provides replicable approaches for similar assessments. Comparative research across diverse rural, peri-urban, and global South settings could enhance understanding of contextual variations in implementation approaches whilst building broader evidence base for asset-based implementation in diverse cultural contexts, extending the cultural navigation approach and conservative-radical transformation concepts to different religious, ethnic, and socio-economic contexts.

Comprehensive economic evaluation of implementation costs and benefits, including analysis of cost-effectiveness compared to traditional deficit-based approaches, could provide crucial evidence for policy development and resource allocation decisions whilst investigation of asset-based approaches for environmental health challenges and climate adaptation could extend theoretical understanding whilst addressing urgent practical needs in rural communities facing environmental challenges. The integration of mental health and social wellbeing applications within community development frameworks represents another crucial research priority (Campbell and Murray, 2004, Patel et al., 2018), examining how asset-based approaches can address individual psychological needs within collective empowerment frameworks whilst respecting cultural understandings of mental health and healing.

Research examining the relationship between asset-based approaches and broader social change processes could provide insights into how community development initiatives contribute to progressive transformation whilst maintaining cultural authenticity and social cohesion. The radical incrementalism requires further development through comparative case studies that examine how this process operates across different cultural contexts and policy environments, whilst the cultural navigation concept needs refinement through practitioner-researcher collaboration that develops practical tools and training approaches for implementation in diverse settings. Methodologically, future implementation research should utilise and further validate the innovative proxy intervention approach developed in this study, testing its effectiveness across different contexts whilst refining understanding of its strengths and limitations for assessing implementation feasibility before committing to full-scale interventions.

The findings of this thesis are not generalisable to all rural communities in Saudi Arabia, the Middle East, or the wider Global South. Al-Jumum is not presented as a representative rural community. Instead, the study offers analytical transferability to contexts that share similar characteristics, including rural/peri-urban transformation, strong family and social networks, links with surrounding villages, developing health and civic infrastructure, gendered participation norms, and policy reforms that emphasise community participation and preventive health. The detailed contextual description provided throughout the thesis allows readers to judge whether the findings may be relevant to other settings. However, transferability depends on careful attention to local histories, governance arrangements, service infrastructure, and community relationships.

7.7.6 Conclusion: Toward Culturally Grounded Community Empowerment

This research demonstrates that implementing asset-based approaches in Al-Jumum's rural/peri-urban community is conditionally feasible and promising, but only when such approaches are adapted to local cultural norms, governance structures, community relationships, and existing assets, offering significant potential for addressing health inequalities whilst building upon existing community strengths and cultural assets that provide foundations for sustainable empowerment and health improvement. However, successful implementation requires sophisticated adaptation strategies that respect cultural authenticity whilst promoting necessary systemic changes for sustainable community empowerment. These approaches must enhance rather than threaten cultural identity while contributing to evidence-based health outcomes and Saudi Arabia's 2030 Vision goals.

The findings provide both theoretical insights and practical guidance for implementing asset-based approaches in contexts characterised by hierarchical governance, traditional authority structures, and conservative cultural norms. Rather than representing insurmountable barriers, these characteristics can be transformed into assets for sustainable community development when approached with patience, respect, and sophisticated understanding of cultural dynamics that recognise the wisdom embedded in traditional social structures whilst creating space for beneficial adaptation and empowerment expansion.

Most significantly, this research contributes to broader understanding of how public health and community development frameworks originating in the global north can be adapted to diverse cultural contexts without sacrificing either evidence-based effectiveness or cultural authenticity. The findings on radical incrementalism, cultural adaptation strategies, and the interaction between governance structures and community assets provide conceptual tools

for similar contexts globally whilst advancing implementation science theory for cross-cultural application, demonstrating that global north-developed frameworks can be respectfully adapted rather than imposing universal models that ignore cultural specificity and local wisdom.

In conclusion, this thesis has examined the feasibility of implementing asset-based approaches to health in Al-Jumum as a Saudi rural/peri-urban community context. The findings show that asset-based principles are not absent from existing Saudi health and community initiatives; rather, they appear in partial, uneven, and institutionally mediated forms through Healthy Cities activities, volunteering practices, and health coaching services. Al-Jumum's rural/peri-urban character shaped these processes through local trust relationships, family and neighbourhood networks, gender norms, community leadership, service-access patterns, religious and cultural values, and connections with surrounding villages. However, the findings also show that asset-based implementation is constrained when community participation is managed primarily through top-down institutional structures. The thesis therefore argues for culturally responsive, context-sensitive, and genuinely participatory approaches that build on existing community assets while allowing local people greater influence over health promotion priorities, practices, and evaluation.

Appendices

Appendix A: Ethical Approval Obtained From the University of Glasgow Ethics

Committee



College of Social
Sciences

09 August 2022

Dear Sabreen Batarfi

College of Social Sciences Research Ethics Committee

Project Title: The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Peri Urban Community: The Case of Al-Jumum

Application No: 400210239

The College Research Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. It is happy therefore to approve the project, subject to the following conditions:

- Start date of ethical approval: 09/08/2022
- Project end date: 01/10/2024
- Any outstanding permissions needed from third parties in order to recruit research participants or to access facilities or venues for research purposes must be obtained in writing and submitted to the CoSS Research Ethics Administrator before research commences: socsci-ethics@glasgow.ac.uk
- The research should be carried out only on the sites, and/or with the groups and using the methods defined in the application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research: (https://www.gla.ac.uk/media/media_490311_en.pdf)
- Any proposed changes in the protocol should be submitted for reassessment as an amendment to the original application. The **Request for Amendments to an Approved Application** form should be used: <https://www.gla.ac.uk/colleges/socialsciences/students/ethics/forms/staffandpostgraduateresearchstudents/>

Yours sincerely,

Dr Susan A. Batchelor
College Ethics Lead

Appendix B: University of Glasgow's Participant Consent Form



College of Social
Sciences

Consent Form

Title of Project: The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Peri-Urban Community: The Case of Al-Jumum

Name of Researcher: Sabreen Batarfi

Name of Supervisor: Dr. Alistair Hunter & Dr. Alexander Whitelaw

Please tick as appropriate

- Yes ☐ No ☐ I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions.
- Yes ☐ No ☐ I understand that my participation is voluntary, and I am free to withdraw from participating in the work at the point of actual data collection and then within 14 days after the interviews.
- Yes ☐ No ☐ I consent to interviews being audio-recorded
- Yes ☐ No ☐ I acknowledge that participants will be referred to by pseudonym.
- Yes ☐ No ☐ I acknowledge that there will be no effect on my employment arising from my participation or non-participation in this research and will remain confidential.

I agree that:

- Yes ☐ No ☐ All names and other material likely to identify individuals will be anonymised.
- Yes ☐ No ☐ The material will be treated as confidential and kept in secure storage for a period of ten years in line with the University of Glasgow Guidelines.
- Yes ☐ No ☐ The material may be used in future publications, both print and online.
- Yes ☐ No ☐ I waive my copyright to any data collected as part of this project.
- Yes ☐ No ☐ Other authenticated researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.
- Yes ☐ No ☐ I acknowledge the provision of a Privacy Notice in relation to this research project.

I agree to take part in this research study ☐

I do not agree to take part in this research study ☐

Name of Participant: Signature:

.....

Date

Name of Researcher: **Sabreen Batarfi** Signature

Date

End of consent form

Appendix C: University of Glasgow's Participants Information Sheet



College of Social
Sciences

Participant Information Sheet

Study Title: The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Peri-Urban Community: The Case of Al-Jumum.

Researcher Details:

Name: Sabreen Batarfi

Email: xxxxxxxx@student.gla.ac.uk

You are being invited to take part in a research study. Before you decide to take part, it is important for you to understand why the research is being done and what is involved. Please read the following information carefully and discuss it with others if you wish. Ask the researcher/s if there is anything that is not clear or if you would like more information. Take some time to decide whether or not you wish to take part. Thank you for reading this.

What is this study about?

The purpose of this research is to better understand the current situation for Saudi rural/peri-urban communities in terms of health and to explore the potential to implement an asset-based approach there. An asset-based approach highlights the capacity, skills and knowledge, and connections in individuals and communities. It focuses on the strengths of individuals and communities rather than focusing on their needs, deficits, and problems. This approach is concerned with identifying the protective factors that support health and well-being. It can act as the foundation from which to build a positive future.

Therefore, this research will assess the knowledge and opinions of practitioners and other stakeholders about their job role, work environment, services, local assets, and asset-based approaches. The results of the research will be used to provide recommendations to local and national policymakers about the feasibility of implementing asset-based approaches in Saudi Arabia.

This study may benefit the wider community as it will support the design and use of a new approach to achieve the goals of the Ministry of Health's 2030 vision. It will provide an opportunity for participants to see their communities in a different new way that could help them improve their health and wellbeing. It will also address the lack of attention devoted to the implementation of asset-based approaches.

Who is organising and funding the research?

The research is being led by the primary researcher, Sabreen Batarfi, with the guidance of two supervisors Dr. Alistair Hunter and Dr. Alexander Whitelaw at the School of Interdisciplinary Studies, University of Glasgow's Dumfries campus. The project is funded by a Saudi Arabia Ministry of Education scholarship.

Why have I been invited?

You have been invited because of your experience and job position as (a health professional / educator / other stakeholder – will be adapted for each group) in this local community.

Do I have to take part? Can I withdraw from the research if I change my mind?

The participation is entirely voluntary. It is important to us that you feel comfortable during the interviews. You can at any time stop the interview without giving a reason if you do not feel comfortable. This will not affect your circumstances in any way. You can also withdraw from participating in the work at the point of actual data collection and then within 14 days after the interviews.

What will happen to me if I agree to take part?

You will be invited to take part in an interview (focus group), which is expected to last for approximately 60 minutes (between 1 and 2 hours for the focus group). During the interview, you will be asked questions about your job role, experiences, knowledge about the service area and work practices.

Are there any potential risks from taking part in the research?

Taking part in this research may cause you a few potential distresses including divulging personal information and triggering unpleasant memories. Confidentiality and privacy cannot be completely guaranteed in the interviews and focus groups. Also, it may be impossible to truly anonymize the research data, but any identifying information about you will be replaced with pseudonymous or fake identifiers. If you have felt any type of distress during the interviews, feel free to stop the discussion and inform the researcher, immediately.

Will personal details be kept confidential?

The information you provide will remain confidential. Additionally, no data collected from the interviews will be shared with your line manager, colleagues, ensuring your privacy and anonymity. The managers will not know who has participated because they will send an email on behalf of the researcher with her contact information. Thus, the connection will be with the researcher directly. Consequently, your participation will have no effect on your work, work relationships, or progress at work. We will keep all personal data confidential, and only share them with the researcher's supervisors. Access to the research data for use by other researchers will only be permitted based on personal request. Confidentiality will be respected subject to legal constraints and professional guidelines provided by the Saudi Ministry of Health. The Ministry's research and studies department will be informed if evidence of wrongdoing or potential harm is uncovered.

What will the results be used for?

The results of this study will be used for the completion of the lead researcher's PhD degree. They will also be used to provide recommendations about the use of asset-based approaches for policy makers. Additionally, results may be published in journal

articles and included in conference papers. Any data used in publications will be presented in such a way that it does not identify participants. Please contact Sabreen Batarfi (primary researcher) if you wish to receive a copy of the final research findings.

How will data be stored?

We will store all files in a secure location; files will be stored on the university's OneDrive and a password-protected computer. Paper files will be locked in a filing cabinet. Data collected during the PhD will be retained for a period of ten years in line with the University of Glasgow Guidelines. Then they will be destroyed in a secure manner.

Who has reviewed the study?

The study has been reviewed and approved by the College of Social Sciences' Ethics Committee at the University of Glasgow.

Who should I contact if I wish to make a complaint or want more information about this study?

To pursue any complaint about the conduct of the research please contact the College of Social Sciences Ethics Officer, Dr Susan Batchelor, email:

Susan.Batchelor@glasgow.ac.uk

If you have any questions about any aspect of this study that have not been answered here or need to know more information about it, please contact:

- 1- Sabreen Batarfi at xxxxxxx@student.gla.ac.uk
- 2- Dr. Alistair Hunter at Alistair.Hunter@glasgow.ac.uk
- 3- Dr. Alexander Whitelaw at Alexander.Whitelaw@glasgow.ac.uk

Details of support organisations in case of distress?

In case of any distress, Dr. Nadir Motair can be contacted on research-makkah@moh.gov.sa. He will be able to provide more advice and refer you to the right people.

_____End of Participant Information Sheet_____

Appendix D: University of Glasgow's Privacy Notice



College of Social
Sciences

PRIVACY NOTICE

Privacy Notice for Participation in Research Project: The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Per-Urban Community: The Case of Al-Jumum

Your Personal Data

The University of Glasgow will be what's known as the 'Data Controller' of your personal data processed in relation to your participation in the research project (**The Feasibility of Implementing Asset-Based Approaches to Health in a Saudi Rural/Per-Urban Community: The Case of Al-Jumum**)

This privacy notice will explain how The University of Glasgow will process your personal data.

Why we need it

We are collecting basic personal data such as your name and contact details in order to conduct our research. We need your name and contact details to arrange interviews and potentially follow up on the data you have provided.

We only collect data that we need for the research project and any identifying information about participants will be replaced with pseudonymous or fake identifiers. Please note that your confidentiality may be impossible to guarantee due to the small size of the participant group, and location, as the study will be conducted in two small rural areas where people know each other.

Please see accompanying **Participant Information Sheet**,

Legal basis for processing your data

We must have a legal basis for processing all personal data. As this processing is for Academic Research we will be relying upon **Task in the Public Interest** in order to process the basic personal data that you provide. For any special categories data collected we will be processing this on the basis that it is **necessary for archiving purposes, scientific or historical research purposes or statistical purposes**

Alongside this, in order to fulfil our ethical obligations, we will ask for your **Consent** to take part in the study. Please see accompanying **Consent Form**.

What we do with it and who we share it with

All the personal data you submit is processed by the main researcher Ms. Sabreen Batarfi, and two supervisors from the University of Glasgow, Dr. Alistair Hunter and Dr. Alexander Whitelaw. In addition, security measures are in place to ensure that your personal data remains safe. Encrypted OneDrive cloud storage at the University of Glasgow will be used for storing the research data with a password to access. The paper-based data will be stored in secure locked facility. Data from this research will be stored in a secured location until the research has been completed.

The data collected from this research will be used for the completion of the lead researcher's PhD degree. Additionally, this study may be published in journal articles and included in conference papers.

We will provide you with a copy of the study findings and details of any subsequent publications or outputs on request

Please consult the **Consent form** and **Participant Information Sheet** which accompanies this notice.

What are your rights?*

GDPR provides that individuals have certain rights including: to request access to, copies of and rectification or erasure of personal data and to object to processing. In addition, data subjects may also have the right to restrict the processing of the personal data and to data portability. You can request access to the information we process about you at any time.

If at any point you believe that the information, we process relating to you is incorrect, you can request to see this information and may in some instances request to have it restricted, corrected, or erased. You may also have the right to object to the processing of data and the right to data portability.

Please note that as we are processing your personal data for research purposes, the ability to exercise these rights may vary as there are potentially applicable research exemptions under the GDPR and the Data Protection Act 2018. For more information on these exemptions, please see [UofG Research with personal and special categories of data](#).

If you wish to exercise any of these rights, please submit your request via the [webform](#) or contact dp@gla.ac.uk

Complaints

If you wish to raise a complaint on how we have handled your personal data, you can contact the University Data Protection Officer who will investigate the matter. Our Data Protection Officer can be contacted at dataprotectionofficer@glasgow.ac.uk

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner's Office (ICO) <https://ico.org.uk/>

Who has ethically reviewed the project?

This project has been ethically approved via the College of Social Sciences Research Ethics Committee or relevant School Ethics Forum in the College.

How long do we keep it for?

Your **personal** data will be retained by the University only for as long as is necessary for processing and no longer than the period of ethical approval (01/10/2024). After this time, personal data will be securely deleted.

Your **research** data will be retained for a period of ten years in line with the University of Glasgow Guidelines. Specific details in relation to research data storage are provided on the Participant Information Sheet and Consent Form which accompany this notice.

End of Privacy Notice

Appendix E: University of Glasgow's Risk Assessment Form



College of Social Sciences

Field Work Risk Assessment

Many research students will spend periods conducting fieldwork, often in places far from Glasgow and often in remote locations far from conventional academic facilities. Ideally, such fieldwork should not be conducted alone, but it is recognised that lone fieldwork will on occasion be unavoidable. Sometimes such fieldwork will be conducted from a base in another institution, in which case the regulations in Section 2 of the University **Research Further Regulations** also apply.

A formal risk assessment must be undertaken, and the risk assessment form completed by the student, and approved by the supervisor(s) before being submitted to the Graduate School for noting. Where appropriate, reference should be made to the CVCP Code of Practice for Safety in Fieldwork, to the University Code of Practice for Fieldwork and to relevant professional guidelines.

Please note that any UK travel involving a flight or an overnight stay, and all international travel, must be registered with the insurance team via the **University Travel Portal** (GUID log in required). **The Travel Process Flowchart** helps to explain the process and please find further details via the **Business & Study Travel Policy**.

Student Details

Student Name: Sabreen Batarfi

Student ID: xxxxxxxx

Tier 4 Visa Holder: Yes ☒ No ☐

Tier 4 Visa expiry date: 12/31/2024

Registration Status: Full Time ☒ Part Time ☐

Principal Supervisor: Alistair Hunter

Second Supervisor(s): Alexander Whitelaw

Please complete the following:

(a) Identify precisely the field area and/or field sites;

Initially, the data will be collected in two rural areas in the western region of Saudi Arabia.

(b) Identify the likely field conditions (i.e. climate, topography, remoteness, political sensitivities);

Going to these areas and entering them will not be difficult. Travel will be by car. It takes 2 to 3 hours to arrive. The roads are paved, have services, and are adequately and comfortably equipped for travel. The weather will be mostly summer, hot, and dry. The temperature can reach 45 degrees Celsius.

(c) Establish what resources (i.e. shelter, clothing, provisions, safety equipment) will be required to cope with these conditions;

Going to these areas will be on a daily basis as it is close to the city where my home is. And as mentioned earlier, the roads are easy to travel and I will not be alone while traveling. However, first aid kits will be carried with me in case I need them

(d) Establish what safety procedures (e.g. to do with moving across rough terrain, avoiding fatigue, keeping warm) will be required to cope with these conditions;

I think this is a problem that will not be encountered when I go to the rural cities. I mentioned previously, the roads are equipped for travel and all services are available. And in the case of the weather in Saudi Arabia, as it is summer, the car's air conditioning will be relied upon during travel.

(e) Identify any persons who can provide local advice on safety matters;

In the rural area, Dr. Nadir Motair, the ministry of health representer, can be contacted on research-makkah@moh.gov.sa. He will be able to provide more advice and refer me to the right people.

(f) Confirm that all possible training for fieldwork has been identified and completed prior to the entering the field. Where specialist training is required which goes beyond generic training in the Graduate School and School/Research Institute courses, arrangements should be made by the supervisor(s) to ensure that such training is provided;

I confirm that all needed training courses have been completed before submitting the ethical form and getting the approval.

(g) Confirm that the research student is trained in all appropriate first aid and emergency procedures. Again, if the generic training on offer is insufficient, arrangements should be made by the supervisor(s) to ensure that such training is provided;

I confirm that the student is trained in all first aid and emergency procedures. She got a course and has a certificate from the ministry of health in Saudi Arabia

(h) Specifically, definite procedures should be established in advance whereby the research student can report a fieldwork problem to his/her supervisor(s) as swiftly as possible.

The agreed method for communicating with the supervisors will be via e-mail.

Signatures

Student name: Sabreen Batarfi

Student signature:

Date: 06/23/2022

Supervisor Name:

Supervisor Signature:

Date:

Appendix F: Interviews and Focus groups Questions

draft on interviews and focus groups questions in English:

Interviews questions:

1st stage – Asset Mapping:

These interviews will begin with introducing the topic, defining assets, and explaining the asset-based approach to the interviewees. Then, the following questions will be asked:

- 1- Would you tell me the name of your community?
- 2- What are the boundaries of your community?
- 3- What are the key organizations in your community? Where are they located?
- 4- What kinds of services does your community have?
- 5- In your own words, how would you describe the nature of your community? (such as income, employment, social assistance, age profile)
- 6- What are the skills, professions, and expertise / specialist knowledge of community members/organizations? Where are they located?
- 7- What are the opportunities in your community and the organizations, institutions, or businesses that support them? Where are they located?
- 8- In general, what are the available resources and assets in the community that can help in improving citizens' health and wellbeing? Could you provide some examples?

Focus Groups Questions:

These groups will start with clarifying the idea of the asset-based approach to health, mentioning some examples of it. One of the articles I read, was about a case study from a rural community in Egypt to assess the application of asset-based community development. In the paper, the researcher mentioned some examples of different asset-based approaches that I know we have in big cities in Saudi Arabia. I want to discover if we have the same in rural areas & how we could benefit from them to apply the approach to health. The assets that were generated in the first stage of research will be highlighted to participants. A map of how assets are distributed in the community will be shown to the participants. Then, the following questions will be asked:

- 1- From your point of view, what do you think about this map of assets in your community? Do you agree or disagree with these identified assets?
- 2- Are there any other assets that you know of which are not mentioned in the map?
- 3- How can these assets be used to improve people's health?
- 4- If community members wanted to implement the asset-based approach, what kinds of opportunities and/or challenges might they face when implementing this approach?
- 5- Who would be the main stakeholders in the implementation process?
- 6- What do you think needs to be changed for the implementation to succeed?
- 7- What factors might influence the implementation decision?

2nd stage – The Implementation Factors:

Before starting the interviews, the implementation stakeholders will be given a short briefing paper that includes an explanation of asset-based approach. The following are indicative questions, and the interviewees will be asked more specific questions based on the progress of the interview, and the findings of the focus groups during the first stage.

1. Tell me a bit about the nature of current approaches to healthcare provision.
2. What do you think are the main challenges in this form of provision?
3. Are you aware of any innovative things happening in this respect?
4. How do you generally feel about ABA?
5. In terms of making this work on the ground - what potential would this approach have and what would be needed to be in place for this to happen?
6. In terms of making this work on the ground - what would be the barriers? – please specify if possible

Appendix G: Interviews and Focus groups Questions

draft on interviews and focus groups questions in Arabic:

المرحلة الأولى – رسم خريطة الأصول (Asset Mapping):

ستبدأ هذه المقابلات بتعريف المشاركين بالموضوع، وتحديد مفهوم الأصول، وشرح النهج القائم على الأصول. ثم سيتم طرح الأسئلة التالية:

- ١ - هل يمكنك إخباري باسم مجتمعك؟ ٢ - ما هي حدود مجتمعك؟ ٣ - ما هي المنظمات الرئيسية في مجتمعك؟ وأين تقع؟ ٤ - ما أنواع الخدمات المتوفرة في مجتمعك؟ ٥ - بكلماتك الخاصة، كيف تصف طبيعة مجتمعك؟ (مثل الدخل، والتوظيف، والمساعدات الاجتماعية، والتوزيع العمري) ٦ - ما هي المهارات والمهن والخبرات والمعرفة المتخصصة لدى أفراد ومنظمات المجتمع؟ وأين تتواجد؟ ٧ - ما هي الفرص المتاحة في مجتمعك والمنظمات والمؤسسات أو الشركات التي تدعمها؟ وأين تقع؟ ٨ - بشكل عام، ما هي الموارد والأصول المتاحة في المجتمع التي يمكن أن تساعد في تحسين صحة المواطنين ورفاهيتهم؟ هل يمكنك تقديم بعض الأمثلة؟

أسئلة مجموعات التركيز (Focus Groups):

ستبدأ هذه المجموعات بتوضيح فكرة النهج القائم على الأصول في مجال الصحة، مع ذكر بعض الأمثلة عليه. إحدى المقالات التي اطلعت عليها كانت حول دراسة حالة من مجتمع ريفي في مصر لتقييم تطبيق التنمية المجتمعية القائمة على الأصول. وقد ذكر الباحث في الورقة بعض الأمثلة على أساليب مختلفة قائمة على الأصول أعلم أنها موجودة في المدن الكبرى في المملكة العربية السعودية. وأريد أن أكتشف ما إذا كانت موجودة في المناطق الريفية وكيف يمكننا الاستفادة منها لتطبيق هذا النهج في مجال الصحة. سيتم تسليط الضوء على الأصول التي تم تحديدها في المرحلة الأولى من البحث للمشاركين، وسيتم عرض خريطة توضح توزيع الأصول في المجتمع. ثم سيتم طرح الأسئلة التالية:

- ١ - من وجهة نظرك، ما رأيك في هذه الخريطة للأصول في مجتمعك؟ هل توافق أم تختلف مع الأصول المحددة؟ ٢ - هل هناك أصول أخرى تعرفها غير مذكورة في الخريطة؟ ٣ - كيف يمكن استخدام هذه الأصول لتحسين صحة الناس؟ ٤ - إذا أراد أفراد المجتمع تطبيق النهج القائم على الأصول، ما أنواع الفرص و/أو التحديات التي قد يواجهونها عند تطبيق هذا النهج؟ ٥ - من هم أصحاب المصلحة الرئيسيون في عملية التطبيق؟ ٦ - ما الذي تعتقد أنه يجب تغييره لنجاح التطبيق؟ ٧ - ما العوامل التي قد تؤثر على قرار التطبيق؟

المرحلة الثانية – عوامل التطبيق:

قبل البدء في المقابلات، سيتم تزويد أصحاب المصلحة في التطبيق بورقة إحاطة مختصرة تتضمن شرحاً للنهج القائم على الأصول. فيما يلي أسئلة استرشادية، وسيتم طرح أسئلة أكثر تحديداً على المشاركين بناءً على مجريات المقابلة ونتائج مجموعات التركيز خلال المرحلة الأولى.

- ١ - أخبرني قليلاً عن طبيعة أساليب تقديم الرعاية الصحية الحالية ٢ - ما هي التحديات الرئيسية التي تراها في هذا النوع من تقديم الخدمات؟ ٣ - هل أنت على علم بأي مبادرات مبتكرة تحدث في هذا الشأن؟ ٤ - ما هو شعورك العام تجاه النهج القائم على الأصول؟ ٥ - من حيث تطبيق هذا النهج على أرض الواقع - ما هي الإمكانيات التي يمكن أن يوفرها هذا النهج وما الذي يجب توفيره لتحقيق ذلك؟ ٦ - من حيث تطبيق هذا النهج على أرض الواقع - ما هي العوائق؟ يرجى التحديد إن أمكن

Appendix H: The Saudi Ministry of Health Approval



المملكة العربية السعودية
وزارة الصحة
المديرية العامة للشؤون الصحية
بصحة منطقة مكة المكرمة
اللجنة المحلية لأخلاقيات البحوث
بصحة منطقة مكة المكرمة
(H-02-K-076)
1439/4/28

Institutional Review Board Opinion Letter

Date of Issue	30.05.2022
Research Title	The Feasibility of Implementing Asset-Based Approaches to Health in Saudi Rural Communities
Primary Investigator	Sabreen Saleh Abdullah Batarfi
IRB Number:	H-02-K-076-0522-735
Category of Approval	Approved (Expedite)

Dear Ms. Sabreen Batarfi, Dr. Alistair Hunter, and Dr. Alexander Whitelaw,

This is to inform you that the above-mentioned proposal has been reviewed and discussed by IRB Committee and was approved according to ICH GCP guidelines. Please note that this letter is from research perspective only. You will still need to get permission from the head of research department in the Directorate of health affairs, Makkah Region to commence data collection and start your project.

We wish you all the best in your project and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown in this letter.

Please be advised that regulations require that you submit a progress report on your research every 6 months. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

As a researcher, you are required to have a valid certification on protecting human research subject.

If you have further questions, feel free to contact me:

(research-makkah@moh.gov.sa).

Dr. Nadir Hamza Mojall

Chairman, Institutional Review Board (IRB),
Makkah



Appendix I: The Saudi Ministry of Health Participants Consent Form

Protocol Number:		رقم البحث العلمي
Name of Subject:		اسم المشارك
Medical Record Number:		رقم السجل الطبي
Study Title: The Feasibility of Implementing Asset-Based Approach to Health in a Saudi Rural/Peri-Urban Community: The Case of Al-Jumum		عنوان البحث العلمي دراسة مدى جدوى تطبيق النهج القائم على الأصول في السعودية
Principal Investigator: Sabreen Batarfi		الباحث الرئيس: صابرين صالح باطرفي
Address: Mecca – Aladi Dis		العنوان: مكة - حي العدل
Telephone: 0592646704		رقم الهاتف: ٠٥٩٢٦٤٦٧٠٤

Why Is This Study Being Done?
This study is being done to test the feasibility of implementing the asset-based approach in Saudi Arabia. It is a new approach that is used in other countries which can help to improve people health.

ما سبب القيام بهذا البحث العلمي ؟
يتم إجراء هذه الدراسة لاختبار جدوى تطبيق النهج القائم على الأصول في المملكة العربية السعودية. إنه نهج جديد يتم استخدامه في بلدان أخرى يمكن أن يساعد في تحسين صحة الناس.

How Many People Will Take Part in This Study?
30 people

كم عدد الأشخاص المفترض مشاركتهم في هذا البحث العلمي؟
٣٠ شخص كحد أقصى

What is involved in the Study?
This study will include in-depth and semi-structured interviews and focused groups. They will be conducted with patients and individuals who work in the primary care centers. The interviews will start with the managers of the two primary care centers. Then, other workers in the primary care centers will be interviewed.

ماذا يتضمن هذا البحث العلمي؟
ستشمل هذه الدراسة مقابلات متعمقة وشبه منظمة ومجموعات مركزة. سيتم إجراؤها مع المرضى الأفراد الذين يعملون في مراكز الرعاية الأولية. ستبدأ المقابلات مع مديري مركزي الرعاية الأولية. بعد ذلك ، سيتم إجراء مقابلات مع العاملين الآخرين في مراكز الرعاية الأولية.

4- Study location:
The interviews will be conducted in the primary care centers in two rural area in the western region which are Bny-Yazed and Az-Zemah

موقع إجراء هذا البحث العلمي :
ستجرى المقابلات في مركزي رعاية أولية في منطقتين ريفيتين في المنطقة الغربية وهما بني يزيد والزيمة.

5- What is Expected of Me During the Study?

You will be asked several questions about the current scenario of providing health services and current structure of the health system. You are expected to answer these questions.

هذا البحث العلمي؟ ما المطلوب مني خلال ستطرح عليك عدة أسئلة حول السيناريو الحالي لتقديم الخدمات الصحية والهيكل الحالي للنظام الصحي. من المتوقع أن تجيب على هذه الأسئلة.

6- How Long Will I Be in This Study?
60 minutes

7- Can I Stop Being in This Study?
Yes, you can decide to stop at any time.

كم مدة مشاركتي في هذا البحث العلمي؟

هل يمكنني إنهاء المشاركة في هذا البحث العلمي؟

8- What are the Benefits of This Study?

There will be no direct benefits to you from taking part in this study. Study results may be useful to the research field and health system in the future.

ما هي فوائد هذا البحث العلمي؟ لن تكون هناك أي فائدة مباشرة لك من المشاركة في هذا البحث العلمي. نتائج هذا البحث قد تكون مفيدة للمرضى في المستقبل.

9- What are the Risks of This Study?

There will be no risks to participate in this study

المتوقعة من المشاركة 9. ما هي المخاطر في هذا البحث العلمي؟ لن تكون هناك مخاطر للمشاركة في هذه الدراسة

10- What if I am Injured Because I Took Part in This Study?

If you are injured as a result of being in this study, treatment will be provided by primary care centers at no cost to you.

10- ماذا سيحدث إذا أصابني ضرر جراء المشاركة في هذا البحث العلمي؟ إذا تعرضت للإصابة نتيجة لوجودك في هذه الدراسة ، فسيتم توفير العلاج من قبل مراكز الرعاية الأولية دون أي تكلفة عليك

11- What are the Costs of This Study?

There are no costs to you if you take part in this study.

11- وما هي تكاليف المشاركة في هذا البحث العلمي؟ لا توجد تكاليف لمشاركتك في هذا البحث العلمي

12- Will I Be Paid for Taking Part in This Study?

You will not be paid for taking part in this study.

12- هل هنالك اجر مقابل المشاركة في هذا البحث العلمي؟ لا يوجد اجر مقابل مشاركتك في هذا البحث العلمي

13- What are the Alternatives?

There are no alternatives. You can either decide to participate in this study or not.

13- ما هي البدائل؟ لا توجد بدائل. يمكنك إما أن تقرر المشاركة في هذه الدراسة أم لا.

14- Will My Information Be Kept Private?

Your personal information will be kept private. It will be given out only if required by law. Your personal information will not be used in any reports.

14- هل سيتم الحفاظ علي معلوماتي بسرية؟ معلوماتك الشخصية سيتم الحفاظ عليها بسرية تامة. ولا تعطي إلا إذا اقتضى الأمر وذلك في حدود النظم والقوانين المطبقة

بهذا الخصوص. معلوماتك الشخصية لن تستخدم في أي تقارير.

15- What are My Rights if I Take Part in This Study?

Taking part in this study is your choice. You may choose to take part or not. If you decide to take part in the study, you can quit at any time. There will be no penalty to you for your decision. Your medical care will not change.

15- ما هي حقوقي إذا شاركت في هذا البحث العلمي؟

المشاركة في هذا البحث العلمي هي بمحض اختيارك. يمكنك أن تختار المشاركة أو لا. إذا قررت أن تشارك في هذا البحث العلمي، يمكنك التوقف في أي وقت تشاء. وإذا لم تشارك لن تكون هناك أي عقوبة لك، ولا تتأثر الرعاية الطبية المقدمة لك بسبب هذا القرار.

16- Who Do I Call if I Have Questions or Problems?

If you have questions about the study, you can call the primary researcher at XXXXXXXXXXXX. If you have any questions about "rights of human subjects," you may call the Chairman of the IRB at . If you have an emergency, call .

16- بمن يمكنني الاتصال إذا كان لدي أسئلة أو مشاكل ؟

إذا كانت لديك أسئلة عن هذا البحث العلمي ، يمكنك الاتصال بالباحث الرئيسي على هذا . إذا كانت لديك أي أسئلة حول "حقوق الاشخاص موضوع البحث،" يمكنك الاتصال برئيس لجنة أخلاقيات البحث . إذا كان (على الرقم IRB العلمي) لديك مكالمة طارئة اتصل ب .

CONSENT:

Subject

I will receive a signed copy of this consent form.

إقرار بالموافقة

المشارك

بأن هذا البحث العلمي أقر أنا وإجراءاته قد تم شرحها لي. لقد سمح لي بأن أسأل كل سؤال لدي الآن. ويمكنني أن أسأل أي أسئلة إضافية في أي وقت لاحق. كما يمكنني إنهاء المشاركة في هذا البحث العلمي في أي وقت دون أن تتأثر الرعاية الصحية المقدمة لي. سأحصل على نسخة موقعة من الإقرار بالموافقة.

Subject Signature

توقيع المشارك

Date: / /
Time (AM PM)

التاريخ / /
الوقت (ص م)

Person Obtaining Consent:

الشخص الحاصل على الإقرار بالموافقة

I have explained the nature and purpose of the study and the risks involved. I have answered and will answer questions to the best of my ability. I will give a signed copy of the consent form to the subject.

أقر بأنني قد شرحت بصورة كاملة ، طبيعة هذا البحث العلمي والغرض منه وما ينطوي عليه من مخاطر. ولقد أجبت على جميع الأسئلة بقدر الإمكان. سأعطي نسخة موقعة من الإقرار بالموافقة للمشارك المذكور أعلاه.

Signature of Person Obtaining Consent

توقيع الشخص الحاصل على الإقرار
بالموافقة

Date / /

التاريخ : / /

Time (AM ☐ PM ☐)الوقت ☐ م ☐ ص

يتم ملئ هذا الجزء بواسطة الباحث الرئيس

To be filled by PI

Principal Investigator: Sabreen Batarfi

إسم الباحث الرئيسي: صابرين صالح عبدالله
باطرفي

Signature of Principal Investigator

التوقيع :

Date:

Time (AM ☒ PM ☐)التاريخ : ☐ م ☒ ص الوقت

Appendix J: The Saudi Ministry of Health Non-Disclosure Agreement

NON-DISCLOSURE AGREEMENT

اتفاقية عدم الإفصاح
عن المعلومات

This Agreement is effective this day of, 01/07/2022, is by and between the General Administration of Research and Studies, Ministry of Health /Kingdom of Saudi Arabia ("MOH")

And Sabreen Saleh Batarfi ("Collaborator"), each defined below.

This Agreement may be bilateral in confidential exchange. The party disclosing confidential information shall be referred to as the "Provider." The party receiving confidential information shall be referred to as the "Recipient."

First party:

General Directorate of Research & Studies/Ministry Of Health/ Kingdom of Saudi Arabia

Address:

Riyadh Postal Code 11176

MOH Contact

General Director for Research & Studies.

Second party: Collaborator

Address:

Contac: XXXXXXXXXXXX.

WHEREAS, either party may have certain technical information described below which shall hereinafter be referred to as

"CONFIDENTIAL INFORMATION";

WHEREAS, RECIPIENT is interested in examining the CONFIDENTIAL INFORMATION solely for the PURPOSE, defined below;

PURPOSE: testing the feasibility of implementing asset-based approach to health in Saudi communities

Information exchange in the field of Health Policy

(identified according to the needs)

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein, the parties hereto agree as follows:

1. PROVIDER, through its employee, the PROVIDER Contact, shall disclose CONFIDENTIAL INFORMATION to RECIPIENT, through its employee, the

01/07/2022 يسري العمل بهذه الاتفاقية المبرمة إعتباراً من تاريخ بين الطرفين المحددين أدناه وهما الإدارة العامة للبحوث والدراسات بوزارة الصحة بالمملكة العربية السعودية وصابرين صالح باطرفي ("الطرف التعاون") ويجوز اعتبار هذه الاتفاقية بمثابة اتفاقية ثنائية بشأن تبادل المعلومات السرية. يُشار إلى الطرف المُفصح عن المعلومات السرية بـ "الطرف المقدم للمعلومات". ويُشار إلى الطرف المتلقي للمعلومات السرية بـ "الطرف المتلقي للمعلومات".

طرف الأول :

المملكة العربية / الإدارة العامة للبحوث والدراسات/وزارة الصحة السعودية

العنوان:

الرياض- الرمز البريدي 11176

الشخص الذي يمكن الاتصال به بوزارة الصحة السعودية

مدير عام الإدارة العامة للبحوث والدراسات

طرف ثاني: (أفراد/مؤسسة/ شركة/ منظمة/ مركز/ محلية/دولية)

العنوان:

٠٥٩٢٦٤٦٧٠٤: الشخص الذي يمكن الاتصال به

حيث أن كل طرف لديه بعض المعلومات الفنية الموضحة أدناه والتي يُشار إليها فيما بعد بـ "المعلومات السرية"

وبما أن الطرف المتلقي للمعلومات يرغب في فحص المعلومات السرية للغرض الموضح أدناه فقط وهو:

موضوع الاتفاقية : دراسة مدى جدوى تطبيق النهج القائم على الأصول في السعودية

تبادل المعلومات في مجال السياسات الصحية (يحدد حسب الاحتياج)

وبناءً على التعهدات المتبادلة بين الطرفين على النحو المنصوص عليه في هذه الاتفاقية، اتفق الطرفان على ما يلي:

يقوم الطرف المقدم للمعلومات، من خلال أحد موظفيه أو الشخص الذي يمكن الاتصال به، بالإفصاح عن المعلومات السرية للطرف المتلقي للمعلومات من خلال أحد موظفيه أو الشخص الذي يمكن الاتصال به، وذلك لتمكين الطرف المتلقي للمعلومات من إجراء تقييم

RECIPIENT Contact, to enable RECIPIENT to fully evaluate such disclosure solely for the PURPOSE. CONFIDENTIAL INFORMATION shall be indicated as confidential at the time of disclosure.

2. RECIPIENT agrees to accept the CONFIDENTIAL INFORMATION and to take reasonable care to maintain the CONFIDENTIAL INFORMATION as secret and confidential, such efforts to be no less than the degree of care employed by RECIPIENT to preserve and safeguard RECIPIENT's own confidential information. The CONFIDENTIAL INFORMATION shall not be disclosed or revealed to anyone except employees of RECIPIENT who have a need to know the CONFIDENTIAL INFORMATION for the PURPOSE and who agree to be bound by the terms of this Agreement.

3. It is hereby acknowledged by PROVIDER that RECIPIENT shall incur no liability merely for examining and considering the CONFIDENTIAL INFORMATION. However, RECIPIENT agrees that it will not use the CONFIDENTIAL INFORMATION for any purpose other than the PURPOSE without the prior written consent of PROVIDER.

4. RECIPIENT's obligations under Paragraphs 2 and 3 above shall not extend to any part of the CONFIDENTIAL INFORMATION:

that can be demonstrated to have been in the public domain or publicly known prior to the date of the disclosure; or

that can be demonstrated, from written records or other competent evidence, to have been in RECIPIENT's possession or available to RECIPIENT from another source not under obligation of secrecy to PROVIDER prior to the disclosure; or

that becomes part of the public domain or publicly known by publication or otherwise, not due to any unauthorized act by RECIPIENT; or

that is subsequently disclosed to RECIPIENT by a third party who is not under an obligation of confidentiality to PROVIDER; or that is required by any law, regulation, or order of court to be disclosed by RECIPIENT. Prior to disclosing proprietary or CONFIDENTIAL INFORMATION of the PROVIDER, the RECIPIENT shall first notify and provide it an opportunity to prevent disclosure.

كامل بأن هذا الإفصاح يأتي فقط من أجل الغرض الموضح أعلاه. يُشار إلى المعلومات السرية على أنها سرية عند الإفصاح عنها.

يوافق الطرف المتلقي للمعلومات على قبول المعلومات السرية ويبدل العناية اللازمة المعقولة للحفاظ على سريتها، على ألا تقل هذه الجهود عن تلك الجهود التي يبذلها الطرف المتلقي من جانبه للحفاظ على سرية المعلومات الخاصة به وحمايتها. لا يتم الإفصاح عن المعلومات السرية أو الكشف عنها إلى أي شخص غير موظفي الطرف المتلقي للمعلومات الذين هم بحاجة لمعرفة المعلومات السرية للغرض المحدد بهذه الاتفاقية والذين وافقوا على الالتزام بشروط هذه الاتفاقية.

أقر الطرف المقدم للمعلومات بموجب هذه الاتفاقية بالألا يتحمل الطرف المتلقي أي التزام يقتصر فقط على فحص ودراسة المعلومات السرية. غير أن الطرف المتلقي للمعلومات يوافق على عدم استخدام المعلومات السرية لأي غرض كان غير الغرض المحدد في هذه الاتفاقية دون الحصول على موافقة خطية مسبقة من الطرف المقدم للمعلومات.

لا تشمل التزامات الطرف المتلقي المبينة في البندين الثاني والثالث أعلاه أي جزء من المعلومات التالية:

(أ) المعلومات التي ثبت أنها متاحة للملكية العامة أو معلومة للعامة قبل تاريخ الإفصاح عنها، أو

(ب) المعلومات التي ثبت أنها، من واقع السجلات المكتوبة أو بناء على بيئة مقبولة، مملوكة للطرف المتلقي أو أنها متاحة له من مصدر آخر غير ملزم تجاه الطرف المقدم للمعلومات بأية التزامات بالسرية قبل الإفصاح عن تلك المعلومات، أو

(ج) المعلومات التي أصبحت جزءاً من الملكية العامة أو معلومة للعامة عن طريق النشر وليس نتيجة لأي تصرف غير شرعي من قبل الطرف المتلقي للمعلومات، أو

(د) المعلومات التي يتم الإفصاح عنها لاحقاً للطرف المتلقي للمعلومات من جانب طرف آخر غير ملزم تجاه الطرف المقدم للمعلومات بأية التزامات بالسرية، أو

(هـ) المعلومات التي يُطلب من الطرف المتلقي الإفصاح عنها بقوة القانون أو الأنظمة أو بأمر محكمة. وقبل الإفصاح عن الملكيات الخاصة بالطرف المقدم للمعلومات أو معلوماته السرية، يقوم الطرف المتلقي للمعلومات بإشعاره أولاً وإتاحة الفرصة له لمنع الإفصاح عنها.

5. RECIPIENT's obligations under Paragraphs 2 and 3 shall extend for a period of five (5) years from the effective date of this Agreement.

6. It is understood that nothing herein shall be deemed to constitute, by implication or otherwise, the grant to RECIPIENT of any license or other rights under any patent, patent application, or to any trade secret, proprietary information, or other intellectual property right or interest belonging to PROVIDER, or as permitting RECIPIENT to unfairly obtain the right to use any CONFIDENTIAL INFORMATION which becomes publicly known through an improper act or omission on its part.

7. Neither party shall use the name of the other or any contraction or derivative thereof or the name(s) of the other party's faculty members, employees, or students, as applicable, in any advertising, promotional, sales literature, or fundraising documents without prior written consent from the other party.

8. The terms of this Agreement supersede any previous non-disclosure agreements or any other preliminary representations or understandings that have been entered into by the parties to this Agreement with regard to the subject CONFIDENTIAL INFORMATION.

9. The parties agree that electronic signatures or signatures affixed to any one of the originals and delivered by facsimile, PDF or other electronic means shall be valid, binding and enforceable.

10. This agreement can be translated into a foreign language, Arabic is the language adopted in case of any difference in the application of the provisions of the Convention.

11. The laws of the Kingdom of Saudi Arabia shall be applied at any case of dispute at this agreement.

We agree to examine and consider the subject matter of the CONFIDENTIAL INFORMATION on the foregoing basis.

تمتد التزامات الطرف المتلقي للمعلومات الواردة بالبندين الثاني والثالث لمدة خمس (5) سنوات من تاريخ سريان هذه الاتفاقية.

من المفهوم أنه لا تحتوي هذه الاتفاقية على أي شيء، سواء ضمناً أو غير ذلك، يمنح الطرف المتلقي أي ترخيص أو أي حقوق أخرى بموجب براءة اختراع أو تطبيقاته أو أية أسرار تجارية أو معلومات عن الملكية أو أي حقوق ملكية فكرية أو مصلحة تخص الطرف المقدم للمعلومات، أو السماح للطرف المتلقي للمعلومات بالحصول بشكل مجحف على حق استخدام أية معلومات سرية أصبحت معلومة للعامة من خلال فعل غير لائق أو تقصير من جانبه.

لا يستخدم أي من الطرفين اسم الآخر أو مختصره أو مشتقاته أو اسم / أسماء أعضاء هيئة تدريس الطرف الآخر أو موظفيه أو طلابه، حسبما ينطبق ذلك، في أي دعاية أو أعمال ترويج أو مطبوعات مبيعات أو مستندات للحصول على تمويل، دون موافقة خطية مسبقة من الطرف الآخر.

تحل شروط هذه الاتفاقية محل أية اتفاقيات عدم إفصاح سابقة أو أية إقرارات مبدئية أو مذكرات تفاهم أبرمها طرفا هذه الاتفاقية فيما يخص موضوع المعلومات السرية.

9. اتفق الطرفان على أن التوقيعات الإلكترونية أو التوقيعات الممهور بها أي من النسخ الأصلية التي يتم تسليمها عن طريق الفاكس أو الوسائل PDF كصورة طبق الأصل أو بصيغة البي دي إف الإلكترونية الأخرى تعتبر صحيحة وملزمة ونافذة المفعول.

يمكن ترجمة هذه الاتفاقية إلى لغة أجنبية، على أن تكون اللغة العربية هي اللغة المعتمدة في حالة الاختلاف في تطبيق أحكام الاتفاقية.

11. تخضع هذه الاتفاقية لقوانين المملكة العربية السعودية لحل أي نزاع قد ينشأ بين الطرفين.

اتفقنا على أن نقوم بفحص ومراعاة موضوع الاتفاقية وهو المعلومات السرية وفقاً للأساس سالف الذكر.

General Directorate of Research &
Studies/M.O.H/K.S.A

By (Title):

Name:

Date:

PROVIDER contact

Name:

بواسطة (المسمى الوظيفي):

الاسم:

التاريخ:

الشخص الذي يمكن الاتصال به لدى الطرف المقدم

للمعلومات:

الاسم:

DATA RECIPIENT (2ND PARTY):

NAME: Sabreen Batarfi

By (Title): Lecturer

Date: 10/5/2022

SING RECIPIENT:

الطرف المتلقي للمعلومات (طرف ثاني):

الاسم : صابرين صالح باطرفي

المسمى الوظيفي: عضو هيئة تدريس في الجامعة السعودية

الإلكترونية

التاريخ: ٢٠٢٢/٥/١٠

التوقيع المتلقي :

PROVIDER contact

Name: Sabreen Batarfi - XXXXXXXXXXXX.

الشخص الذي يمكن الاتصال به لدى الطرف المتلقي

للمعلومات:

الاسم: صابرين باطرفي

رقم الهاتف: ٠٥٩٢٦٤٦٧٠٤

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