Community participation and attitudes of decision-makers towards community involvement in health development in Saudi Arabia

Y. Al-Mazroa & S. Al-Shammari

National policies and government strategies in Saudi Arabia are adequate for the promotion of community involvement in health development (CIH). The system of government is decentralized and has ample scope for intersectoral cooperation. In Hā'il and Qasim regions active efforts are being made to realize intersectoral coordination through regional committees in which community leaders are involved; unfortunately, however, such mechanisms are lacking at the central level. Decision-makers and community leaders adequately recognized and interpreted the importance of CIH. Most of the respondents advocated community participation in planning and evaluation, while less than 50% thought that communities could participate in the implementation of health services.

A survey in Hā'il and Qasim regions of 2417 residents indicated that community participation in health activities was in its infancy and that considerable effort is still needed at the central, regional, and peripheral levels to achieve meaningful community involvement in health.

Introduction

In recent years community participation has assumed an increasingly important role in societies. This has been emphasized in the health sector, where, within the framework of primary health care (PHC), it has been asserted that communities have both the right and responsibility to be involved in the planning, implementation and evaluation of their own health programmes.

Although there is general consensus about community involvement for health development (CIH), there are differences in the approaches adopted, depending on the sociopolitical situation in a particular country and on the extent of community organization. Also, the perception of community involvement by high-level decision-makers and health workers varies from one country to another.

WHO promotes community participation in PHC, and the WHO Regional Office for Europe has reported the result of an analysis of various forms of community participation in PHC in nine countries. Also, the WHO Regional Office for Africa has completed a study of the essential features of CIH in the African Region. A similar study has also been carried out for the WHO South-East Asia Region.

In Africa it has been reported that “passive” community participation was achieved but that “active” participation remains a challenge (1). The results of a study in rural India that involved existing public and private health systems demonstrated the importance of socioeconomic and political factors for CIH (2). Finally, a study in Kenya of volunteers who took part in a community-based health development programme addressed the issue of community leadership and participation (3, 4). Because growth monitoring has been recommended as an entry point to PHC (5), community development has been considered to be a starting point for community participation in health programmes (6). Efforts to encourage community participation in health are being carried out in the Arab countries of the WHO Eastern Mediterranean Region. Saudi Arabia has

1 Director-General, Health Centres, Ministry of Health, Saudi Arabia, and Assistant Secretary-General, Council of Health Ministers of the Gulf Arab States.
2 Assistant Professor, Department of Family and Community Medicine, College of Medicine 34, King Saud University, P.O. Box 2925, Riyadh 11461, Saudi Arabia. Requests for reprints should be sent to Dr Al-Shammari at this address.
3 Community involvement in health systems for primary health care. Unpublished WHO document SHS/83.6.
Reprint No. 5144

© World Health Organization 1991
adopted the strategy of Health for All by the Year 2000 as well as the resolution taken in 1978 adopting the Declaration of Alma-Ata (7, 8). Supported by a 5-year plan, the Saudi Ministry of Health embarked in 1985 on nationwide implementation of PHC, including community participation.6,7

Objectives of the study

The objectives of the study were as follows:

— to determine whether the current government and Ministry of Health policy and strategy are optimum, practical, and suit the situations in Saudi Arabia with respect to CIH;
— to appraise the present level of community support at central and regional levels in disseminating relevant information about PHC and interaction between health and other related sectors;
— to define the types, patterns, and level of community participation that support the PHC team; and
— to elucidate the attitude of individuals about future community participation activities and their impact.

Method

The national policies and government structures were first reviewed. Discussions were then held with planners and decision-makers at the central and regional levels and with community leaders at the regional level about the importance of CIH and intersectoral coordination. Using a structured interview format, the following 29 individuals were interviewed:

— six senior decision-makers at the Ministry of Health (Directors-General of hospitals, international health, planning, preventive health, communicable disease control and health institutes);
— the two Directors-General of health affairs in Hā'il and Qasim regions;
— six senior decision-makers from the Ministries of Planning, Education, Labour and Social Welfare, Agriculture, and Municipalities and Rural Affairs at the central level, as well as the Presidency of Girls Education; and
— a total of 15 similar officials and community leaders at the regional level in Hā'il and Qasim regions.

Those interviewed were selected to be representative of the decision-makers at various locations dealing with primary health care in Saudi Arabia. Included was at least one authority to represent each health delivery service or related governmental sectors.

A questionnaire was also prepared in Arabic to determine the views of individual community members about CIH and what action had been taken towards its implementation. The questionnaire was pre-tested in a pilot study in both rural and urban settings and was subsequently used to carry out a survey in Hā'il and Qasim regions, in the centre of the country. The total estimated population in the catchment areas of the urban and rural health centres in both regions combined was 241,585 (46%) and 284,021 (54%), respectively (total, 525,606).

The sample for the study was selected using a two-stage cluster sampling procedure. For this purpose, the first step was stratification into rural and urban localities. The health centres formed natural clusters, and a 20% random sample (8 centres from the urban and 33 from the rural areas in both regions) was selected in each stratum. Secondly, 138 urban and 40 rural households from the catchment area of each selected health centre were selected. One adult member of each household (male or female) was asked to complete the questionnaire. A total of 2400 individuals (1104 (46%) from the urban and 1296 (54%) from the rural communities) were interviewed. The study was completed over the period October 1988 to February 1989.

The data were analysed on an IBM PC microcomputer using dBASE III + software. Frequency distribution tables and cross tabulations were obtained using SPSS software.

Results

Decision-maker level

National policies. These focused on the implementation of a package of services that include the following: the eight components of PHC and the enhancement and promotion of intrasectoral and intersectoral planning and action for community development. In Hā'il and Qasim regions these national policies and strategies have been adopted by the decision-makers and been implemented. A regional development committee, consisting of decision-makers and planners from various government sectors as well as community leaders and other prominent individuals has been formed to promote both intersectoral activities and community involvement for regional socioeconomic development, including health. Similar committees have been formed at the subregional and peripheral level.


**Government structure.** Government policy in Saudi Arabia is to decentralize the decision-making process, particularly in areas concerned with development. Each region is autonomous in making decisions within the general frame of national policies. In 1982, the Council of Ministers issued a decree for the formation of rural development committees. Each committee is responsible for a number of villages, and includes representatives from eight related ministries, including health, as well as prominent local individuals. The proposals made by these committees are submitted to the regional development committee for further discussions, integration, and approval. In 1986 the Council of Ministers issued a further decree to establish and approve the operating plans for social development centres, whose main purpose is to encourage community participation in local/rural socioeconomic development. Several of these centres have been established in different parts of Saudi Arabia, and almost all are adjacent to a PHC centre or have such a centre within their premises.

**Results of the interviews.** The results of the views of the 29 central and regional planners, decision-makers, and community leaders are outlined below.

1) **Interpretation and understanding of CIH.** A total of 28 (96%) of those interviewed understood CIH to be the participation of communities in actions related to the development of their health standards; these individuals considered CIH to comprise effective cooperation between community members and health workers, leading to the appropriate use of available health services, especially promotive and preventive services. Altogether, 27 (93%) of the respondents considered CIH to be a means of using locally available community potentials and resources to support government activities for community health and socioeconomic development.

2) **Importance of CIH as a basic principle of PHC.** CIH was considered by 28 (96%) of the respondents to be an essential tool and basic principle for the success of PHC within the context of overall socioeconomic development; in contrast, 23 (79%) considered it to be a good starting point for PHC at the peripheral level. It was held by 27 respondents (93%) that CIH helps planners, decision-makers, and community leaders to identify community needs and to make their plans more realistic and responsive. Of these individuals, 25 added that it generates a feeling of responsibility among individuals for their health, and thus promotes self-reliance. Altogether, 24 (83%) interviewees believed that CIH will lead to improvements in health and in the delivery of health-related services because communities should become better able to define critically the shortcomings in such services and assist in rectifying them; this group added that CIH should make communities more aware of the importance of following healthy attitudes, behaviours, and a lifestyle that should protect them from disease and injuries. In addition, 20 (69%) interviewees thought that realization of CIH will reduce the cost of health services, because people will rely more on promotive and preventive activities to improve their own health.

3) **Levels, depth, and dimensions of CIH.** It was held by 19 (65%) of the interviewees that communities can be involved in planning health and health-related services, while 14 (48%) thought that communities can be involved in implementing PHC activities. Overall, 25 interviewees (86%) believed that communities can be involved in the evaluation of PHC activities or services.

4) **Current standards of CIH at the central and regional levels.** All the respondents at the central level considered that CIH is in its infancy in Saudi Arabia and needs more time to develop. More exposure to the PHC approach and the CIH concept is still required before there will be participation at the central level. Although the majority of respondents at the regional level believed that achievements in CIH were satisfactory also at this level, more time is needed to make it more effective.

5) **Coordination between health and health-related sectors.**

- **At the central level**

  This was discussed with the six Ministry of Health officials and six planners and decision-makers in related sectors. Nine thought that currently there is some coordination between these sectors, since all sectoral development plans are usually discussed together and compiled into a single national socioeconomic plan. Half of those interviewed cited the example of the rural development committees where eight sectors discuss and coordinate their plans.

  Five respondents cited the following examples of successful coordination:

  - that between the Ministry of Health, municipalities, and the agricultural sector to improve environmental health and sanitation;
  - that between the Ministry of Health, municipalities, the agricultural sector, and emirates to control zoonotic diseases, particularly brucellosis;
  - that between Ministry of Health, Ministry of Education, the Presidency of Girls Education and
other ministries concerned with school health;
— that between the Ministry of Health, industrial, agricultural, and labour and social welfare sectors on workers’ health; and
— that between the Ministry of Health and the labour and social welfare sector on the care of disabled persons.

7) Means, methods, and mechanisms for promoting more effective CIH. A total of 25 (86%) of the 29 respondents believed that this could be attained by continuously educating and informing the community about the importance of their involvement in socioeconomic activities, including health. Twenty respondents (69%) suggested that decision-makers should accept the concept of CIH and regard communities as their partners, while 15 (48%) held that promotion of effective intersectoral coordination was a prerequisite for promoting CIH. Altogether, 17 interviewees (58%) believed that improvement of health services will encourage CIH.

Fourteen interviewees (48%) believed that communities have to be made aware of their potentials and responsibilities in various areas of socioeconomic development, including health. In addition, 16 (55%) considered that recognition and inclusion in development plans of reasonable demands of communities will motivate them to participate in CIH. To this, 12 (41%) interviewees added that shortcomings in services identified by communities should be taken seriously, in order to encourage their participation, and that good relationships between communities and PHC workers will promote CIH.

Community level

Interviews of 2417 persons (1208 males, 1209 females) were carried out in 41 clusters in Há’il (926 people) and Qasim (1491 people) regions. Table 1 shows the sex distribution of the respondents, depending on their attitude towards and participation in community health activities. With the exception of the responses for protection of water sources and material assistance, all the differences shown in Table 1 are statistically significant.

Table 2 shows the targets for community participation, as perceived by the 528 individuals in the Há’il and Qasim regions who were aware of the existence of health committees.

Table 3 shows the distribution in rural and urban areas of the 2417 interviewees in Há’il and Qasim regions in terms of their attitude towards and participation in community health activities. All the differences in Table 3 are statistically significant, except those for whether community participation is important.

Discussion

Decision-maker level

The national policies and strategies for PHC in Saudi Arabia are adequate for the promotion of community participation. The government structure is decentralized and there is ample scope for
Table 1: Sex distribution of the 2417 interviewees in Hā'il and Qasim regions, depending on their attitude towards and participation in community health activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes Males</th>
<th>Yes Females</th>
<th>No Males</th>
<th>No Females</th>
<th>Didn't know/ no reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of sanitation</td>
<td>1087 (89.9)*</td>
<td>1162 (96.1)</td>
<td>112</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Protection of water sources</td>
<td>1095 (90.6)</td>
<td>1114 (92.1)</td>
<td>97</td>
<td>85</td>
<td>26</td>
</tr>
<tr>
<td>Provided material assistance</td>
<td>181 (14.9)</td>
<td>153 (12.6)</td>
<td>1013</td>
<td>1024</td>
<td>46</td>
</tr>
<tr>
<td>Attended at least one education meeting</td>
<td>331 (27.4)</td>
<td>399 (33.0)</td>
<td>869</td>
<td>800</td>
<td>18</td>
</tr>
<tr>
<td>Transmitted information about PHC</td>
<td>707 (58.5)</td>
<td>806 (66.6)</td>
<td>497</td>
<td>395</td>
<td>12</td>
</tr>
<tr>
<td>Aware of existence of health committee</td>
<td>310 (25.6)</td>
<td>218 (18.0)</td>
<td>883</td>
<td>970</td>
<td>36</td>
</tr>
<tr>
<td>Community participation important</td>
<td>1163 (96.2)</td>
<td>1153 (95.3)</td>
<td>20</td>
<td>36</td>
<td>45</td>
</tr>
</tbody>
</table>

* Figures in parentheses are percentages.

Table 2: Targets for community participation, as perceived by the 528 respondents who were aware of the existence of health committees

<table>
<thead>
<tr>
<th>Target</th>
<th>No. of responses</th>
<th>% of total interviewed*</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve health conditions</td>
<td>252 (47.7)*</td>
<td>10.4</td>
</tr>
<tr>
<td>To identify community needs</td>
<td>112 (21.2)</td>
<td>4.6</td>
</tr>
<tr>
<td>To improve social conditions</td>
<td>204 (38.6)</td>
<td>8.4</td>
</tr>
<tr>
<td>To study community problems</td>
<td>153 (28.9)</td>
<td>6.3</td>
</tr>
<tr>
<td>Others</td>
<td>58 (10.9)</td>
<td>2.4</td>
</tr>
<tr>
<td>Total responses</td>
<td>779</td>
<td></td>
</tr>
</tbody>
</table>

* Expressed as a percentage of the 2417 interviewees in the Hā'il and Qasim regions.

Table 3: Rural and urban distribution of the 2417 interviewees in Hā'il and Qasim regions, depending on their attitude towards and participation in community health activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes Rural</th>
<th>Yes Urban</th>
<th>No Rural</th>
<th>No Urban</th>
<th>Didn’t know/ no reply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of sanitation</td>
<td>1187 (91.5)*</td>
<td>1062 (96.1)</td>
<td>94</td>
<td>51</td>
<td>23</td>
</tr>
<tr>
<td>Protection of water sources</td>
<td>1210 (93.3)</td>
<td>999 (90.4)</td>
<td>69</td>
<td>113</td>
<td>26</td>
</tr>
<tr>
<td>Provided material assistance</td>
<td>207 (15.9)</td>
<td>127 (11.5)</td>
<td>1066</td>
<td>971</td>
<td>46</td>
</tr>
<tr>
<td>Attended at least one education meeting</td>
<td>520 (40.1)</td>
<td>210 (19.0)</td>
<td>769</td>
<td>900</td>
<td>18</td>
</tr>
<tr>
<td>Transmitted information about PHC</td>
<td>786 (61.0)</td>
<td>727 (65.1)</td>
<td>502</td>
<td>390</td>
<td>12</td>
</tr>
<tr>
<td>Aware of existence of health committee</td>
<td>320 (24.6)</td>
<td>208 (18.8)</td>
<td>962</td>
<td>891</td>
<td>36</td>
</tr>
<tr>
<td>Community participation important</td>
<td>1230 (94.9)</td>
<td>1086 (98.3)</td>
<td>33</td>
<td>23</td>
<td>45</td>
</tr>
</tbody>
</table>

* Figures in parentheses are percentages.

Table: Community involvement in health development in Saudi Arabia

intersectoral cooperation. The results of the survey in Hā'il and Qasim regions showed that active steps are being taken to make intersectoral coordination effective, and that community leaders are involved in the regional intersectoral committees. However, at the central level the lack of mechanisms to support and coordinate actions taken by the regional intersectoral committee impeded actions taken by the latter. This could delay requests for assistance or advice; for example, the mobilization of resources such as financial support between sectors at the central level. In contrast, at the community level people accepted the idea of participation, and this was reflected by the formation of voluntary health committees ("friends-of-health committees"), on a good number of which related sectors were also represented.

The 29 central and regional planners, decision-makers, and community leaders recognized and
interpreted the importance of CIH, probably because the majority of them considered that it essentially involved intimate cooperation between community and health workers that would lead to appropriate use of services and of the community’s potential for health development. Furthermore, most of the respondents at this level believed that community participation would assist planners and decision-makers to set realistic and responsive plans to tackle community health and associated problems; and at the same time it should help to improve services by defining their shortcomings and reducing their cost. Most of these respondents also advocated community participation in planning and evaluating services, but less than half believed that the communities could participate in implementing the services. This difference arose because the decision-makers perceived implementation of CIH to be a technical process that should be carried out by health workers, and not as part of the broader primary health care concept. The erroneous belief that curative services are more important than preventive may have influenced the thinking of the decision-makers; protection of water sources and environmental sanitation are, however, also extremely important elements of PHC, a fact which was acknowledged by the responses of those interviewed at the community level.

The information provided by the respondents at the central level suggested that in the planning process intersectoral coordination was limited to the compilation of sectoral plans into a national plan. Furthermore, the role of the community in the preparation of these plans was not defined. This explains why the majority of respondents (83.3%) at this level suggested that an intersectoral coordination committee for planning purposes be established for orientation of decision-makers, planners, and community leaders about intersectoral planning, and to give importance to the role of the community in this respect.

There was nevertheless some coordination between the eight sectors involved with those rural development committees that were more account-able to regional than central levels. At the same time, intersectoral coordination occurred in connection with specific action on community health development, e.g., improvement of environmental health and sanitation, control of zoonotic diseases, improvement of workers’ and schoolchildren’s health, and care of the disabled.

Regional intersectoral coordination and community participation were satisfactory. The regional development committees, consisting of decision-makers, planners, and community representatives, prepared and discussed their plans before compiling them; the success of PHC and the evolution of community participation in the two study regions was greatly supported by these committees. At the peripheral and regional levels, representatives of various sectors coordinate with each other and the health sector through the friends-of-health committees. The process of bottom-up and intersectoral planning was also emphasized by the rural development committees. Different sectors were therefore not only coordinating with each other at the planning stage but also in various actions related to community health development, which promoted and motivated community participation at the regional and peripheral levels.

**Community level**

The majority of respondents at the community level were highly motivated towards improving sanitation and protecting water resources. However, the extent to which they provided material assistance, attended education meetings, or transmitted information about PHC was unsatisfactorily low. The differences between the two sexes in this respect may have arisen because the female respondents were more exposed to education programmes at health centres, which they attended frequently with their children. In rural areas people have no alternative but to use the free health centre services. The health and social activities provided there are a novelty for the local populations, who are more loyal to such centres than are their urban counterparts. People in rural areas were therefore more aware of health committees and attended health centres more regularly than those who lived in cities. Both the urban–rural differences and those between the sexes that are discussed above can be narrowed through efficient health education programmes.

More than 95% of the community respondents were in agreement about the importance of community participation with the PHC teams, and gave good reasons for their affirmative answers. However, only one fourth or less of those interviewed knew about the friends-of-health committees in their areas and could define the roles that such committees played. This may be because the PHC concept is relatively new in the community. Furthermore, the benefits derived from the availability of free health services may predispose some individuals to behave only as recipients. Schemes to promote community cooperation and participation should therefore be adopted. In general, however, the communities did participate as indicated by their activities in refuse disposal, protection of water sources from pollution, dissemination of information, and admittedly to a lesser extent, in providing...
Community involvement in health development in Saudi Arabia

For more than 30 years various types of community participation activities have existed in Saudi Arabia. These vary from area to area, and their income is mainly derived from private donations. Some support the needy or the disabled or both, while others provide primary health services free or at a minimal cost. At present the total number of such voluntary welfare organizations is 93 (Directorate of Social Development, private communication).

Initially, community participation in Saudi Arabia involved only fund-raising, but with time, it has evolved to cover other aspects, particularly after the adoption of the PHC approach and its implementation in different parts of the country. This represents a vital change from the original approach, where the community was seen as the passive recipient of services planned and/or supplied by the central government. It cannot be expected that the switch-over from centrally managed to community-based activities will happen immediately. In many countries such a step will require significant changes in policy together with reorganization and reorientation of health workers as well as of the community.

Below are some of the ways in which the results of the study have been used.

- The outcome was widely distributed to relevant decision-makers at central and regional levels in Saudi Arabia.
- Seminars on PHC in Saudi Arabia and Arab countries of the Gulf discussed the findings and considerable interest was generated.
- In Saudi Arabia at least 200 PHC supervisors attended training courses directed at planning activities to promote PHC and motivate community participation.
- Several regions in Saudi Arabia shared their experiences on setting up health committees and the procedures adopted for motivating the community, and almost every health centre now has a health committee.

**Recommendations**

- A wide national programme should be launched in Saudi Arabia to orientate decision-makers and the community towards CIH.
- An intersectoral coordination committee at the central level would facilitate action to achieve CIH.
- The two Council of Ministers’ decrees on CIH should be implemented properly.
- Bottom-up planning should be developed and promoted through greater involvement of the different sectors and community representatives.
- More studies are needed to identify the knowledge, attitude, and practices of populations towards community participation.
- Information about good examples and experiences of community participation in different parts of Saudi Arabia should be disseminated.
- Active support for the friends-of-health committees is needed, by setting clear plans that define community roles.

**Acknowledgements**

The study was supported financially by WHO (award of the Jacques Parisot Foundation Fellowship to Y. Al-Mazroa) and by the Ministry of Health, Saudi Arabia.

**Résumé**

Participation de la communauté et attitudes des décideurs à l’égard de l’engagement communautaire en faveur du développement sanitaire en Arabie saoudite

mais moins de 50% ont indiqué que les communautés pourraient participer à la mise en place des services de santé.

Une enquête sur le niveau de participation des membres de la communauté au développement sanitaire a été réalisée auprès de 2417 habitants de communautés rurales et urbaines dans les régions de Qasim et Ha'il. Un nombre égal d'hommes et de femmes ont été interviewés. Les résultats ont montré que la participation des membres de la communauté aux activités sanitaires en est encore à ses débuts dans la région étudiée. L'approche adoptée en vue de la participation communautaire était de former des "comités d'amis de la santé", dont le travail principal consistait à diffuser des informations sanitaires et à promouvoir une meilleure utilisation des services de santé, en particulier des activités de prévention et de promotion. Néanmoins, de gros efforts sont encore nécessaires aux niveaux central, régional et périphérique pour obtenir un engagement communautaire significatif dans l'action de santé en Arabie saoudite.

Les différences observées entre les réponses (sexe et lieu géographique) sont analysées et des explications possibles sont données. Plusieurs façons d'utiliser les résultats de ces études sont également proposées.

References