

## Problems Facing Community Involvement in Primary Health Care and Proposed Solutions in Two Major Saudi Cities<sup>(\*)</sup>

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**ABSTRACT.** This research investigates the problems facing community involvement in primary Health Care and the methods to activate such involvement as viewed by health center's staff. Based on a field survey under-taken in Riyadh and Jeddah, K.S.A. during 1410-1412 (1989-1991), the most important problems identified are: Illiteracy; lack of health awareness among citizens; non-responsiveness to co-operation with the center among many individuals; hesitation to provide needed information to health workers; reliance on non-Arabic speaking health workers; reliance on the private medical sector by some individuals and families; and lack of Female participation in health activities.

Health centers staff agreed upon the following methods to activate community involvement: Illiteracy eradication, especially among females; intensify health education through media; strengthening co-operation and coordination with the local government agencies; home visits to encourage individuals and families co-operate with the health team, follow-up pregnant women and immunization of children; formation of local health friends committees; involving community members in health activities in the center; offering incentives to individuals and families who participate more than others in health activities; selection of PHC staff who are scientifically capable and can communicate well with people in local communities; and implementation of decentralization in PHC centers, with sufficient authority to undertake work. Such results may be useful in planning for the implementation of these methods in order to activate community involvement in primary health care program.

### **Introduction**

Community Involvement (CI) has become an integral component of almost all developmental efforts, including health. This is particularly seen in the adoption of CI by World Health Organization (WHO) as a basic principle of the Primary Health Care (PHC) approach. PHC is viewed as the main strategy to achieve the "Health for All by the Year 2000" objectively by most nations.

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<sup>(\*)</sup> Results of a field study in Riyadh and Jeddah.

CI is defined as "the active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care, using local, national and other resources", also, "community involvement, individuals and families assume responsibility for their, and their community's health and welfare and develop the capacity to contribute to their and the community's development"<sup>(1)</sup>.

The road leading to full CI in PHC activities is not covered with roses. Obstacles arising from lack of understanding of the concept, and disagreement on what it means, or how it can be realized, activated and managed are prevalent. Also, problems facing CI vary among communities, health systems and health personnel. Local communities often lack the enthusiasm and capabilities needed for active and sustained involvement in health care activities. Health authorities in most developing countries are still skeptical about the merits of community involvement and hesitate to transfer their decision-making powers to local communities. Also, health personnel have different perceptions of community involvement as indicated by a field study conducted by the authors<sup>(2)</sup>. Some health care specialists see it as a threat to their professional authority.

In 1400H (1980), the Kingdom of Saudi Arabia (KSA) has adopted the PHC approach as a part of its Third Development Plan. The Saudi Ministry of Health (MOH) views CI as a means to improve the relationship between the health system and its clients. The required involvement can be achieved through field work in the community to identify local health needs and develop programs to satisfy these needs. It is also viewed as a way to change the negative attitudes towards the PHC centers; all too often viewed as merely drug stores. The MOH considers CI as a supportive effort to PHC which should become a permanent characteristics of communities and should involve an increasing number of individuals in health activities<sup>(3)</sup>.

### Study Purposes

This study is concerned with the problems facing CI in PHC in KSA. It reports the results of a comprehensive field research about "Community Involvement in PHC" in the PHC Centers of two large cities in the K.S.A., Riyadh and Jeddah, which was undertaken during 1410-1412 (1989-1991) by the authors. Specifically, the purpose of this study are:

1. To identify problems facing community involvement in primary health care in Riyadh and Jeddah health centers.
2. To probe the views of PHC personnel in the two cities on means to encourage and activate CI in PHC.
3. To compare the two cities in terms of the problems faced and the means proposed to activate CI.
4. To recommend appropriate measures to solve problems facing CI in PHC.

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(1) **WHO**, Glossary of Terms Used in the "Health for All" series No.1-8, **WHO**, Geneva. 1984, pp. 10-11.

(2) **Hussein Al-Borie** and **Abdelsalam Abdel-Hadi**, The Prevailing Perceptions about Community Participation among *PHC Center's Personnel and the Extent of its Application in Management of PHC*, an unpublished report on a field research for the Ministry of Health. KSA. May 1991.

(3) **The Ministry of Health**, Assistant Undersecretariat for Curative Medicine. General Directorate of Health Centers, *Primary Health Care. Manual for Health Centers Personnel*. First Edition. Riyadh. Ministry of Health, 1986. pp. 15, 99-108.

### Significance of the Study

The widespread acceptance of CI as a strategy for health development requires better understanding of the kinds of problems and obstacles that may hinder its application, and achievement of its potentialities. Health professionals who support the CI approach need to become more aware of and prepared for the problems expected in performing their duties. National health systems which adopt CI and restructure their programs to meet CI requirements, need to do so with full recognition of the related problems and issues. Such recognition would help them to overcome impediments, reduce costs and avoid costly errors. Also, local communities which anticipate having a substantial say in matters concerning their health needs, should understand that the realization of their dream is never an easy task.

KSA has adopted the PHC approach and developed a national network of PHC Centers which included 1668 centers with a total staff of 30,082 as of 1410H (1990). CI is recognized as the principle upon which all PHC activities should be based. In practice, however application of this principle falls short of its potential contributions due to misunderstandings and misconceptions regarding CI and ways to implement it in the local communities.

In addition, KSA extends over an area of 2.2 million sq. kilometers, which involves a considerable amount of variation among its geographic regions in terms of natural resources, terrain, climate and population characteristics. Such variation is expected to reflect on the health conditions of local population and consequently, affect the pattern of health care planning and delivery. Thus, it is important to study the effects of such variations on health and health related issues such as PHC and CI. Hence, an investigation of the problems facing CI in PHC, and the means of activating CI in the largest two cities of the Kingdom will make available needed information for planning and management of PHC program.

### Theoretical Framework

This framework is divided into two sections. The first reviews the major concepts of the study, and the second examines the experience of some countries with regard to the problems facing CI in PHC.

#### *First: Major Concepts*

The World Health Organization (WHO) is the main force behind the PHC approach. It has played a major role in promoting the approach and encouraging countries to adopt it. The major concepts in this study are defined by the WHO as in the following:

*The PHC approach* has been adopted by most countries of the world following the International Conference on PHC held in 1978 in Alma-Ata, Kazakhstan. It means "the establishment of a health system with PHC as the central function and main focus supported by the rest of the health system"<sup>(4)</sup>.

*Primary health care* is defined as "essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it"<sup>(5)</sup>. Elements of PHC include: community education

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(4) WHO, *Glossary*, 1984, *op. Cit.*, p.11.

(5) *Ibid*, p.10.

on health problems; adequate food supplies and proper nutrition; safe water; basic sanitation, maternal and child health care; prevention and control of endemic diseases; immunization; appropriate treatment of common diseases and injuries and the provision of essential drugs<sup>(6)</sup>.

Community involvement is necessary for the success of PHC. It means "the active involvement of people living together in some form of social organization and cohesion in planning, operation and control of PHC, using local, national and other resources"<sup>(7)</sup>.

Primary health care is provided by health workers with different types and levels of training. They work together as a health team, "which is a group of persons having a common health goal, to the achievement of which each member of the team contributes in accordance with his or her competence and skill and in coordination with the functions of others"<sup>(8)</sup>.

A health team is usually linked with a health center which provides health care to a defined community or area. It carries out "promotive, protective, preventive, diagnostic, curative and rehabilitative activities for ambulant people"<sup>(9)</sup>. However, there are variations among countries in the level of care provided by such centers.

*Health for All* is seen as a social group for all governments and WHO. It involves "the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life"<sup>(10)</sup>. WHO considers HFA as a process which leads to progressive improvement in the health of people, and not a single finite target"<sup>(11)</sup>.

A discussion of CI in PHC is logically related to health development, which is an important *element* of over-all development. The development concept itself is loaded with different perceptions of what constitutes development and underdevelopment. However, the concept of participation has emerged as an essential feature of the development process. Participation refers to the idea that "whatever material form the development process may take, the active participation of the people in any activities proposed or undertaken must be encouraged"<sup>(12)</sup>. Oakley points to two schools of thought in viewing participation. One which considers past failures in development efforts as a result of neglecting the human element, and thus people did not want to involve themselves in activities they know little about. Making information available is believed to convince people to participate. The second school views the failures as resulting from the unreflecting way in which people have been left out of the development equation and treated as passive recipients rather than active participants. Thus, participation should involve the production of knowledge, new directions and new modes of organization, rather than the wide dissemination of already available knowledge<sup>(13)</sup>. The author concludes that there is not a single, valid, widely accepted

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(6) *Ibid.*

(7) *Ibid.*, p.11.

(8) *Ibid.*, p.13.

(9) *Ibid.*, p.15.

(10) *Ibid.*, p.9;

(11) *Ibid.*, p. 11;

(12) Peter Oakley, Community involvement in Health Development, An Examination of the Critical Issues. Geneva, WHO 1989, p. 1.

(13) *Ibid.*, pp.1-2.

interpretation of participation. However, he argues that all ideas agree that people must be given a voice in, the development decisions, access to the resources and knowledge required for development, and a share in the benefits achieved. Also, participation is expected to vary from area to area, depending on local conditions and the development approach adopted<sup>(14)</sup>.

As far as health development is concerned, it is observed that community participation is widely accepted and favored. However, WHO prefers the term "community involvement" because it implies a deeper and more personal identification of community members with PHC. A view which these authors adopted in the current research.

Finally, Oakley argues that the obstacles in the way of achieving HFA are not the lack of scientific knowledge needed to improve health, but lack of knowledge of how to achieve massive, widespread involvement of people in determining their health priorities and how to allocate scarce resources. Community participation is seen as the vehicle for instituting new forms of health care that are capable of tapping local resources and changing current patterns of health care delivery to be essentially people's services<sup>(15)</sup>. Thus, it could be concluded that a study of the problems facing CI in PHC and the methods to activate it is a contribution toward needed knowledge in the field.

### ***Second: Countries Experience***

This section presents a brief review of the literature on the problems and obstacles facing CI in different cultures. The purpose is to develop a theoretical model which will be used classify CI problems. This classification model will be used later in the design of the conceptual model, variables, and the data collection tool for this study. The review will focus on published works on the Indian, European and Arab experiences in the application of CI in PHC.

#### ***India***

The Indian experience is best illustrated by Bhatt and Maru who argue that the problems of CI arise from the nature of the community, the health system and attitudes of health personnel<sup>(16)</sup>.

Local communities in India, particularly in poor, rural areas view outside change agents with distrust, suspicion and fear. Also, Indian communities are not homogeneous. They are highly stratified, with severe economic and social inequalities. Caste, ethnic and religious orientations reflect negatively on CI. The dominant groups such as landowners, money-lenders, traders, indigenous doctors, local politicians and bureaucrats have vested interests in keeping the status quo. The decision making process is largely dominated by these groups, which direct most benefits of development efforts away from those who need them. Attempts to encourage CI threaten established interests and create disturbances. In addition, PHC officials shun being involved in local politics. The poor groups do not consider health a priority. Their primary concern is survival. When they do fall ill, they would want curative rather than preventive or pro-motive health services; and, they are used to receiving these services free of charge. In such conditions it is very difficult to generate any kind of CI.

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(14) Ibid., p.2.

(15) Ibid., p.3.

(16) **Anil Bhatt** and **Rushikesh Maru**, Managing Community Involvement in Primary Health Care. Impediments, Limitations and Dangers, in: Anil Bhatt (ed.), *Community Involvement in Primary Health Care* (Ahmed Abad, India, Indian Institute of Management, PSG Monograph 53, March 1984), pp. 67-77.

Health system structure and environment and the attitudes of health officials are other obstacles to CI in India. Services are provided by government organizations which emphasize hierarchy, status and reliance on rules and directives from a central authority, which are not conducive to CI. Government organizations have standard ways of operating which leave very little discretion to local health officials to plan or make important decisions. In the field, local health teams often face budget cuts and shortages in materials, medicines and equipment. This interrupts activities and the fulfillment of promise made to community members.

Because of their technical training and orientation, health officials at local and intermediate levels, are not prepared for CI activities which place emphasis on the social, administrative and political dimensions. This reflects negatively on their attitudes toward work with local communities and paramedical staff and mitigate against shared decision making. Most central officials have little understanding of CI and believe that it concerns field officials only. However, they are unwilling to support the field officials by making changes in program design and procedures to facilitate CI.

### **Europe**

The European experience presents a distinctive set of problems in the application of PHC concept and principles. Kapiro argues that historical influences, relative affluence and an abundance of medical care serve as limitations to implementation of CI<sup>(17)</sup>. He points to some examples of the operational and technical obstacles facing the application of each of the following principles of PHC<sup>(18)</sup>.

- (1) that health care should be "needs-related", universally accessible, and acceptable;
- (2) that community participation is essential;
- (3) that PHC should form part of all national development and of the wider health care system.

Kapiro believes community non-participation is a general problem in Europe because of the supreme position of physicians in the delivery of health care, and community respect of this position. Therefore, health care does not "spring from the community" in the ideal sense of PHC. Extensive CI is usually precluded by the various payment schemes, confidentiality, and emphasis on the patient-physician relationship. Nevertheless, he concludes that it is not clear that this non-participation threatens the health of the population in any significant way<sup>(19)</sup>.

O'Neil provides a different view when he warns against an impending health crisis by the year 2000, unless steps are taken by the public, the profession, industry and governments. European health policies, followed since World War II, have set the stage for such a crisis<sup>(20)</sup>. He points to the inability of health services to respond properly to the needs of communities, despite wide coverage, and argues that health is not a commodity that is given, rather, it must be generated from within. Health action should not be imposed from outside, but must be a response to the community to problems that the people perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure. However, he notes that CI is virtually non-

(17) **Leo A. Kapiro**, *Primary Health Care in Europe* (Copenhagen, Regional Office for Europe, WHO 1979), p. 10.

(18) *Ibid.*, p. 11.

(19) *Ibid.*, p. 16.

(20) **Peter O'neil**, *Health Crisis 2000*, London, William Heinemann Medical Books Ltd., and William Heinemann Ltd., 1983, p. ix.

existent in PHC systems of most European countries. One reason is the monopoly of decision-making by the medical profession, particularly at the top level and not primary care personnel<sup>(21)</sup>.

### ***The Middle-East***

The Arab experience in the application of PHC and the problems facing CI is varied as the social, economic and political conditions of the Arab countries. One of the few studies made in the subject involved three Arab countries, Bahrain, Egypt and the Arab Republic of Yemen. The study revealed that CI is generally lacking in these three countries, with the exception of a few experimental cases<sup>(22)</sup>. This, in addition to the inability of the formal health system to cater to people's needs have led to underutilization of basic health services and resorting to informal health care (home-care, pharmacies and traditional healers). The study does not address the problems facing CI in particular. Another field study involved KSA and was conducted in Qaseem and Hail regions. The study reports a moderately high level of awareness and understanding of PHC (61.46% of respondents at community level), acceptance and utilization of PHC services, and actual participation<sup>(23)</sup>. The study does not point to problems facing CI in PHC in the two regions.

### **Methodology**

For the purposes of study, a stratified random sampling procedure was used to select one-third of the total of PHCCs in Riyadh (19 centers) and Jeddah (14 centers). Data were collected by means of a self-addressed, structural questionnaire which was delivered to all health employees of the selected PHCCs (physicians, nurses, pharmacists, technicians, administrators, and health inspectors in Riyadh and Jeddah cities). Prior to preparation of the final form of the questionnaire, it was pretested for reliability and validity among a group of PHC centers' staff and used by the graduate students of the Master's Program in Health and Hospital Administration under the supervision and direction of the authors, in various regions of K.S.A. including Al-Ahsaa and Asir. These regions were selected because they were not included in the research sample and for availability of information. The pre-tested yielded a list of (16 problems) and (16 steps and mechanisms to activate CI in PHC) which were used in the final version of the questionnaire.

Of the 500 questionnaires distributed, 364 were returned (a response rate of 73%), of which 180 came from Riyadh and 184 from Jeddah. Collected data were analyzed using Statistical Package for the Social Sciences (SPSS) to produce frequency distributions, percentages, and results of the stepwise discriminant analysis. The stepwise discriminant analysis was used to determine which set of variables (problems), combined in a linear function form, will best sort or account for the two distinct groups (problems facing CI in Riyadh versus those in Jeddah). By using this technique, all the problems will compete together and the problem which discriminates the most between the dependent variable (PHC centers in Riyadh versus Jeddah) is selected first. Additional problems are added in the order of their ability to further distinguish between

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(21) *Ibid.*, pp. 61-62.

(22) **W. A. Hassouna**, "Reaching the People: A Three-Country Study of Health Systems", *World Health Forum*. vol. 4, 1983, p. 61.

(23) **Yaqob Al-Mazrou**, *Awareness, Acceptance and Participation of Saudi Community in PHC Program*, Riyadh, Ministry of Health. 1989, p. 39, 47, 55.

the two groups. Wilk's Lambda is the statistic used to determine the additional discriminant power of each problem. It is the proportion of the variance between the two groups that has not been explained by the discriminant function. The problems that do not satisfy the following criteria will be excluded: (a) Each problem must reduce Wilk's Lambda by at least 1%, (b) The P-value of the change in Wilk's Lambda when the problem is added must be no greater than 0.10<sup>(24)</sup>.

### Data Analysis and Study Findings

#### A - The Problems Facing CI

Table (1) shows the basic descriptive statistics, i.e., frequencies and percentages of the problems facing the application of CI in PHC centers in Riyadh. The ordering of problems was made on the basis of their frequencies. Table (2) provides the same information for Jeddah's PHC centers. Both Tables (1) and (2) indicate relatively high agreement among respondents in the two cities with regard to the most important problems facing CI in PHC. The following discussion focuses on these problems.

The two most important problems in the two cities are illiteracy; which ranked first in Riyadh and second in Jeddah; and lack of health awareness among citizens; which ranked second in Riyadh and first in Jeddah.

Table (1)  
Problems Facing the Application of CI in PHC Centers in Riyadh.

|     | Problems  | Frequency | %    |
|-----|---|-----------|------|
| 1.  | Illiteracy.   | 97        | 53.9 |
| 2.  | Lack of health awareness among citizens.  | 85        | 47.2 |
| 3.  | Non-responsiveness to cooperation with the center among many individuals.                       | 81        | 45.0 |
| 4.  | Hesitation to provide needed information to health workers.                                     | 64        | 35.6 |
| 5.  | Reliance on non-Arabic speaking health workers.   | 59        | 32.8 |
| 6.  | Reliance on the private medical sector by some individuals and families.                        | 55        | 30.6 |
| 7.  | Lack of female participation in health activities.  | 54        | 30.0 |
| 8.  | Desire to avoid any financial obligations.  | 31        | 17.2 |
| 9.  | Individualism and lack of interest in public issues.  | 30        | 16.7 |
| 10. | Lack of staff who are willing, capable, and has sufficient training to undertake CI activities. | 25        | 13.9 |
| 11. | The concept of CI is still unclear to many health workers.                                      | 24        | 13.3 |
| 12. | Lack of female organization for CI.   | 21        | 11.7 |
| 13. | Dominance of administrative bureaucracy in PHC centers.   | 8         | 4.4  |
| 14. | Work environment in government offices has many negative aspects which do not encourage CI.     | 8         | 4.4  |
| 15. | Lack of local information on population, resources, and health problems.                        | 8         | 4.4  |
| 16. | Vested interests in the local community, such as traditional healers and midwives oppose CI.    | 6         | 3.3  |

The next most important problem, which ranked third in both cities, is lack of cooperation with health centers among citizens. These three problems are closely interrelated, since illiteracy and lack of health awareness are expected to affect the degree and the manner in which people cooperate with health centers. It follows that whatever resources are allocated to educate the community will positively reflect upon cooperation with PHC activities.

[24] A. Afifi and V. Clark, *Computer-Aided Multi-variate Analysis*. 2nd Edition, New York: Van Nostrand Reinhold Company, 1990, pp. 271-295.



Table (2)  
Problems Facing the Application of CI in PHC Centers in Jeddah

|     | Problems  | Frequency | %    |
|-----|---|-----------|------|
| 1.  | Lack of health awareness among citizens.  | 125       | 67.9 |
| 2.  | Illiteracy.   | 124       | 67.4 |
| 3.  | Non-responsiveness to cooperation with the center among many individuals.                       | 84        | 45.7 |
| 4.  | Reliance on the private medical sector among many individuals.                                  | 55        | 29.9 |
| 5.  | Hesitation to provide needed information to health workers by many individuals.                 | 54        | 29.3 |
| 6.  | Lack of female participation in health activities.  | 48        | 26.1 |
| 7.  | Lack of staff who are willing, capable, and has sufficient training to undertake CI activities. | 44        | 23.9 |
| 8.  | Reliance on non-Arabic speaking health workers..  | 40        | 21.7 |
| 9.  | The concept of CI is still unclear to many health workers.                                      | 31        | 16.8 |
| 10. | Lack of female organizations for CI.  | 25        | 13.6 |
| 11. | Dominance of administrative bureaucracy in PHC centers.   | 24        | 13.0 |
| 12. | Desire to avoid any financial obligations.  | 23        | 12.5 |
| 13. | Individualism and lack of interest in public issues.  | 23        | 12.5 |
| 14. | Lack of local information on population, resources, and health problems.                        | 19        | 10.3 |
| 15. | Vested interests in the local community, such as traditional healers and midwives oppose CI.    | 14        | 7.6  |
| 16. | Work environment in government offices has many negative aspects which do not encourage CI.     | 11        | 6.0  |

Hesitation to provide needed information to health workers ranked fourth in Riyadh and fifth in Jeddah. It reflects, to some extent, the conservative nature of Easterners in general and Saudis in particular in the face of outsiders. This requires careful selection of data collectors from among Saudi health employees and training them on confidence building with community members in order to gain their confidence and cooperation to provide needed information willingly.

The fifth problem in Riyadh, and eighth in Jeddah, is the reliance on non-Arabic speaking health workers, which is one of the continuing problems of the health system in KSA, and which will stay with it for sometime in the future. A temporary solution for this problem is to teach this group the Arabic language. However, PHC should rely on national and local resources and manpower as much as possible.

The problem which ranked sixth in Riyadh, and fourth in Jeddah, is the reliance on the private medical sector, which may reflect dissatisfaction with the quality of services or inconvenience in getting governmental services. However, this trend is expected to grow in the future as the standards of living rise, which requires a definition of the role of private medicine in PHC.

Lack of female participation in health activities ranked seventh in Riyadh and sixth in Jeddah. Women play a major role in health care for their families in all cultures. Their role should be more than just receiving services. They could be involved in many types of PHC activities, especially home visits, data collection from families, keeping records and health education. Also, the experience of Women Committees in some PHC centers should be encouraged and replicated.

The rest of the problems have smaller frequencies in both cities, and are considered less important. However, they still represent obstacles toward the achievement of CI in PHC.

Table (3) presents the results of the stepwise discriminant analysis of the problems facing CI in Riyadh versus Jeddah PHC centers. Of the 16 problems entered into the discriminant equation, three problems (lack of health awareness; reliance on non-Arabic speaking workers, and illiteracy) explained 7.44 percent of the variance between the two groups (problems facing CI in Riyadh versus those in Jeddah). The other 13 problems made such a small contribution to the discriminant function, i.e., they explained less than 4.2 percent of the variance between the two groups. As a result, their retention in the discriminant equation was not justified. Each of the first three problems above the dashed line in Table (3) reduce the unexplained variance (Wilk's Lambda) by at least 1.5 percent, and the P-value for the change in Wilk's Lambda is less than 0.0126 which means that these three problems are significant in explaining the difference between the two cities.

Table (3)  
Stepwise Discriminant Analysis on Problems Facing Application  
of CI in Riyadh versus Jeddah PHC Centers.

| Steps | Problems  | Standard weight | Wilk's Lambda | Change in W.L | P-value |
|-------|---|-----------------|---------------|---------------|---------|
| 1.    | Lack of health awareness among citizens.  | 0.5128          | 0.9560        | 0.0440        | 0.0001  |
| 2.    | Reliance on non-Arabic speaking health workers.   | - 4704          | 0.9407        | 0.0153        | 0.0131  |
| 3.    | Illiteracy.   | 0.3188          | 0.9256        | 0.0151        | 0.0121  |
| 4.    | Lack of information on population, resources, and health problems.                        | 0.2108          | 0.9180        | 0.0076        | 0.0729  |
| 5.    | Hesitation to provide needed information to - health workers by many individuals.         | 0.2647          | 0.9110        | 0.0070        | .0818   |
| 6.    | Vested interests in local community such as (traditional healers and midwives) oppose CI. | 0.2918          | 0.9042        | 0.0068        | 0.0832  |
| 7.    | Desire to avoid any financial commitments or-obligations.                                 | 0.2709          | 0.8979        | 0.0118        | 0.0956  |
| 8.    |   |                 |               |               |         |
| 9.    |   |                 |               |               |         |
| 10.   |   |                 |               |               |         |
| .     |   |                 |               |               |         |
| 16.   | Reliance on the private medical sector by some individuals and families                   | -0.0192         | 0.8763        | 0.0069        | 0.8736  |

The most significant problem was the "lack of health awareness among citizens" which explained 4.4 percent of the variance and had a P-value of the change in Wilk's Lambda of less than 0.0001.

The results of the discriminant analysis indicated that the problems facing CI, as viewed by PHC centers employees in Riyadh and Jeddah are approximately the same, with some differences in the first three problems shown in Table (3), when all 16 problems are combined together.

#### ***B - Methods to Activate CI***

Sub-program "Frequencies" of the SPSS was used to obtain the frequency distributions and percentages of the proposed methods to activate CI. The results presented in Table (4), show the proposed methods by the staff in PHC centers in the two cities, and their frequencies and percentages.

In Riyadh, the first five of the proposed methods to activate CI include the following (in order of frequency and percentage):

- 1 - Intensify health education through the media (73.9%).
2. Field work by the health team to study community problems, establish their priorities, and reach solutions through discussions and consultation with community leaders (61.1%).
3. Selection of PHC staff who are scientifically capable and can communicate well with people in local communities (58.9%).

Table (4)  
Frequencies and Percentages of the Proposed Methods to  
Activate CI in Riyadh and Jeddah PHC Centers.

| Methods |  | Riyadh |      | Jeddah |      |
|---------|--|--------|------|--------|------|
|         |  | Freq   | %    | Freq   | %    |
| 1.      | Illiteracy eradication esp. among females.   | 89     | 49.4 | 103    | 56.0 |
| 2.      | Intensify health education through media.  | 133    | 73.9 | 130    | 70.7 |
| 3.      | Strengthening cooperation and coordination with local government agencies.   | 82     | 45.6 | 92     | 50.0 |
| 4.      | Home visits to encourage individuals and families to cooperate with the health team. follow-up pregnant women and immunization of children.                            | 100    | 55.6 | 109    | 59.2 |
| 5.      | Field work by the health team to study community problems, stablish their priorities. and reach solutions through discussion and consultations with community leaders. | 110    | 61.1 | 80     | 43.5 |
| 6.      | Formation of local health friends committees.  | 48     | 26.7 | 42     | 22.8 |
| 7.      | Involving community members in health activities in the center.  | 71     | 39.4 | 64     | 38.8 |
| 8.      | Offering incentives to individuals and families who participate more than others in health activities.   | 71     | 39.4 | 75     | 40.8 |
| 9.      | Selection of PHC staff who are scientifically capable and can communicate well with people in local communities.   | 106    | 58.9 | 99     | 53.8 |
| 10.     | Implementation of decentralization in PHC centers. with sufficient authority to undertake work.  | 37     | 20.6 | 43     | 23.4 |
| 11.     | Increase coverage of health services and extending services to remote areas.   | 68     | 37.8 | 85     | 46.2 |

4. Home visits to encourage individuals and families to cooperate with the health team, follow-up pregnant women, and immunization of children (55.6%).

5. Illiteracy eradication, especially among females (49.4%).

It is interesting to note that these five methods generally address the first five problems identified by PHC personnel in Riyadh (see Table 1), which indicates a high level of consistency among the respondents.

In Jeddah, the first four proposed methods are the same as those selected by Riyadh PHC personnel, though with little variation in the ordering of the methods. However, the fifth proposed method in Jeddah is: "Strengthening cooperation and coordination with local government agencies", which ranked sixth in Riyadh.

The same observation generally holds with regard to the relevance of the proposed methods in addressing the identified problems in Jeddah (see Table 2).

### Conclusion

This research investigates the problems facing community involvement in Primary Health Care Centers and the proposed methods to activate CI in two large cities of K.S.A. The results of the research suggest the following:

1. The identified problems (16 PHCCs of each city) could serve as a basis for problem solving efforts in the two cities. However, it may be advisable to undertake similar investigations to identify problems facing CI as viewed by other groups such as community members, users of services, and health officials at regional and national levels.

2. The differences between the two cities in the problems facing PHC are best explained by three problems, namely: (a) Lack of health awareness among citizens; (b) Reliance on non-Arabic speaking health workers; (c) Illiteracy. These three problems represent the discriminating variables between the two cities. Consequently, the remaining 13 problems are viewed as equally important by PHC employees in the two cities. These results should facilitate the selection of specific solutions for each city, or, general solutions that may work in both cities.

3. In the selection of methods to activate CI in PHC, the personnel in both cities exhibited a high degree of agreement on such methods. Four of the first five proposed methods which were selected by Riyadh PHC were also selected by Jeddah PHC staff. In general, the staff in both Riyadh and Jeddah PHCCs were in close agreement on none of the eleven proposed method for activating CI in PHC. They were in less agreement with regard to the following:

- (a) Field work by the health team to study community problems (61% in Riyadh and 43.5% in Jeddah).
- (b) Increase coverage of health services (37.8% in Riyadh and 46.2% in Jeddah).
- (c) Extending services to remote areas (37.8% in Riyadh and 46.2% in Jeddah).

Thus, health authorities in the two cities are advised to consider the proposed methods that were highly agreed upon by the staff in both cities. These represent common solutions to the problems facing CI in PHC and thus facilitating the design of implementation programs with joint administration, training and resource allocation.

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## المشكلات التي تعوق مشاركة المجتمع في الرعاية الصحية الأولية والحلول المقترحة في مدينتين كبيرتين بالمملكة العربية السعودية

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**المستخلص:** تستقصى هذه الدراسة المشكلات التي تواجه مشاركة المجتمع في الرعاية الصحية الأولية من وجهة نظر العاملين في المراكز الصحية بمدينتي الرياض وجدة بالمملكة العربية السعودية، وكذلك الأساليب التي يقترحونها لتنشيط تلك المشاركة وذلك من خلال نتائج البحث الميداني الشامل لموضوع مشاركة المجتمع الذي أجري خلال أعوام ١٤١٠ / ١٤١٢ هـ. وقد خلصت الدراسة إلى تحديد أهم المشكلات التي تواجه المشاركة في الرعاية الصحية الأولية في: (١) الأمية، (٢) قلة الوعي الصحي بين المواطنين، (٣) عدم الاستجابة للتعاون مع المركز الصحي بين كثير من الأفراد، (٤) التردد في تقديم المعلومات اللازمة للفريق الصحي، (٥) الاعتماد على العمالة الصحية التي لا تتكلم العربية، (٦) الاعتماد على القطاع الصحي الخاص من جانب بعض الأفراد الأسر، (٧) قلة مشاركة النساء في الأنشطة الصحية.

وفي اختبار الأساليب المناسبة لتنشيط المشاركة، اتفق العاملون في المراكز الصحية بالمدينتين في تسع من الأساليب المختارة وهي: (١) محور الأمية لاسيما بين النساء، (٢) تكييف برامج الثقافة الصحية من خلال وسائل الإعلام، (٣) دعم التعاون والتنسيق مع الإدارات الحكومية المحلية، (٤) القيام بزيارات منزلية لتشجيع الأفراد والأسر على التعاون مع الفريق الصحي ومتابعة السيدات الحوامل وتطعيم الأطفال، (٥) تكوين لجان أصدقاء الصحة على المستوى المحلي، (٦) زيادة مشاركة أعضاء المجتمع في الأنشطة الصحية للمركز، (٧) تحفيز الأفراد والأسر التي تشارك أكثر من غيرها في الأنشطة الصحية، (٨) اختيار أفراد الرعاية الصحية الأولية من بين المؤهلين علمياً والقادرين على الاتصال الجيد مع الناس في المجتمعات المحلية، (٩) تطبيق اللامركزية في مراكز الرعاية الصحية الأولية مع إعطائها السلطات الكافية لأداء العمل.

تلك النتائج قد تفيد في التخطيط لوضع هذه الأساليب موضع التنفيذ من أجل تنشيط مشاركة المجتمع في برامج الرعاية الصحية الأولية.